

# 2013

## Annual Reports and Resolutions

154th Annual Session  
New Orleans, Louisiana  
November 1–5, 2013

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American Dental Association  
211 East Chicago Avenue  
Chicago, Illinois 60611

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# Council on Access, Prevention and Interprofessional Relations

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Hebl, Monica M., 2013, Wisconsin, chair  
Thompson, W. Roy, 2014, Tennessee, vice chair  
Bruce, Daniel S., 2013, Idaho, *ex officio*\*  
Chase, Timothy D., 2014, Arkansas  
Crystal, Yasmi O., 2016, New Jersey  
Fisher, John P., 2015, Massachusetts  
Gillette, E. Jane, 2015, Montana  
Hanck, John J., 2013, Colorado  
Heddens, Heather B., 2013, Iowa  
Lang, Melanie S., 2013, Washington, American Hospital Association  
Logan, Bernadette A., 2015, Pennsylvania  
Mitchell, G. Lewis, Jr., 2016, Alabama  
Napier, Rocky L., 2014, South Carolina  
Pankratz, Todd A., 2013, Nebraska, American Medical Association  
Roberts, Matthew B., 2014, Texas  
Sabates, Cesar R., 2016, Florida  
Schirmer, David C., 2015, New York  
Soderstrom, Andrew P., 2013, California, *ad interim*  
Watson-Lowry, Cheryl D., 2016, Illinois  
Wynn, Mary Ellen, 2016, Ohio

Grover, Jane S., director  
Geiermann, Steven P., senior manager, Access, Community Oral Health Infrastructure and Capacity  
Strock, Sheila A., senior manager, Interprofessional Relations  
McGinley, Jane S., manager, Fluoridation and Preventive Health  
Smith, Barbara J., manager, Geriatrics and Special Needs  
Sweis, Luciana, project manager, Community Dental Health Coordinator (CDHC)  
Clough, Sharon R., coordinator, Preventive Health Services  
Radosevich, Amy, coordinator, Council Programs and Administrative Activities  
Campbell, Carrie, interim coordinator, Community Dental Health Coordinator (CDHC)

The Council's 2012-13 liaisons include: Dr. Jeffrey D. Dow (First District trustee, Board of Trustees), Dr. Michael Maihofer (Council on Communications) and Ms. Rebecca Warnken (American Student Dental Association).

## Mission and Purpose

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The Council on Access, Prevention and Interprofessional Relations (CAPIR) is the primary agency dedicated to providing leadership, vision and coordination of ADA's activities to advance oral health care within the health delivery system, promote prevention as the cornerstone of oral health and improve access to oral health services to underserved populations. The Council facilitates collaboration and promotes dialogue between the ADA and a broad array of communities which serve, support or impact the health care environment and delivery of oral health care. It assists members to position themselves as community leaders on oral health. The Council has assumed major responsibility in assuring that programs, policies and strategies are established to address the preventive and therapeutic oral health needs of sizable segments of the population that do not see a dentist on an annual basis.

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

In April 2012, the Council transitioned from the Division of Dental Practice and Professional Affairs to the Division of Government and Public Affairs. Its volunteer leaders, staff and consultants have expertise in epidemiology/population health, health policy, environmental health and health education/health promotion, which adds value to the work of the Council on Government Affairs, the Department of State Government Affairs and the State Public Affairs program. At approximately the same time, the Give Kids A Smile (GKAS) program responsibility was transferred from CAPIR to Corporate Relations, though CAPIR continues to offer support for GKAS as needed.

In early September 2012, Dr. Lewis Lampiris resigned as CAPIR director. Dr. Steven Geiermann served as interim director for eight months, until Dr. Jane Grover was selected as the new Council director beginning on April 15, 2013. Dr. Grover most recently served as the dental director for the Center for Family Health, a Federally Qualified Health Center in Jackson, Michigan. In addition, she is an adjunct faculty member of the University of Michigan School of Dentistry and Lutheran Medical Center of New York. She has been active in organized dentistry, first as a trustee of the Michigan Dental Association, and also on the ADA Strategic Planning Committee in the 1990s. She completed five years on the ADA Political Action Committee, serving 2003-2005 as chair. She served as vice president of the ADA from October 2006 until October 2008.

### **Supporting the Strategic Plan: Activities, Results and Accomplishments**

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*2013 National Oral Health Conference.* Having a strong organized dentistry presence with five CAPIR volunteers, representatives of 12 state dental associations and five CAPIR staff presenting made quite a positive showing for increased collaboration between the ADA and dental public health. CAPIR presented sessions addressing use of the CDHC and moving forward caries management by risk assessment, as well as multiple roundtables discussing the individual initiatives within the *Action for Dental Health* campaign. Dr. O'Loughlin, ADA executive director, spoke to the ADA's commitment to health literacy in dentistry. The ADA exhibit was prominent and attracted significant traffic. In addition, Dr. O'Loughlin was invited to observe the American Association of Public Health Dentistry annual meeting held in conjunction with the National Oral Health Conference.

Two town hall meetings of the assembled dental public health community to address Res.17-2012 elicited generalized acceptance of the compromise language brought forth by the ad hoc CDEL workgroup addressing this resolution, which was returned to CDEL by the 2012 House of Delegates. (Supports Strategic Goals 1 and 3)

*Action for Dental Health.* CAPIR continues to take the lead on developing the eight initiatives within this major Association initiative. Individual interagency workgroups meet regularly to further develop each initiative. State dental associations are encouraged to "adopt" a minimum of three initiatives each, while promoting collaboration across diverse oral health stakeholder groups to further implement these efforts and track demonstrable outcomes. (Supports Strategic Goals 1, 2 and 3)

*CAPIR-Sponsored Continuing Education Courses.* Five courses were accepted for the 2013 annual session:

- *Fluoridation: The Science and Challenges*
- *Maintaining Your Sanity & Viability as a Medicaid Provider*
- *The ABCs of FQHCs*
- *Help, I Have a One-Year Old in the Chair (charge \$20)*
- *Caries Risk in a Toxic Food Environment*

Four of these courses will be offered free of charge as they are seen as a member benefit. The Council strongly suggests that future CDE offerings include courses from Interprofessional Relations and the Geriatric and Special Needs areas. (Supports Strategic Goals 1, 2 and 3)

*Interprofessional Relations Campaign.* The ADA has the opportunity to position itself as a leader in impacting the quality of health care and interprofessional education through development of policy and by strategically collaborating with our medical colleagues. ADA staff is currently investigating how this will be designed to elevate the ADA's interprofessional collaborations to a strategic level across divisions so that key relationships provide tangible member value and benefit and improve the health of the public. (Supports Strategic Goals 1 and 3)

### **Access, Community Oral Health Infrastructure and Capacity**

*U.S. National Oral Health Alliance.* As a demonstrable outcome of the 2009 ADA-convened *Access to Dental Care Summit*, the U.S. National Oral Health Alliance continues to convene leadership colloquia addressing six access priority areas. The Alliance individual members come together to listen and learn from one another, while honoring individual dedication to innovative oral health improvement. Topics addressed include *Metrics and Oral Health*, *Financing Models for Oral Health*, and *Strengthening the Dental Care Delivery System*. Social analysis of the first four Alliance colloquia has shown that the greatest increase in collaborative networking took place among organized dentistry participants. At this point in time, there are no organizational partners within the Alliance. (Supports Strategic Goals 2 and 3)

*Health Resources and Services Administration (HRSA).* In March 2013, HRSA and ADA leaders met to discuss current and future collaboration. As a direct result of previous collaboration, the ADA, HRSA, the American Congress of Obstetricians and Gynecologists (ACOG), and the National Maternal and Child Health Oral Health Resource Center released its *National Consensus Statement on the Importance of Oral Health during Pregnancy*. Multiple venues for sharing and distribution of this information are being utilized. Current collaboration include: inappropriate use of the emergency room for oral health services, utilization of the CDHC and case management within health centers, integration of oral health into school-based health centers, and increasing familiarity between private practicing dentists and those working in health centers. (Supports Strategic Goals 1, 2 and 3)

*Medicaid Provider Advisory Committee (MPAC).* CAPIR's MPAC continues to advise the Council and the ADA on current issues affecting those dentists providing care for Medicaid-eligible individuals, including regular input on the *Action for Dental Health* initiative seeking to reduce the administrative burdens associated with Medicaid. Recent emphasis has focused on the growing number of fraud and compliance issues highlighted in the media. The ADA is coordinating efforts with the American Academy of Pediatric Dentistry (AAPD) to offer technical assistance to a New York Office of the Inspector General's (OIG) investigation of pediatric dental billing practices and access, as well as monitoring a recent Raleigh OIG audit of the North Carolina state dental Medicaid program. Representatives of both the Centers for Medicare and Medicaid Services (CMS) and the Medicaid-CHIP State Dental Association (MSDA) actively participate on this committee. (Supports Strategic Goals 1 and 3)

*Health Literacy in Dentistry:* The Institute of Medicine (IOM) Roundtable on Health Literacy "brings together leaders from academia, industry, government, foundations and associations, and representatives of patient and consumer interests who work to improve health literacy. To achieve its mission, the Roundtable discusses challenges facing health literacy practice and research, and identifies approaches to promote health literacy through mechanisms and partnerships in both the public and private sectors." The current Roundtable is comprised largely of representatives from pharmaceutical and insurance companies, and the medical field. The dental profession is currently represented by the California Dental Association, who has invested in this membership. With the realization of its five-year action plan, it is hoped that the ADA will be a viable candidate to represent the dental profession as a future member organization on the IOM Roundtable on Health Literacy.

*Medicaid-CHIP State Dental Association (MSDA).* MSDA's Center for State Medicaid and CHIP Oral Health Program Quality, Policy and Financing continues to promote policies and "Best Practice" models that improve Medicaid and CHIP oral health program quality, processes and services. CAPIR and CMS representatives actively participate on the MSDA Best Practices committee seeking to streamline the Medicaid credentialing process and encourage greater collaboration among the state dental Medicaid program, the state oral health program, and the state dental association, thus laying the groundwork for

greater advocacy. This collaboration has begun to increase the number of dentists willing to participate in state dental Medicaid programs. (Supports Strategic Goals 1 and 3)

*Increasing Collaboration Between Private Practitioners and Dentists Working Within Health Centers.* CAPIR staff provided technical assistance to state oral health coalitions in Idaho, Ohio and Vermont seeking to increase familiarity of private practicing dentists with FQHCs, medical/dental collaboration, and contracting between private dentists and health centers to increase capacity to meet the oral health needs of the underserved. CAPIR continues to provide guidance to the leadership of the National Network for Oral Health Access. (Supports Strategic Goals 1 and 3)

### **Geriatric and Special Needs**

The Long Term Care Initiative was launched to equip dentists with funding mechanisms and education necessary to facilitate delivery of dental care in nursing homes, including production of an online continuing education program, revision of a training manual into an online interactive resource, and hosting educational webinars.

This initiative promotes the *Incurred Medical Expense (IME)* reimbursement strategy to assist dentists in being reimbursed for care provided to nursing home residents eligible for Medicaid. Presentations on IME were made at the American Society of Constituent Dental Directors and ADA Lobbyists Conference, as well as the National Oral Health Conference. Guidelines and promotional materials were developed and posted online. Three webinars were held targeting ADA members, state dental directors, and the long-term care industry.

Two articles, *Prevention of Root Caries in the Vulnerable Elderly* and *Restoration of Root Caries in Vulnerable Elders*, were published through the Council's gap analysis/manuscript project in the Special Care in Dentistry Journal. This ongoing effort to encourage new and renewed interest in research relevant to the vulnerable elderly population (per Res. 5H-2006) continues with new investigations into *complications and management of xerostomia and salivary hypofunction* and *improved systemic outcomes in elderly diabetics receiving dental care* (working titles).

Five updated background manuscripts developed in conjunction with the ADA hosted *National Coalition Consensus Conference: Oral Health of Vulnerable Older Adults and Persons with Disabilities* were published as a regular issue of the *Journal of the Special Care in Dentistry Association* without cost to the ADA. These articles include a summary of the recommendations derived from the aforementioned conference. (Supports Strategic Goals 1 and 3)

### **Prevention**

*Status of Fluoridation in the United States.* Challenges to current and proposed community water fluoridation continue at an unabated rate. According to the CDC 2010 Fluoridation Census, 73.9% of all Americans on public water systems have access to fluoridated water. Sixteen communities in seven states voted to initiate community water fluoridation in 2012. Sixteen communities in 12 states voted to retain community water fluoridation in 2012, and 71 water systems in 21 states were recognized for 50 years of fluoridation in 2012.

Following two successful outcomes to challenges to existing fluoridation programs in Milwaukee and Phoenix earlier in 2012, the outcome of the November 2012 ballots was split. Voters in Pinellas County, Florida, elected two pro-fluoridation candidates to the County Commission which had voted to cease fluoridation in October 2011. With the newly elected Commissioners installed, the Commission voted to reinstate fluoridation in November 2012. Fluoridated water was returned to the approximately 700,000 individuals served by the county water system in March 2013. Despite the support of more than 500 health professionals, Wichita voters rejected fluoridation by 60% to 40% in November 2012. More recently, voters in Portland, Oregon, rejected fluoridation by the same margin. The May 2013 defeat followed a vote of unanimous support from the Portland City Council. Voters in Wichita and Portland have voted multiple times in the past to reject fluoridation.



*Fluoridation Facts* will be published following the final U.S. Department of Health and Human Services announcement regarding the level of fluoride to be used in community water fluoridation. The April 2013 acknowledgement of the importance of fluoridation by Dr. Regina Benjamin, the U.S. Surgeon General (who recently stepped down as of June 2013) was well received. The ADA Fluoridation Toolkit is available online for use by all state dental associations and state oral health programs. (Supports Strategic Goals 1, 2 and 3)

*The 2013 Prevention Summit.* Planning continues for this interdisciplinary event that will be held at ADA Headquarters from November 18-20. Serving as the convener, the ADA facilitated 11 diverse key oral health stakeholder representatives as planners to draft an agenda, develop a participant list, and invite speakers. External funding has been secured by Colgate-Palmolive Company, the DentaQuest Foundation and the California Dental Association. (Supports Strategic Goals 2 and 3)

*Fluoridation Training.* In support of the Fluoridation Initiative of the *Action for Dental Health*, the ADA held a day of fluoridation training on April 12. Twenty-eight registrants from across the country heard presentations on the science base for fluoridation, campaign strategies and tips for dealing with the media. A portion of the course will be posted to ADA365. A volunteer summarized this training opportunity best as: "This was just another example of the benefits of being a long-term ADA member." (Supports Strategic Goal 2)

### **Interprofessional Relations**

The National Roundtable for Dental Collaboration met for the fourth time from January 4-5, 2013, at ADA Headquarters. Dr. Faiella, ADA president, hosted the annual event with 21 of the 24 member organizations present. The focus was on dental education with the attendees discussing student debt, innovations in dental education, and how the profession can support dental school faculty. (Supports Strategic Goal 3)

*Smiles for Life.* In October 2012, the ADA announced its official endorsement of *Smiles for Life*, the Society of Teachers of Family Medicine's national online oral health curriculum. As a foundational element of the National Interprofessional Initiative on Oral Health, this curriculum was first released in 2005 and is available in an interactive online 3rd edition. *Smiles for Life* is the nation's most comprehensive and widely used oral health curriculum specifically designed by and for primary medical care clinicians. (Supports Strategic Goals 2 and 3)

*Collaborative Efforts.* ADA volunteers and staff continue on-going relationships with The Joint Commission (TJC), the Accreditation Association for Ambulatory Healthcare (AAAHC) and the Organization for Safety, Asepsis and Prevention (OSAP) to monitor issues of interest in patient safety, quality initiatives and infection control practices. CAPIR staff will present at the OSAP annual symposium in June 2013 on the culture of safety in oral healthcare, which is timely considering recent infection control events in Oklahoma. (Supports Strategic Goals 1 and 3)

### **Community Dental Health Coordinator**

*Community Dental Health Coordinator (CDHC) Pilot Program.* Thirty-four CDHCs completed the pilot program training and are working in seven states across the nation. Preliminary evaluation results have been published in a *Breaking Down Barriers* white paper with subsequent case study development and pilot evaluation ongoing. A supplemental report regarding the CDHC pilot program will be prepared for the 2013 House of Delegates.

*Community Dental Health Coordinator Demonstration.* New Mexico, the only state that currently recognizes the CDHC in its dental practice act, as yet, has no training programs, nor CDHCs employed in the state. Starting in May 2013, a CDHC from Pennsylvania began a four-month sabbatical at the Hidalgo Medical Services, a Federally Qualified Health Center in New Mexico, where she will demonstrate her knowledge and skills gained through the CDHC training program. She will work with local community health workers and clinical staff to develop outreach programs and improve access to oral health care

through patient navigation. In addition, she will promote oral health through education and deliver preventive services. Hopefully, this will pave the way for future CDHCs in the state, as a local community college is investigating adding this educational opportunity. (Supports Strategic Goal 1)

### **Emerging Issues, Priorities and Trends**

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- Efforts are underway to integrate existing state dental association efforts into the *Action for Dental Health* campaign, such as the state oral health coalition building efforts required of the multiple state grantees funded by the DentaQuest Foundation's *Oral Health 2014* program and the CDC's state oral health infrastructure grants.
- There is interest beyond organized dentistry to better understand the rising trend in use of the emergency department for preventable non-traumatic dental problems and a willingness to find collaborative community-based solutions.
- Dentistry continues to be cast in a negative light by the media due to the growing number of fraud and compliance allegations with dental Medicaid. This challenge could lessen public trust in dentists and has already made it more difficult to recruit and/or retain dentists as Medicaid providers.
- Though ADA councils and volunteers are becoming more mindful of the importance of medical/dental collaboration, there is a need to increase awareness about the potential benefits of this type of collaboration with the general membership. This will be the primary focus for the Interprofessional Relations campaign of the ADA, including the importance of health literacy in dentistry.
- Despite decades of community water fluoridation use and acknowledgment of its benefits, there continues to be an increase in the challenges to existing and proposed fluoridation efforts. The anticipated U.S. Department of Health and Human Services' final recommendation on fluoride levels to be used in fluoridation, due to be released in 2013, will be used by pro-fluoridation and anti-fluoridation factions alike to support their positions and will most likely increase fluoridation initiation efforts and challenges in the next several years.
- Among the membership, there continues to be a perception that dental public health is something "other" than an integral component of organized dentistry. Dental public health professionals should be encouraged to participate fully and accept leadership positions within component and constituent societies.
- The need to improve access to oral health services for the increasingly dentate vulnerable elderly population continues to be critical. In addition, preplanning necessary to move currently insured adults to an uninsured status post-retirement is also receiving increased attention.
- Due to increased marketing efforts by tobacco companies, there has been an increased use of spit tobacco products by adolescents. In addition to the harm caused by smokeless tobacco use, it can also lead to nicotine addiction and subsequent cigarette smoking.

### **Responses to House of Delegates Resolutions**

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The Council will report on the status of Resolutions 105-2012 and 106-2012 in a supplemental report to the House.

### **Policy Review**

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In accordance with Resolution 111H-2010, Regular Comprehensive Policy Review, and Resolution 170H-2012, the Council will submit a supplemental report to the 2013 House of Delegates.

### **Summary of Resolutions**

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This report is informational and no resolutions are presented.

## **Council Minutes**

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For more information on recent activities, see the Council's minutes on ADA.org:  
<https://www.ada.org/members/1293.aspx#relations>.

# Council on ADA Sessions

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Blicher, Michael M., 2013, Washington, DC, chair  
Barsley, Robert E., 2013, Louisiana, *ex officio*  
Bertagni, Hugo F., 2013, Illinois  
Cohen, Barry I., 2015, Pennsylvania  
Curcuro, Grace A., 2016, Michigan  
Foster, James R., 2014, Texas  
Galati, James E., 2014, New York  
Lancaster, T. Harold, 2016, North Carolina  
Lee, William E., 2013, Kentucky  
Lum, Calbert, M., 2016, Hawaii  
Martin, Rise L., 2014, Texas, *ex officio*  
Parker, Steven E., 2015, Ohio  
Peppes, Gregory J., 2013, Kansas  
Pietrasik, John P., 2014, Massachusetts  
Roesch, Robert E., 2015, Nebraska  
Samy, S. Shane, 2014, Oregon  
Schwab, Brian M., 2013, Pennsylvania, *ex officio*\*  
Torgerson, Neil E., 2015, Florida  
Tourial, Sidney R., 2016, Georgia  
Van Sicklen, Jr., James H., 2016, California

Mills, Catherine H., director  
Wilkins, Glynis P., coordinator

The Council's 2012-13 liaisons included: Dr. Joseph P. Crowley (Seventh District trustee, Board of Trustees) and Mr. Scott B. Levitz (American Student Dental Association).

## Mission and Purpose

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To create a world-class dental experience that incorporates value, innovation, and diversity of attendees and location, to the benefit of the entire dental community.

## Supporting the Strategic Plan: Activities, Results and Accomplishments

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In October 2012, the Council on ADA Sessions finalized a strategic plan in order to fulfill the council's above mission statement.

- Make the ADA annual session the first meeting the professional dental community and exhibitors select for participation.
- Attract new and diverse attendees and create brand loyalty among current and new attendees, as well as exhibitors.
- Add value to our membership by maintaining a profitable meeting to drive future success and yearly expansion, increasing the perceived benefits of ADA membership.

Tactics and quantifiable measures for these goals were put into place in October 2012. One of the tactics of achieving the first two goals has been approached by gathering both quantifiable and qualitative data on members who both attend and don't attend the annual session. The results of the "Experience Design Project" are enabling the Council to create unique marketing strategies and experiences to engage attendees at all touch points—pre-meeting, onsite, post-meeting and year-round.

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

These marketing and experience strategies will be rolled out in 2013, 2014 and 2015, and include a rebranding of the annual session which will be “revealed” during the 2013 annual session.

### 153rd Annual Session, San Francisco, California, October 18–21, 2012

The ADA’s 153rd Annual Session was held at the Moscone Convention Center under the direction of the Council on ADA Sessions. Total actual registration for the meeting was 35,074 attendees. There were 10,860 dentists and 10,565 professional staff at the meeting, totaling 61% of all meeting registrants. The ADA Marketplace featured 1,465 booths from more than 600 companies during a three-day exhibition period.

<b>Table 1. 2012 Annual Session Financial Overview*</b>	
<i>Revenue</i>	
Exhibit	\$6,901,498
Registration	\$1,626,958
Sponsorship/Advertising	\$952,923
CE Tickets	\$1,338,330
Housing Rebate	\$735,198
Other	\$76,875
<i>Gross Revenue</i>	\$11,631,782
<i>Total Expenses</i>	\$7,358,836
<i>Net Revenue</i>	\$4,272,946
<i>*All figures above are unofficial and unaudited.</i>	

### Emerging Issues and Trends

Overall attendance at the annual session has been making a slow recovery since 2008 and the economic downturn. Attendance numbers have been below the ADA’s 10-year average (*excluding San Francisco in 2003 and 2007 as the California Dental Association does not hold their fall meeting in San Francisco when the ADA rotates to that city—therefore, inflating numbers every time the ADA is there*). Exhibit space and sponsorship have also not recovered to pre-2009 levels. Dental exhibitors are buying smaller space on the floor and also being more selective in the meetings they attend and sponsor. Despite these trends, the annual session has made more money per attendee than it has in the past due to: negotiations with vendors, strict management of controlling expenses, and changes to the structure of pricing for continuing education courses to increase ticket sales revenue.

### Summary of Resolutions

This report is informational and no resolutions are presented.

### Council Minutes

For more information on recent activities, see the Council’s minutes on ADA.org:  
<https://www.ada.org/members/1293.aspx#sessions>.

# Council on Communications

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Shenkin, Jonathan D., 2013, Maine, chair  
Hewett, Sally J., 2014, Washington, vice chair  
Austin, Joshua A., 2016, Texas  
Boghosian, Alice G., 2015, Illinois  
Campbell, Jeffrey A., 2014, Ohio  
Chesser, William E., 2014, Alabama  
Howell, Ralph L., 2016, Virginia  
Jenkins, James F., 2014, Nebraska  
Johnson, J. Michael, 2013, Kentucky  
Jones, Krista M., 2013, Oklahoma  
Maihofer, Michael G., 2015, Michigan  
Manzanares, Robert J., 2016, New Mexico  
Maupin, Heather A., 2013, Indiana *ex officio*\*  
Nase, John B., 2013, Pennsylvania  
Patel, Minerva, 2015, New York  
Paul, John H., 2016, Florida  
Sahota, Ruchi K., 2016, California  
Shepley, George R., 2015, Maryland

MacLachlan, Janine, director  
Cebula, Marcia, coordinator

The Council's 2012-13 liaisons include: Dr. Roger L. Kiesling (Eleventh District trustee, Board of Trustees) and Ms. Jaclyn Rivera (American Student Dental Association).

## Mission and Purpose

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The Council on Communications 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. Further, this Council advises the Association regarding integrated and strategic communications plans and policies between itself, the public, members and the profession.

## Supporting the Strategic Plan: Activities, Results and Accomplishments

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### Initiative to Enhance the Image and Advance the Reputation and Brand of the ADA

Given an increase in media attention and reputational risk to the ADA and the dental profession on an array of issues, the Council on Communications (CC) submitted a resolution to the House of Delegates to fund a national communications initiative to enhance the ADA image and advance its reputation and brand. Resolution 75H-2012 was adopted by the 2012 House of Delegates, and Dr. Robert Faiella appointed a workgroup of volunteers and staff to select a public relations agency. The workgroup included CC Chair Dr. Jonathan Shenkin, Vice Chair Dr. Sally Hewett and Board liaison Dr. Roger Kiesling, as well as Board of Trustees member Dr. Carol Summerhays, Dr. Henry Fields of the Council on Government Affairs (CGA), and staff from communications and government affairs. The workgroup selected [FleishmanHillard, Inc.](#) ADA and Fleishman staff participated in workgroups to develop the infrastructure of the initiative. The overarching presentation theme of "Progress Through Prevention" will be supported by three pillars: Science of Dentistry, which will promote awareness of oral health topics; MouthHealthy, to drive coverage and traffic to the ADA's consumer-facing website; and *Action for Dental Health: Dentists Making a Difference*, the ADA's initiative to offer up a suite of solutions to the complex challenges of providing quality oral care to all Americans. *Action for Dental Health* is discussed further in this report.

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

### **Action for Dental Health: Dentists Making a Difference**

To maintain a more focused articulation of the ADA as America's leading advocate for oral health, the *Action for Dental Health* presents a suite of tangible, affordable and measurable solutions to address the access issue. The program was launched in May in Washington, DC, in tandem with the Washington Leadership Conference, and was attended by journalists as well as representatives from allied organizations and ADA leadership. *Action for Dental Health* strives to target the "dental divide" via three key areas: 1) Provide care now to people suffering with untreated disease, 2) Strengthen and expand the public/private safety net to provide more care to more Americans, and 3) Bring dental health education and disease prevention into communities. Specific programs include: increasing community water fluoridation, emergency room interception, nursing home care, Give Kids A Smile expansion, placing private-practice dentists in Federally Qualified Health Centers, work to simplify Medicaid and increase Medicaid dental coverage, and increasing the number of Community Dental Health Coordinators (CDHCs). The Council will report further on program results in its supplemental report following its June Council meeting.

### **Subcommittee on Social and Digital Media**

The Council's subcommittee advises on implementation of the Social Media Strategic Plan, including planning for long-term expansion across the Association. This year the subcommittee completed the development, review and publication of the *ADA Practical Guide to Social Media Planning, First Edition*, published as an e-book in October 2012 and subsequently made available in a print version. Both versions are offered for sale in the ADA online store. The guide is designed to help dentists determine how they can best use social media to further their professional reputations and make their practices more accessible online. The subcommittee also developed the ADA Social Media Posting Protocol and the ADA Social Media Code of Conduct, which were adopted by the Board of Trustees at its March meeting. These documents are designed to ensure that the ADA is prepared to manage its reputation in the social media space. These guidelines led to the opening of the ADA Facebook wall, thereby promoting open engagement with ADA core audiences, resulting in an increase of Facebook followers to 30,104, an increase of 16% since December 2012.

Subcommittee members include Dr. John Nase, chair; Dr. Joshua Austin; Dr. Jeffrey Campbell; Dr. James Jenkins; Dr. Heather Maupin; Dr. Minerva Patel; Dr. John Paul and Dr. Ruchi Sahota.

### **Reputation Management Advisory Subcommittee**

Due to the ongoing and essential nature of the work of this group, the CC voted in January 2013 to transition it from a workgroup to a subcommittee. The subcommittee, through the Council on Communications, serves as an advisory body to the Association and its agencies by providing strategic communications insight and recommendations related to the reputational implications of its plans, programs, services and activities.

The ADA Issues Management Plan, which was developed by the subcommittee and adopted by the Board of Trustees at its September 2012 meeting, is intended to address known, emerging and potential issues in order to protect and promote the reputation and brand of the Association and the profession. The Issues Management Plan has been provided as a guiding document to the national public relations agency as have the ADA Strategic Plan goals.

An online issues management resource toolkit entitled "Fluoridation: Tap In To Your Health" was developed in 2012 for use by dental societies and local coalitions in support of the ADA Issues Management Plan. The toolkit includes resource materials, including infrastructure development tools, guidelines for successful coalitions, and the publication Fluoridation Facts in a free downloadable format. The next issues management toolkit will focus on dental amalgam because this is a long-term core issue for the Association. Along with the Subcommittee, Communications staff will work with staff in the divisions of Science and State Government Affairs to develop content for the kit.

Subcommittee members include Dr. Jeffrey Campbell, chair; Dr. Alice Boghosian; Dr. Ralph Howell; Dr. Michael Maihofer; Ms. Jaclyn Rivera and Dr. Jonathan Shenkin.

### **Advocacy Communications Subcommittee**

Due to the ongoing and essential nature of the work of this group, the CC voted in January 2013 to transition it from a workgroup to a subcommittee. The subcommittee offers guidance on the ADA's overall communications with regards to issues involving access to oral health for underserved populations, the legislative and regulatory aspects of such risk issues as water fluoridation and dental amalgam, government financing of dental care, the *Action for Dental Health* program and other issues involving public policy. The group also provides input into the "Breaking Down Barriers to Oral Health for All Americans" series of papers. A paper about the Community Dental Health Coordinator was released in November 2012.

Subcommittee members include Dr. J. Michael Johnson, chair; Dr. William Chesser; Dr. Sally Hewett; Dr. Ralph Howell; Dr. Krista Jones; Dr. Robert Manzanarez; Dr. Jonathan Shenkin and Dr. George Shepley.

### **Brand Management Workgroup**

The purpose of the Brand Management Workgroup is 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. The workgroup provided oversight on the development of the consumer facing website, [MouthHealthy.org](http://MouthHealthy.org), which launched in June 2012. The MouthHealthy Symptom Checker application launched in January 2012, and MouthHealthy is now available as a mobile app. MouthHealthy.org won a bronze award in the Association TRENDS 2012 All-Media Contest in the website category. The workgroup will also provide oversight into the reorganization and redesign of ADA.org scheduled to be completed by the end of 2013.

Subcommittee members include Dr. Williams Chesser, chair; Dr. Sally Hewett; Dr. James Jenkins; Dr. J. Michael Johnson; Dr. Ruchi Sahota and Dr. Jonathan Shenkin.

### **MouthHealthy.org Business Plan**

MouthHealthy presents an opportunity to generate non-dues revenue by offering advertising and sponsorships to marketers both within the dental products category and those unrelated to oral care. Advertising sales have had a slow start, however, because the ad server was initiated in November, later than expected. No revenue budget adjustments have been recommended at this time due to the proposals under consideration by major advertisers. Preliminary conversations with ADA Seal of Acceptance manufacturers about opportunities on MouthHealthy.org have been positive, and there is interest from four major manufactures so far.

### **Ad Council Public Service Campaign on Children's Oral Health**

The ADA has played a lead role in the [Partnership for Healthy Mouths Healthy Lives](http://Partnership for Healthy Mouths Healthy Lives), a coalition of 35 dental and health-related organizations, which worked with the Ad Council to develop a three-year national public service campaign to improve children's oral health. In 2012, the campaign included 3,700 public service television airings in 124 markets, with more to come as the program advances. The key message is that parents should have their children brush their teeth for two minutes, two times a day. The 2min2x message is delivered in all elements of the program. The Ad Council, with significant input from the ADA, created the [2min2x.org](http://2min2x.org) website as a robust source of information for parents and children. It contains 30-second public service announcements as well as downloadable two-minute videos for children to play as they brush their teeth. In April 2013, the ADA participated in a Twitter chat with campaign spokesperson Laila Ali about 2min2x, which generated 294 tweets and more than 191,000 impressions. A benchmark survey was conducted among the target audience prior to the campaign launch. The Ad Council will conduct a post wave survey nine to 12 months following the launch to measure the impact and gauge shifts in key attitudes and behaviors. Key indicators include increases in children brushing and duration of brushing, as well as reported parental oversight and monitoring of daily brushing behavior.



### **Targeted Consumer Outreach**

In October 2012, the ADA collaborated with PopCap Games for a campaign called [Stop Zombie Mouth](#) to promote alternative treats for Halloween. More than 20,000 sets of trading cards were distributed through 5,000 member dentists, each set with a free download of the popular computer game Plants v Zombies. A two-minute video is posted on 2min2x.org as well as on MouthHealthy and YouTube. The initiative was supported with a television tour featuring pediatric spokesperson Dr. Jonathan Shenkin, as well as additional media relations. Coverage included 382 media stories with an audience of more than 152 million.

In May 2013, the ADA participated in a Twitter chat with social media community Mom It Forward on the topic of oral health and pregnancy. Spokesperson Dr. Ruchi Sahota tweeted content and answered questions with 267 participants, surpassing the expected 150-200 participants. A total of 2,160 tweets garnered a reach of 554,187, a number that reflects the number of followers reached by the participants. These results are considered a great success because all metrics surpassed expectations.

### **Give Kids A Smile**

[Give Kids A Smile](#) (GKAS) is an ADA signature program where volunteer dentists and their teams provide care to large numbers of underserved children. For the third year, in tandem with GKAS sponsor 3M, Give Kids A Smile is working with NASCAR driver Greg Biffle of the 3M car to drive awareness for oral health and GKAS, now expanded to 11 races throughout the season. Mr. Biffle appears in a public service announcement for broadcast, and will sport the GKAS logo on his car and jersey during the race weekend of June 16, 2013, in Michigan. In addition, the program features two screening events and two educational events at elementary schools. At each race weekend, oral health information kits are distributed to children outside the track, including donated Thomas the Tank Engine toothbrushes from Arm & Hammer, toothpaste and floss from Colgate, and instructions on how to brush effectively. Council member Dr. Minerva Patel serves on the Give Kids A Smile advisory committee.

### **Responses to House of Delegates Resolutions**

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As discussed earlier in this report, the Council provides volunteer oversight to the public relations agency hired following the adoption of Resolution 75H-2012.

### **Policy Review**

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In accordance with Resolution 111H-2010, Regular Comprehensive Policy Review, and Resolution 170H-2012, the Council on Communications is in the process of reviewing assigned policies and will present recommendations in its 2013 supplemental report.

### **Summary of Resolutions**

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This report is informational and no resolutions are presented.

### **Council Minutes**

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For more information on recent activities, see the Council's minutes on <https://www.ada.org/members/1293.aspx#communications>.

# Commission on Dental Accreditation

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Knoernschild, Kent L., 2013, Illinois, chair, American College of Prosthodontists  
Messura, Judith, 2013, North Carolina, vice chair, American Association of Hospital Dentists and American Dental Education Association  
Benson, Byron, 2015, Texas, American Academy of Oral and Maxillofacial Radiology  
Biermann, Michael E., 2013, Oregon, American Dental Association  
Burr, Kristi, 2014, Ohio, Public Member  
Cangialosi, Thomas, 2015, New Jersey, American Association of Orthodontists  
Carlson, Eric R., 2013, Tennessee, American Association of Oral and Maxillofacial Surgeons  
Curran, Elizabeth, 2013, Arizona, National Association of Dental Laboratories  
DiFranco, Geri Ann, 2013, Illinois, American Association of Dental Boards  
Dodge, William, 2015, Texas, American Dental Education Association  
Donly, Kevin, 2015, Texas, American Association of Pediatric Dentists  
Eliason, Joseph, 2013, California, American Student Dental Association and American Dental Education Association  
Gagliardi, Lorraine, 2016, California, American Dental Assistants Association  
Giasolli, Robert, 2014, California, Public Member  
Glicksman, Milton, 2016, Massachusetts, American Association of Dental Boards  
Greenwell, Henry, 2014, Kentucky, American Academy of Periodontology  
Hardesty, W. Stan, 2015, North Carolina, American Association of Dental Boards  
Kahn, Richard, 2016, New Jersey, American Dental Association  
Leffler, William, 2014, Ohio, American Association of Dental Boards  
Mascarenhas, Ana Karina, 2016, Florida, American Association of Public Health Dentistry  
Neville, Brad Wesley, 2014, South Carolina, American Academy of Oral and Maxillofacial Pathology  
Rivera-Nazario, Yilda, 2013, Puerto Rico, American Dental Education Association  
Royeen, Charlotte, 2015, Missouri, Public Member  
Schindler, William, 2016, Texas, American Association of Endodontists  
Schonfeld, Steven E., 2014, California, American Dental Association  
Shepherd, Kathi, 2015, Michigan, American Dental Hygienists Association  
Sherrard, James, 2015, Connecticut, Public Member  
Tuneberg, Perry K., 2015, Illinois, American Dental Association  
West, Karen, 2016, Nevada, American Dental Education Association  
Williams, John N., 2014, Indiana, American Dental Education Association

Tooks, Sherin, director  
Bauman, Catherine, manager, Advanced Specialty Education  
Horan, Catherine, manager, Predoctoral Dental Education  
Snow, Jennifer, manager, Advanced Specialty Education  
Soeldner, Peggy, manager, Postdoctoral General Dentistry Education  
Renfrow, Patrice, manager, Allied Dental Education

The Commission's 2012-2013 Board of Trustees liaisons included: Dr. Maxine Feinberg (Fourth District trustee) and Dr. Dennis Engel (Ninth District trustee). Dr. W. Stan Hardesty resigned as of February 20, 2013.

## Mission and Purpose

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The Commission on Dental Accreditation serves the oral health care needs of the public through the development and administration of standards that foster continuous quality improvement of dental and dental related educational programs.

## Supporting the Strategic Plan: Activities, Results and Accomplishments

### Summary of Accreditation Actions

The Commission's accreditation actions from August 2012 through February 2013 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 that detailed the degree to which specific recommendations included in previous evaluation reports had been implemented. In addition, other actions (report of program change, change in sponsorship, authorized enrollment requests, etc.) were taken at the August 2012 and February 2013 meetings, for a total of 536 accreditation actions.

Applications for initial accreditation of education programs were reviewed. During this time, two predoctoral dental education programs, one advanced education in general dentistry, two advanced education in general practice residency, four advanced general dentistry in orofacial pain, one oral and maxillofacial pathology, one oral and maxillofacial radiology, one prosthodontic, one pediatric dentistry, one clinical fellowship in oral and maxillofacial surgery (oncology), one clinical fellowship in craniofacial and special care orthodontics, and two dental assisting programs were granted the accreditation status of "Initial Accreditation." As indicated in Table 2, the total number of educational programs accredited is 1,453. This represents an increase of four programs from the previous reporting period. Of the 1,453 accredited programs, 57 (3.9%) hold the status of "Initial Accreditation," and 1,337 programs (92.0%) are in compliance with all requirements and have been awarded "Approval *Without* Reporting Requirements." During this reporting period, 59 programs (4.0%) were found to have deficiencies or areas of noncompliance and hold the status of "Approval *With* Reporting Requirements." Each of the 59 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 eight complaints against programs during this time.

During this reporting period, one dental assisting education program had accreditation withdrawn. As 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, 14 programs voluntarily discontinued their participation in the Commission's accreditation program.

**Table 1. Selected Accreditation Actions: Two Meetings—August 2012 and February 2013**

	Dental	Specialty	Advanced General Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Initial Accreditation Granted	2	5	4	0	3	0	14
Initial Accreditation—Continuing	3	6	4	2	0	0	15
Approval Without Reporting Requirements	23	137	85	59	75	2	381
Approval With Reporting Requirements	2	16	12	32	29	3	94
Accreditation Denied	0	0	0	0	0	0	0
Discontinued Programs	0	2	1	10	1	0	14
Intent to Withdraw	0	0	0	10	7	0	17
Accreditation Withdrawn	0	0	0	1	0	0	1
Decision Appealed	0	0	0	0	0	0	0
Number of Accreditation Actions	30	166	106	114	115	5	536

**Table 2. Total Number of Accredited Programs as of February 2013**

	Dental	Specialty	Advanced General Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Initial Accreditation	7	19	11	5	15	0	57
Approval Without Reporting Requirements	56	433	281	249	300	18	1,337
Approval With Reporting Requirements	1	7	8	22	20	1	59
Number of Accredited Programs	64	459	300	276	335	19	1,453

**Proposed Revised Standards**

The Commission directed the following proposed revisions to Accreditation Standards be circulated to the communities of interest for comment:

- Accreditation Standards for Dental Laboratory Technology Education Programs, for circulation to the communities of interest until June 1, 2013, for consideration at the August 2013 meeting of the Commission;
- Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Radiology, for circulation to the communities of interest until June 1, 2013, for consideration at the August 2013 meeting of the Commission;
- Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics, for circulation to the communities of interest until June 1, 2013, for consideration at the August 2013 meeting of the Commission;
- Accreditation Standards for Advanced Education in General Dentistry, for circulation to the communities of interest until December 1, 2013, for consideration at the January 2014 meeting of the Commission;
- Accreditation Standards for Advanced Education in General Practice Residency, for circulation to the communities of interest until December 1, 2013, for consideration at the January 2014 meeting of the Commission; and
- Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery Education (Standards 2-1.3, 4-3, 4-9, and definitions for "month" and "Board Certification") for circulation to the communities of interest until December 1, 2013, for consideration at the January 2014 meeting of the Commission.

**Adoption of Accreditation Standards**

The Commission adopted revisions to the following Accreditation Standards:

- Dental Assisting Education Programs standards 4-3 and 4-6, with immediate implementation;
- Dental Hygiene Education Programs standards 3-7 and 3-8, for implementation on January 1, 2013;
- Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery (Pediatric Craniomaxillofacial Surgery) standard 6-4.2, with immediate implementation;
- Accreditation Standards for Advanced General Dentistry Education Programs in Dental Anesthesiology, with implementation July 1, 2015;
- Accreditation Standards for Dental Assisting Education Programs, with implementation January 1, 2014;
- Accreditation Standards for Advanced Specialty Education Programs in Dental Public Health, with implementation January 1, 2014;

- Accreditation Standards for Advanced Specialty Education Programs in Endodontics, with implementation January 1, 2014;
- Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Pathology, with implementation January 1, 2014;
- Accreditation Standards for Advanced Specialty Education Programs in Orthodontics and Dentofacial Orthopedics, with implementation January 1, 2014;
- Accreditation Standards for Advanced Specialty Education Programs in Periodontics, with implementation January 1, 2014; and
- Standard 5, Eligibility and Selection, of the Common Standards for the Dental Specialty Education Programs, with implementation as the specialty standards are revised.

### **Oral Medicine Accreditation Standards**

The Commission initiated the Validity and Reliability Study of the Accreditation Standards for Advanced General Dentistry Education Programs in Oral Medicine in spring 2012. Data were collected and reviewed at the winter 2013 Commission meeting. Due to the amount of data received, and to ensure careful, thorough review, the Commission determined continued review at the summer 2013 meeting was warranted. A final report may be presented at the summer 2013 Commission meeting.

### **Dental Therapy Accreditation Standards**

The Commission's Task Force on Development of Accreditation Standards for Dental Therapy Education Programs conducted a thorough review of dental therapy programs currently in operation or under development, noting that several states were reviewing legislation on the dental therapy scope of practice. The task force discussed pathways of education and believed that dental therapy education should consist of three academic years of full-time instruction resulting in a baccalaureate degree. The task force proposed a set of standards as a non-dental hygiene track; however, the task force noted modification to a dental hygiene track could be made. Further, the framework for the standards was based on the assumption that the dental therapist would work under the supervision of a licensed dentist. The Commission accepted the proposed Accreditation Standards and directed circulation for comment from the communities of interest through December 1, 2013. An open hearing was conducted at the American Dental Education Association annual session in March 2013; additional hearings will be scheduled during the American Dental Hygienists' Association, American Dental Assistants Association, and American Dental Association annual sessions in 2013. The Commission will not implement the Accreditation Standards until documentation is presented that criteria #2 and #5 of the Principles and Criteria Eligibility of Allied Dental Programs for Accreditation by the Commission on Dental Accreditation are met. The proposed standards are found on the Commission's website at: <http://www.ada.org/117.aspx#Comments due>.

### **United States Department of Education Renewal of Recognition**

The United States Department of Education (USDE) recognition process ensures the agencies and associations included on the USDE list are those determined to be the reliable authorities in evaluating the quality of education offered by educational institutions or programs. The Commission on Dental Accreditation is the only nationally recognized accrediting agency for dental and dental-related education programs and has been recognized continuously by the USDE since 1952. In order for institutions to become eligible for federal funds, the Commission on Dental Accreditation must be recognized by the USDE. The Commission's scope of recognition is for "the accreditation of predoctoral dental education programs (leading to the D.D.S. or D.M.D. degree), advanced dental education programs, and allied dental education programs that are fully operational or have attained the 'Initial Accreditation' status, and for its accreditation of programs offered via distance education." The Commission initiated its most recent application for renewal of its listing by the USDE in June 2011. The Commission submitted its renewal report on January 9, 2012, and was reviewed at the June 2012 meeting of the National Advisory Committee on Institutional Quality and Integrity (NACIQI). At the June 2012 NACIQI meeting, the Commission was granted renewal and requested to submit a progress report on three outstanding criteria. In January 2013, the Commission submitted a progress report on the three outstanding criteria

and on March 25, 2013, the USDE Staff Report noted that the Commission's progress report provided sufficient evidence of compliance and a recommendation for renewal for a period of four years; no further concerns were noted. The Commission's progress report and USDE Staff report will be considered at the June 2013 meeting of the NACIQI.

### **Revised Policies**

The Commission adopted the following revised policies:

- *Policy on Criteria for Selection of Site Visitors for Advanced Specialty Education*, requiring that candidates recommended to serve as consultants/site visitors be board certified and/or have completed or participated in a CODA-accredited specialty education program, with immediate implementation.
- *Policy on Third Party Comments*, requiring programs with the status of initial accreditation and programs seeking initial accreditation to solicit comment through appropriate notification of communities of interest and the public such as faculty, students, program administrators, Commission consultants, specialty and dental-related organizations, patients, and/or consumers, with an immediate implementation.
- *A new Policy on Requests for Email Distribution Lists*, with immediate implementation, to guide staff in responding to these requests.
- *Policy on Visiting Committee Members*, removing the word "possible" in the introduction of the list of conflicts of interest for visiting committee members.
- *Policy on Simultaneous Service*, including standing and review committee members in the simultaneous service policy.
- *Policy on Silent Observers on Site Visits*, clarification of the "silent" role of observers who are from another dental education program on site visits.
- *Policy on Review Committee Structure*, clarification that at least two nominees must be submitted for consideration and clarification that the member may serve multiple terms on the same or different committee with one year waiting period between terms for a maximum of two terms total served.
- *Policy on Required Record of Complaints*, revision based on U.S. Department of Education requirement that the program maintain a record of all student complaints and that the record of complaints be reviewed during a site visit.
- *Policy on Selection Criteria for Appeal Board Members*, clarification that discipline-specific appeal board members may be program directors, faculty, or practitioners.
- *Policy on Off-Campus Sites*, with development of a supplemental Guideline document, providing further clarification on categories of off-campus sites and how sites must be reported to the Commission.

### **Quality Assurance and Strategic Planning**

The Commission continues to develop a Memorandum of Understanding between the Commission and the American Dental Association outlining agreed upon duties and expectations of each party. Additionally, the Commission is gathering information for a white paper, comparative analysis, workforce study and professional development plan, and technology needs assessment to inform the agency's prospective operational budget plan and strategic plan.

### **Accreditation Fees**

The Commission directed an increase in the 2014 accreditation fees assessed to programs in an effort to ensure greater fiscal responsibility within the Commission. The increase in 2014 fees will allow the Commission to assume a greater portion of direct and indirect expenses associated with its accreditation program. The Commission approved an increase in 2014 annual accreditation fees to \$6,000 for predoctoral programs; \$1,500 for dental assisting, dental hygiene and oral and maxillofacial surgery programs; \$1,050 for dental laboratory technology programs; and \$1,000 for all advanced education programs except oral and maxillofacial surgery. The Commission also approved a policy to be

implemented in 2014 to double annual fees in the year in which a program's regular accreditation site visit is scheduled. The Commission approved an increase in application fees for 2014 to \$50,000 for predoctoral programs and \$15,000 for all other programs. The Commission approved an increase in the administrative fee for special focused site visits to \$4,000, effective immediately.

## **Joint Advisory Committee on International Accreditation (JACIA) Activities**

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### **Mission and Purpose**

The joint committee of the American Dental Association and the Commission on Dental Accreditation provides guidance to the Commission in the selection, development and implementation of a program of consultation and accreditation for international, predoctoral dental education programs.

Members of the JACIA include Dr. Roger Kiesling, chair; Dr. Steven Bruce, ADA; Dr. Gary Herman, ADA; Dr. Yilda Rivera-Nazario, CODA; and Dr. Karen West, CODA. The ADA president, Dr. Robert Faiella, and the CODA chair, Dr. Kent Knoernschild, serve as *ex officio* members of this committee. Dr. Michael Reed serves as a consultant to the JACIA, with staff support provided by Dr. Catherine Horan, manager, predoctoral dental education, and Dr. Sherin Took, director, CODA.

### **Background**

Since January 1, 2007, the JACIA has accepted initial applications (Preliminary Accreditation Consultation Visit-PACV surveys) from international, predoctoral programs that are interested in the Commission's accreditation program. The JACIA has met regularly since 2007 to review applications from international programs, review and update policies and procedures, and monitor budgetary matters, including revision of international accreditation fees. Ten international programs have submitted PACV surveys since 2007. Following review and discussion, JACIA approved all of the programs to attend a U.S. comprehensive visit and submit a PACV self-study.

Since 2009, five international programs have submitted a PACV self-study and have requested a PACV site visit. One program in Lima, Peru, did not provide sufficient information to warrant a PACV site visit. Three programs (Dharwad, India; Jeddah, Saudi Arabia and Monterrey, Mexico) provided sufficient documentation and received a comprehensive PACV site visit. Staff were directed to make arrangements for a committee of dental professionals with experience in dental education in the United States and/or who have served as site visitors to predoctoral programs to complete a consultation visit to the schools. One program, Yeditepe University, Faculty of Dentistry, Istanbul, Turkey, submitted the PACV self-study on January 22, 2013, and will be reviewed by JACIA in 2013.

No international predoctoral dental education programs have been accredited by the Commission on Dental Accreditation at this time.

### **Activities, Results and Accomplishments**

The following is a summary of the activities, results and accomplishments of recent meetings of the JACIA:

- The JACIA considered a request for a second extension, from January 1, 2013 (granted May 13, 2011) to June 1, 2013, to submit the self-study PACV for Yonsei University College of Dentistry, Seoul, Korea. The reason for the request was to afford the program additional time to translate the documents to English. After careful review, the JACIA approved the extension.
- The JACIA was informed of recent interest from international programs in Chile (the Finis Terrae University School of Dentistry, Santiago, Chile), Egypt (Cairo University), Japan (Tokyo Medical and Dental University), the Netherlands (ACTA), Kuwait and the United Arab Emirates. Commission staff met with representatives from the Netherlands, Japan and Chile.
- The JACIA reviewed the Consultation Site Visit Report for King Abdulaziz University, Jeddah, Saudi Arabia. The consultation visit occurred from April 1-4, 2012. The JACIA reviewed two

responses from the institution and determined that the program has the potential to pursue accreditation with the Commission on Dental Accreditation using the new accreditation standards (implementation July 1, 2013).

- In conjunction with the January 2013 recommendation that the King Abdulaziz University be informed of the JACIA decision, the JACIA suggested that the Commission on Dental Accreditation's Predoctoral Dental Education Review Committee and Standing Committee on Documentation and Policy Review review and determine the number of site visits for international programs in the application process. The Commission concurred with this recommendation at its winter 2013 meeting.
- The JACIA approved a deadline of August 1, 2014, for the Universidad Autonoma de Nuevo Faculty of Odontology, Leon, Monterrey, Mexico, to submit the PACV self-study document.
- A PACV self-study document and consultation fees from Yeditepe University, Faculty of Dentistry, Istanbul, Turkey were received and will be reviewed at the next meeting.
- The JACIA discussed the Guidelines for International Consultation, noting the Guidelines lacked specificity regarding extension(s) to the steps in the consultative process. Staff was requested to carefully review the document and submit proposals for additional guidance for the programs to the JACIA at a future meeting. The JACIA also noted that the Guidelines lacked specificity as to the consultation report, including but not limited to ensuring consultant team comment on each accreditation standard and the usage of terms "recommendation" and "suggestion" to follow the Commission on Dental Accreditation terminology.

### Emerging Issues and Trends

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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, and the standing 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;
- Trends in the National Advisory Committee on Institutional Quality and Integrity (NACIQI) evaluation of accreditors for USDE recognition;
- Requests from the communities of interest; and
- Reports of accreditation standard frequency of citations for all disciplines.

### Responses to House of Delegates Resolutions

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*112H-2012. Commission on Dental Accreditation Rules Revision (Trans.2012:470)*

**Resolved**, that the *Rules of the Commission on Dental Accreditation* be approved as revised in Appendix 1, Worksheet:5153 (proposed deletions are ~~stricken~~; proposed additions are underlined).

Commission Response: The Commission on Dental Accreditation revised its Mission Statement. No further Commission action was required.

*164H-2012. Supervision of PGY-1 Programs (Trans.2012:470)*

**Resolved**, that the ADA encourage CODA to examine accreditation criteria for faculty supervision and site coordinators of postgraduate dentistry programs that are in locations remote from the sponsoring institutions, and be it further

**Resolved**, that CODA be requested to provide a report on this issue to the 2013 House of Delegates.

Commission Response: The Commission on Dental Accreditation's Standing Committee on Documentation and Policy Review considered the qualifications and duties of off-site coordinators. Prior to the Standing Committee's review, each review committee of the Commission was requested



to consider this topic. The Standing Committee noted that none of the review committees believed that off-site coordinators should be required to possess the same qualifications as the program director. In addition, the Standing Committee believed that any requirements of off-campus site coordinators should be discipline-specific. It was noted that the standards include requirements for faculty and that the program director should maintain oversight of the program's off-site locations and maintain oversight of the faculty who teach at those locations. The Commission accepted the recommendation of the Standing Committee that off-site coordinators not be required to possess the same qualifications as program directors.

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**Policy Review**

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The Commission did not review Current Policies in accord with Resolution 111H-2010, as a comprehensive review of policies was conducted in 2010. The 2010 ADA House of Delegates accepted the Commission's recommendations on the policy review resolutions.

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**Summary of Resolutions**

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This report is informational and no resolutions are presented.

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**Council Minutes**

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For more information on recent activities, see the Commission's minutes on ADA.org:  
<http://www.ada.org/117.aspx#minutes>.

# Council on Dental Benefit Programs

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May, A. David, Jr., 2013, Texas, chair  
Toy, Bruce G., 2013, California, vice chair  
Blaisdell, Mark H., 2015, Utah  
Brady, Thomas V., 2016, Connecticut  
Eder, B. Scott, 2013, West Virginia  
Harrell, Gavin G., 2014, North Carolina  
Hoffman, Charles W., 2015, Florida  
Jurkovich, Mark W., 2014, Minnesota  
Krantz, Daniel B., 2016, New Jersey  
Larson, David R., 2016, Pennsylvania  
Masak, John G., 2015, Wisconsin  
Mazzola, Robert L., 2015, Ohio  
Pak, Sammy B., 2016, Washington  
Riggins, Ronald D., 2013, Illinois  
Rives, Robert W., 2016, Mississippi *ad interim*  
Vorrasi, Andrew G., 2014, New York  
Wood, C. Rieger, III, 2014, Oklahoma  
Yanase, Rex R., 2013, California, *ex officio*\*

Preble, David M., director  
Aravamudhan, Krishna, senior manager  
Pokorny, Frank, senior manager  
McHugh, Dennis, manager

The Council's 2012-13 liaisons include: Dr. Maxine Feinberg (Fourth District trustee, Board of Trustees) and Ms. Jessica K. Hsieh (American Student Dental Association). Dr. C. Celeste Coggin, Georgia, resigned in October 2012.

## Mission and Purpose

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The mission of the Council on Dental Benefit Programs is to promote quality dental care through the development, promotion and monitoring of dental benefit programs for the public, as well as by development and maintenance of coding taxonomies and quality assessment and improvement tools and methodologies.

## Supporting the Strategic Plan: Activities, Results and Accomplishments

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The activities of the Council on Dental Benefit Programs (CDBP) 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 Council fulfills Goal 3—improve public health outcomes through a strong collaborative profession; including effective collaboration across the spectrum of stakeholders outside of dentistry.

Annual *CDT Code* maintenance proceeds in accordance with protocols established by the Council's *CDT Code* Maintenance Committee (CMC). The process has matured into a broad-based collaborative and efficient effort. *CDT Code* updates are more responsive to member dentist needs, as well as those of dental specialty organizations and third-party payers. Summary statistics on actions taken during the 2013 CMC meeting, with CDBP's as a subset, are in the following table. Accepted changes will be effective January 1, 2014.

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

All Requests	Action	Submitted		Accepted		Declined		Other (Table/Moot)	
		#	%	#	%	#	%	#	%
	Add	68	66.67%	32	47.06%	32	47.06%	4	5.88%
	Revise	30	29.41%	22	73.33%	5	16.67%	3	10.00%
	Delete	4	3.92%	4	100.00%	0	0.00%	0	0.00%
	Total	102	100.00%	58	56.86%	37	36.27%	7	6.86%
ADA Subset									
	Add	8	53.33%	7	87.50%	0	0.00%	1	12.50%
	Revise	7	46.67%	7	100.00%	0	0.00%	0	0.00%
	Delete	0	0.00%	0	0.00%	0	0.00%	0	0.00%
	Subtotal	15	100.00%	14	93.33%	0	0.00%	1	6.67%

Information about the maintenance process, including the CMC's membership, action request submission and evaluation guidelines, and reports on change requests to be considered and in queue for implementation, is available online at <http://www.ada.org/3827.aspx>.

The next closing date for *CDT Code* change requests is November 1, 2013. All submissions will be on the CMC agenda when the Committee convenes February 27–28, 2014, and March 1, 2014. Those accepted will be incorporated into the version of the *CDT Code* that is effective January 1, 2015.

The Council's efforts to foster member awareness of the *CDT Code* maintenance process continues with another *CDT Code* Open Forum at Annual Session 2013. The Council expects to identify concepts that it may wish to pursue further to ensure that this code taxonomy continues to fulfill the needs of the dental community.

In 2012, the Dental Benefit Information Service (DBIS) Subcommittee met with representatives from CIGNA and MetLife on September 13 (immediately preceding the National Dental Benefits Conference which has since been sunsetted). In 2013, the DBIS Subcommittee met with representatives from Humana and WellPoint on February 15 as part of the annual DBIS Subcommittee meeting. 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 Council will determine which carriers the Subcommittee meets with in 2014.

The Dental Quality Alliance (DQA) continues to move forward with efforts to develop quality measures in dentistry. Validation of the first set of measures is complete. The measures are posted at <http://www.ada.org/8472.aspx>. These measures will be useful to evaluate Medicaid/CHIP programs as well as compare care quality among dental plans participating in exchanges. This project is funded [in part] by a grant from the ADA Foundation with data [in part] for validation testing provided by DentaQuest Plan. The DQA is also developing two measures for the Meaningful Use program to be adopted in Stage III. The Centers for Medicare & Medicaid Services and the Office of the National Coordinator for Health IT are funding this project. New efforts are currently underway to identify quality measures for the adult population. The DQA held a conference on Quality Measurement from June 28–29, 2013, at the ADA Headquarters. Over 100 registered participants engaged in the conversation on how to promote measurement. Grants from the Agency for Healthcare Research and Quality as well as United Concordia Dental supported this conference.

## Emerging Issues and Trends

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Under the broad goal “to transform healthcare,” the Department of Health and Human Services (HHS) hopes to improve healthcare quality and patient safety, in part by implementing payment reforms that reward quality care and working with physicians and practitioners across the public and private sectors in quality improvement efforts (HHS Strategic Plan 2010–2015, [HHS Strategy](#)). Interest in quality measurement is very high both for federal agencies and commercial payers.

As the single largest payer of health services for children in the United States, the Centers for Medicare & Medicaid Services (CMS) plays a pivotal role in working with states and other partners in implementing quality measurement and improvement strategies. CMS has expressed interest in moving towards more robust quality measures to track improvements. The Texas Medicaid program is emerging as a pioneer in instituting a pay for performance program for the Managed Care Organizations (MCOs) that it contracts with by holding them accountable for selected quality measures. The MCO contract includes a Performance-Based Capitation Rate and a Quality Challenge Award. As the program is implemented, it will provide an opportunity to evaluate the impact of an MCO pay for performance initiative.

Legislation passed in 2011 requires Coordinated Care Organizations (CCOs) in Oregon to meet benchmarks for quality measures. Oregon’s first CCOs were implemented in the fall of 2012. In line with Oregon’s health reform legislation, all CCOs are expected to contract with Dental Care Organizations (DCOs) prior to July 2014 to ensure the integration of dental care into the functions of the CCOs and their global budgets. Contracts between CCOs and DCOs must delineate appropriate performance and quality measures regarding dental care in order to fulfill legislative expectations of accountability and achievement. These measures will be central to establishing the contribution of dental providers within the CCO. A recent report submitted to the Oregon state authorities identifies potential quality measures on oral health. Several of these measures are DQA measures.

Many demonstration projects have been established across the nation to evaluate the concepts of “Accountable Care Organizations” and “Patient-Centered Medical Homes.” Oral health quality measures are not yet included within the primary care standards for these delivery models.

Private payers have long engaged in administrative data analysis to understand some aspects of quality within each of their benefit plans. Much of the knowledge gained from these analyses has been proprietary. The requirement for quality reporting through emerging exchanges will facilitate more transparency and accountability of health plans by comparing quality and cost scores for different plans.

## Responses to House of Delegates Resolutions

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Policies that were referred to the Council or otherwise require council action pursuant to discussions by the 2012 House of Delegates are addressed in the policy review section of this report.

## Policy Review

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In accordance with Resolution 111H-2010, Regular Comprehensive Policy Review, and Resolution 170H-2012, the CDBP reviewed Association policies and presents a series of resolutions with recommendations to rescind or amend some of those policies. Also listed are policies the Council voted to maintain.

## Recommendations—Policies to be Maintained

The CDBP concluded that the following policies should be maintained as written. Policies that are followed by an asterisk were policies that the Council originally suggested for rescission; however, the action of the House of Delegates was not to adopt the rescission and the Council subsequently agreed that the policies have merit and should be maintained. The policy with two asterisks was originally suggested by the Council for rescission; however, the House of Delegates referred this to the Council for further study. The Council subsequently agreed that the policy has merit and should be maintained.

Dental Coverage for Retiring Employees (*Trans.*1993:689)  
 Participation in Public Agency Sponsored Programs Involving Dental Health Benefits\*  
 (*Trans.* 1995:648)  
 Freedom of Choice of Dentists\* (*Trans.*1983:582)  
 Patient and Provider Advisory Panel\* (*Trans.*1997:704)  
 Disputes Concerning Dental Treatment Provided Under Dental Benefits Programs\* (*Trans.* 1992:600)  
 Use of Peer Review Process by Patients and Third-Party Payers\* (*Trans.*1990:534)  
 Direct Reimbursement Mechanism\*\* (*Trans.*1978:510)

## Recommendations—Policies to be Amended

### *Tooth Designation Systems*

The CDBP believes that the policy “Tooth Designation Systems” should be amended to better reflect ADA agencies responsible for maintaining these systems.

The Universal/National Tooth Numbering System has been maintained by the ADA through adoption and amendment of policy by the House of Delegates. The Council on Dental Benefit Programs is the lead agency for maintenance and recommendations for amendment. This enumeration schema is well known and used within the domestic dental community. Its last amendment (2002:394) incorporated enumeration of supernumerary teeth.

Reference to the International Standards Organization (ISO) TC 106 Designation System for Teeth and Areas of the Oral Cavity is obsolete and misleading. This international standard is the basis for the ISO/ANSI/ADA Standard No. 3950, which is the ADA enumeration standard maintained by the ADA Standard’s Committee on Dental Informatics (SCDI). The ADA is an accredited ANSI standards development organization and Standard No. 3950 maintenance is in accordance with ANSI protocols, which do not provide for House of Delegates approval of any changes.

Both the Universal/National Tooth Numbering System and the ISO/ANSI/ADA Specification No. 3950 for Designation System for Teeth and Areas of the Oral Cavity are incorporated by reference in the HIPAA standard electronic dental claim transaction. This reference states that the ADA is the source of both schemas.

**5. Resolved**, that the ADA policy on Tooth Designation Systems (*Trans.*1994:652; 2002:394) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that the American Dental Association accepts the ~~following definitions of the Universal/National Tooth Designation System and the International Standards Organization (ISO) TC 106 ISO/ANSI/ADA Specification No. 3950 for Designation System for Teeth and Areas of the Oral Cavity as the human tooth and oral cavity enumeration schemas, and be it further~~  
**Resolved**, that the Universal/National Tooth Designation System is defined as follows:

#### *Permanent Dentition*

Teeth are numbered 1-32, starting with the third molar (1) on the right side of the upper arch, following around the arch to the third molar (16) on the left side, and descending to the lower third molar (17) on the left side, and following that arch to the terminus of the lower jaw, the lower right third molar (32).

Supernumerary teeth are identified by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar (e.g., supernumerary #51 is adjacent to the upper right molar #1; supernumerary #82 is adjacent to the lower right third molar #32).

#### *Primary Dentition*

Consecutive upper case letters (A-T), in the same order as described for permanent dentition should be used to identify the primary dentition.

Supernumerary teeth are identified by the placement of the letter “S” following the letter identifying the adjacent primary tooth (e.g., supernumerary “AS” is adjacent to “A”; supernumerary “TS” is adjacent to “T”).

and be it further

**Resolved**, that ISO/ANSI/ADA Specification No. 3950 for International Standards Organization (ISO) TC 106 Designation System for Teeth and Areas of the Oral Cavity is defined as in standards documents prepared and published by the ADA Standards Committee on Dental Informatics.

#### *Designation of Areas of the Oral Cavity*

The oral cavity is designated by a two-digit number where at least one of the two digits is zero, as follows:

00 designates the whole of the oral cavity  
01 designates the maxillary area  
02 designates the mandibular area  
10 designates the upper right quadrant  
20 designates the upper left quadrant  
30 designates the lower left quadrant  
40 designates the lower right quadrant  
03 designates the upper right sextant  
04 designates the upper anterior sextant  
05 designates the upper left sextant  
06 designates the lower left sextant  
07 designates the lower anterior sextant  
08 designates the lower right sextant

#### *Designation of Teeth*

Teeth are designated by using a two-digit code. The first digit of the code indicates the quadrant and the second indicates the tooth in this quadrant:

##### *a. First digit (quadrant)*

Digits 1-4 are used for quadrants in the permanent dentition and digits 5-8 for those in the deciduous dentition, clockwise from the upper right quadrant.

##### *b. Second digit (tooth)*

Teeth in the same quadrant are designated by the second digit 1-8 (1-5 in the deciduous dentition); this designation is from the median line in a distal direction.

#### **Reporting of Dental Procedures to Third Parties**

The CDBP believes that the policy “Reporting of Dental Procedures to Third Parties” should be amended to reflect the *CDT Code* as a named national standard by federal regulation.

HIPAA regulations that name the *CDT Code* as the national standard for reporting dental services is a notable accomplishment that establishes a regulatory basis for use of this ADA intellectual property. Use of the *CDT Code* is required on all HIPAA standard electronic dental claim transactions and use of any

other taxonomy on paper claims or those submitted by other means is contrary to the expanding use of electronic data interchange by dentists. Use of proprietary code sets on paper claims or other means is likely to result in claim rejection and reimbursement delay.

The HIPAA requirement for *CDT Code* use is well established in all sectors of the dental community and ADA continued promotion of its use is redundant effort. Federal regulations require all HIPAA covered entities to only send or accept the *CDT Code*.

The remaining changes simplify language for clarity.

**6. Resolved**, that the ADA policy on Reporting of Dental Procedures to Third Parties (*Trans.* 1991:637; 2009:418) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that the ADA acknowledges the specification of the *CDT Code* as the sole taxonomy for reporting dental services on HIPAA standard electronic dental claims, and be it further

**Resolved**, that when reporting dental treatment under dental plans, the method used by dentists for submitting claims to third-party payers and for filing fees ~~should~~ must be the American Dental Association's *Code on Dental Procedures and Nomenclature*, ~~as contained in the ADA's publication, *Current Dental Terminology* (*CDT Code*)~~, and be it further

**Resolved**, that third-party payers and their agents who process dental claims should not require the reporting of dental treatment or filing fees by any other coding taxonomies, and be it further

~~**Resolved**, that the Association formally contact commercial carriers, service corporations, any and all other third-party payers and their agents who process dental claims, and vendors of electronic claims processing, to request that the ADA's *Code on Dental Procedures and Nomenclature* be used as the code taxonomy for their claims adjudication process, and be it further~~

**Resolved**, that when an unusual procedure, or a procedure that is accompanied by unusual circumstances, is reported with a procedure code that includes "by report" in its nomenclature, that procedure code and its accompanying ~~by a~~ narrative description, ~~that may or may not include a reference to an appropriate unspecified (-999) code~~, it should be accepted by the third-party payer to assist in benefit determination.

### ***Recognition of Tooth Designation Systems for Electronic Data Interchange***

The CDBP believes that the policy "Recognition of Tooth Designation Systems for Electronic Data Interchange" should be amended for consistency with proposed revision to ADA policy "Tooth Designation Systems" and to reflect the HIPAA standard electronic dental claim transaction.

Changes to the first resolving clause are consistent with proposed amendments to Tooth Designation Systems (*Trans.* 1994:652; 2002:394). Reference to the "International Standards Organization (ISO) TC 106..." is obsolete and misleading. This international standard is the basis for the ISO/ANSI/ADA Standard No. 3950, which is the ADA enumeration standard maintained by the ADA Standard's Committee on Dental Informatics (SCDI).

The HIPAA standard electronic dental claim transaction recognizes both the Universal/National system (given identifier "JP") and the Standard No. 3950 (given identifier "JO"), and notes the ADA as the source for each taxonomy.

The sixth resolving clause of the policy is proposed for deletion as it addresses mounting radiographs, not electronic data interchange.

These amendments clarify and update the current policy text.

**7. Resolved**, that the ADA policy on Recognition of Tooth Designation Systems for Electronic Data Interchange (*Trans.* 1994:675) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that the American Dental Association recognizes that the two major systems used in the United States for tooth designation are the Universal/National Tooth Designation System ~~used primarily in the United States~~ and the ISO/ANSI/ADA Specification No. 3950 for Designation System for Teeth and Areas of the Oral Cavity ~~International Standards Organization (ISO) TC 406 method used in most other countries~~, and be it further

**Resolved**, that electronic oral health records should be designed to provide dentists the flexibility to select which tooth designation system best suits his or her office, and be it further

**Resolved**, that software intended for electronic transmission of clinical information should have the capability of translating ~~this~~ tooth designation information into either system, and be it further

**Resolved**, that the American Dental Association, through its activities as secretariat and sponsor of the Accreditation Standards Committee (ASC) MD 156, support ~~the~~ integration of the ISO/ANSI/ADA Specification No. 3950 for Designation System for Teeth and Areas of the Oral Cavity, in addition to the Universal/National ~~ISO/FDI~~ Tooth Designation System, into clinical computer systems to allow information on tooth designation and other areas of the oral cavity to be transmitted electronically, and be it further

**Resolved**, that the American Dental Association encourage all accredited dental schools to familiarize dental students with both the Universal/National Tooth Designation System and the ISO/ANSI/ADA Specification No. 3950 for Designation System for Teeth and Areas of the Oral Cavity, ~~and the ISO/FDI Systems for designation of teeth and areas of the oral cavity, and be it further~~

**Resolved**, that looking at the teeth from outside the mouth, radiographs should be viewed in the same manner ~~and so mounted~~.

### ***Statement on Capitation Dental Benefit Programs***

The CDBP believes that the policy “Statement on Capitation Dental Benefit Programs” should be maintained with the recommended syntax and other changes necessary to bring this policy up to date and to make it clearer and easier to understand based on similar changes made to related policies on capitated programs. Sections of the policy that appear to blame benefit plan design for unethical practices by a dentist have been removed.

**8. Resolved**, that the ADA policy on Statement on Capitation Dental Benefit Programs (*Trans.* 1985:582; 1993:689) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

A capitation dental benefit program is one in which a dentist or dentists contract with the program’s sponsor or administrator to provide all or most of the dental services covered under the program to subscribers in return for payment on a per capita basis.

~~Because the contracting dentist’s compensation in these programs is entirely or largely unrelated to the services actually provided, a circumstance is created in which the possibility of needed treatment being delayed or withheld by the contracting dentist, compelled by financial exigencies of maintaining a practice, must be acknowledged.~~

~~Because the financial responsibility of the capitation program subscriber for the payment from treatment provided is wholly or largely removed by this system of “prepaying” the contracting dentist, the subscriber-patient’s participation in decisions about his treatment is likewise reduced or eliminated.~~

~~Because it is a practical certainty that not all dentists in a given community will choose to contract with~~ will participate in a given capitation program, ~~even if invited to do so, Therefore, the~~



opportunity for capitation program subscribers to freely choose their ~~receive treatment from any dentist in their community~~ is necessarily restricted.

~~Because in capitation dental benefit programs payment for covered services by specialists must be paid for in whole or part by the contracting general dentist or the program itself, a circumstance is created in which the possibility of the contracting general dentist's undertaking treatment beyond his or her capabilities or referring patients to a specialist of the program's rather than the dentist's choice must be recognized.~~

~~These inherent design limitations in capitation dental benefit programs make it incumbent upon the American Dental Association to provide the following recommendations to group benefit purchasers considering such programs:~~

1. Capitation dental benefit programs should be offered only as an additional alternative to a benefit program which does not restrict the subscriber's opportunity to receive treatment from the dentist of his or her choice on a fee-for-service basis.
2. The scope of services covered in the ~~unrestricted~~ freedom of choice and capitation programs should be equal.
3. Each employee (or group member) should be provided comprehensive, unbiased information about the programs being offered and should be given a reasonable opportunity to select the program which ~~he the employee~~ believes best suits his or her needs, as well as periodic opportunities thereafter to choose to continue ~~his~~ enrollment in the program of ~~his~~ the employee's initial selection or to enroll in a different program.
4. All dentists willing to abide by the terms of the capitation program's provider contract should be eligible to participate in the program.
5. There should be no automatic enrollment in capitation dental benefit programs.
6. A system of monitoring the dental needs and treatment provided under a capitation dental benefit program should be required of the administrator by the group purchaser. In this regard, the dental needs and procedures performed should be reported, not merely on an aggregate, but on an individual patient basis.
7. ~~Additionally, a~~ All services provided by specialists should be separately reported on both an aggregate and individual patient basis.
8. ~~Finally, all~~ Patients treated under a capitation dental benefit program should be provided in writing a list of their overall dental needs and the dental procedures rendered at each treatment visit.
9. Questions regarding the quality, appropriateness or thoroughness of treatment provided under capitation dental benefit programs should be resolved through the peer review system of the appropriate dental society.

### ***Dental Health Maintenance Organizations***

The CDBP feels that the two current ADA policies on dental health maintenance organizations (DHMOs), "Closed Panel Dental Benefit Plans" (*Trans.*1989:545) and "Guidelines for Dental Components of Health Maintenance Organizations" (*Trans.*1988:476; 1993:689; 1995:610), should be combined into one easy to locate policy titled "Guidelines for Components of Dental Health Maintenance Organizations" with redundant statements deleted and appropriate updates included.

**9. Resolved**, that the ADA policy on Guidelines for Dental Components of Health Maintenance Organizations (*Trans.*1988:476; 1993:689; 1995:610) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

#### **Guidelines for ~~Dental~~ Components of Dental Health Maintenance Organizations**

~~The A dental~~ health maintenance organization (DHMO) ~~concept has been defined as an organized system for health care~~ is a dental benefits plan that is a legal entity that accepts the

responsibility to provide or otherwise ensure the delivery of an agreed upon set of comprehensive oral health care services for a voluntarily enrolled group of persons in a geographic area, and is reimbursed through a pre-negotiated and fixed periodic payment made by or on behalf of each person or family unit enrolled in the plan, with dental care provided by a limited number of dentists having contracts with the DHMO to provide these services.

The American Dental Association ~~recognized the HMO concept (Trans.1971:501) but opposes this approach as the only one~~ DHMOs as the sole benefit plan available to subscribers. Rather, ~~such plans~~ a DHMO should be presented to consumers as an alternative mode of financing and delivering oral health services, along with a comparable program that permits free choice of health provider dentist.

~~The HMO concept has not demonstrated itself to be more economical, efficient or otherwise better in the delivery of dental services. Therefore, the ADA maintains that DHMOs should not receive preferential treatment and~~ The Association suggests the following guidelines for DHMOs dental components:

1. The DHMO should be recognized as only one of many alternatives to ~~deliver~~ finance oral health care.
2. A complete description of benefits provided under each plan should be given to all eligible individuals prior to each enrollment period. Benefit limitations and exclusions of each plan should be clearly described, and a complete and current list of dentists who participate in the closed panel plan should be provided. ~~The subscriber should be made aware of limitations on choice of dentist and treatment location prior to enrollment.~~
3. Development and administration of a ~~dental component of an~~ DHMO should be under the control of a dentist.
4. Dental subscribers in an DHMO setting should be made fully aware of, and have access to, the profession's peer review mechanism.
5. A dental health education program with emphasis on prevention should be provided to all enrolled in an DHMO dental program.
6. The utilization of dental personnel should be consistent with American Dental Association policy.
7. Benefit programs offering dental care through an DHMO should also offer a ~~comparable dental plan with equal or comparable benefits~~ that permits free choice of dentist under a fee-for-service arrangement. Under this dual choice system, the individual consumers should also have periodic options to change plans and there should be equal premium dollars per subscriber available to both dental ~~delivery systems plans.~~
8. The freedom of choice plan should be designated the primary enrollment plan, i.e., eligible individuals who fail to enroll in any plan should be enrolled in the freedom of choice plan.
9. Administration should assure maximum benefits in dental care and minimum expenditures for administration.
10. When requested by the patient, the DHMO should pay for a second opinion from a dentist outside the DHMO network.
- ~~10. Dental services available from HMOs should be limited to HMO subscribers.~~
11. A broad range of dental services should be available to subscribers.
12. There should be no economic deterrent imposed that would discourage the utilization of diagnostic, preventive and emergency services.

The CDBP reviewed the policy "Closed Panel Dental Benefit Plans" and recommends rescission because it closely resembles Guidelines for Dental Components of Health Maintenance Organizations (Trans.1988:476; 1993:689; 1995:610) which is being amended and will include information from this policy. Basically, it is recommended that these two policies be combined into one easy to understand policy. The full text of this policy can be found in Appendix 1.

**10. Resolved,** that Resolution 6H-1989, "Closed Panel Dental Benefit Plans" (Trans.1989:545), be rescinded.

### **Statement on Dental Benefit Plans**

The CDBP believes that the policy “Statement on Dental Benefit Plans” should be amended because dental benefit plans have not demonstrated an ability to keep pace with the economy; therefore, it is recommended that this statement be removed from policy.

In addition, the Purchaser Information Service is now the Dental Benefit Information Service and the ADA continues to promote fee-for-service freedom of choice dental plans, e.g., Direct Reimbursement on ADA.org.

**11. Resolved**, that the ADA policy on Statement on Dental Benefit Plans (*Trans.* 1988:481) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

From their inception, dental benefit plans have had the support of the American Dental Association on the premise that they can increase the availability of dental care and consequently foster better oral health in the United States. Research confirms that utilization of dental services increases proportionately with the availability of dental benefits.

In the interest of assuring that the best level of dental care possible is available under dental benefit plans, the following guidelines are offered for reference in the establishment and growth of dental benefit plans.

*Mechanisms for Third-Party Payment.* The Association believes that the dental benefit programs administered by commercial insurance companies, dental service corporations, other service corporations and similar organizations offering dental plans are an effective means of assisting patients in obtaining dental care. Conventional dental benefit plans are usually structured in ways that encourage prevention. Health maintenance organizations have followed dentistry’s example and represent a similar approach in their preventive orientation. Direct reimbursement dental plans reimburse patients based on dollars spent, rather than on category of treatment received, and provide maximum flexibility to their specific dental needs.

The Association also believes that if dental plans restricting patients’ freedom of choice are offered to subscribers, a plan that offers free choice of dentist should be offered as an option. This approach should include periodic options to change plans and equal premium dollars per subscriber for each option.

*Standards for Dental Benefit Plans.* The Association urges all purchasers and third parties involved with dental benefit plans to review the “Standards for Dental Benefit Plans.” These “Standards” have been developed to reflect the profession’s views on all types of dental benefit plans and will be a useful benchmark in reviewing the many options that are available.

*Dental Society Review Mechanisms.* The Association urges patients, plan purchasers and third-party payers to make use of the peer review committees that have been established by the constituent dental societies. The Association believes that it is important to use review mechanisms as established by organized dentistry, in order to obtain objective and impartial professional review. Third-party review is recognized as an important first step in the screening process for clarification and resolution of disputes which arise out of pretreatment or post-treatment review. However, it is not equivalent to, nor is it a substitute for, the constituent or component peer review process.

*Statement on Areas Needing Improvement.* ~~Dental benefit plans have demonstrated an ability to keep pace with the economy without contributing significantly to inflation of dental care costs. However, the~~ The American Dental Association believes that dental benefit plans should be expanded in several areas, as follows:

1. Most dental benefit plans limit preventive services to topical fluoride applications, regular prophylaxes, the application of pit and fissure sealants and space maintainers for children. The inclusion of broader prevention benefits, such as oral health risk assessments, the application of pit and fissure sealants, application of adult fluoride, screening for oral cancer and other dental/medical related conditions, ~~and~~ oral hygiene instruction and ~~or~~ dietary counseling, is encouraged.

2. ~~Experience~~Research has shown that substantial numbers of covered individuals do not utilize their dental benefit plans. The Association supports a dental benefit plan design which encourages utilization of diagnostic and preventive services, such as a plan that covers these services at 100%, without a deductible.

~~To help dental benefit decision makers, the Council maintains a dynamic Purchaser Information Service. The Service conducts research on the factors which influence a purchaser's dental benefit decisions. This knowledge equips the Service to carry out a full-time program to reach plan purchasers to promote the Association's policies of traditional fee-for-service dentistry and freedom of choice of provider. It is also able to clarify the plans and options available to those purchasers, so that they may make a more qualified dental benefit decision.~~

The Association and its constituent and component societies should maintain active communication with all groups and individuals interested in the development and operation of dental benefit plans. Because of this activity, a great deal of knowledge about all aspects of dental benefits has been acquired. The dental profession is eager to share this knowledge with all interested parties.

### ***Support for Individual Practice Associations***

The CDBP originally recommended that the policy "Support for Individual Practice Associations (IPAs)" be rescinded. The Reference Committee heard testimony that this policy has continued relevance and should be referred back to the Council for revision, study and report to the 2013 House of Delegates.

The Council determined that information regarding IPAs should be made available on ADA.org, particularly to clarify the legal and regulatory limitations on the use of IPAs, as a service to dentists that may wish to consider the creation of an IPA in the future.

**12. Resolved**, that the ADA policy on Support for Individual Practice Associations (IPAs) (*Trans.* 1988:475; 1994:655; 2000:458) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that the American Dental Association provide information to members and plan purchasers about dental individual practice associations (IPAs) that includes legal and regulatory limitations on the uses of IPAs, ~~are established and/or directed by organized dentistry and that conform to Association policy, and be it further~~

**Resolved**, that discussion of IPAs be included in the Purchaser Information Service Program

### ***Government Reports on Payments to Dentists***

The CDBP notes that the policy "Government Reports on Payments to Dentists" concerns government reporting of gross reimbursements for services delivered under government programs. Changes to the first resolving clause now state this clearly, as well as noting specific information needed to establish the payment context. Reporting should include overhead expense, including the salary of the dentist as a legitimate aspect of overhead. The ADA's Washington office also reviewed this proposed amendment and notes that this policy will have no practical application as it is not aware of any federal agency reports of dental reimbursements for government programs.

The second resolving clause's reference to overhead costs duplicates content in the first clause. Also the second and third resolving clauses date back to 1976 and are not currently on the ADA's advocacy agenda.

**13. Resolved**, that the ADA policy on Government Reports on Payments to Dentists (*Trans.*1976:858) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that government agencies issuing reports on reimbursements ~~income amounts~~ paid to dentists for services rendered under public programs be strongly urged to release such information in a clear context accompanied by such facts as:

- the number of ~~practitioners~~ dentists represented in the payment
- the number of patients cared for, and the fact that these payments are gross receipts from which the dentist(s) ~~or dentists~~ must pay all overhead costs, ~~and be it further~~

~~**Resolved**, that the American Dental Association exhort governmental agencies that there is yet other expense incurred by these public dental care programs. This expense includes pro-rata governmental administrative expense and pro-rata overhead expense of the facilities they use. In total fairness these additional expenses must be included in releases to the news media to reflect actual cost to the public, and be it further~~

~~**Resolved**, that the Washington Office of the Association bring this matter forcefully to the attention of all federal agencies involved in such programs.~~

#### ***Use of DEA Numbers for Identification***

The CDBP notes that shortly after the policy on "Use of DEA Numbers for Identification" was adopted, the National Provider Identifier (NPI) was implemented. An NPI is a unique, government-issued, standard identification number for individual health care practitioners such as dentists, and practitioner organizations such as an incorporated dental practice. Federal law requires use of an NPI by a dentist or practice that uses a HIPAA standard electronic transaction such as the dental claim. Some state laws and some participating provider contracts also require a dentist or practice to use their NPI on paper claims. Benefit plans and pharmacies should not require the DEA registration number for any purpose other than the prescribing of controlled substances, consistent with the DEA's position.

**14. Resolved**, that the ADA policy on Use of DEA Numbers for Identification (*Trans.*2000:454) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that the ADA agrees with the Drug Enforcement Administration (DEA) that the DEA number is to be used solely for purposes of prescribing controlled substances. ~~take steps to assure that unauthorized and non-discretionary use by the insurance industry and other entities regarding the DEA number cease as promptly as prudence and reality permit, and be it further~~

~~**Resolved**, that health care insurance providers be urged to immediately discontinue the use of the Drug Enforcement Administration (DEA) Registration Numbers as a means of identification and instead, voluntarily switch to a more appropriate and safer method of identifying health care providers who prescribe medications to insured patients such as the national health care provider identifier currently under development by the Health Care Financing Administration (HCFA), and be it further~~

~~**Resolved**, that the ADA contact the HCFA and the DEA by the end of year 2000 to offer input for the expeditious development and implementation of the alternative number currently being considered.~~

### **Authorization of Benefits**

The CDBP believes that the policy “Authorization of Benefits” is an important policy and should be maintained with necessary changes to make the policy clearer.

**15. Resolved**, that the ADA policy on Authorization of Benefits (*Trans.* 1994:665) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that the American Dental Association supports the right of each dentist to accept or reject authorized benefits from any dental benefits plan, and be it further

**Resolved**, that the Association supports the right of every patient to authorize that his or her benefits be paid to the treating dentist and to have the authorization honored by the third-party payer, and be it further

**Resolved**, that when a third-party payer ~~inadvertently~~ submits payment directly to the patient, contrary to the patient's authorized preference, it is the third-party payer's responsibility ~~of the third-party payer~~; ~~first, to submit the correct payment to the dentist and second, to reclaim the erroneously submitted payment from the patient,~~ and be it further

**Resolved**, that in those states where dentists are not notified of the rescission of a prior authorization of benefits, the Association encourage state dental societies to seek legislative relief.

### **Statement on Preventive Coverage in Dental Benefits Plans**

The CDBP feels that the policy “Statement on Preventive Coverage in Dental Benefits Plans” is important and that it is necessary to clarify and update this policy to reflect current practice.

**16. Resolved**, that the ADA policy on Statement on Preventive Coverage in Dental Benefits Plans (*Trans.* 1992:602; 1994:656) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that preventive dentistry refers to the procedures in dental practice and health programs which, ~~in conjunction with clinical and radiographic examinations,~~ aid in the prevention of oral diseases, and be it further

**Resolved**, that the American Dental Association recognizes the importance of implementing preventive oral health practices as an effective means of promoting ~~affording~~ optimal oral health to all individuals, and be it further

**Resolved**, that the ADA urges that all dental benefit plans include the following ~~preventive~~ procedures as covered services:

- prophylaxis ~~(at least twice in a calendar [contract] year);~~
- topical fluoride applications for all patients ~~(at least twice in a calendar [contract] year);~~
- application of pit and fissure sealants and reapplication as necessary;
- oral health risk assessment;
- screening for oral cancer and other dental/medical related conditions;
- preventive resin restorations;
- resin infiltrations;
- fixed and removable appliances to prevent malocclusion ~~in the developing dentition;~~
- construction of athletic mouth protectors for use in sports guards;
- prescription or use of supplemental dietary or topical fluoride for home use; and
- in-office patient education, i.e., oral hygiene instruction, and dietary counseling, and tobacco cessation counseling with regard to the promotion of good oral and overall health.

and be it further

**Resolved**, that the Council on Dental Benefit Programs continue to recommend to third-party payers, service plans, prospective purchasers and policyholders that, ~~where considered necessary and appropriate, contract limitations on frequency of providing benefits allow for certain services be stated~~ coverage of preventive services as at least “twice in a calendar (or contract) year” and more frequently if risk factors are identified that warrant increased frequency rather than “once in every six months,”.

### **Age of Child**

The CDBP believes that the ADA policy “Age of Child” is very important and that there are two distinct issues regarding age of child in dental benefit plans. For specific procedures, it is appropriate for the ADA to support determination based on the development of the dentition.

For eligibility issues, the ADA has supported the use of age 21 for adult status, specifically for purposes of interpreting federal legislation.

**17. Resolved**, that the ADA policy on Age of “Child” (*Trans.* 1991:635) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that when dental plans differentiate coverage of specific procedures based on the child or adult status of the patient, this determination be based on the clinical development of the patient’s dentition, and be it further

**Resolved**, that for the sole purpose of eligibility for coverage, chronological age of 21 be used to determine enrollment status. ~~where administrative constraints of a dental plan preclude the use of clinical development so that chronological age must be used to determine child or adult status, the plan defines a patient as an adult beginning at age 12 with the exclusion of treatment for orthodontics and sealants.~~

### **ADA’s Dental Claim Form**

The CDBP believes that the ADA policy “ADA’s Dental Claim Form” should be amended with editorial changes that reflect current status of the claim form and the *CDT Code* as the approved vocabulary for use in electronic transactions and electronic health records.

**18. Resolved**, that the ADA policy on ADA’s Dental Claim Form (*Trans.* 1991:633; 2001:428) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that the Council on Dental Benefit Programs, with the approval of the Board of Trustees, have the authority to evaluate and effect all changes to the American Dental Association’s Dental Claim Form in consultation with the dental benefits and electronic data interchange industries, and be it further

~~**Resolved**, that the American Dental Association urge universal use and acceptance of the ADA’s Dental Claim Form and *Code on Dental Procedures and Nomenclature* by third-party payers, third-party payer organizations, and electronic data interchange agencies, and be it further~~

**Resolved**, that the constituent dental societies be encouraged to work with third-party payers and ~~third-party payer organizations~~ to take whatever steps are necessary to influence dentists and third parties in their respective states to use and accept the most current approved Dental Claim Form.

### **Bulk Benefit Payment Statements**

The CDBP believes that the ADA policy “Bulk Benefit Payment Statements” is an important policy and should be amended with necessary changes to make the policy language current and clearer.

**19. Resolved**, that the ADA policy on Bulk Benefit Payment Statements (*Trans.* 1990:536) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

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

1. Subscriber (employee) name;
2. Patient name;
3. Dates of service;
4. Specific ~~treatment service~~ reported on the submitted claim, by ~~ADA procedure code~~ CDT Code number and nomenclature;
5. Total fee charged;
6. Specific ~~ADA e-CDT Code~~ CDT Code number and nomenclature on which benefits were determined;
7. Total covered expense;
8. Total benefits paid; and
9. In instances where benefits are reduced or denied, an explanation of the reason(s) ~~that~~ why the total covered expense differs from the total fee charged, consistent with Association policy on Explanation of Benefits Statements.

and be it further

**Resolved**, that insurance companies should not withhold funds from current bulk benefit payments as a means of settling disputes over prior claims experience with the dentist and that constituent dental societies be encouraged to seek legislation to resolve this problem, and be it further

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

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

### ***Medically Necessary Care***

The CDBP believes that the policy "Medically Necessary Care" should be amended to reflect the ADA's position on benefit plans and their dental consultants making determinations of medical necessity without the complete information needed for a definitive diagnosis.

In addition, the second resolving clause was changed to reflect that contacting plan purchasers directly is not currently a tactic utilized by CDBP.

**20. Resolved**, that the ADA policy on Medically Necessary Care (*Trans.* 1988:474; 1996:686) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that the American Dental Association make every effort on behalf of patients to see that the language specifying treatment coverage in health insurance plans be clarified so that medically necessary care, essential to the successful treatment of a medical or dental condition ~~being treated by a multidisciplinary health care team~~, is available to the patient, and be it further

**Resolved**, that ~~third-party payers and their consultants should appropriately limit their benefit determinations to plan design and not make benefit determinations based on medical necessity without the complete information that would be required for a definitive diagnosis. when the ADA is notified of a situation in which a patient's treatment is jeopardized by the narrow interpretation of language contained in a medical benefit policy, the Association, with the assistance of its legal advisor, shall contact the plan purchaser directly in an effort to see that the employer's intentions regarding the benefit purchased for the employee are conveyed to the third-party payer.~~



### ***Third-Party Acceptance of Descriptive Information on Dental Claim Form***

The CDBP believes that the ADA policy “Third-Party Acceptance of Descriptive Information on Dental Claim Form” is an important policy and should be amended with necessary changes to make the policy language current and clearer.

**21. Resolved**, that the ADA policy on Third-Party Acceptance of Descriptive Information on Dental Claim Form (*Trans.* 1978:507) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that the descriptive narrative included on a claim submission when the CDT Code nomenclature includes “...by report” in its nomenclature, ~~of a dental procedure claim form~~ be given professionally appropriate consideration during adjudication ~~to the procedure codes which are used by third-party payers~~ carriers for administrative purposes, and be it further

**Resolved**, that ~~the any~~ descriptive narrative ~~or any information~~ voluntarily submitted by the dentist to assist in benefit determination should be considered during claim adjudication ~~accepted~~ by the third-party payer.

### ***Charge for Administrative Costs***

The CDBP believes that the ADA policy “Charge for Administrative Costs” is an important policy and should be amended with necessary changes to make the policy language current and clearer.

**22. Resolved**, that the ADA policy on Charge for Administrative Costs (*Trans.* 1974:656; 1989:553) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that when ~~administration~~ costs are incurred by dental providers for non-clinical services such as filling out a claim form, ~~an administrative charge~~ separate fees may be charged for ~~this~~ such services.

### ***Development of ADA Diagnostic Coding***

The CDBP believes that the ADA policy “Development of ADA Diagnostic Coding” is an important policy and should be amended with necessary changes to indicate that development of the ADA’s diagnostic coding should be referred to as SNODENT clinical terminology and maintenance of the terminology is performed in conjunction with the National Library of Medicine (NLM) and the International Health Terminology Standards Development Organization (IHTSDO). Also, the list of organizations that should be encouraged to adopt SNODENT has been updated.

**23. Resolved**, that the ADA policy on Development of ADA Diagnostic Coding (*Trans.* 1995:619) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

#### **Development of ADA Diagnostic Coding SNODENT Clinical Terminology**

**Resolved**, that the Council on Dental Benefit Programs, acting within its Bylaws authority, ~~with the approval of the Board of Trustees~~, shall continue to develop and maintain the a diagnostic coding SNODENT clinical terminology system for the dental profession, in conjunction with the National Library of Medicine and the International Health Terminology Standards Development Organization, and be it further

**Resolved**, that the American Dental Association ~~urge~~ encourage universal use and acceptance ~~adoption~~ of the ADA’s ~~diagnostic coding~~ SNODENT clinical terminology system by: public and private healthcare organizations; national and international standards developing development organizations; national quality measurement initiatives; dental schools; computer practice management dental information technology vendors, including but not limited to developers of

Electronic Health Records (EHR) systems, digital imaging systems, and peripheral devices that capture clinical data; health information databases and networks; electronic data interchange organizations; plan purchasers; third-party payers and third-party organizations.

### **Policy on Fees**

The CDBP believes that the ADA “Policy on Fees” should be amended to more accurately reflect the manner in which these issues are handled.

**24. Resolved**, that the ADA Policy on Fees (*Trans.*1990:540) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

#### **Policy on Fees for Dental Services**

**Resolved**, that the fiscal and health interests of patients are best served by the existence of an economic climate within which a dentist and his or her patient are able to freely arrive at a mutual agreement with respect to fees for service, and be it further

**Resolved**, that the American Dental Association considers third-party intervention in fee determination to be potentially anticompetitive in nature and to be a disservice to the public, which is interested in securing the best possible dental care for themselves and their families, and be it further

**Resolved**, that the Association is opposed to any law, regulation or third-party intervention that disrupts the relationship between the dentist and patient, including, but not limited to, encouraging patients to select dentists principally on the basis of cost, and be it further

**Resolved**, that if a disagreement with regard to fees arises between a dentist, a patient and/or third-party, the ~~American Dental Association should transmit the complaint~~ should be transmitted to the appropriate constituent and component dental society peer review program, which should then be available to assist in resolving the disagreement within the limitations of applicable law.

### **Fee Profiles**

The CDBP believes that the ADA policy “Fee Profiles” should be amended as changes are needed to update this policy, make it clearer and to provide timely information on the ADA Legal Division’s contract analysis service.

**25. Resolved**, that the ADA policy on Fee Profiles (*Trans.*1987:502) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that when a dentist is employed and then leaves for new employment or to open his or her own practice, all insurance companies and/or dental service corporations shall allow said dentist to establish a new fee profile, and be it further

**Resolved**, that dentists beginning practice ~~should be advised~~ made aware of this policy on the development of individual fee profiles and also ~~be advised~~ made aware of the ~~potential limitations due to methodologies used by the insurance industry and service corporations to develop fee profiles for individual practitioners~~ ADA’s contract analysis service which is authorized to analyze various types of dental provider contracts at no charge to members who request a review through their constituent dental society, and be it further

**Resolved**, that the Council on Dental Benefit Programs work with the insurance industry, dental service corporations and other appropriate agencies to ~~solve this problem for~~ assist dentists beginning practice.

### ***Hospitalization Insurance for Dental Treatment***

The CDBP believes that the ADA policy “Hospitalization Insurance for Dental Treatment” is still relevant today and should be amended by updating the term “hospital insurance carriers” to “medical plans.”

**26. Resolved**, that the ADA policy on Hospitalization Insurance for Dental Treatment (*Trans.*1972:674) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that the Association actively urge ~~hospital insurance carriers~~ medical plans to include hospitalization benefits for dental treatment in public and private insurance programs so that the resources of a hospital are available to those dental patients whose condition, in the professional judgment of the dentist, makes hospitalization necessary.

### ***Alteration of Dental Treatment Plans by Third-Party Claims Analysis***

The CDBP believes that the ADA policy “Alteration of Dental Treatment Plans by Third-Party Claims Analysis” is still relevant today and should be maintained with these appropriate updates.

**27. Resolved**, that the ADA policy on Alteration of Dental Treatment Plans by Third-Party Claims Analysis (*Trans.*1999:929) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that in consideration of existing policy on standards for dental benefit plans (*Trans.*1988:478; 1989:547; 1993:696; 2000:458; 2001:428; 2008:453; 2010:546) (~~*Trans.*1993:696~~), the challenge of a dental treatment plan by a third-party claims analysis is considered diagnosis and thereby constitutes the practice of dentistry, which can only be performed by a dentist licensed in the state in which the procedures are being performed, who has equivalent training with that of the ~~submitting~~ treating dentist, and carries with it full liability, and be it further

**Resolved**, that the ADA encourage the adoption of this position by the American Association of Dental Consultants ~~Examiners~~, all state dental associations, and all states’ boards of dentistry, and be it further

**Resolved**, that the ADA urges ~~the American Association of Dental Examiners~~, all state dental associations and all states’ boards of dentistry to pursue legislation and/or regulations to meet this end.

### ***Principles for Pay-for-Performance or Other Third-Party Financial Incentive Programs***

The CDBP believes that the ADA policy “Principles for Pay-for-Performance or Other Third-Party Financial Incentive Programs” should be amended to provide clarity to the intent of the policy and update the wording to reflect advancements in this field. Additionally, the word “must” has been changed to “should” to more accurately reflect the aspirational nature of ADA policy.

**28. Resolved**, that the ADA policy on Principles for Pay-for-Performance or Other Third-Party Financial Incentive Programs (*Trans.*2006:328) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

#### **Principles for Pay-for-Performance or Other Third-Party Financial Incentive Programs**

1. The primary objective of Pay-for-Performance (P4P) or other third-party financial incentive programs must be improvement in the quality of oral health care, so performance measures in those ~~plans programs shall~~ should be valid measures of healthcare quality, quality-related.
2. The provisions of P4P or other third-party financial incentive programs ~~should~~ must not interfere with the patient-doctor relationship by injecting factors unrelated to the patient’s needs into treatment decisions. Treatment plans can vary based on a clinician’s sound judgment.

available evidence and the patient's needs and preferences. Benchmarks to judge performance should allow for such variations in treatment plans.

3. The incentives in P4P or other third-party financial incentive programs should ~~must~~ reward both the progressive quality improvement as well as attainment of achievement of desired quality metrics. ~~levels and significant improvement in quality directed toward meeting the desired quality levels.~~

4. P4P or other third-party financial incentive programs should ~~must~~ not limit access to care for patients requiring extraordinary levels or types of care-, nor provide a disincentive for practitioners to treat complex or difficult cases because of concern about performance ratings. There should be a system of risk adjustments for difficult or complex cases.

5. ~~The incentives in a P4P or other third-party financial incentive program must be positive and of a type and magnitude that will drive improvement in the quality of care or support consistently high quality care.~~

6. The measures upon which incentive payments are based:

- should ~~must~~ be valid, reliable and feasible ~~exact, clear, measurable~~ and based on valid science
  - should ~~must~~ be standardized and have broad acceptance within the dental community
6. Before comparing measure scores between two entities the results should ~~must~~ be risk-adjusted to account for patient differences.
- ~~must~~ factor in patient compliance
  - ~~must~~ require a minimum of measurements

7. Reporting of quality to the public should ~~must~~ be fair and provide an opportunity for dentists to comment on ratings. Payers should ~~must~~ discuss quality problems they identify with dentists before any public ~~action is taken~~ reporting of ratings.

8. Participation by dentists should ~~must~~ be voluntary, with no financial penalties for not participating.

9. Savings in costs should ~~must~~ not accrue to plans but should ~~must~~ be returned to patients in reduced co-payments or expansion of benefits.

10. Development and subsequent ~~Regular~~ reassessment of P4P or other third-party financial incentive programs should ~~must~~ be done, with input from participating dentists.

and be it further

**Resolved**, that the American Dental Association use these principles in discussions with organizations designing P4P or other third-party financial incentive programs and also monitor and continue to evaluate Pay-for-Performance or other third-party financial incentive programs being implemented in dental benefit plans, and be it further

**Resolved**, that the ADA advocacy efforts with respect for P4P or other third-party financial incentive programs be guided by these principles.

### **Quality Health Care**

The CDBP believes that the ADA policy "Quality Health Care" should be amended to include the definition of quality of care which is now standard in the field.

**29. Resolved**, that the ADA policy on Quality Health Care (*Trans.* 1995:609) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

Oral health care is an integral component of health care. The Association promotes the public's oral health through commitment of member dentists to provide quality dental care.

~~Historically, the quality of dental care and the level of oral health care enjoyed by citizens of the United States have been significantly enhanced by freedom of choice, fee-for-service dentistry.~~

Quality of care is the degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Institute of Medicine).

*Quality oral health care* is characterized by the effective integration of multiple components of care consisting of prevention, acceptable treatment modalities, access, availability, utilization, patient management, patient autonomy, practice management, dental ethics and professionalism.

*Quality oral health care* is only possible when treatment decisions and planning are determined by the dentist and the patient, based on the patient's oral health needs and health status.

Any entity which seeks to participate in the managed dental benefit marketplace should be required by federal and state legislation to design and fund managed care dental plans that emphasize the value and importance of prevention, utilization, access, availability, cost effectiveness, acceptable treatment modalities, specialist referrals, the profession's peer review system and an efficient administrative process.

### ***Position Statement on the Appropriate Use of Assessment Data***

The CDBP believes that the ADA policy "Position Statement on the Appropriate Use of Assessment Data" should be amended to improve clarity and reflect the current terminology used in this field. Additionally, the word "must" has been changed to "should" to more accurately reflect the aspirational nature of ADA policy.

**30. Resolved**, that the ADA policy on Position Statement on the Appropriate Use of Assessment Data (*Trans.*1998:701) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

#### **Position Statement on the Appropriate Use of Assessment Data From Quality Measurement**

~~It is widely recognized that assessment data~~ Data from quality measurement can provide very useful information when ~~dealing with~~ addressing the many different issues confronting the health care system, from improving the quality and effectiveness of patient care, to improving the efficiency of care, to designing health benefit plans, based on the value of care. ~~However, as productively as~~ While data from quality measurement can be used productively, it can also be misused and counterproductive. ~~Measurement instruments~~ Measure specifications must be precisely designed to address specific concerns. One set of data cannot appropriately fit all purposes. ~~To try to fit one set of data to meet all purposes is a major pitfall that should be avoided.~~

~~Assessment data~~ Quality measures, ~~are used~~ is used today, ~~is used~~ for three basic quite distinct purposes: ~~to improve the quality of direct patient care delivery improvement, to demonstrate accountability in the delivery of health care, and to conduct research on the effectiveness of direct health care or on the efficiency of different delivery and financing structures.~~ Quality improvement, accountability and research are three quite distinct purposes and one ~~One set of data~~ uniform measures should ~~does not satisfy the discrete needs of each purpose, e.g.: improve the quality of care; demonstrate accountability in the delivery of health care; and conduct research on the effectiveness of health care, or on the efficiency of different delivery and financing structures~~ be used to meet these three purposes, uniformly.

Practitioners and health care institutions, such as hospitals, frequently use data from measurement for internal quality improvement, where the objective is:

- to understand the process of care and how it varies
- to understand how the process of care relates to the effectiveness of care for patients

- to clarify the clinician's perspective on the process of care and the need to change
- to plan and test changes in the process of care

The data collected for *quality improvement* is used in planning and implementing change. Thus, it should not be used prematurely as a conclusive or absolute statement about the quality of care. Because internal quality improvement requires that practitioners identify potential quality of care concerns, critique the process of care and test change, the practitioner must know that the data will remain confidential and will not be used as a premature judgment of either the practitioner or the process of care. Thus, internal improvement data should not be used for purposes of public accountability.

Accountability is distinct from internal quality improvement. ~~Accountability data~~ It is intended to be publicly reported information. ~~For example, although the specific data from the internal quality improvement program would not be suitable for accountability purposes, the fact that a practitioner has a quality improvement program in place could be an indication of accountability.~~ ~~Accountability data~~ It is generally focused on the results or outcomes of care, and is often (but not exclusively) used to compare institutions, practitioners and health plans. In using such data for comparison, the sample must be large and the data measures must be adjusted for the different populations, environments and markets within which the practitioners, health plans and institutions operate. For example, there the measures must be risk-adjusted ~~must be adjustments~~ for severity of illness or demographic factors.

~~Research is also distinct in its use of assessment data.~~ Quality of care research is often focused on examining the outcomes of care or the effectiveness of care. Measures should be specified in a manner that yields very precise results. Identifying and controlling variables that can influence the results is a more precise and extensive part of the data collection process than it is in either internal assessment or accountability.

There are, ~~however,~~ overlaps among the data measures used for internal quality improvement, public accountability and research. The results of research can be applied to identifying the best practices for quality improvement. Likewise, the need for accountability can set agendas for outcomes research and internal quality improvement. Internal quality improvement can define reasonable expectations for public accountability and the need for specific outcomes research. However, the feedback that will occur among internal quality improvement, accountability and research, should not be confused with the distinct purposes of each and the need for different ~~measurements~~ measures for each. The limits of the data ~~that is~~ collected from each sphere of assessment should ~~must~~ be recognized. Caution should ~~must~~ be used in applying ~~interpreting~~ ~~assessment~~ measurement data.

### ***Principles for the Application of Risk Assessment in Dental Benefit Plans***

The CDBP believes that the ADA policy "Principles for the Application of Risk Assessment in Dental Benefit Plans" should be amended to provide clarity and better distinguish between individual and population level risk assessment.

**31. Resolved,** that the ADA policy on Principles for the Application of Risk Assessment in Dental Benefit Plans (*Trans.*2009:424) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

#### **Individual Risk Assessment:**

1. The assessment of the risk for the development of oral diseases, the progress of existing disease or the adverse outcomes of treatment of oral disease for an individual patient is a professional matter that is the sole responsibility of the attending dentist.
2. Individual risk assessment is an important consideration in developing a complete diagnosis and treatment recommendations for each patient, the complexity of which is influenced

determined by the oral health status, goals and desires of the individual patient. The assessment should be scientifically based, clinically relevant and continually refined through outcomes studies.

3. There should be no interference by outside parties in the patient-doctor relationship by injecting factors unrelated to the patient's needs in any aspect of the diagnosis of the patient's oral health status or the attending dentist's treatment recommendations.

~~4. Risk assessments should not limit access to care for patients, including individuals who require extraordinary levels or type of care, nor provide a disincentive for practitioners to treat complex or difficult cases because of concern about performance ratings. There should be a system of risk adjustments for difficult or complex cases.~~

54. Risk assessments should be conducted periodically on a schedule determined by the attending dentist based upon the needs and medical status of the individual patient, since risk can change over time due to application of preventive measures, changes in science, the effects of therapy and changes in patient behaviors.

65. Self-administered patient questionnaires provided by third-party payers used for risk assessment purposes should contain the admonition that they are not to be considered as a substitute for a clinical evaluation performed by a dentist.

#### **Population Risk Assessment:**

17. Risk assessment for ~~communities or groups~~ populations within a community is a science separate from individual patient risk assessment, one that requires different skills and techniques than those used in the assessment of individual patients.

2. If dental plans develop models to categorize their members based on risk, this should be accomplished through a scientifically validated method.

3. At no time should these risk assessment models be applied to design benefit packages for the purpose of cost savings.

4. Eligibility for preventive services within a dental benefit plan should not be limited based on population level risk assessment.

~~8. When a disease is present in a community and its prevalence is low because of the effectiveness of preventive efforts, third-party payers should continue those preventive services as benefits of a dental plan.~~

#### ***Third-Party Payers Overpayment Recovery Practices***

The CDBP believes that the ADA policy "Third-Party Payers Overpayment Recovery Practices" should be amended to delete the second resolving clause as it basically says the same thing as the first resolving clause except that the first clause now includes constituent societies.

**32. Resolved**, that the ADA policy on Third-Party Payers Overpayment Recovery Practices (*Trans.* 1999:930) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that the American Dental Association shall and its constituent societies are urged to seek or support legislation to prevent opposing all in appropriate third-party payers from withholding assigned benefits when an incorrect payment has been made on behalf of a different patient covered by the same third-party payer overpayment recovery practices, and be it further  
~~**Resolved**, that the American Dental Association encourage state dental societies to seek or support legislation to prevent third-party payers from withholding fully assigned benefits to a dentist when an incorrect payment has been made to the dentist on behalf of a previous patient with the same third-party payer.~~

## Summary of Resolutions

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- Resolution 5. Amendment of the Policy, Tooth Designation Systems  
Resolution 6. Amendment of the Policy, Reporting of Dental Procedures to Third Parties  
Resolution 7. Amendment of the Policy, Recognition of Tooth Designation Systems for Electronic Data Interchange  
Resolution 8. Amendment of the Policy, Statement on Capitation Dental Benefit Programs  
Resolution 9. Amendment of the Policy, Guidelines for Dental Components of Health Maintenance Organizations  
Resolution 10. Rescission of the Policy, Closed Panel Dental Benefit Plans  
Resolution 11. Amendment of the Policy, Statement on Dental Benefit Plans  
Resolution 12. Amendment of the Policy, Support for Individual Practice Associations (IPAs)  
Resolution 13. Amendment of the Policy, Government Reports on Payments to Dentists  
Resolution 14. Amendment of the Policy, Use of DEA Numbers for Identification  
Resolution 15. Amendment of the Policy, Authorization of Benefits  
Resolution 16. Amendment of the Policy, Statement on Preventive Coverage in Dental Benefits Plans  
Resolution 17. Amendment of the Policy, Age of "Child"  
Resolution 18. Amendment of the Policy, ADA's Dental Claim Form  
Resolution 19. Amendment of the Policy, Bulk Benefit Payment Statements  
Resolution 20. Amendment of the Policy, Medically Necessary Care  
Resolution 21. Amendment of the Policy, Third-Party Acceptance of Descriptive Information on Dental Claim Form  
Resolution 22. Amendment of the Policy, Charge for Administrative Costs  
Resolution 23. Amendment of the Policy, Development of ADA Diagnostic Coding  
Resolution 24. Amendment of the Policy on Fees  
Resolution 25. Amendment of the Policy, Fee Profiles  
Resolution 26. Amendment of the Policy, Hospitalization Insurance for Dental Treatment  
Resolution 27. Amendment of the Policy, Alteration of Dental Treatment Plans by Third-Party Claims Analysis  
Resolution 28. Amendment of the Principles for Pay-for-Performance or Other Third-Party Financial Incentive Programs  
Resolution 29. Amendment of the Policy, Quality Health Care  
Resolution 30. Amendment of the Position Statement on the Appropriate Use of Assessment Data  
Resolution 31. Amendment of the Principles for the Application of Risk Assessment in Dental Benefit Plans  
Resolution 32. Amendment of the Policy, Third-Party Payers Overpayment Recovery Practices

## Council Minutes

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For more information on recent activities, see the Council's minutes on ADA.org:  
<https://www.ada.org/members/1293.aspx#benefit>



**Appendix 1. Policy to be Rescinded  
As Recommended by the Council on Dental Benefit Programs**

**Closed Panel Dental Benefit Plans (*Trans.1989:545*)**

A closed panel dental benefit plan exists when patients eligible to receive benefits can receive them only if services are provided by dentists who have signed an agreement with the benefit plan to provide treatment to eligible patients. As a result of the dentist reimbursement methods characteristic of a closed panel plan, only a small percentage of practicing dentists in a given geographical area are typically contracted by the plan to provide dental services.

While the Association recognizes this concept as one way of providing benefits for dental services, closed panel plans have not demonstrated themselves to be more economical, efficient or otherwise better than other forms of benefit plans in effectively providing dental benefits to patients. Further, due to the overwhelming economic incentive for patients to choose a personal dentist from a limited number of available dentists, this benefit concept has the potential to reduce the patient's access to comprehensive dental care.

In view of these concerns, the Association opposes this approach as the only dental benefit plan available to subscribers. To protect the patient's freedom to receive benefits for dental services provided by any legally qualified dentist of his or her choice, the Association suggests the following guidelines for dental benefit plan sponsors who choose to offer a closed panel dental benefit plan:

1. Benefit programs that offer dental benefits through a closed panel should also offer a plan with equal or comparable benefits that permits free choice of dentist.
2. Equal premium dollars should be allocated between the freedom of choice plan and the closed panel plan.
3. A complete description of benefits provided under each plan should be given to all eligible individuals prior to each enrollment period. Benefit limitations and exclusions of each plan should be clearly described, and a complete and current list of dentists who participate in the closed panel plan should be provided.
4. The freedom of choice plan should be designated the primary enrollment plan, i.e., eligible individuals who fail to enroll in any plan should be enrolled in the freedom of choice plan.
5. Subscribers should have periodic options to change plans.
6. When requested by the patient, the closed panel plan should provide benefits for a second opinion provided by a dentist who does not participate in the closed panel plan.

# Council on Dental Education and Licensure

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Venezie, Ronald, 2014, North Carolina, chair, American Dental Association  
Dolan, Teresa, 2014, Florida, vice chair, American Dental Education Association  
Boyle, James M., III, 2015, Pennsylvania, American Dental Association  
Brysh, L. Stanley, 2016, Wisconsin, American Dental Association  
Edwards, Michael D., 2013, Alabama, American Dental Association  
Feldman, Cecile A., 2016, New Jersey, American Dental Education Association  
Hoelscher, Diane C., 2015, Michigan, American Dental Education Association  
Holm, Steven J., 2016, Indiana, American Dental Association  
Javed, Tariq, 2013, South Carolina, American Dental Education Association  
LeBlanc, Michael, Kansas, *ex officio*\*  
Manning, Dennis E., 2016, Illinois, American Association of Dental Boards  
Miller, Jade A., 2014, Nevada, American Association of Dental Boards  
Rhea, Ronald L., 2013, Texas, American Dental Association  
Robinson, William F., 2013, Florida, American Association of Dental Boards  
Simonian, Roger B., 2015, California, American Dental Association  
Stenberg, Donna J., 2014, Minnesota, American Dental Association  
Strathearn, Jeanne P., 2015, Connecticut, American Association of Dental Boards

Hart, Karen M., director  
Borysewicz, Mary, manager  
Jasek, Jane Forsberg, manager  
Monehen, Rosemary, manager

The Council's 2013 liaisons included: Dr. Donald L. Seago (Fifth District trustee, Board of Trustees) and Ms. Keri Jamison (American Student Dental Association).

## Mission and Purpose

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The Council on Dental Education and Licensure (CDEL) is the ADA agency dedicated to promoting high quality and effective processes of dental education, dental licensure and credentialing in the United States. CDEL, through its unique representative structure (eight ADA appointees, four ADEA appointees and four AADB appointees) conducts business in accord with its duties:

- Acts as the agency of the Association in matters related to the evaluation and accreditation of all dental educational, allied dental educational and associated subjects.
- Studies and makes recommendations including proposed policy formulation on:
  - (1) Dental education, continuing dental education and allied dental education;
  - (2) The recognition of dental specialties;
  - (3) The recognition of interest areas in general dentistry, excluding ADA recognized specialties;
  - (4) The recognition of categories of allied dental personnel;
  - (5) The approval or disapproval of national certifying boards for dental specialties and for allied dental personnel;
  - (6) The educational and administrative standards of the certifying boards for dental specialties and for allied dental personnel;
  - (7) Associated subjects that affect all dental, allied dental and related education; and
  - (8) Dental licensure and allied dental personnel credentialing.
- Acts on behalf of this Association in maintaining effective liaison with certifying boards and related agencies for dental specialties and for allied dental personnel.

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

- Monitors and disseminates information on continuing dental education and encourages the provision of and participation in continuing dental education.
- Monitors and disseminates information on careers in dentistry.

### **Supporting the Strategic Plan: Activities, Results and Accomplishments**

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The Council continues 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 the 2012-2013 year were:

- Improve the safety of patient care, and improve dentist's ability to provide for that safety by providing quality continuing education (CE) activity to members by promoting CE Online, Seminar Series and the Recognizing and Managing Complications during Minimal and Moderate Sedation CE Course.
- Improve the quality and integrity of CE for members through oversight and governance of ADA CE offerings via the Council's interagency CE Committee and exploring an alternative governance and business model for ADA CERP.
- Be the trusted source of information for the public and profession by supporting the ADA/CODA/ADEA Liaison Committee on Surveys and Reports in collecting, analyzing and disseminating trend data on dental education.

### **Emerging Issues and Trends**

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#### **Dental Education and Accreditation**

As called for by ADA House Resolution 39H-2011, Monitoring of Accreditation Matters on Behalf of the ADA (*Trans.*2011:467), a Council representative (Dr. Ronald Venezie) attends Commission on Dental Accreditation (CODA) meetings and provides the Council and Board of Trustees with a report on observations of major policy and procedural actions taken by CODA. The Council also reviews matters related to the accreditation of dental, advanced dental and allied dental education programs for the Association. This year, the Council:

- Supported proposed changes to the CODA Accreditation Standards for Advanced Specialty Education Programs in Periodontics; Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Radiology; Accreditation Standards for Dental Laboratory Technology Education Programs; Accreditation Standards for Advanced Education Programs in General Dentistry; Accreditation Standards for Advanced Education Programs in General Practice Residency; and the Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery.
- Opposed the proposed revision to Standard 5 of the accreditation standards for advanced specialty education programs related to the admission of U.S. and international students, recommending that Standard 5 not be amended.
- Prepared, in collaboration with other ADA agencies, comments on the CODA proposed Accreditation Standards for Dental Therapy Education Programs. The Council intends to provide testimony at the CODA Open Hearing at the ADA annual session and submit written comment to CODA prior to the December 1, 2013 deadline. Although an implementation date for accrediting dental therapy programs will not be set by CODA until a request to accredit the programs satisfies the Commission's *Principles and Criteria Eligibility of Allied Dental Programs for Accreditation*, the Council believed it was important to submit comment on the draft document.
- Supported the majority of proposed changes to Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics but opposed the inclusion of the statement, "At the specialty level, Prosthodontics also embraces single provider comprehensive care as part of its primary care responsibility" in the Clinical Program section of Standard 4. The Council concluded that this sentence is not consistent with the Council's definition of Prosthodontics as an ADA-recognized specialty or the spirit of Section 5H, Announcement of Specialization and Limitation of

Practice of the *ADA Principles of Ethics and Code of Professional Conduct*. The Council recommended that the sentence in question be deleted from the proposed standards and that CODA and the sponsoring organization carefully review the specific standards and intent statements contained in the Clinical Program section of Standard 4 and revise any language that is based on that sentence.

- Assisted the Board of Trustees in reviewing the revised Accreditation Standards for Dental Education Programs (effective July 2013). The Board was concerned that the new standards may not provide current and developing dental schools and site visitors with enough specificity, especially in regards to the clinical curriculum. The accreditation standards which permit each school to define its own competencies “based on the school’s goals, resources, accepted general practitioner responsibilities and other influencing factors,” could lead to inconsistent interpretation by dental schools and inconsistent evaluation by site visitors and that these inconsistencies may compromise students’ opportunities to be adequately prepared to enter dental practice. The Council’s recommendations were considered by the Board in March 2013. Subsequently, the Board forwarded to CODA several proposed changes to the predoctoral dental education program standards.

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

*Golden Apple Award—Inspiring Careers in Dental Education.* The Council sponsors this award annually to recognize individuals for outstanding mentoring of students interested in academic careers. The Council received numerous outstanding nominations for the 2013 award. This year’s recipient is Dr. William F. Vann, Jr., Research Professor of Pediatric Dentistry, University of North Carolina at Chapel Hill School of Dentistry. Dr. Vann was presented with the Golden Apple Award along with funding to attend the ADA’s 2013 Annual Session.

*Career Resource.* In late 2012, the Career Guidance Department was sunset, including the Student Ambassador Program. Information and resources about [careers in dentistry](#) and [dental team careers](#) are posted on ADA.org.

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

*Clinical Licensure Examinations.* There are five regional dental testing agencies, each consisting of member states that utilize the agencies examinations for the purposes of granting initial licensure in their states. The regional agencies include 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). Nearly all U.S. licensing jurisdictions are members of one or more of the regional testing agencies; only Delaware, Florida, Nevada, New York and the Virgin Islands are not.

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 Licensing Examinations. Approximately 30 states are members of ADEX, and approximately 41 states accept results of the examinations.

The ADA encourages state boards of dentistry to accept a common core of requirements and guidelines for clinical examinations, so as to increase acceptance of results by state boards of any state or regional examination. Currently, NERB, SRTA, Hawaii, Nevada and Florida administer the ADEX Examinations while the remaining regional testing agencies administer their own examinations.

### **Alternative Models to the Traditional Clinical Licensure Examination**

*Portfolio-Style Examination.* California Assembly Bill 1524, effective January 2011, enacted a dental school-based clinical portfolio as a pathway to licensure. The Dental Board of California is in the process of developing rules and regulations to implement this process. Once regulations are final, students from all California dental schools will have the option to take a school-based licensure exam that allows them

to build a portfolio of completed clinical experiences and competency exams in seven subject areas over the entire course of their final year of dental school. Resolution 110H-2012 directed that the ADA continue to monitor the Dental Board of California's development of the portfolio examination option and provide a report back to the 2013 House of Delegates. ADA President, Dr. Robert Faiella, appointed a workgroup to monitor the California Board's progress. Dr. Cecile Feldman represents the Council on the workgroup which, through the Board of Trustees, will be providing a report to the 2013 House of Delegates.

**Canadian Exam.** The Minnesota Board of Dentistry accepts the National Dental Examining Board of Canada's two-part exam (a written examination and non-patient based Objective Structured Clinical Examination (OSCE)), for initial licensure in Minnesota for graduates of the University of Minnesota School of Dentistry graduating after 2009. This year North Dakota codified a long standing practice of accepting passing scores on either the Joint Commission on National Dental Examination (Parts I and II) or the National Dental Board of Canada's written examination. Candidates for licensure in North Dakota also must pass a clinical examination administered by a regional dental testing agency.

**Post-Graduate Residency of One-Year (PGY-1).** New York continues to be the only state that mandates the PGY-1 for initial licensure. Several other states (California, Washington, Minnesota and Connecticut) offer the option to complete a PGY-1 instead of taking a clinical licensure exam. Delaware requires both a one-year residency and a clinical licensure examination.

### **Licensure by Credentials**

There have been no changes in state laws regarding licensure by credentials since the Council's 2012 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 has a law 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.

### **Joint Commission on National 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 National Board Dental Examination](#) that will replace NBDE Part I and Part II. The Council is monitoring this long-term project. A minimum of four years' notice will be provided to the communities of interest prior to discontinuing the NBDE Parts I and II. The JCNDE recognizes that a change of this magnitude has implications for many stakeholder groups and strives to keep all stakeholders informed.

### **State Licensure Legislation**

With assistance from the ADA Department of State Government Affairs, the Council monitors proposed and enacted state legislation. The following summarizes legislation enacted by the states during this past year:

#### **Licensure Exams**

- *North Dakota 2013 SB 2084* was enacted to provide that passing scores on the National Dental Examining Board of Canada Examination or the JCNDE National Board Dental Examination Parts I and II satisfy written examination requirements to apply for a North Dakota dental license.
- *Indiana S 590* was enacted in 2013 and a portion of the law provides a pathway and requirements for graduates of unaccredited dental schools to apply for licensure. Among other requirements, such applicants must pass the U.S. National Board Dental Examination Parts I and II; a clinical exam (or alternatively be licensed in another state or have been practicing as a

military, V.A. or U.S. Public Service dentist for five years); and complete either a clinical training program of at least two years in an accredited institution that assures a level of competency equal to graduates of accredited dental colleges, or a general practice residency program at an accredited institution or an advanced education in general dentistry from an accredited institution.

### **Miscellaneous Licensure**

- *Mississippi SB 2419* was enacted to provide that occupational licensing boards, including the Board of Dentistry, shall issue a license, certification or registration to a military-trained applicant to allow the applicant to lawfully practice the applicant's occupation in Mississippi if the applicant satisfies certain conditions.
- *Montana 2013 H 259* was enacted to require licensing boards, including the dental board, to apply prior relevant education, training, or service by members of the armed forces (military) as fulfilling certain qualifications for licensure.
- *Arizona 2013 H 2064* was enacted to require the Board of Dental Examiners and the Arizona Medical Board to issue training permits to qualified military professionals at no cost to the applicant.
- *Indiana S 590* allows the Dental Board to issue a voluntary charitable permit to a dentist or dental hygienist valid for 90 days if the individual is licensed in Indiana or is the holder of an inactive Indiana license or is licensed in another state. The applicant must prove they will provide care without compensation and that either they or the charitable clinic has or will have malpractice insurance.

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

As part of its *Bylaws* responsibilities, the Council annually surveys the ADA-recognized dental specialty certifying boards. The [2013 Report of the ADA-Recognized Dental Specialty Certifying Boards](#) shows that all nine specialty certifying boards certified diplomates in 2012. The American Board of Endodontics initiated a certification pathway for internationally trained endodontists, joining four other certifying boards (dental public health, oral and maxillofacial pathology, oral and maxillofacial surgery, and pediatric dentistry) that offer an alternative pathway to certification for internationally trained dental specialists; however, none of these boards reported certifying individuals via this alternative pathway in 2012.

### **Anesthesiology**

*Safety Awareness Campaign.* The Council's Safety Awareness Campaign provides member value by reminding dentists about the importance of proactively checking dental office equipment and emergency management supplies on a routine basis. Safety Awareness Campaign promotions in *ADA News*, e-publications and on ADA.org appear twice a year coinciding with daylight savings time changes. A downloadable [checklist](#) assists dentists and their office staff in performing periodic equipment and supply checks.

*Recognition and Management of Complications During Minimal and Moderate Sedation.* Part 1 (4 CEUs) of this ADA CE course is available on [ADA Continuing Education Online](#). Part 2 (5 CEUs) was offered twice during the 2012 ADA Annual Session. For 2013, the Council has communicated with specialty organizations, university simulation centers, and residency programs in a variety of geographic locations encouraging them to sublicense Part 2. This course supports the ADA Strategic Plan by improving the ability of dentists to provide safe and effective patient care.

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

The ADA CERP promotes continuous quality improvement of CE and provides dental regulatory agencies with a sound basis for uniform acceptance of CE credits that are mandated by 49 licensing jurisdictions for maintenance of licensure. The [CERP Annual Report](#) is posted on ADA.org. At the time this report was

prepared, there were 430 ADA CERP nationally recognized providers. Through the CERP Extended Approval Process (EAP), 16 of these approved providers (three specialty societies and 13 ADA constituent societies) have extended approval to an additional 108 component societies. ADA CERP-approved providers list their [CE Course Offerings](#) on ADA.org.

Effective August 1, 2013, the CMS Physician Payment Transparency Program requires manufacturers to report payments or transfers of value over \$10 to individual physicians (and dentists) in a public database. The program provides an exemption of reporting requirements for payments by manufacturers to ADA CERP approved providers of continuing dental education if specific conditions to ensure independence and transparency are met.

*New CERP Application Forms for CE Providers.* In response to CERP user concerns, the CERP Standard and Abbreviated Application Forms have been revised, reorganized and reformatted so that they are clearer, more logical and easier to follow. The new forms will be implemented in July 2013. Over time, CERP plans to transition to an online application process.

*CERP Governance Structure.* The Council and CERP Committee are exploring a proposal to restructure ADA CERP as an agency separate from the Council to better support the program's mission, enhance its impartiality and objectivity, and minimize internal conflicts of interest. Proposed revisions to the ADA *Bylaws* and draft rules for this proposed agency (similar to those of other ADA commissions) are being circulated to the communities of interest and the Board of Trustees for comment. The Council will review the comments at its December 2013 meeting.

### **Continuing Education Matters**

*Interagency Committee on Continuing Education.* The Council reaffirmed its commitment to establishing a unique market niche for the ADA's CE activities and aligning CE programming on an agency-wide basis. A restructured interagency CE Committee including a representative from each of the following agencies: CDEL (appointee to serve as chair), CDP/CPS, ADA CE Online (editor-in-chief), JADA Editorial Board, CAS, CEBJA (or other agency, on a rotating, as-needed basis), CSA/EBD, CM and NDC has been established. Criteria for the development of new CE endeavors by the ADA have been adopted. The criteria will provide the CE Committee with a framework to evaluate the potential benefits of developing new CE programs as well as to continue or sunset current CE activities.

*ADA CE Online.* [ADA Continuing Education Online](#) is in its sixth year of operation. Registered users and revenue continue to grow. Currently there are 35,404 registered users, of which 6,572 registered in 2012. Revenue for 2012 was \$80,520 representing a 47% increase compared to 2011. There are 100 course offerings in the library; 14,294 courses were taken in 2012. The Editorial Board reviews existing and new courses for continued relevance on an ongoing basis. During 2013, 26 new courses are being reviewed.

*ADA's Recognition as a CERP-Approved CE Provider.* In June 2012, the ADA submitted an application to ADA CERP for continued recognition as a CE provider. The six areas of the Association that deliver continuing dental education collaborated on the application. In late 2012, CERP approved the ADA's continued recognition as a CE provider for the maximum four-year period.

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

The Council oversees the [Dental Admission Test Program](#), which continues to be exclusively administered as a computer-based examination via Prometric Testing Centers throughout the United States and its territories. Trends in the DAT Program from 2008 to 2012 include:

- The reliabilities of scores achieved on each test on the DAT battery are strong ( $\geq 0.90$  for the Survey of the Natural Sciences and Perceptual Ability Test, 0.86 and 0.85 for the Reading Comprehension Test and Quantitative Reasoning Test, respectively).

- This criterion-related validity evidence remains consistent over time and helps to reassure dental school admission committees of the continued value of including DAT scores as part of admission criteria.
- In 2012, a total of 13,156 individuals sat for the DAT (both first-time and repeat administrations); 8,883 of these were taking the test for the first time. Comparing 2008 with 2012 suggests an overall decrease of 983 DAT administrations (a 7% decrease). For first-time DAT examinees, there was a slight decrease of 81 examinees between 2008 and 2012.
- Between 2008 and 2012, the percentage of male test takers slightly decreased from 50.0% to 48.4%, while the percentage of females taking the DAT slightly increased from 50.0% to 51.6%.
- The percentage of test administrations involving American Indian (less than 2%) and Black examinees (about 6%) has been stable since 2008. With respect to Asian examinees, the percentage of administrations for 2012 (more than 20%) was the lowest since 2008. For Hispanic examinees the percentage increased from 6.8% to 8.1% from 2008 to 2012, while the percentage of White examinees decreased from 55.8% to 52.2%. The ethnicity category 'Native Hawaiian/other Pacific Islander' was added beginning in 2011; less than 2% of administrations involved Native Hawaiian/other Pacific Islander examinees during the time period for which data was available.

### Responses to House of Delegates Resolutions

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#### *17-2012. Amendment to the Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists (Trans.2012:473)*

In 2011, the ADA House of Delegates adopted Resolution 48H-2011, directing the Council to review the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists* (Trans.2011:478). The Council was requested to consider Requirement 1(a) in the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists* which states that a recognized specialty sponsoring organization's membership should be reflective of the special area of dental practice (as defined by the *ADA Code of Ethics*, Section 55.H., General Standards, for announcing specialization or limitation of practice), and consider interpreting "reflective" to mean that only specialist dentist members be able to vote and to hold office. In response, the Council transmitted Resolution 17 to the 2012 ADA House of Delegates:

#### **Resolution 17-2012 —Amendment to the Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists**

**Resolved**, that Requirement (1) of the Requirements for Recognition of Dental Specialties be revised as follows (additions are underscored; deletions are ~~stricken~~):

(1) In order for an area to ~~be~~ become and/or remain recognized as a dental specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of ~~the special area of that proposed or recognized dental specialty practice~~; (b) in which the privileges to vote and hold office are reserved for dentists who have either completed a CODA-accredited residency program in that proposed or recognized specialty or a formal advanced education program as defined in Requirement (6); and ~~(bc)~~ that demonstrates the ability to establish a certifying board.

and be it further

**Resolved**, that the introductory paragraph of the Requirements for Recognition of National Certifying Boards for Dental Specialists be revised as follows (additions are underlined; deletions are ~~stricken~~):

In order to become, and remain, eligible for recognition by the American Dental Association as a national certifying board for a ~~special area of practice~~ dental specialty, the ~~area~~ specialty shall have a sponsoring or parent organization ~~whose membership is reflective of the recognized special area of dental practice~~ that meets all the elements of Requirement (1) of the Requirements for Recognition of Dental Specialties. A close working relationship shall be



maintained between the parent organization and the board. Additionally, the following requirements must be fulfilled.

and be it further

**Resolved**, that requirement (2) in the section on Organization of Boards be revised as follows (additions are underscored; deletions are ~~stricken~~):

(2) Each board shall submit in writing to the Council on Dental Education and Licensure a program sufficiently comprehensive in scope to meet the requirements established by the American Dental Association for the operation of a certifying board. This statement should include evidence of sponsorship of the board by a national organization ~~representing dental practitioners interested in that special area of practice~~ that meets all the elements of Requirement (1) of the Requirements for Recognition of Dental Specialties.

and be it further

**Resolved**, that the sponsoring organizations representing the currently recognized dental specialties be given until July 1, 2015, to demonstrate compliance with this revised requirement, and be it further **Resolved**, that the Council on Dental Education and Licensure develop and implement a procedure to certify compliance by each sponsoring organization representing a currently recognized dental specialty and report its findings to the 2015 House of Delegates.

As a result on considerable testimony presented at the Reference Committee Hearing as well as in the House of Delegates meeting, the 2012 House of Delegates referred Resolution 17 back to the appropriate ADA agency(ies) for further consideration. In recommending this referral, the Reference Committee on Dental Education, Science and Related Matters offered the following guidance:

*The Reference Committee heard testimony from many members on Resolution 17. The Reference Committee believes that there will be unintended consequences if the Requirements for Recognition are amended as proposed. The Committee concluded that the Council on Dental Education and Licensure; the Council on Access, Prevention and Interprofessional Relations; the Board of Trustees and the American Association of Public Health Dentistry should be given the opportunity to further explore options to define the term “reflective” and to arrive at a procedure to bring the sponsoring organization of public health dentistry into alignment with the other dental specialty organizations regarding this policy without disenfranchising dentists in the public health community. Accordingly the Reference Committee supports referral of Resolution 17 to the appropriate ADA agency(ies) for further study with a report to the 2013 House of Delegates.*

Council Chair, Dr. Ronald Venezie, established and chaired an ad hoc workgroup to make recommendations to the Council. Workgroup members included Dr. Teresa Dolan, vice chair of CDEL, Dr. Donald L. Seago, ADA Board of Trustees liaison to CDEL, Dr. Jane Gillette, CAPIR member and Dr. Catherine Hayes, president-elect, American Association of Public Health Dentistry (AAPHD). The workgroup as well as the Council unanimously supported the following key principles:

- The recognized specialties of dentistry are a vital part of the profession and must be maintained at the highest standards.
- The sponsoring organization of a recognized dental specialty serves as the voice of that specialty and must be governed by dentists who either have completed advanced dental specialty education or have substantially comparable experience in that dental specialty.
- The specialty sponsoring organization and its certifying board must determine jointly whether a dentist is appropriately experienced in that dental specialty in order to be eligible to hold office in the specialty sponsoring organization or to vote on any issue related to the specialty.
- The sponsoring organization of a dental specialty has the right to offer one or more affiliate membership categories to non-dentists—provided that such membership categories do not include the privileges to hold office in the specialty sponsoring organization or to vote on any issue related to the specialty.

- At present, the sponsoring organizations of the dental specialties, with the exception of the AAPHD, meet Requirement 1(a) as proposed.
- All sponsoring organizations should be given until July 2015 to demonstrate/confirm compliance with the amended Requirement 1(a).
- The Council on Dental Education and Licensure should then confirm that all sponsoring organizations are in compliance with the amended Requirement 1(a) and report its findings to the 2015 House of Delegates.

Thus, the Council on Dental Education and Licensure recommends that the following resolution be adopted by the 2013 House of Delegates:

**33. Resolved**, that Requirement (1) of the Requirements for Recognition of Dental Specialties be revised as follows (additions are underscored; deletions are ~~stricken~~):

(1) In order for an area to ~~be~~ become and/or remain recognized as a dental specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of ~~the special area of that proposed or recognized dental specialty practice~~; (b) in which the privileges to hold office and to vote on any issue related to the specialty are reserved for dentists who either have completed a CODA-accredited advanced education program in that proposed or recognized specialty or have sufficient experience in that specialty as deemed appropriate by the sponsoring organization and its certifying board; and (b~~c~~) that demonstrates the ability to establish a certifying board.

and be it further

**Resolved**, that the introductory paragraph of the Requirements for Recognition of National Certifying Boards for Dental Specialists be revised as follows (additions are underlined; deletions are ~~stricken~~):

In order to become, and remain, eligible for recognition by the American Dental Association as a national certifying board for a ~~special area of practice~~ dental specialty, the ~~area~~ specialty shall have a sponsoring or parent organization ~~whose membership is reflective of the recognized special area of dental practice~~ that meets all the elements of Requirement (1) of the Requirements for Recognition of Dental Specialties. A close working relationship shall be maintained between the parent organization and the board. Additionally, the following requirements must be fulfilled.

and be it further

**Resolved**, that requirement (2) in the section on Organization of Boards be revised as follows (additions are underscored; deletions are ~~stricken~~):

(2) Each board shall submit in writing to the Council on Dental Education and Licensure a program sufficiently comprehensive in scope to meet the requirements established by the American Dental Association for the operation of a certifying board. This statement should include evidence of sponsorship of the board by a national organization ~~representing dental practitioners interested in that special area of practice~~ that meets all the elements of Requirement (1) of the Requirements for Recognition of Dental Specialties.

and be it further

**Resolved**, that the sponsoring organizations representing the currently recognized dental specialties be given until July 1, 2015, to demonstrate compliance with this revised requirement, and be it further

**Resolved**, that the Council on Dental Education and Licensure develop and implement a procedure to certify compliance by each sponsoring organization representing a currently recognized dental specialty and report its findings to the 2015 House of Delegates.

*19H-2012. Rescission of the Policy, Communication Between State Boards of Dentistry (Trans.2012:462)*

The rescinded policy has been removed from appropriate ADA documents.

*20H-2012. Amendment of the Policy, Monitoring Clinical Dental Licensure Examinations (Trans.2012:462)*

Appropriate ADA documents have been corrected to reflect the amended policy.

*21H-2012. Amendment of the Policy, Clinical Licensure Examinations in Dental Schools (Trans.2012:462)*

Appropriate ADA documents have been corrected to reflect the amended policy.

*22H-2012. Amendment of the Policy, State Board Support for CDA as Responsible to Evaluate Dental Education Programs (Trans.2012:463)*

Appropriate ADA documents have been corrected to reflect the amended policy.

*23H-2012. Amendment of the Policy on One Standard of Competency: State Boards Review Limited Licensure Graduates of Nonaccredited Dental Schools for Providing Access to Care for Underserved Populations (Trans.2012:463)*

Appropriate ADA documents have been corrected to reflect the amended policy.

*24H-2012. Amendment of the Policy on Dual Degreed Dentists (Trans.2012:464)*

Appropriate ADA documents have been corrected to reflect the amended policy.

*25H-2012. Amendment of the Policy, Endorsement of Recommendations of the ADA Guidelines for Licensure by Credentials (Trans.2012:464)*

Appropriate ADA documents have been corrected to reflect the amended policy.

*26H-2012. Amendment of the Policy on Licensure of Graduates on Nonaccredited Dental Schools (Trans.2012:477)*

Appropriate ADA documents have been corrected to reflect the amended policy.

*27H-2012. Amendment of the Policy, Guideline for Licensure (Trans.2012:464)*

Appropriate ADA documents have been corrected to reflect the amended policy.

*28H-2012. Amendment of the Position Statement on Federal Intervention in Licensure (Trans.2012:468)*

Appropriate ADA documents have been corrected to reflect the amended policy.

*29-2012. Amendment of the Policy, Eliminating Use of Human Subjects in Board Examinations. (Trans.2012:478)*

Resolution 29 was referred to the appropriate ADA agencies for evaluation of the accuracy and relevance of the second resolving clause. The resolution was assigned to the Council on Ethics, Bylaws and Judicial Affairs and CDEL. Both Councils collaborated to develop a revised resolution that is reported by CEBJA in its annual report to the 2013 House of Delegates. The Councils agreed on all but one proposed change. The Council on Dental Education and Licensure does not support the proposed inclusion of the phrase "or a portfolio style format" in the penultimate resolving clause of the policy statement. CDEL is supportive of the concept of a "portfolio style examination," but objects to the revision at this time because the House of Delegates has not yet approved a formal definition for the term "portfolio style examination." Further, no jurisdictions currently grant initial licensure based on a portfolio style examination.

*30H-2012. Amendment of the Policy, Acceptance of Results of Regional Boards (Trans.2012:468)*

Appropriate ADA documents have been corrected to reflect the amended policy.

*31H-2012. Amendment of the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists (Trans.2012:468)*

Appropriate ADA documents have been corrected to reflect the amended policy.

*32H-2012. Amendment of the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (Trans.2012:469)*

Appropriate ADA documents have been corrected to reflect the amended policy.

*161H-2012. Nominating Non-Professional (Public) Members of CODA (Trans.2012:470)*

The Council has implemented a process to assist the Board of Trustees in seeking nominations for public members to serve on the Commission on Dental Accreditation.

*185H-2012. Requirement for Specialty Recognition/Process and Evaluation Criteria for Specialty Recognition (Trans.2012:521)*

Resolution 185H requested the Council to conduct a comprehensive review of the Requirements for Recognition of Dental Specialties, the Criteria for Recognition of Interest Areas in General Dentistry, and the application process. The last comprehensive review of and amendments to the specialty recognition requirements and process occurred in 2001. The House amended the Requirements again in 2009. The Criteria for Recognition of Interest Areas in General Dentistry were adopted by the House in 2010. To date, no application for recognition of an interest area in general dentistry has been received.

In conducting this review, the Council studied comprehensive background information regarding the processes for specialty recognition and recognition of interest areas in general dentistry. This included information regarding the duties of the Recognition Committee, history of the recognition processes, requirements/criteria for recognition, the 2012 House of Delegates discussions on Resolution 17 and 185H, and the procedures for managing applications. The Council also solicited input from the sponsoring organizations of the recognized dental specialties and their respective certifying boards. Responses were received from the American Association of Oral and Maxillofacial Surgeons, American Academy of Oral and Maxillofacial Pathology, American Association of Orthodontists, the American Board of Oral and Maxillofacial Surgery, The American Board of Orthodontics, American Board of Prosthodontics, American College of Prosthodontists and the American Academy of Periodontology. The following summarizes the Council's findings:

In regard to the process for managing applications for recognition of a dental specialty or an interest area in general dentistry, the Council considered a suggestion that that the sponsoring organizations representing the recognized dental specialties be given equal time and opportunity to provide oral and written testimony on an application for recognition to the Council, its subcommittees, the ADA Board of Trustees and the district caucuses. The Council determined that proposed written comments received from the communities of interest regarding an application for recognition should be posted electronically on ADA.org and that, following receipt of a recognition application in June an open hearing should be conducted at the subsequent ADA annual session, inviting oral and written comments from the broad communities of interest. The Council believes that, with these additional steps, the broad communities of interest will have ample opportunity to provide comment regarding an application for recognition.

Suggestions were considered to increase the timeframe in which a new application may be submitted after final action by the House to deny recognition (or in the event the application is voluntarily

withdrawn) from the current 24 months to 36, 48 or 60 months. The Council believed that 36 months was a reasonable length of time, allowing an applicant additional time necessary to document progress and compliance with the requirements/criteria more thoroughly.

The Council also considered a recommendation that the ADA *Bylaws* be amended to include a provision relative to the recognition of new dental specialties. The recommendation suggested requiring a two-thirds vote of the House of Delegates to recognize new specialties. The Council strongly opposed this concept, noting that a two-thirds or super majority vote is only required for items of great magnitude such as amendment of the ADA *Constitution and Bylaws* and establishing annual dues. The Council believes that a two-thirds vote should not be required by ADA *Bylaws* or policy for a new specialty to be recognized by the House of Delegates.

Accordingly, in response to Resolution 185H-2012, the Council revised its procedures for recognition of a dental specialty or interest area in general dentistry so that:

1. Comments received from the communities of interest regarding an application for recognition will be posted electronically on ADA.org and be accessible to all interested parties;
2. Following receipt in June of an application for recognition, an open hearing will be conducted at the subsequent ADA annual session, inviting oral testimony and written comment from the broad communities of interest; and
3. The recognition application fee will be set annually, commensurate with the real costs related to managing the application (\$12,200 for 2014).

The recognition reapplication process and procedures were amended so that:

1. A new application may not be submitted until 36 months (formerly 24 months) after final action on the application has been taken by the House of Delegates or, in the event of voluntary withdrawal, 36 months (formerly 24 months) from the time that action would have been taken by the House of Delegates if the application had not been withdrawn.
2. Resubmission of the application must be in its entirety, including the current application fee (formerly \$3,000 fee). The applicant is responsible for highlighting new and/or clarifying information since the time of previous submission. Further, the information submitted should address deficiencies noted at the time the application was denied/withdrawn.

In regard to the [Requirements for Recognition of Dental Specialties](#), the Council carefully considered a proposed revision to Requirement 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; (b) that demonstrates the ability to establish the viable practice of the specialty across a broad national geographic distribution, preferably in every state; and (c) that demonstrates the ability to establish a certifying board.”

The Council believes that the proposed recommendation to amend Requirement 1 is overly restrictive, cannot be assessed in a meaningful way and may have unintended consequences for some of the currently recognized specialties. Additionally, the Council believes that documenting the viability of a proposed dental specialty is inherent in the recognition process and is adequately addressed in the current Requirements for Recognition.

The Council also carefully considered a proposed revision to Requirement 4:

“The specialty applicant must document scientifically, by valid and reliable statistical evidence/studies conducted by an independent source and/or verified by an independent psychometric analysis and that are not merely survey results or studies from small geographic areas (e.g., studies from only one or two states then extrapolated to represent a broad geographic area), 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 in a viable manner over a national geographic distribution; all of which are currently not being met by general practitioners or dental specialists.”

The Council believes that the composition and criteria for the selection of individuals serving on the Committee on Recognition is appropriate and coupled with the expertise of the Council on Dental Education and Licensure, provides the necessary expertise to conduct a thorough and critical review of an application for recognition. It is within the purview of the Council to seek further expert review in the event that the Committee and/or the Council determine that independent consultation or expert review of an application is warranted. In addition, the Council's proposed revisions of the recognition process will provide ample opportunity for the communities of interest to comment on the validity of data presented in an application.

In summary, the Council supports the amendment to the Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists as presented in Resolution 33, and proposes no further amendment to Requirements 1 through 6 at this time.

In regard to the [Criteria for Recognition of Interest Areas in General Dentistry](#), the Council reviewed the Criteria adopted by the 2010 House of Delegates, noting that to date no group has sought formal recognition of a general dentistry interest area. The Council also reviewed comments from some of the dental specialty sponsoring organizations and certifying boards questioning the need for and opposing in general the Association's recognition of interest areas in general dentistry. The Council concluded that there is no experience or evidence to support changes to or rescission of the Criteria for Recognition of Interest Areas in General Dentistry at this time. In accordance with Resolution 170H-2012, Reaffirming Existing ADA Policy, the Council is scheduled to review the Criteria again in no more than five years.

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## Policy Review

In accordance with Resolution 111H-2010, Regular Comprehensive Policy Review, and Resolution 170H-2012, the Council established a five-year schedule for reviewing ADA policies related to dental education and accreditation, continuing education, licensure, dental specialties, and anesthesia and sedation.

This year, in response to referred Resolution 17-2012, Amendment to the Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists, and Resolution 185H-2012 Requirements for Specialty Recognition/Process and Evaluation Criteria for Specialty Recognition, the Council focused solely on these policies as well as the process for managing applications for the recognition of dental specialties and general dentistry interest areas. The Council's actions and recommendations related to these matters are noted previously in this report.

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## Summary of Resolutions

Resolution 33. Amendment to the Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists

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## Council Minutes

For more information on recent activities, see the Council's minutes on ADA.org: <https://www.ada.org/members/1293.aspx#licensure>.

# Council on Dental Practice

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Knapp, Jonathan B., 2013, Connecticut, chair  
Sessa, Kevin D., 2014, Colorado  
Armstrong, Craig S., 2013, Texas  
Bengtson, Gregory J., 2016, Idaho  
Brown, Andrew B., 2016, Florida  
Childs, Miranda M., 2015, Arkansas  
Cole, Jeffrey M., 2013, Delaware  
Creasey, Jean L., 2016, California  
Davidson, Madalyn M., 2013, Illinois, *ex officio*\*  
Dawley, Joanne, 2014, Michigan  
Dowd, Brendan P., 2014, New York  
Johnston, Jon J., 2013, Pennsylvania  
Marshall, Todd W., 2016, Minnesota  
Maxwell, Charles B., 2015, South Carolina  
Smith, J. Christopher, 2016, West Virginia  
Thomas, J. Mark, 2015, Indiana  
Torbush, Douglas B., 2014, Georgia  
Unger, Joseph G., 2015, Illinois

Willey, James L., director  
Porembski, Pamela M., senior manager  
Bregenzer, James, manager  
Siwek, Alison, manager

The Council's 2012-13 liaisons include: Dr. Gary L. Roberts (Twelfth District trustee, Board of Trustees), Dr. James F. Jenkins (Council on Communications) and Mr. Benjamin Youel (American Student Dental Association).

## Mission and Purpose

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The mission of the Council on Dental Practice is to recommend policies and provide resources to empower our members to continue development of the dental practice, and to enhance their personal and professional lives for the betterment of the dental team and the patients they serve.

## Supporting the Strategic Plan: Activities, Results and Accomplishments

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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 has led interagency efforts to create an ADA Center for Professional Success (CPS) in 2013. A soft launch with beta testing of the web portal took place starting in July 2013 and the marketing plan kick-off is scheduled for September 2013. The roll-out of the CPS practice management resource portal is planned for the 2013 ADA annual session. Building member value is one of the ADA's priority items for 2013 related to the CPS. The CDP invested considerable efforts in 2012-13, leading and coordinating the interagency team of over 50 staff members that implemented the CPS initiative. The new CPS web portal is filled with practice management content divided into three areas confirmed by qualitative and quantitative market research: Practice, Learn, and Live. The "Practice" section includes a plethora of information on building a successful career in dentistry, regardless of the professional path chosen. The "Learn" section includes executive level online and in-person continuing education, including a certificate program in practice management. The "Live" section includes information on wellness, well-being and work/life balance. There are opportunities to create

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

multiple member value applications, products and services and also promote the cross marketing of existing ADA products and services through the CPS.

The biennial Conference on Dentist Health and Well-Being, “Beyond the Tooth: Your Career/Life Balance,” will be held September 19-20, 2013. The Council also produced an opioid webinar program series in 2012 and 2013. For year two (June 2012–June 2013) of the Physician Clinical Support System-Opioid (PCSS-O) grant, the ADA developed four additional webinars for interested health professionals. “The Chemically Dependent Patient” by Dr. William Kane was presented at the 2012 ADA annual session to a sold out audience of 289 attendees. “Opioid Prescribing—Spokane County Dentists” was presented by Amy Riffe, MA, MPH in January 2013. “Statewide Survey of Opioid Prescribing Patterns in Adult Dental Patients in West Virginia” was presented by Michael O’Neil, Pharm.D. Opioids in February 2013 and “Non-Opioids Prescription for Dental Care in Emergency Departments in the United States” was presented by Dr. Christopher Okunseri in April 2013. For year three, the PCSS-O grant funded four opioid prescribing and addiction sessions at the ADA’s Conference on Dentist Health and Well-Being in September 2013.

The Council collaborated with the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) in reviewing Resolution 165-2012, Declaring an Employee Dentist’s Bill of Rights (*Trans.*2012:505), which the House referred for further study and report. Both councils agreed to a proposed “Statement Regarding Employment of a Dentist,” which broadens the scope of the statement to focus on both employer and employee dentists and puts the focus on the protection of the patient. CEBJA’s annual report provides more detail on this collaborative effort.

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 collaborated with the Department of Product Development and Sales (DPDS) to develop 25 oral health brochures for distribution by dentists to their patients. Additionally, the project selected by the 2011-12 Hillenbrand Fellow was the creation of a primer on the development of some type of oral health care safety net system for an “unserved” area. The end result, entitled “Avenues to Access,” included an instructional PowerPoint presentation and a companion print piece, both of which are available at <http://www.ada.org/2574.aspx?currentTab=2>. The material is directed toward interested parties who are unfamiliar with the public health arena, yet desire to do “something to help” in their community.

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 and/or collaborating with national organizations representing members of the dental team. These included the American Dental Assistants Association (ADAA), the Dental Assisting National Board (DANB), the American Dental Hygienists’ Association (ADHA), the American Association of Dental Office Managers (AADOM), the National Board for Certification in Dental Laboratory Technology (NBC), the National Association of Dental Laboratories (NADL) and the 2013 Lab Summit. Staff also attended annual meetings of the American Academy of Dental Group Practice (AADGP) and the American Academy of Dental Practice Administration (AADPA) to develop an enhanced expertise and knowledge base and identify emerging issues related to dental practice management. The CDP collaborated with the DPDS to update *The ADA Practice Guide to Effective Infection Control*, and helped to promote this revised publication.

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 collaborations with DPDS and the sharing of its content expertise through the revision of oral health brochures and practice management publications. The *Dental Office Design Book* was redesigned and released in January 2013. The CDP continues to maintain modest revenue from advertising revenues derived from its *Directory of Dental Practice Appraisers and Brokers* and *Directory of Dental Practice Management Consultants*. Although primarily focused on building member value, there will be opportunities for non-dues revenue within the CPS.



The Council went through a major reorganization of its activities, subcommittees and priorities in 2012. A list of 38 distinct activities shared across 14 council subcommittees was reduced to four major project areas, which included the following five subcommittees: the CPS Advisory Committee; the Subcommittee on Group Practice and the Economy; the Subcommittee on the Dental Team; the Dental Wellness Advisory Committee; and the Subcommittee on Policy Review.

The Council held a strategic planning session at its May 9–11, 2013, meeting to discuss Building Member Value, the ADA's Strategic Initiative for 2013.

## Emerging Issues and Trends

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### The Department of Standards

The CDP reviews the work products of the Standards Committee on Dental Informatics (SCDI) as part of its *Bylaws* duties.

**Objective of the Standards Department:** The objective of the Department of Standards is to help dentists succeed by developing standards and technical reports for current and emerging technologies used in the dentist's practice. The ADA's voluntary standards program is an American National Standards Institute (ANSI) accredited program that manages the development of voluntary consensus standards that support dentists and provides member value.

The ADA standards program supports dentists by ensuring that ADA Standards have proper dental representation and reflect the practice of dentistry. ADA Standards provide member value by providing the ADA member confidence in purchasing and using products in his or her practice. If the ADA did not develop standards for dentistry, outside organizations would step in and determine what is best for dentistry. ADA Standards help keep dentistry independent.

The ADA SCDI is involved in developing standards and technical reports for electronic health records, interoperability and other issues involving the safe and secure storage and exchange of digital images and patient data in dentistry.

To carry out the ADA's commitment to fostering interoperability of dental data and devices, the ADA Standards program supports the development, adoption and implementation of the Digital Communications and Imaging in Medicine (DICOM) standard in dentistry. The Standards Department also has become an active participant in Integrating the Healthcare Enterprise (IHE). IHE provides a way to assure purchasers about digital technology system performance in the real world practice setting and to assist in establishing interoperability between imaging systems and Electronic Health Records (EHR) systems.

Over the past year, the ADA Standards Department supported dentists through the following informatics activities:

**Teledentistry Activities.** In response to Resolution 107H-2012, Teledentistry (*Trans.*2012:455), the SCDI formed a new working group on teledentistry. The group is recruiting volunteers to begin considering new work standard projects in teledentistry.

**SCDI Digital Technologies.** The IHE Dental Domain progressed in its multi-year project to develop dental standards implemental projects that will assist ADA members in selecting digital dental information systems whose interoperability in real-world practice settings has been demonstrated. The first IHE profile, covering secure exchange of digital dental images, has been completed and the testing software needed to demonstrate conformance is now in development.

Planning is underway for the 2014 IHE Connect-a-thon, an annual event where vendors of healthcare information systems test the implementation of interoperability standards.

An interoperability demonstration exhibit is planned for the 2014 ADA annual session, whereby dentists will be able to exchange images in a real-world setting.

The ADA Standards Department is the Secretariat of DICOM Working Group 22-Dentistry. The working group is developing a supplement to the DICOM standard that will update and expand the dental terminology and coding used in the standard to make it more user-friendly for dental systems.

*Forensic Dental Data Standard Implementation Activities.* The ADA Standards program is continuing to collaborate with the National Institute of Standards and Technology (NIST) to incorporate *ANSI/ADA Standard No. 1058 on Forensic Dental Data Set* into ANSI/NIST Information Technology Laboratory (ITL) 2011, a standard that deals with the transmission of biometric information between police agencies. The resulting standard will provide dentists with the specifications needed to forensically code dental information and exchange this dental and radiographic data with national and international law enforcement agencies to assist in missing person and victim identification.

*Inaugurating Free Viewing of Standards for Members.* This past year, both ADA standards committees, the Standards Committee on Dental Products (SCDP) and the SCDI, approved a proposal to provide read-only viewing of ADA standards, technical reports and other standards-related products on the members-only area of ADA.org and ADA Connect. This new program, now in development, will provide a significant new benefit for members, who previously had to purchase a standards-related product in order to read it.

*New ANSI/ADA Standards for Electronic Dental Record Approved.* The SCDI approved *ANSI/ADA Standard No. 1067 for Electronic Dental Record System (EDR) Standard Functional Requirements*. This new standard marks a major advancement in the ADA's development of the electronic dental record by enumerating the functional requirements of the EDR. The SCDI also took another step in the development of the orthodontic health record with the approval of *ADA Technical Report No. 1065 for Use Cases of the Orthodontic Health Record*.

*ADA Standards and Technical Reports Cover New Technologies.* The SCDI is proactive in providing standards, technical reports or white papers on the state-of-the-art new products and technologies to provide members with up-to-date information as soon as it becomes available. This past year, the SCDI developed a *White Paper on Clinical Oral Health Risk Assessment Software Programs*. This paper is available free to members in 2013. The SCDI approved a new standards project, *Proposed ADA Technical Report No. 1073 for Monitoring the Patient's Exposure to Ionizing Radiation in Dentistry*. This new project addresses the need for monitoring patient radiation dose by assessing methods for recording and communicating the patient's exposure to ionizing radiation in dentistry.

*New Work Projects.* The following new work items were approved by the SCDI this past year:

- Proposed ADA Technical Report No. 1077 for Dental Biometric Descriptors;
- Proposed ADA Technical Report No. 1076 for Practitioner's Guide to E-Mail Transmission of Digital Images;
- Proposed ADA Technical Report No. 1078 for Preparing Images for Digital Exchange; and
- Proposed ADA Standard No. 1079 for Electronic Attachments for Dental Claim.

The Electronic Health Records (EHR) Primer and EHR Frequently Asked Questions were also updated and posted on ADA.org.

### **Trends in Dental Group Practice**

The growth in group practice has been noted as an increasing trend by several ADA agencies, each with unique perspectives and concerns. The CDP's interest in group practice is gaining a better understanding of group business models. The Council's second ADA annual session forum on current dental topics, "The Growth of Group Practice and Implications for the Profession," will focus on the growth of dental group practice and its potential impact on dentistry. Other agencies with an interest in group practice

include the Health Policy Resources Center; the New Dentist Committee; and the Councils on Membership, Government Affairs, Ethics, Bylaws and Judicial Affairs, and Communications. The CDP led an Interagency Workgroup on Dental Group Practice that met by conference calls in 2012-13. Two Board of Trustees members were added to this group at the Board's March 2013 meeting. The CDP's Subcommittee on Practice Models and Economics would like to help educate members in response to this emerging trend based on a group practice research agenda proposed by the Health Policy Resources Center.

## **Responses to House of Delegates Resolutions**

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### ***34-2012. Amendment of the Policy, Definition of Fee-for-Service Private Practice (Trans.2012:447)***

Resolution 34-2012 proposed an Amendment of the Policy, Definition of Fee-for-Service Private Practice (*Trans.1979:620*) and was referred by the House for study and report back to the 2013 House of Delegates. The Council on Dental Practice recommended that this Policy should be maintained. Accordingly, no resolution is needed or being proposed. Although fee-for-service is not the only model for reimbursement, it is still perceived to be the predominant method for the delivery of oral health care.

### ***46-2012. Rescission of the Policy, Sale of Dental Equipment to Illegal Practitioners (Trans.2012:450)***

Resolution 46-2012 proposed rescission of the Policy, Sale of Dental Equipment to Illegal Practitioners (*Trans.2001:436*) and was referred by the House for study and report to the 2013 House of Delegates. The Council unanimously recommended rescission of this policy because of legal concerns and the unlikelihood of enforceability. A supplemental report on Resolution 46-2012 will be submitted to the 2013 House of Delegates.

### ***107H-2012. Teledentistry (Trans.2012:455)***

The 2012 House of Delegates adopted Resolution 107H-2012, which provided a definition of teledentistry and directed that dentists be encouraged to consider conformance with the DICOM standards when selecting and using imaging systems. It also directed that the appropriate agencies develop standards and implementation guidelines to assist dentists with all aspects of teledentistry. The SCDI reviewed the definition of teledentistry that was approved by the 2012 ADA House of Delegates. The SCDI formed a working group for teledentistry under its Subcommittee on Information Exchange at its February 2013 meeting to develop standard documents for teledentistry.

### ***109H-2012. Optional Donation on Constituent Society Dues Statement for Well-Being Programs (Trans.2012:445)***

The 2012 House of Delegates adopted 109H-2012, which urged each constituent dental society to implement an optional donation line-item for well-being programs on its annual dues statement. In an effort to support constituent dental societies in the development and maintenance of diversion programs that identify and assist dentists, dental team members and dental students affected by addiction and impairment issues, the Council on Dental Practice's Dentist Health and Wellness Program has been collaborating with constituent dentist well-being program directors to inform constituent dental society leadership of Resolution 109H-2012. Awareness efforts include email updates to constituent dentist well-being program directors and development of an ADA Dentist Health and Wellness Newsletter article promoting Resolution 109H-2012. In addition, a memo was sent to the constituent society executive directors and membership staff asking them to consider adding a voluntary line-item on their annual dues statements in support of well-being programs in their society. Fourteen of 35 constituent dental societies responded that their organizations were incorporating an optional dues line-item. Four of the 35 that responded will bring the resolution to their September Board meetings for consideration.

*162H-2012. Bone Marrow Matching Programs (Trans.2012:458)*

Resolution 162H-2012, which was included in matters considered by the Reference Committee on Dental Benefits, Practice and Health, states, "The ADA urges members to support participation in the bone marrow matching program by providing appropriate literature in their offices, gathering samples and forwarding them for registration." Implementation of this resolution was assigned to the Divisions of Dental Practice/Professional Affairs and Science/Professional Affairs. The *ADA News* published an article in its May 20, 2013, issue promoting bone marrow matching programs. Additionally, information will be posted to ADA.org regarding bone marrow matching programs and will refer dentists to the major testing sites.

## Policy Review

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In accordance with Resolution 111H-2010, Regular Comprehensive Policy Review, and 170H-2012, the Council on Dental Practice reviewed ADA policies and presents a series of resolutions with recommendations to rescind or amend those policies. The Council also proposed new policy.

## Policies to be Maintained

The Council on Dental Practice reviewed the following policies and determined they should be maintained as written.

Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform Irreversible Procedures (*Trans.2005:343; 2010:521*)  
 Best Dentist Lists (*Trans.2005:339*)  
 Delegation of Radiographic Film Exposition (*Trans.1982:534*)  
 Maintenance of Multi-Pathway Options for Dental Assistants (*Trans.1996:696*)  
 New Clinical Responsibilities for Dental Assistants (*Trans.1996:701*)  
 ADA Position on Dental Mid-Level Provider (*Trans.2008:439*)  
 State Mass Disaster Plan (*Trans.2002:387*)  
 Liability Protection for Bioterrorism Responders (*Trans.2002:398*)  
 ADA Involvement in Electronic Data Interchange Activities (*Trans.1992:598*)  
 Development of Electronic Dental Patient Records (*Trans.1992:598*)  
 Electronic Technology in Dentistry (*Trans.1992:608*)  
 Seamless Electronic Patient Record (*Trans.1996:694*)  
 Dental Practice Management Software (*Trans.2001:428*)  
 Economic Credentialing (*Trans.1993:692*)  
 Hospital Medical Staff Membership (*Trans.1999:923*)  
 Recognition Program for Meritorious Service by Certified Dental Technologists (*Trans.1987:496; 1999:922*)  
 Support of the Dental Laboratory Technician Certification Program and Continuing Education Activities (*Trans.1997:682; 2010:547*)  
 Ownership of Dental Practices (*Trans.2000:462*)  
 Guidelines Related to Alcohol, Nicotine, and/or Drug Use by Child or Adolescent Patients (*Trans.2005:330*)  
 Dental Needs Survey (*Trans.1985:588*)  
 Support for Programs That Forecast Public Demand for Dental Services (*Trans.1995:609*)  
 Measuring the Demand for Dental Services (*Trans.1995:623*)  
 Diagnosis of Performance of Irreversible Dental Procedures by Nondentists (*Trans.2004:328; 2010:494*)  
 Collaboration With Specialty Organizations on Workforce (*Trans.2009:420*)  
 Statement to Encourage U.S. Dental Schools to Interact With U.S. Dental Laboratories (*Trans.2010:547*)  
 Comprehensive Policy Statement on Allied Dental Personnel (*Trans.1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307; 2010:505*)

Opposition to Corporate Mandated Requirements for Patient Treatments (*Trans.*2009:420)  
 Dentistry's Role in Emergency Preparedness and Disaster Response (*Trans.*2007:431)  
 Statement on Prosthetic Care and Dental Laboratories (*Trans.*1990:543; 1995:623; 1999:933;  
 2000:454; 2003:365; 2005:327; 2007:430)  
 Availability of Survey Results (*Trans.*2008:474)  
 Volunteerism (*Trans.*2010:587)  
 ADA's Position on New Members of the Dental Team (*Trans.*2009:419)  
 Teledentistry (*Trans.*2012:000)  
 Bone Marrow Matching Programs (*Trans.*2012:000)

### **Recommendation—Policy to be Rescinded**

The Council reviewed the policy, "The National Healthcare Information Infrastructure (NHII) Task Force" (*Trans.*2005:338) and recommends rescission because the objectives of the resolved clauses were completed and the Task Force was dissolved by the Board of Trustees in 2007 when the Electronic Health Record Working Group was established.

**34. Resolved**, that Resolution 58H-2005 "The National Healthcare Information Infrastructure (NHII) Task Force" (*Trans.*2005:338), be rescinded.

The full text of the policy recommended for rescission is included in Appendix 1.

### **Recommendations—Policies to be Amended**

#### ***Recommendations of Future of Dentistry Report***

The Council believes that the policy "Recommendations of Future of Dentistry Report" should be amended because the last two resolved clauses are no longer relevant.

**35. Resolved**, that the ADA policy, "Recommendations of Future of Dentistry Report" (*Trans.*1983:552) be amended as follows (deletions are ~~stricken~~):

**Resolved**, that the Association accept the following five principal recommendations of the Future of Dentistry Report as priority guidelines for the ADA to prepare the profession for the challenges of the future.

- Convert public unmet need into demand for dental services;
- prepare the practitioners (existing and future) to be more patient/market oriented;
- broaden the practitioner's clinical skills and mix of services offered to the public;
- influence the quality and quantity of the manpower supply; and
- stimulate research and development.

and be if further

~~**Resolved**, that all appropriate Association agencies be directed to reassess their current programs and use these guidelines in formulating their future program activities, and be it further~~  
~~**Resolved**, that a report be forwarded annually by the Board of Trustees to the House of Delegates describing to what extent these guidelines have been incorporated.~~

#### ***Electronic Technology Activities***

The Council believes that the policy "Electronic Technology Activities" (*Trans.*1993:695) should be amended because the ADA activity in the area of electronic technology has been intense for several years as seen by the activities of the Department of Dental Informatics and the Standards Committee for Dental Informatics and the first resolved clause should be changed to reflect this activity and to acknowledge that more intensity is not possible.

**36. Resolved**, that the ADA policy “Electronic Technology Activities” (*Trans.*1993:695) be amended as follows (additions are underscored; deletions are ~~stricken~~):

~~**Resolved**, that the American Dental Association intensify its efforts in the field of electronic technology and that such efforts be established as~~ is a high priority for the American Dental Association, and be it further

**Resolved**, that appropriate agencies of the Association are encouraged to provide full services in the areas of information science and dental electronic technology, and report developments and trends in these fields on a regular basis to the Board of Trustees, and be it further

**Resolved**, that the Association is opposed to mandatory participation in electronic data interchange for dental claims processing.

## **Recommendation—New Policies**

### ***Statement Supporting the Dental Team Concept***

The Council believes that the policy “Statement Opposing Unsupervised Practice by Dental Auxiliaries” should be replaced with new policy because a positive statement would better serve the ADA, while preserving the concept of supervision of auxiliaries by dentists.

**37. Resolved**, that constituent dental societies, dental educators and dental examiners are encouraged to work closely and cooperatively with the ADA to support the dental team concept to prevent fragmentation of the dental team, and be it further

**Resolved**, that these parties are urged to support ADA policies on supervision of dental auxiliaries in all settings including, but not limited to, educational institutions, skilled nursing facilities and public health clinics, and be it further

**Resolved**, that Resolution 68H-1987, “Statement Opposing Unsupervised Practice by Dental Auxiliaries” (*Trans.*1987:514), be rescinded.

### ***Production of Dental Products***

The Council believes that the policy “Use of Biodegradable Materials in Manufacture and Packaging of Disposable Dental Products” (*Trans.*1991:585) should be replaced with new policy because requiring manufacturers to perform particular activities is inappropriate. A more flexible statement to cover the manufacturing process, as well as the end products, presents a better policy position.

**38. Resolved**, that the American Dental Association strongly encourages dental manufacturers to employ environmentally conscientious measures in the production, packaging and shipping of their products including, but not limited to, the use of disposable materials that are biodegradable whenever possible, and be it further

**Resolved**, that Resolution 93H-1991, “Use of Biodegradable Materials in Manufacture and Packaging of Disposable Dental Products” (*Trans.*1991:585) be rescinded.

## **Summary of Resolutions**

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Resolution 34. Rescission of the National Healthcare Infrastructure (NHII) Task Force

Resolution 35. Amendment of the Policy, Recommendations of Future of Dentistry Report

Resolution 36. Amendment of the Policy, Electronic Technology Activities

Resolution 37. Statement Supporting the Dental Team Concept

Resolution 38. Use of Environmentally Conscientious Measures in the Production, Packaging and Shipping of Dental Products

## **Council Minutes**

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For more information on recent activities, see the Council's minutes on ADA.org:  
<https://www.ada.org/members/1293.aspx#denprac>.

**Appendix 1. Policies to be Rescinded**  
**As Recommended by the Council on Dental Practice**

**The National Healthcare Information Infrastructure (NHII) Task Force (*Trans.2005:338*)**

**Resolved**, that the ADA acknowledges President Bush's NHII initiative for the healthcare environment that provides interoperable patient information will impact the future of dentistry, and be it further

**Resolved**, that the ADA position itself as the advocate for dentistry in all appropriate NHII activities, and be it further

**Resolved**, that the NHII Task Force provide an annual progress report on its activities to the 2006 House of Delegates, with appropriate recommendations for future years.

**Statement Opposing Unsupervised Practice by Dental Auxiliaries (*Trans.1987:514*)**

**Resolved**, that constituent dental societies, dental educators and dental examiners work closely and cooperatively to oppose any legislation that would allow unsupervised practice or the fragmentation of the dental team concept, and be it further

**Resolved**, that in conjunction with these legislative efforts these parties support ADA policies on supervision of dental auxiliaries in all settings including, but not limited to, educational institutions, skilled nursing facilities and public health clinics.

**Use of Biodegradable Materials in Manufacture and Packaging of Disposal Dental Products (*Trans.1991:585*)**

**Resolved**, that the American Dental Association seek to require manufacturers of disposable dental products to use wherever possible materials that are biodegradable in both the manufacture and packaging of such products.



# Council on Ethics, Bylaws and Judicial Affairs

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Henner, Kevin A., 2013, New York, chair  
Rosato, Richard J., 2014, New Hampshire, vice chair  
Auld, Douglas A., 2016, Oklahoma  
Beard, Darryll L., 2015, Illinois  
Brooks, Dwyte E., 2013, Nevada  
Chinoy, Walter I., 2013, New Jersey  
Curry, Barry D., 2015, Kentucky  
Esterburg, Jeffrey C., 2013, Ohio  
Himmelberger, Linda K., 2015, Pennsylvania  
Muller, G. Jack, II, 2016, South Dakota  
Pansick, Ethan A., 2014, Florida  
Raimann, Thomas E., 2016, Wisconsin  
Reynolds, Elizabeth C., 2014, Virginia  
Salierno, Christopher J., New York, *ex officio*\*  
Scarbrough, A. Roddy, 2016, Mississippi  
Senseny, Charlotte L., 2014, California  
Walton, William M., 2016, Texas  
Williams, Laura, 2015, Washington

Elliott, Thomas C., Jr., director  
Elster, Nanette R., manager, ethics outreach and programs

The Council's 2012-13 liaisons include: Dr. Joseph F. Hagenbruch (8th District Trustee, Board of Trustees), and Ms. Christine Hammer (American Student Dental Association).

## **Mission and Purpose**

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The Council on Ethics, Bylaws and Judicial Affairs (the Council) is the ADA agency dedicated to enhancing 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.

## **Supporting the Strategic Plan: Activities, Results and Accomplishments**

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During the current term, the Council reviewed its programs and determined them to be supportive of the current Strategic Plan or required to be performed by the ADA *Bylaws*. Since its last report, the Council engaged in numerous activities in furtherance of the Association's 2011-2014 Strategic Plan:

### **Continuing Education Program** (Goal 1-Support Members' Success, Goal 2-Trusted Source of Oral Health Information)

In October 2012, the Council presented a continuing education course on ethics at the ADA Annual Session in San Francisco. The program was very well attended with over 230 participating practitioners, students and dental auxiliaries from a wide range of settings as well as geographic areas. Participant evaluations of the course were extremely positive and the Council has submitted a proposal to offer a similar course at the 2013 Annual Session in New Orleans that has been accepted. In addition, research is underway to evaluate mechanisms for making the course available to constituent societies throughout the year.

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

### **New Dentist Ethics Hotline (Goal 1, Goal 2)**

In June 2012, Council member Dr. Richard J. Rosato attended the New Dentist Committee (NDC) meeting in Washington, DC and, with Dr. Rex Yanase (then the Council's NDC *ex officio* member), made a presentation to the NDC about a proposed ethics mentoring collaboration and sought feedback from the NDC regarding the project. Following the meeting, it was determined that an ethics hotline service would be a member service and benefit that would be more valuable and that could be utilized by the entirety of Association members. Following the development of an intake process and system for tracking cases and collecting data, the hotline was launched in February of 2013. Additional information concerning the ethics hotline service can be found at <http://www.ada.org/ethicshotline>. From the data that will be collected, it is anticipated that the Council may be able to identify emerging trends that impact professionalism and ethics at an earlier time than is currently possible.

The hotline was featured in the [ADA News](#) and on "Mouthing Off," the official blog of the American Student Dental Association (ASDA). The hotline has been promoted primarily to new dentist members (in practice 10 years or fewer) by the NDC during the initial piloting of the system. However, inquiries have been received from all segments of membership and the Council has responded to each of those inquiries. Approximately 20 inquiries (five per month) have been received by the hotline since its inception in February 2013; the Council and the NDC are engaged in further efforts to make this benefit more widely known to ADA membership. The Council expresses its gratitude to the NDC for its thoughtful collaboration on this project.

### **Participation in New Dentist Committee Ethics Mega Topic (Goal 1)**

At the request of the NDC, while attending the NDC meeting in July, 2012, Dr. Rosato participated in the NDC Mega Topic discussion on ethics.

### **Student Ethics Video Contest (Goal 1)**

Seven entries were submitted to the 2012 Student Ethics Video Contest. The entry submitted by Stony Brook School of Dental Medicine was awarded the grand prize and a video submitted by students at Virginia Commonwealth University School of Dentistry received an honorable mention. The 2013 Student Ethics Video Contest was announced in September 2012 and publicity about the contest has appeared periodically in appropriate venues since that time. Members of the Council were urged to show previous video entries in their trustee districts on appropriate occasions to publicize the contest and to encourage individual students and student groups to submit videos for the 2013 contest. Entries for the contest may be submitted until July 31, 2013. As in past years, the winning video will be shown at the 2013 ADA annual session in New Orleans. Prior years' winning videos may be viewed on [ADA.org](http://ADA.org).

### **Disciplinary Appeals (Goal 1, Goal 2)**

Since the preparation of the Council's 2012 annual report, the Council conducted two judicial hearings in response to appeals from members disciplined by the members' constituent dental associations, respectively, for unethical conduct. Following the hearing at the November 2012 meeting, the Council affirmed the finding of culpability against a member of the Massachusetts Dental Society but modified the consequence imposed to a letter of censure. Following the hearing at the April 2013 meeting, the Council affirmed the finding of culpability imposed against a member of the New York State Dental Society but modified the consequences imposed to active suspension for a period of six months, followed by probation for 18 months and a letter of censure.

### **Ethical Moment (Goal 1, Goal 2)**

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 differing reimbursement schedules, earning continuing education credit for courses that were not attended, treatment of a minor when the parent disagrees with the dentist, and the

use of social coupons to expand a dentist's patient base, among other topics. The Council acknowledges with thanks the *Ethical Moment* article submitted by its trustee liaison, Dr. Joseph F. Hagenbruch. The Council welcomes suggestions for topics and questions from members.

## **Emerging Issues and Trends**

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### **Large Group Practice**

During the past year, the Council has been examining ways that it can create membership value for the Association. One suggestion that emerged is a campaign directed to consumers of dental services marketing the *ADA Principles of Ethics and Code of Professional Conduct* to the public as a way of differentiating ADA member dentists from nonmember dentists. This concept was presented by a Council representative to the Interagency Taskforce on Large Group Practice formed by the Council on Dental Practice and was very well received. As envisioned, the marketing campaign would inform the public that ADA members voluntarily agree to be bound by the ADA Code, the primary goal of which is to put the welfare of the patient first and which is enforceable by a disciplinary system. When so educated, if consumers begin to choose ADA member dentists over nonmember dentists in sufficient numbers, nonmember dentists, including those in large group practices, would be incentivized to become ADA members. This is a long-term strategy, but in light of the changing dental health market and practice environment, it may be a beneficial strategy to employ in the near future. The concept has been communicated to the ADA Division of Communications and Marketing and the Council will work with the division in developing this strategy.

### **The Ethics of Single Sitting Exams**

During the term the Council began to examine the ethical issue of basing the dental licensure decision in part on the results of a clinical examination that must be completed at one time where the predictive validity of that type of examination has been called into question. The Council will continue this discussion in the 2013-2014 term.

## **Responses to House of Delegates Resolutions**

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### *Resolution 29-2012. Amendment of the Policy, Eliminating Use of Human Subjects in Board Examinations (Trans.2012:478)*

Following debate, the House of Delegates referred Resolution 29-2012 to appropriate agencies to evaluate the second resolving clause for accuracy and relevance. In December 2012, the resolution was assigned to the Division of Legal Affairs (the Council) and the Division of Education/Professional Affairs (Council on Dental Education and Licensure or CDEL). The referred resolution as it was amended by the 2012 House of Delegates before referral appears in Appendix A.

The Council would like to acknowledge with sincere appreciation the thorough and thoughtful review performed by CDEL on Resolution 29-2012 and the Council's proposed revisions to the Resolution. The Council and CDEL have reached agreement on all but one of the revisions to the substitute for Resolution 29-2012 proposed, as indicated below and in correspondence between the Chair of the Council on Dental Education and Licensure and the Council's chair (Appendix B).

The Council, through a workgroup and assisted by a liaison from CDEL, conducted an in-depth review of the resolution, focusing much of its attention on the accuracy and relevance of the second resolving clause of the policy. Initially, a level of discomfort was expressed in labeling the clinical licensure examination process "ethical" or "not unethical." However, as the Council's review progressed, the Council came to believe that the policy expressed by the resolution remains valid. It was recognized that it is not the employment of patients in clinical examinations that is unethical; rather, it is in the areas of the identification of patients to participate in clinical examinations and the provision of follow-up or necessary ongoing treatment subsequent to the participation in the clinical licensure examination process where conduct considered to be unethical may take place. For that reason, the Council deemed it important that the policy reference the Council's 2008 statement entitled "Ethical Considerations When Using Patients in

the Examination Process”

([http://www.ada.org/sections/educationAndCareers/pdfs/ethics\\_clinical\\_exam.pdf](http://www.ada.org/sections/educationAndCareers/pdfs/ethics_clinical_exam.pdf)).\*

Additionally, concern was expressed regarding the specific wording of the second resolving clause of the policy because of the use of a double negative (“not . . . unethical”). It was also felt that a stronger distinction needed to be made between the clinical licensure process itself and the procurement and post-treatment care of patients who participate in the examination process. Consequently, the Council approved a new resolution that does away with the problematic double negative and clearly differentiates between the clinical licensure examination itself and the unethical practices that may arise during patient identification and post-treatment care referenced in the Council’s 2008 statement.

During its review of the resolution, the Council received information concerning the frequency with which curriculum integrated format examinations are available. That information led the Council to understand that curriculum integrated format examinations as defined by the ADA—involving patients of record who have received care properly sequenced with a treatment plan and with assessments of candidates’ skills being available at multiple times—are relatively rare given the number of variables that must be aligned to meet the ADA definition. The Council was also informed that the phrase “curriculum integrated format” is used to refer to examinations that do not meet the ADA’s definition found in 1H-2007 (*Trans.*2007:389) (for example, when multiple assessments of students’ clinical skills are not available). This information led the Council to insert the phrase “as defined by the ADA” following the recitation of “curriculum integrated format” in the fourth resolving clause of the policy.

Further, the Council was alerted to the fact that a patient of record is not a requirement in a curriculum integrated format examination. Rather, a patient of record is only used “whenever possible,” to quote the words of the ADA definition. This greatly concerned the Council because the same ethical issues discussed in the Council’s 2008 statement may arise when a patient not of record is used during the clinical examination, even though it is categorized as a curriculum integrated format examination.

This concern led the Council to discuss other examination formats and, in particular, the portfolio style format. Because that format relies on an assessment of a portfolio of a candidate’s clinical treatment completed during dental school on patients of record of the dental school clinic, the Council believed that the portfolio style format clinical examination provides an assessment mechanism free of the ethical concerns that are present when patients not of record are used during clinical licensure examinations including patient solicitation, selection, involvement, consent, care and follow-up treatment. Consequently, the Council proposed the inclusion of the phrase “or a portfolio style format” in the penultimate resolving clause of a new resolution.

That revision is the one revision to Resolution 29-2012 that has not been agreed upon between the Council and CDEL. CDEL’s objections to the revision are that the House of Delegates has not as yet approved a formal definition for the phrase “portfolio style examination” and that no jurisdictions as yet grant initial licensure based on a portfolio style examination (Appendix B).

Following the receipt of the correspondence from the CDEL chair, the Council carefully considered and weighed CDEL’s objections to the inclusion of the phrase “or a portfolio style format.” The Council believed that irrespective of any formal definition of the term portfolio style that might be adopted it will include the feature that makes the examination format singularly attractive from an ethics perspective—it will assess treatment of patients of record, thus avoiding the ethical pitfalls in patient identification, care and follow-up that can arise when non-record patients are used in the clinical examination process. It should also be noted that the lack of a formal definition did not deter the ADA Board of Trustees from convening a task force to study portfolio style examinations. Concerning CDEL’s second objection, the Council did not feel the fact that no states are using portfolio style format clinical examinations detracts

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\* This Council statement was originally entitled “Ethical Considerations When Using Human Subjects/Patients in the Examination Process.” In view of the observation expressed in correspondence between the chair of the Council on Dental Education and Licensure and the Council’s chair (Appendix B) that “human subjects” has biomedical research connotations not appropriate to the subject of the statement, the Council approved revising its 2008 statement to replace the phrase “human subjects/patients” with the term “patients.”

from its proposed revision. Instead the Council believed that the revision proposed may supply the impetus needed for states to adopt portfolio style clinical examinations in their licensure processes. As the ethical conscience of the ADA, it is incumbent on the Council to lead on this issue.

As a result of the Council's review of referred Resolution 29-2012, the Council is not offering Resolution 29-2012 to the House. Instead, the Council recommends that the following resolution be adopted:

**39. Resolved**, that the ADA policy "Eliminating Use of Human Subjects in Board Examinations" (*Trans.*2005:335) be amended as follows (additions are underscored and deletions are ~~stricken~~):

**Eliminating Use of ~~Human Subjects~~ Patients in Board Examinations**

**Resolved**, that dental students providing patient care under the direct and/or indirect supervision of qualified faculty is an essential method of learning clinical skills including the ability to manage the anxieties, fears, reflexes and other emotions related to dental treatment, and be it further

**Resolved**, that the Association recognizes that ethical considerations, including those identified in the ADA Council on Ethics, Bylaws and Judicial Affairs statement entitled *Ethical Considerations When Using Patients in the Examination Process* (Annual Reports and Resolutions 2008:103), arise from the use of patients in the clinical licensure examination process, even though the clinical examination process is itself ethical, and be it further

**Resolved**, ~~that the ADA~~ supports the elimination of ~~human subjects~~/patients in the clinical licensure examination process with the exception of the curriculum integrated format, as defined by the ADA, or a portfolio-style format within dental schools, and be it further

**Resolved**, that the Association encourages all states to adopt methodologies for licensure that are consistent with this policy.

and be it further

**Resolved**, that Resolution 147H-1996, Use of Human Subjects in Clinical Examinations (*Trans.*1996:712), be rescinded.

*Resolution 165-2012. Declaring an Employee Dentist's Bill of Rights (Trans.2012:505)*

Following debate on Resolution 165-2012 and amendment of the resolution, the House of Delegates voted to refer the resolution to the appropriate agencies for study and report to the 2013 House. Subsequently, the Board of Trustees forwarded the resolution to the Division of Legal Affairs (Council on Ethics, Bylaws and Judicial Affairs) and the Division of Dental Practice/Professional Affairs (Council on Dental Practice). The referred resolution, as amended, appears in Appendix A.

The Council acknowledges with thanks the thoughtful work and collaboration of the Council on Dental Practice on the referral of Resolution 165-2012.

The Council agrees with the concept of Resolution 165-2012. However, in examining the referred resolution, the Council was concerned that identifying the listed items as "rights" might inadvertently convey to employed dentists or employers that the items were stringent requirements and that employed dentists would be able to enforce the enumerated rights through a corresponding legal remedy when such might not be the case. For this reason, the Council recast the statement to provide guidelines to both dentists entering into or in an employment relationship and employers.

The Council also believes that it would be beneficial for the statement to focus on employers as well as employed dentists and to broaden the scope of the statement so that it is applicable to dentists working as independent contractors as well as employees. The Council also thinks the guidelines on the employment of dentists would be more useful if the individual guidelines presented were grouped under three unifying core principles: (1) dentists' paramount responsibility to their patients, (2) the employers'

and dentists' joint obligations to obey applicable laws and regulations, and (3) the status of the dentist as a member of a learned profession.

As a result of the study and consideration of referred Resolution 165-2012 by the Council and the Council on Dental Practice, it is recommended that Resolution 165-2012 not be adopted. Rather, the Council recommends that the following resolution be adopted, and understands that the Council on Dental Practice joins in the Council's recommendation:

**40. Resolved**, that the American Dental Association adopts the following as a statement of fair practices in employing a dentist:

#### **Statement Regarding Employment of a Dentist\***

These guidelines provide guidance for practice owners or management companies (collectively "employers") in their working relationships with dentists associated with their practices, either as employees or independent contractors (collectively "employees"). The purpose of these guidelines is to protect the public in the provision of safe, high-quality and cost-effective patient care. Employers and employees should recognize and honor each of the guidelines set forth in this policy statement.

- I. As described in the *ADA Principles of Ethics and Code of Professional Conduct*, dentists' paramount responsibility is to their patients. An employee dentist should not be disciplined or retaliated against for exercising independent professional judgment in patient assessment, diagnosis, treatment and comprehensive management, including with respect to but not limited to:
  - a. The use of any materials, or the delivery of a prosthetic device, that represents an acceptable standard of care or the refusal to use materials or deliver a prosthetic device that does not represent an acceptable standard of care;
  - b. The use of techniques that are reasonably believed to be within the standard of care and are in the patient's best interest or the refusal to use techniques that are not within the standard of care and are not in the patient's best interests (recognizing the patient's right to select among treatment options);
  - c. The mandated provision of treatment that the employee dentist feels unqualified to deliver; and
  - d. The provision of treatment that is not justified by the employee dentist's personal diagnosis for the specific patient.
- II. Because all employers and employee dentists must conform to applicable federal, state, and local laws, rules and regulations, an employed dentist should not be disciplined or retaliated against for 1) adherence to legal standards and 2) reporting to appropriate legal authorities suspected illegal behavior by employers. Employers should make certain that, for example:
  - a. Appropriate business practices, including but not limited to billing practices, are followed;
  - b. Facilities and equipment are maintained to accepted standards;
  - c. Employment contractual obligations are adhered to.
- III. Because a dentist is functioning within a professional domain, anyone employing a dentist should, for example:
  - a. Guard against lay interference in the exercise of a dentist's independent professional judgment in patient assessment, diagnosis, treatment and comprehensive management;
  - b. To the extent permitted by law, promptly provide the dentist access to all relevant patient records in the event of peer review, board complaint or lawsuit, both during and subsequent to the dentist's employment; and

- c. Recognize and honor the dentist's commitment, as an ADA member, to comply with the *ADA Principles of Ethics and Code of Professional Conduct*.

\* Dentists are advised that employment contracts may have provisions that conflict with these guidelines and the ADA recommends that dentists seek legal counsel when considering how contracts affect their professional rights and responsibilities.

and be it further

**Resolved**, that the Association publish and promote this statement to dentist employers and employees, and be it further

**Resolved**, that the Association encourage constituent societies to utilize this statement to facilitate legislative and regulatory measures to ensure the fair and ethical treatment of dentist employees and the patients that they treat.

## Other Activities and Accomplishments Related to *Bylaws* Duties

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### ***Bylaws* Amendments Requiring House of Delegates Approval**

*Amendments to Chapter VIII, Sections 30.B and C, 50 and 80.A of the ADA Bylaws.* While performing its perennial review of the *ADA Constitution and Bylaws*, the Council recognized that the amendments to the term provisions for the office of Speaker of the House of Delegates passed by the 2012 House, which imposed term limits, created the potential for issues relating to vacancies in the position should an incumbent Speaker of the House of Delegates fail to complete a term of office or if no eligible candidate for the position is identified. Following consideration of alternatives for addressing those issues, the Council believes that should such a vacancy or lack of eligible candidates occur, there should be an exception to the term limit provisions created to allow a former Speaker of the House to serve as Speaker in a temporary capacity or, in the case of there being no eligible candidate, to allow the incumbent Speaker of the House of Delegates to continue in office. Because some of the same issues arise with respect to vacancies in the office of Treasurer, the Council is proposing amendments to the nomination provisions for that office to parallel the provisions being proposed for the Speaker of the House of Delegates.

In view of the foregoing, the Council recommends that the following amendment of the *ADA Bylaws* be made:

**41. Resolved**, that CHAPTER VIII. ELECTIVE OFFICERS, Section 30. NOMINATIONS, Subsection B of the *ADA Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

B. Nominations for the office of Treasurer shall be made in accordance with the order of business. The search for Treasurer shall be announced in an official publication of the Association in November of the final year of the incumbent Treasurer's term, together with the recommended qualifications for that position as provided in Chapter VII, Section 100G of these *Bylaws*. Candidates for the office of Treasurer shall apply by submitting a standardized Treasurer Curriculum Vitae form to the Executive Director at least one hundred twenty (120) days prior to the convening of the House of Delegates. Each candidate's application shall be reviewed by the Board of Trustees. 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 standardized Treasurer Curriculum Vitae and the determination of the Board of Trustees as to whether the candidate meets the recommended qualifications for the office of Treasurer. 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 Treasurer shall be accepted from the floor of the House of Delegates. If there are no eligible candidates for the office of Treasurer when the House of Delegates meets, the term of the incumbent Treasurer

shall be extended by one (1) year. Should the incumbent Treasurer be unwilling or unable to serve an additional one (1) year term, the office of Treasurer shall be filled in the same manner as provided in Chapter VIII, Section 80 of these *Bylaws*. Under these circumstances, former Treasurers of this Association not otherwise eligible to serve as Treasurer would be eligible to serve as Treasurer ~~pro tem for one (1) additional year~~ until the House of Delegates can elect a Treasurer.

and be it further

**Resolved**, that CHAPTER VIII. ELECTIVE OFFICERS, Section 30. NOMINATIONS, Subsection C of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

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-November of the final year of the incumbent Speaker of the House's term~~. Candidates for the office of Speaker of the House shall apply by submitting 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. If no candidate has applied, or if there is no remaining eligible candidate for election, then the Association shall inform all delegates of this circumstance and the period to apply shall be extended to thirty (30) days prior to the convening of the House of Delegates. If thirty (30) days prior to the convening of the House of Delegates there is no remaining candidate for election then the Association shall inform all delegates of this circumstance and also inform them that nominations shall be permitted from the floor of the House of Delegates. 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 Election Commission. 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 term of the incumbent Speaker of the House shall be extended by one (1) year. Should the incumbent Speaker of the House be unwilling or unable to serve an additional one (1) year term, the office of Speaker of the House shall be filled in the same manner as provided in Chapter VIII, Section 80 of these *Bylaws*. Under these circumstances, former Speakers of the House of this Association not otherwise eligible to serve as Speaker of the House would be eligible to serve as Speaker of the House until the House of Delegates can elect a Speaker of the House of Delegates.

and be it further

**Resolved**, that CHAPTER VIII. ELECTIVE OFFICERS, Section 50. TERM OF OFFICE of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

*Section 50. TERM OF OFFICE:* The President, President-elect, First Vice President and Second Vice President shall serve for a term of one (1) year, except as otherwise provided in this chapter of the *Bylaws*, or until their successors are elected and installed. The Speaker of the House of Delegates shall be limited to two (2) terms of three (3) years each in total, consecutive or otherwise, excepting the case of a former Speaker of the House who has been elected Speaker of the House as provided in Chapter VIII, Section 30 of these *Bylaws*, who may serve until the House of Delegates can elect a Speaker of the House of Delegates. Serving any portion of a three (3) year term shall be considered service of a full three (3) year term. The term of office of the Treasurer shall be three (3) years, or until a successor is elected and installed. The Treasurer shall be limited to two (2) consecutive terms of three (3) years each, excepting the case of a former Treasurer who has been elected Treasurer ~~pro tem~~ as provided in Chapter VIII, Section 30 of these *Bylaws*, who may serve ~~one (1) additional year~~ until the House of Delegates can elect a



Treasurer. Serving any portion of a three (3) year term shall be considered service of a full three (3) year term.

and be it further

**Resolved**, that CHAPTER VIII. ELECTIVE OFFICERS, Section 80. VACANCIES, Subsection A. VACANCY OF ELECTIVE OFFICE of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

A. VACANCY OF ELECTIVE OFFICE: In the event the office of President becomes vacant, the President-elect shall become President for the unexpired portion of the term. In the event the office of President becomes vacant for the second time in the same term or at a time when the office of President-elect is also vacant, the First Vice President shall become President for the unexpired portion of the term. In the event the office of First Vice President becomes vacant, the Second Vice President shall become the First Vice President for the unexpired portion of the term. A vacancy in the office of the Second Vice President shall be filled by a majority vote of the Board of Trustees. In the event of a vacancy in the office of Speaker of the House of Delegates, the President, with approval of the Board of Trustees, shall appoint a Speaker ~~pro tem who shall serve until the House of Delegates can elect a Speaker of the House of Delegates for a three (3) year term.~~ Service as an interim Speaker shall not count toward the term of office limitation for Speaker of the House as set forth in Section 50 of this Chapter. In the event the office of President-elect becomes vacant by reason other than the President-elect succeeding to the office of the President earlier than the next annual session, the office of President for the ensuing year shall be filled at the next annual session of the House of Delegates in the same manner as that provided for the nomination and election of elective officers, except that the ballot shall read "President for the Ensuing Year." A vacancy in the office of Treasurer shall be filled by a majority vote of the Board of Trustees until the process of inviting applications, screening and nominating candidates and electing a new Treasurer has been completed by the Board of Trustees and the House of Delegates. ~~The Treasurer pro tem shall be eligible for election to a new consecutive three (3) year term.~~ Service as an interim Treasurer shall not count toward the term of office limitation for Treasurer as set forth in Section 50 of this Chapter. The newly elected Treasurer shall be limited to two (2) consecutive terms of three (3) years each, excepting the case of a former Treasurer who has been elected Treasurer ~~pro tem~~ as provided in Chapter VIII, Section 30 of these *Bylaws* ~~who may serve one (1) additional year.~~

*Amendment to Chapter X, Section 120, Subsection G, Paragraph i of the ADA Bylaws.* Paragraph i of the Council's enumerated *Bylaws* duties give the Council, upon unanimous vote, the authority to make corrections in punctuation, grammar, spelling, name changes, gender references, and similar editorial corrections in the *Bylaws*. Frequently, when considering the ADA *Bylaws*, there is a difference of opinion concerning whether the proposed revision is editorial or substantive in nature. Consequently, the Council proposes the following amendment to CHAPTER X, Section 120, Subsection G, Paragraph i of the ADA *Bylaws* to provide the Council with additional clarification on what is considered a non-substantive *Bylaws* amendment that can be made on unanimous vote of the Council without taking the valuable time of the House of Delegates.

Accordingly, the Council recommends that the following amendment of the ADA *Bylaws* be made:

**42. Resolved**, that CHAPTER X COUNCILS, Section 120 DUTIES, Subsection G COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS, Paragraph i of the ADA *Bylaws* be amended as follows (additions underscored):

G. COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS. The duties of the Council shall be to:

\* \* \*

- i. Notwithstanding paragraph g of this subsection, the Council shall have the authority to make corrections in punctuation, grammar, spelling, name changes, gender references, change

syntax, delete moot material and make similar editorial corrections in the *Bylaws* which do not alter its context or meaning. Such corrections shall be made only by a unanimous vote of the Council members present and voting.

**Editorial Amendments Unanimously Approved by the Council Pursuant to CHAPTER X, Section 120, Subsection G, Paragraph i of the ADA *Bylaws***

For readability and clarity, the Council unanimously approved the following amendment of Chapter VIII, Sections 30.B and C of the ADA *Bylaws* as shown below (additions underscored, deletions ~~stricken through~~):

B. Nominations for the office of Treasurer shall be made in accordance with the order of business. The search for Treasurer shall be announced in an official publication of the Association in November of the final year of the incumbent Treasurer's term, together with the recommended qualifications for that position as provided in Chapter VII, Section 100G of these *Bylaws*. Candidates for the office of Treasurer shall apply by submitting a standardized Treasurer Curriculum Vitae form to the Executive Director at least one hundred twenty (120) days prior to the convening of the House of Delegates. Each candidate's application shall be reviewed by the Board of Trustees. At least sixty (60) days prior to the convening of the House of Delegates ~~the~~ 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 standardized Treasurer Curriculum Vitae and the determination of the Board of Trustees as to whether the candidate meets the recommended qualifications for the office of Treasurer. 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 Treasurer shall be accepted from the floor of the House of Delegates. If there are no eligible candidates for the office of Treasurer when the House of Delegates meets, the term of the incumbent Treasurer shall be extended by one (1) year. Should the incumbent Treasurer be unwilling or unable to serve an additional one (1) year term, the office of Treasurer shall be filled in the same manner as provided in Chapter VIII, Section 80 of these *Bylaws*. Under these circumstances, former Treasurers of this Association would be eligible to serve as Treasurer ~~pro tem~~ for one (1) additional year.

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 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. At least sixty (60) days prior to the convening of the House of Delegates ~~the~~ 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. If no candidate has applied, or if there is no remaining eligible candidate for election, then the Association shall inform all delegates of this circumstance and the period to apply shall be extended to thirty (30) days prior to the convening of the House of Delegates. If thirty (30) days prior to the convening of the House of Delegates there is no remaining candidate for election then the Association shall inform all delegates of this circumstance and also inform them that nominations shall be permitted from the floor of the House of Delegates. 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 Election Commission. 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*.

To correct a typographical error, the Council unanimously approved an editorial change to Chapter X., Section 120, Subsection G, Paragraph i. of the ADA *Bylaws* as shown below (addition underscored, deletion ~~stricken through~~):

- i. Notwithstanding paragraph gh of this subsection, the Council shall have the authority to make corrections in punctuation, grammar, spelling, name changes, gender references, and similar editorial corrections in the *Bylaws* which do not alter its context or meaning. Such corrections shall be made only by a unanimous vote of the Council members present and voting.

## Policy Review

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In accordance with Resolution 111H-2010, Regular Comprehensive Policy Review, and Resolution 170H-2012, all Association policies are to be reviewed every five years. The Council reviewed four policies in the period following the Council's November 2012 meeting. Actions taken by the Council on each policy are indicated below:

### ***The Dentist's Prayer (Trans.1991:643)***

The Council discussed whether the Dentist's Prayer is true policy of the Association and how it might be perceived by member dentists who do not observe a Judeo-Christian faith. Prior to completing its consideration of this policy, the Council requested input from the Diversity Committee of the Board of Trustees in view of the impact any change in the policy might have on diverse membership segments.

### ***Freedom of Choice (Trans.1994:667)***

The Council determined that the definition of Freedom of Choice set forth in this policy is incorporated in other ADA policies and that it should be maintained without revision.

### ***Patients' Rights and Responsibilities (Trans.2009:477)***

The Council determined that the policy entitled Patients' Rights and Responsibilities should be maintained without revision.

### ***Definition of Committees (Trans.2001:447)***

The Council recommends amendment of the policy entitled Definition of Committees for clarity and conciseness.

**43. Resolved**, that the ADA policy on Definitions of Committees (*Trans.2001:447*) be amended so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken through~~):

**Resolved**, that the American Dental Association accepts the following definitions for the terms standing committee, special committee, ~~task force, and~~ subcommittee, and ~~ad hoc advisory committee~~:

**Standing committee**—A standing committee is ~~ongoing and performs any~~ a group of members whose work, assignments, or tasks are ongoing and that performs any work within its particular field either assigned to it by the *Bylaws* or referred to it by the House of Delegates or Board of Trustees. ~~The councils and commissions of the Association are standing committees of the House of Delegates. The Board of Trustees has standing committees of its own members, and the Committee on the New Dentist composed of one new dentist from each trustee district.~~

**Special committee (also known as a Task Force)**—A special committee or task force is a group of members selected to perform a specific task and automatically ceases to exist once the task is completed. ~~Special committees of the American Dental Association may be created by the House of Delegates or, when the House is not in session, by the Board of Trustees, for the purpose of performing specific tasks~~ not otherwise assigned by the *Bylaws*. The Association's parliamentary authority, The Standard Code of

~~Parliamentary Procedure (4th edition) by Alice Sturgis also refers to special committees as ad hoc committees, and which ceases to exist either when its assigned task is completed or with the adjournment *sine die* of the annual session of the House of Delegates following its creation.~~

~~Task force—A task force is a type of special committee.~~

~~Subcommittee—A subcommittee is a subdivision of a committee subgroup of a body which is organized created for a specific purpose within the jurisdiction of that body, and reports only to the committee that established it. ADA councils and commissions may establish one or more ongoing subcommittees of their own members to which they may delegate have authority delegated to it by the body, and which reports and is are directly responsible to only the delegating body, which may be a the council, committee or commission.~~

~~Ad hoc advisory committee—An ad hoc advisory committee is established by an ADA council or commission for a singular purpose and limited duration. An ad hoc advisory committee is composed of subject matter experts who assist the council or commission with a specific matter.~~

## Summary of Resolutions

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Resolution 39. Amendment of the Policy, Eliminating Use of Human Subjects in Board Examinations

Resolution 40. Statement Regarding Employment of a Dentist

Resolution 41. Amendments to Chapter VIII, Sections 30.B and C, 50 and 80.A of the ADA *Bylaws* (Nominations, Terms of Office and Vacancies for the Offices of Treasurer and Speaker)

Resolution 42. Amendment to Chapter X, Section 120, Subsection G, Paragraph i of the ADA *Bylaws* (Duties of the Council on Ethics, Bylaws and Judicial Affairs)

Resolution 43. Amendment of ADA Policy, Definition of Committees

## Council Minutes

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For more information on recent activities, see the Council's minutes on ADA.org:

<https://www.ada.org/members/1293.aspx#judicial>

## Appendix A. Referred Resolutions

### ***Resolution 29-2012. Eliminating Use of Human Subjects in Board Examinations (Trans.2012:478)***

**29. Resolved**, that the ADA policy “Eliminating Use of Human Subjects in Board Examinations” (*Trans.*2005:335) be amended by inserting language from the policy “Use of Human Subjects in Clinical Licensure Exams” before the first resolving clause of the policy so the new, comprehensive policy “Eliminating Use of Human Subjects in Board Examinations” reads: (additions are underscored):

#### **Eliminating Use of Human Subjects in Board Examinations**

**Resolved**, that dental students providing patient care under the direct and/or indirect supervision of qualified faculty is an essential method of learning clinical skills including the ability to manage the anxieties, fears, reflexes and other emotions related to dental treatment, and be it further

**Resolved**, that although the use of human subjects in licensure examinations raises certain ethical concerns, the practice is not in and of itself unethical as determined by the ADA Council on Ethics, Bylaws and Judicial Affairs (*Trans.*1993:109), and be it further

**Resolved**, that the Association supports the elimination of human subjects/patients in the clinical licensure examination process with the exception of the curriculum integrated format within dental schools, and be it further

**Resolved**, that the Association encourages all states to adopt methodologies for licensure that are consistent with this policy, and be it further

**Resolved**, that Resolution 147H-1996, Use of Human Subject in Clinical Examinations (*Trans.*1996:712), be rescinded.

### ***Resolution 165-2012. Declaring an Employee Dentist’s Bill of Rights (Trans.2012:505)***

**165. Resolved**, that the American Dental Association adopts the following as a statement of fair practices in employing dentists:

#### **The Employee Dentist’s Bill of Rights\***

1. An employee dentist has the right not to be penalized or terminated for exercising appropriate professional judgment in patient assessment, diagnosis or treatment.
2. An employee dentist has the right to refuse to deliver a prosthetic device that he/she believes does not represent an acceptable standard of care.
3. An employee dentist has the right to participate in selecting a lab to fabricate prostheses for which they are responsible.
4. An employee dentist has the right to refuse to use materials and techniques which he/she finds unacceptable or for which they feel unqualified.
- ~~5. An employee dentist has the right and responsibility to report unethical or illegal behavior by employers and other employees with the protection of whistleblower laws.~~
- ~~6. An employee dentist has the right to refuse to provide care for which he/she will not be compensated.~~

5. An employee dentist has the right to expect their employer to comply with applicable dental practice statutes and regulations.
6. An employee dentist has the right to expect appropriate and ethical business and billing practices by his/her employer.
7. An employee dentist has the right to expect employers to maintain facilities and equipment to accepted standards.
8. An employee dentist has the right to expect that HIPAA, OSHA and CDC guidelines are being enforced and adhered to.
9. An employee dentist has the right to perpetual access to the records of a patient he/she has treated, in the event of peer review, board complaint or lawsuit.
10. An employee dentist has the right to be a member of the professional organization of his/her choice.
11. An employee dentist has the right to abide by ADA Principles of Ethics and Code of Professional Conduct without obstruction by their employers.
12. An employee dentist has the right to refuse to perform treatment not justified by his/her own diagnosis.

*\*Dentists are advised that employment contracts may have provisions that conflict with these rights and the ADA recommends that dentists seek legal counsel when considering how contracts affect their professional rights and responsibilities.*

and be it further

**Resolved**, that the Association will publish and promote this statement to dentist employers and employees, and be it further

**Resolved**, that the Association encourages constituent societies to utilize this statement to facilitate legislative and regulatory measures to ensure the fair and ethical treatment of dentist employees and the patients that they treat.



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## APPENDIX B

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May 2, 2013

Dr. Kevin A Henner  
Chair  
Council on Ethics, Bylaws and Judicial Affairs  
163 Half Hollow Road, Suite 1  
Deer Park, New York 11729

Dear Doctor Henner:

At our recent meeting, the Council on Dental Education and Licensure (CDEL) considered amendments to the ADA policy, Eliminating Use of Human Subjects in Board Examinations as proposed by the Council on Ethics, Bylaws and Judicial Affairs (CEBJA). As you know, changes to this policy were first proposed by CDEL to the 2012 House of Delegates via Resolution 29-2012. The House referred this resolution to the appropriate ADA agencies for evaluation of the accuracy and relevance of the second resolving clause. The referred resolution was assigned to CEBJA and CDEL. On behalf of CDEL, I want to thank CEBJA for its thoughtful work on Resolution 29-2012.

First, CDEL concurs with the revised second resolving clause as proposed by CEBJA. We believe the revised text accurately conveys the intent of the original policy, cites CEBJA's most recent work on pertinent ethical considerations, and eliminates cumbersome wording. CDEL also concurs with the addition of the phrase "as defined by the ADA" to describe the curriculum integrated format in the third resolving clause. We believe this appropriately highlights the ADA's conclusion that, if properly designed and implemented, this examination format has great potential to address the ethical implications of the use of patients in clinical licensure examinations.

However, CDEL has adopted several revisions to the proposed resolution as it was forwarded to us by CEBJA. First, CDEL recommends use of the term "patients" rather than "human subjects" in the title of the resolution and rather than "human subjects/patients" in the body of the resolution. While we understand that each of these terms can have multiple connotations, we believe the term "human subjects" improperly equates clinical licensure examinations with biomedical research protocols. We recognize that the term "human subjects" is contained in the title of a published CEBJA statement and ask that CEBJA consider revising the title of that statement, *Ethical Considerations When Using Human Subjects/Patients in the Examination Process*.

In addition, CDEL does not support the proposed addition of the phrase "or the portfolio-style format" in the third resolving clause. I want to be clear that this does not mean that CDEL is opposed to the concept of a portfolio-style examination. We simply have yet to take a formal position – in large part because the ADA House has not yet adopted a formal definition of a portfolio-style examination. Nor are there any states that currently grant initial licensure via a portfolio-style examination. As a result, CDEL believes it is premature to include a reference to the portfolio-style format in this resolution.

Finally, CDEL supports maintaining the word "adopt" in the last resolving clause. We believe that word more accurately reflects the fact that states adopt licensure methodologies via enactment of laws and regulations rather than simply recognize them.

At our recent meeting, CDEL (1) adopted revisions to Resolution 29-2012 as it was approved by CEBJA at its April 4-5 meeting, (2) asks that CEBJA also support CDEL's revised language, and (3) recommends that this proposed resolution (below) be transmitted jointly by our two Councils to the 2013 House of Delegates.

**29. Resolved**, that the ADA policy "Eliminating Use of Human Subjects in Board Examinations" (Trans.2005:335) be amended by inserting language from the policy "Use of Human Subject in Clinical Licensure Exams" before the first resolving clause of the policy so the new, comprehensive policy "Eliminating Use of Human Subjects in Board Examinations" reads as follows: (additions are underscored and deletions are stricken):

**Eliminating Use of Human Subjects Patients in Board Examinations**

**Resolved**, that dental students providing patient care under the direct and/or indirect supervision of qualified faculty is an essential method of learning clinical skills including the ability to manage the anxieties, fears, reflexes and other emotions related to dental treatment, and be it further

**Resolved**, that ~~although the use of human subjects in licensure examinations raises certain ethical concerns, the practice is not in and of itself unethical as determined by the ADA Council on Ethics, Bylaws and Judicial Affairs (Trans.1993:109), and be it further~~

**Resolved**, that the Association recognizes that ethical considerations, including those identified in the ADA Council on Ethics, Bylaws and Judicial Affairs statement entitled *Ethical Considerations When Using Human Subjects/Patients in the Examination Process* (Annual Reports and Resolutions 2008:103), arise from the use of patients in the clinical licensure examination process, even though the clinical examination process is itself ethical, and be it further

**Resolved**, that the ADA supports the elimination of ~~human subjects/patients~~ in the clinical licensure examination process with the exception of the curriculum integrated format, as defined by the ADA, within dental schools, and be it further

**Resolved**, that the Association encourages all states to adopt methodologies for licensure that are consistent with this policy

and be it further

**Resolved**, that Resolution 147H-1996, Use of Human Subject in Clinical Examinations (Trans.1996:712), be rescinded.

We appreciate the opportunity to collaborate with CEBJA on this important ADA policy. We also look forward to many more opportunities to work together on issues of mutual interest. In the meantime, please contact me if I can provide any additional information.

Sincerely,



Ronald Venezie, DDS, MS  
Chair  
Council on Dental Education and Licensure

RV/jfj:eg

cc: Mr. Thomas C. Elliott, Jr., director, CEBJA  
Ms. Karen M. Hart, director, CDEL



# Council on Government Affairs

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Fields, Henry W., Jr., 2013, Ohio, chair  
LoMonaco, Carmine J., 2014, New Jersey, vice chair  
Black, Richard C., 2015, Texas  
Bowen, Ronald S., 2013, Utah  
Breault, Michael R., 2015, New York  
Determan, Amber A., 2013, South Dakota  
Feldner, Loren J., 2013, Illinois, *ex officio* \*  
Hall, William M., 2014, Louisiana  
Harrington, John F., 2016, Georgia  
Howard, H. Fred, 2014, Kentucky  
Howell, J. Barry, 2016, Illinois  
Huot, Richard A., 2016, Florida  
Isbell, Gordon R., III, 2014, Alabama, *ex officio* \*  
Jaeger, Frederick J., 2016, Wisconsin  
Jennings, Mary S., 2014, Washington  
Lebovics, Irving S., 2015, California  
Martin, Raymond K., 2016, Massachusetts  
Radjabli, Edgar M., 2013, Maryland<sup>†</sup>  
Ray, Herbert L., 2013, Pennsylvania  
Vlahos, Gus C., 2015, Virginia

Spangler, Thomas J., director

The Council's 2013 liaisons included: Dr. Carol Gomez Summerhays (Thirteenth District trustee, Board of Trustees), Dr. J. Michael Johnson (Council on Communications), Dr. W. Roy Thompson (Council on Access, Prevention and Interprofessional Relations), Ms. Georjan Kudyba (Alliance of the American Dental Association), and Mr. Michael Pappas (American Student Dental Association).

## Mission and Purpose

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The Council's duties include: advising the ADA staff, Board of Trustees and House of Delegates as to the effect of legislative and regulatory actions on the health of the public and the art and science of dentistry; recommending changes in legislative and regulatory policy to the Board of Trustees, House of Delegates and ADA staff; commenting on proposed legislation to be submitted to Congress with the Board's approval; disseminating legislative and regulatory information to the constituent and component societies; working with other ADA agencies having subject matter jurisdiction concerning issues affected by proposed legislative and/or regulatory activity; and serving as a liaison with agencies of the federal government.

## Supporting the Strategic Plan: Activities, Results and Accomplishments

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The following activities support dentists so they may succeed and excel throughout their careers and/or help improve public health outcomes through effective collaboration with other stakeholders.

### Federal Activity

Regarding implementation of the Patient Protection and Affordable Care Act (P.L. 111-148; 111-152), health benefit exchanges (essentially a web page that serves as a virtual marketplace in each state, D.C., and the territories to help individuals and small businesses buy private coverage) must be in place in time

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\* ADPAC co-chairs without the power to vote.

<sup>†</sup> New Dentist Committee member without the power to vote.

to begin enrolling beneficiaries by October 2013. They must be fully operational by January 1, 2014. Since the implementation process began in earnest, the ADA and constituent dental societies have stressed in communications with federal and state authorities, respectively, the following key advocacy points.

- *ADA Position:* Exchanges must maximize competition among plans to ensure that the exchange marketplace is competitive on January 1, 2014, and beyond. To meet this goal, plans must offer real value and provide consumers with an adequate network of providers.

*Status:* Although regulators have been receptive to the ADA's message, only after the exchanges have been operational for some time will we know the true nature of the plan offerings and the adequacy of their networks.

- *ADA Position:* The pediatric dental essential health benefit (EHB) must be a required purchase for all families with children who buy their coverage in the individual or small group market after January 1, 2014, if the children do not already have such coverage.

*Status:* In a February 20, 2013, final rule from the Department of Health and Human Services (HHS), the agency stated that consumers (including those with dependents) do not have to purchase the pediatric dental EHB if the purchase is made inside the exchange. However, for purchases outside the exchange, in the individual and small group markets, the benefit must be purchased. The ADA believes states have the authority to require the purchase of the pediatric dental EHB inside the exchange, notwithstanding the HHS decision. The Association is currently working with constituent dental societies in that regard. The ADA also discussed the prospect of federal legislation to fix the problem but to date there is no willingness among the Senate majority to reopen the Affordable Care Act.

- *ADA Position:* Stand-alone dental plans and medical plans with an embedded dental benefit must be able to compete on an equal footing inside and outside the exchange to ensure consumers have a robust selection of dental products.

*Status:* HHS officials have made accommodations for stand-alone dental plans to compete inside the exchange by making it clear that medical qualified health plans (QHPs) do not have to offer the pediatric dental EHB if there is a stand-alone plan in the exchange. However, HHS does not require the medical QHPs inside the exchange offering an embedded pediatric dental EHB to separately price and offer that benefit. HHS' February 20 rule also accommodated stand-alone dental plans operating outside the exchange in the individual and small group markets. The rule allows medical QHPs outside the exchange to offer plans without the pediatric dental EHB—if the medical QHP is “reasonably assured” that such coverage is sold only to consumers who have also purchased a pediatric dental EHB through an exchange-certified stand-alone plan.

- *ADA Position:* Children should be covered by a dental benefit that is “necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions” and necessary to address a health condition where both medical and dental care is clinically required.

*Status:* All states except Utah (which is offering only preventive services) have chosen either the state's Children's Health Insurance Program (CHIP) plan or the MetLife High Option plan from the Federal Employee Dental and Vision Insurance Program (FEDVIP) as their benchmark plan. Both plans provide an adequate array of dental services. HHS defined “pediatric services” as services for individuals under the age of 19, although states have the flexibility to extend such coverage beyond the 19-year-old baseline.

- *ADA Position:* There should be adult dental coverage for emergencies as part of the EHB package.

*Status:* This recommendation was not adopted by any of the state or federal regulators. It is important to note that states expanding coverage in this fashion would have to pay 100% of the cost.

- *ADA Position:* There should be cost-sharing equitability to ensure consumers are treated fairly regardless of whether they select dental coverage as part of an embedded dental product or in a separate stand-alone plan.

*Status:* The ADA addressed this in comments submitted to relevant federal agencies on December 19, 2012, and again on March 15, 2013. There is also an effort underway to bolster this advocacy through Congressional support.

- *Certification and Accreditation:* On February 26, ADA staff spoke with officials at the Center for Consumer Information and Insurance Oversight (CCIO) about the potential certification and accreditation of stand-alone dental plans.

*Status:* The agency agrees with the ADA that certification standards do not apply to stand-alone dental plans at this time. Also, the agency agrees that there is currently no entity authorized to engage in such activity. Going forward, CCIO will continue to work with the ADA. The Association explained that the ADA has taken the lead in developing the Dental Quality Alliance (DQA) to ensure that specific concerns of dentistry are adequately addressed and that the ADA believes any entity designated as an accreditor for dental benefit plans should be required to use specific clinical quality measures developed by the DQA.

Rep. Paul Gosar (R-AZ) introduced the “Dental Insurance Fairness Act of 2013” (H.R. 1798) that would require all self-insured health plans that offer dental benefits to provide uniform coordination of benefits and would also require them to permit assignment of benefits. When a consumer is covered by more than one plan, the secondary payer should be responsible for paying the remainder of the claim (up to, but not exceeding, 100% of the amount of the claim). The bill also will permit consumers to designate payment of dental benefits to a provider who is not participating in the network. Rep. Gosar also introduced the “Competitive Health Insurance Reform Act of 2013” (H.R. 911), which amends antitrust laws (McCarran-Ferguson Act) with respect to the business of health insurance, including dental benefit plans. A 2012 American Medical Association study found that anti-competitive market conditions are common among managed care plans. In fact, the study concluded that a significant absence of health insurer competition is present in 70% of our country’s metropolitan areas. The ADA believes it is important to restore application of the full range of federal antitrust laws to the business of health insurance in order to encourage competition and protect consumers.

In March 2013, the Congress passed, and the president signed, a bill reauthorizing the Pandemic and All-Hazards Preparedness Act. The reauthorization included ADA-supported language clarifying that states may establish a clinical, non-forensic role for dentists in their disaster response plans. It also clarified that dental schools are eligible to compete for federal public health and medical response training funds.

### **State Activity**

As of May 2013, 11 states have filed bills to restrict dental plans’ ability to impose fee caps on non-covered services. Of the 11, one state has enacted a law (Montana) and three have passed both houses and are awaiting gubernatorial approval. So far, 30 states have enacted a non-covered services bill since 2009. Five states have a bill requiring dental plans to allow for assignment of benefits and two would bolster their coordination of benefits status. Three states have bills affecting prompt pay and retroactive denials of claims payments. Five have bills (two enacted) concerning claims review and four would require plans to cover certain dental procedures. Nineteen bills in 11 states would alter community water fluoridation in some way. Most would have had a negative impact if passed. A new law in Colorado requires the state to design and implement an adult dental Medicaid benefit using a collaborative stakeholder process to develop components of the program. Minnesota had great success bolstering its dental access programs. Effective January 1, 2014, there will be a 5% reimbursement rate increase for all

dental services. Dental services for adults with special needs are also enhanced under the new Minnesota program. Effective April 1, 2013, fees paid for Medicaid dental services, along with other services categories, in Alabama were reduced by 5%. Budget constraints required the reductions, according to the state.

The efforts to enact alternative dental workforce plans continued unabated across the nation in 2013. Ten states saw at least one alternative model introduced as legislation (often multiple bills and models) and another five states have experienced concerted efforts to consider the idea, without actual legislation being enacted. As of this writing, none of the bills have been enacted into law, with sessions still pending in Maine and Massachusetts.

In 2013 the ADA's State Public Affairs (SPA) program worked with 23 states on key issues including the ADA's new *Action for Dental Health* initiatives that encompass: access to dental care, workforce and scope of practice issues, Indian (Native American) affairs, fluoridation and healthcare insurance exchanges, as well as other matters. The 2013 budget was approximately \$3 million, and as of this writing, it is anticipated that the entire amount budgeted will be paid in grants to states and contracts with ADA national consultants. State issues worked on within the program include workforce, community water fluoridation, corporate regulation, and dental benefit regulation among others. Work product being developed with the California Dental Association on developing their healthcare insurance exchange is being shared with other state dental societies in their efforts to develop successful exchanges. Feedback from the SPA participating states included in their mid-year reviews about the program has been very positive. The constituent societies are very grateful for the assistance the ADA is providing to them to develop and manage their public affairs efforts.

## Emerging Issues and Trends

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### Federal Activity

Rising student debt is a major concern for organized dentistry and the ADA in particular. The Higher Education Act of 1965 is due for reauthorization in 2013. The ADA is working with several organizations, including the American Dental Education Association and the American Student Dental Association, to secure favorable interest rates and loan repayment terms for borrowers, preserve (and perhaps increase) the tax deductibility of student loan interest and ensure student debt can be appropriately discharged in cases of default or bankruptcy. As a first step, the ADA supports passage of the "Student Loan Interest Deduction Act of 2013" (H.R. 1527), introduced by Rep. Charles Rangel (D-NY), which would increase the current \$2,500 deduction ceiling to \$5,000 for individuals and to \$10,000 in the case of a joint return. Most important, the bill repeals the current income phase out (beginning at \$60,000 for individuals and \$120,000 for couples), making the deduction available to all with student loan debt regardless of income.

Ensuring proper implementation of the Affordable Care Act will continue to be a very high priority in 2014. Findings based largely on a study the ADA commissioned by Milliman, Inc. state that approximately 8.7 million children are expected to gain some form of dental benefits by 2018 as a result of the Affordable Care Act. About 3.2 million children will gain coverage through Medicaid, an additional 3 million children will gain dental benefits through health exchanges and about 2.5 million children through expanded employer sponsored insurance. Although adult dental benefits remain optional, about 4.5 million adults are nevertheless expected to gain "extensive" dental benefits through Medicaid by 2018 out of an estimated 17.7 million adults who will gain some level of dental benefits through expansion of the Medicaid program. These projections should be interpreted as an upper bound estimate as, to date, about half of the states have opted not to expand their Medicaid program.

As mentioned in last year's report, policymakers are continuing to advance proposals to curb the high rate of prescription drug abuse among children and teens. The ADA is continuing to advise with the White House Office of National Drug Control Policy, the Food and Drug Administration and other federal agencies on reasonable strategies to prevent the diversion, misuse and abuse of these drugs. The Supplemental Nutrition Assistance Program (SNAP) is due for reauthorization in 2013. The ADA is lobbying members of Congress to preserve the program's nutrition education component (SNAP-Ed),

which helps states provide nutrition education services to persons eligible for SNAP and improve the likelihood that eligible low-income individuals will make healthy food choices within a limited budget. This can (and often does) include promoting diets that are low in sugar (and acid) to help prevent tooth decay.

Some members of Congress are continuing to advance proposals that would weaken the Food and Drug Administration's authority to regulate tobacco products. These proposals range from exempting premium cigars from regulation to allowing tobacco companies to market smokeless tobacco products as a less harmful (or "reduced risk") alternative to cigarettes. The ADA has been working with several organizations, including the Campaign for Tobacco-Free Kids, to preserve and protect the agency's authority to regulate these cancer-causing products.

### **State-Level Issues**

The ADA expects efforts to enact legislation supporting alternative dental workforce models to continue to be an issue in 2014. The SPA program will continue to play an important role in helping states react to these efforts. Significantly, the ADA anticipates a meaningful expansion of the ADA's *Action for Dental Health* initiatives, which will afford the states opportunities to take the initiative on access to dental care, workforce, scope of practice and other issues. The *Action for Dental Health* initiatives will help states refocus the access to care question on the need to address the multiple barriers to care faced by underserved populations.

The role of the dental board in regulating corporate and mobile dental entities has received increase scrutiny by the states. Arizona has introduced legislation to modify parental informed consent for mobile units and North Carolina has worked to implement a legislative measure on corporate regulation that was enacted in 2011. In Texas, a bill strengthening and streamlining the Board of Dental Examiner's investigation and complaint resolution procedures is expected to become law soon. The bill creates expert review panels for dentists and dental hygienists, defines Dental Service Organizations (DSOs), defines the agreements made between DSOs and dentists (dental service agreements), and authorizes the Board to collect information from dentists and DSOs—such as locations where services are provided and copies of agreements between DSOs and dentists. The information collected will assist the Board with properly enforcing the Dental Practice Act. Dentists in a growing number of states, including Missouri, California, Connecticut, New Jersey, Washington and Idaho, have experienced a reduction in the fees paid by dental plans.

### **Responses to House of Delegates Resolutions**

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#### *122H-2012. Amendment of Policy on Medical Savings Accounts (Trans.2012:495)*

This resolution amended the ADA policy on Medical Savings Accounts by revising the title to Tax Preferred Accounts so that the new policy reads that the ADA supports use of tax preferred accounts for medical and dental expenses as a component of health care reform. On May 10, 2013, the ADA and 10 other dental organizations sent a letter of support to Senator Mike Johanns (R-NE) and Representative Erik Paulsen (R-MN) for introducing "The Family Health Care Flexibility Act of 2013," S. 610 and H.R. 1248, respectively. The legislation repeals the \$2,500 cap placed on flexible spending accounts (FSAs) by the Affordable Care Act. It also would eliminate the need to obtain a physician's prescription to use FSA dollars to purchase over-the-counter medicines. This was also an issue that was available to be lobbied at the 2013 Washington Leadership Conference. Unfortunately, like many other pieces of federal legislation seeking changes to the Affordable Care Act, these bills have not moved due in large part to the partisan stance taken by the parties.

### **Policy Review**

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The Council will continue its review of current policy in accordance with Resolution 111H-2010, Regular Comprehensive Policy Review, and Resolution 170H-2012, in 2014.

### **Summary of Resolutions**

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This report is informational and no resolutions are presented.

### **Council Minutes**

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For more information on recent activities, see the Council's minutes on ADA.org:  
<https://www.ada.org/members/1293.aspx#government>

# Council on Members Insurance and Retirement Programs

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Paumier, Thomas M., 2014, Ohio, chair  
Coleman, Robert A., 2014, Michigan, vice chair  
Barnashuk, Frank C., 2016, New York  
Chaney, Mark S., 2015, Louisiana  
Dodge, Jeffrey E., 2013, Rhode Island  
Gillcrist, James A., 2015, Tennessee  
Grogan, Patrick M., 2016, Washington, D.C.  
Hettinger, Richard F., 2014, Iowa  
Houten, David E., 2016, Washington  
Marron-Tarrazzi, Irene, 2013, Florida, *ex officio*\*  
Miller, Paul R., 2016, Florida  
Patel, Sanjay, 2015, California  
Rashall, Gregory W., 2013, Texas  
Rawls, Douglas S., 2013, South Carolina  
Rosenbaum, George F., 2013, Nevada  
Rubino, Louis F., Jr., 2016, Pennsylvania  
Schwartz, Timmothy J., 2015, Illinois  
Yarbrough, L. Wayne, 2014, Alabama

Abeles, Kelly, director  
Tiernan, Rita, manager

The Council's 2012-13 liaisons include: Dr. Gary S. Yonemoto (Fourteenth District trustee, Board of Trustees) and Mr. Andrew M. Hansen (American Student Dental Association).

## **Mission and Purpose**

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The Council on Members Insurance and Retirement Programs is the agency of the American Dental Association whose purpose is to enhance the value of ADA membership by overseeing the sponsored insurance and endorsed retirement programs and by aiding dentists in the management of their personal and professional risks through educational activities, informational programs and services.

## **Supporting the Strategic Plan: Activities, Results and Accomplishments**

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The Council on Members Insurance and Retirement Programs (CMIRP) supports the 2011-2014 ADA Strategic Plan goals to provide support to members so that they may succeed and excel throughout their careers. In addition, the ADA-endorsed Members Retirement Programs overseen by the Council provide a source of non-dues revenue in support of the strategic plan goal to ensure that the ADA is a financially stable organization that provides appropriate resources to enable operational and strategic initiatives.

ADA Members Insurance Plans are underwritten by Great-West Financial Insurance Company on a direct business model that eliminates many common marketing and related expenses. The ADA is reimbursed by Great-West Financial for two-thirds of its direct expenses related to Council oversight of the members insurance plans as a cost allocation against the operating budget for each plan. The remaining one-third of the Council's annual expense budget is offset by service income paid by AXA Equitable for ADA services rendered in connection with its endorsement of the ADA Members Retirement Program. Any service income revenue in excess of Council expenses is retained by the ADA for general operating budget purposes.

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

The ADA Members Insurance Plans include Term Life, Term Plus (universal life), Disability Income Protection, Office Overhead Expense and MedCASH, as well as the Student life and disability plans. In comparison to insurance plans offered by other national professional associations, the ADA Members Insurance Plans have a much stronger market share (49% penetration of membership).

At end-of-year 2012, approximately 62,730 dentists were participants in at least one of the five ADA-sponsored Members Insurance Plans. Nearly 19,000 of those dentists participate in multiple plans. In addition, the Life and MedCASH plans cover more than 20,000 spouses or domestic partners, along with 7,800 children.

**Table 1. Insured Participation for Policy Years 2008–2012**

Program	2008	2009	2010	2011	2012
Member Term Life <sup>1</sup>	55,143	55,171	55,128	53,989	53,899
Spouse Term Life	19,364	19,259	19,104	19,005	18,830
Child Term Life <sup>2</sup>	7,961	7,764	7,618	7,597	7,493
Term Plus Plan	1,694	1,629	1,577	1,520	1,466
Income Protection	17,596	17,667	17,355	18,695	19,314
MedCASH	5,101	4,851	4,612	4,408	4,248
Office Overhead Expense	8,467	8,420	8,309	9,820	10,726
Student Term Life <sup>3</sup>	11,362	12,344	12,930	13,681	13,388
Student Disability	872	1,114	6,410	11,036	12,524
TOTAL: All Plans	127,560	128,219	133,043	139,751	141,888

Total member participation varied by plan but grew overall by approximately 1% over the five-year period factoring in auto-conversion of graduates from the Student Plans into the Member Plans. Participation declines in the Term Plus and MedCASH Plans reflect the impact of the aging group of insureds and limited marketing investment on these plans in recent years. In addition, the age demographics of the insured participants closely resemble those of the ADA membership. With the baby boomer population aging its way out of the plans, there is an increased focus on developing new marketing strategies to address the insurance needs of new dentist members, as well as product enhancements designed to retain existing member participants.

A key goal of the Council is to increase enrollment of young dentists into the ADA member insurance plans. Offering life and disability coverage at no cost to ADA student members, with premiums funded by the ADA Members Insurance Plans, has been successful in increasing the number of dental student participants. By year-end, the Student Life and Disability plans had 13,388 and 12,524 member participants, respectively.

<sup>1</sup> Member participants plus 2012 graduates reclassified as members on 12/31/12.

<sup>2</sup> This is the number of members who are insuring their children.

<sup>3</sup> Student participants less 3,704 graduates (2012) reclassified as member dentists on 12/31/12.



The positioning of CMIRP within the division of Membership, Tripartite Relations and Marketing has aligned membership and marketing communications to ensure consistent ADA brand messaging and build member value. The ultimate goal is to increase conversions to ADA membership and participation in the ADA Members Insurance Plans.

In support of these objectives, the Council approved the introduction of a nationwide auto-enrollment process for all eligible ADA student members to participate in the no-cost student life and disability insurance plans effective January 1, 2014, as well as a student advocacy initiative to establish an advocate network of student leaders and volunteers to promote the ADA student member insurance plans. Additionally, in support of the ADA's 2013 strategic initiative on member value, and as an added incentive for new members to join the ADA, the Council approved a proposal to provide up to \$100,000 Term Life coverage for six months at no cost for new members as a "thank you" for becoming an ADA member.

One of the Council's most notable accomplishments in 2012 was the successful completion of the financial audit and benchmarking study of the ADA Members Insurance Plans to assess the competitiveness of the insurance products and pricing. The overall goal was to ensure the ADA Members Insurance Plans are returning maximum value to the policyholders. A broader objective was to enable transparent oversight in the future reporting of Plan performance to help ensure compliance with ADA's goals and the financial stability of the members insurance plans.

Milliman, the consultant conducting the study, presented its audit report findings and plan recommendations to the Council for approval in August 2012. The Council developed a report on the proposed course of action which was submitted to and approved by the Board of Trustees at its September meeting. A proposed implementation plan was then developed and ADA and Milliman entered into negotiations with Great-West on key priority proposals.

At its March 2013 meeting, the Council approved recommendations resulting from the negotiations with Great-West and will submit a report for consideration by the Board in June. These recommendations include potentially providing a source of non-dues revenue for the ADA, opportunities to enhance the existing member insurance products, and expanding the member portfolio to include new products. The ultimate goal of enhancing existing products and adding new products is to increase member retention and to increase participation in the plans. Once the insurance audit recommendations are implemented the Council will be developing participation goals for the program.

The Council also oversees the ADA-endorsed Members Retirement Program administered by AXA Equitable Life Insurance Company. The program offers tax-qualified retirement savings plans including 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 Self-Employed IRA (SEP-IRA). During 2012, new passive indexed options for certain asset classes in the investment fund portfolios were added and the Council considered proposals on two new products to expand the ADA-endorsed portfolio of retirement savings plan options for its members.

**Table 2. ADA Members Retirement Program Participation**

	2009	2010	2011	2012
Number of Dentist Employers	5,527	5,198	4,930	4,660
Total Number of Dentists and Employee Participants	19,040	18,721	18,098	17,190

Table 3 lists the number of dentists and employees participating in the IRA (300+ Series) Program.

**Table 3. Individual Retirement Accounts Participation**

Participation	2009	2010	2011	2012
Number of Participants	1,809	1,720	1,679	1,647

Dentist participation in the ADA Members Retirement Program has declined due to a number of participants with mature asset balances transitioning into retirement and fewer new account sales due to the impact of the down economy. Efforts to reverse these trends include multi-channel marketing targeting new dentists, educational seminars to increase awareness of the value of retirement savings, and new product development to address the broader needs of the membership.

The Council identified this trend in downward participation at its August 2012 meeting and approved a proposal to retain Milliman to conduct a program review and benchmarking study of the ADA-endorsed Members Retirement Program. The objectives were to: 1. Evaluate the structure, administration and competitiveness of the program in meeting the needs of ADA members; 2. Explore ways to increase member value to help retain current participants and acquire new plan participants; and 3. Explore new non-dues revenue opportunities for the ADA. Once the retirement program review and benchmarking study recommendations are implemented, the Council will be developing participation goals for the program.

In consideration of the pending study and upon advice of ADA legal counsel, AXA Equitable was given notice that the contract due to renew for another five-year period in April 2013 was not being renewed. To allow sufficient time for the ADA to perform its due diligence and Milliman to complete the program review, AXA did, however, sign an amendment extending the existing contract through April 30, 2014 (but without the automatic renewal provision).

The consultant's recommendations for improvements and opportunities to further enhance the ADA Members Retirement Program were presented and approved by the Council at its March 2013 meeting and presented to the Board in June. In addition, ADA and AXA Equitable will meet in July to conduct a strategic planning session to discuss future opportunities and plan growth goals as well as potential product enhancements.

Table 4 details the service income the ADA has received annually since 2009 under the ADA's endorsement of the Members Retirement Program.

**Table 4. ADA Members Retirement Program: Service Income**

Year	Amount Paid to ADA
2009	466,411
2010	497,064
2011	516,289
2012	516,436
<b>Total</b>	<b>\$1,996,200</b>

The ADA-endorsed Members Retirement Program remains strong financially with a reported increase in total program assets from approximately \$1.4 billion at the end of 2011 to approximately \$1.5 billion as of December 31, 2012. Sales and marketing efforts for the year generated 67 new retirement plan accounts

(almost double the sales for 2011) which indicates an end to a trend of declining sales during the recessionary period from 2008 through 2011 and is a positive sign for future growth in the program.

Raising awareness of the value of the ADA Members Insurance Plans and the ADA Members Retirement Programs, as well as educating the membership on principles of risk management, are key priorities for the Council. These topics have gained greater visibility through enhanced marketing, promotion during ADA meetings and conferences, articles in *ADA News* and e-publications, and other initiatives (such as sponsorship of the ADA Annual Conference on Recruitment & Retention for tripartite staff and volunteers, and the ADA SUCCESS Program in the dental schools). The Council also sponsors three educational risk management seminars at the ADA Annual Session each year for ADA member dentists and their employees.

Additionally, in 2013 the Council will collaborate with the Council on Dental Practice and several other ADA agencies in developing content for the Center for Professional Success to include insurance and financial risk management educational resources for dentists.

### **Emerging Issues and Trends**

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There are several emerging issues and trends that impact the Council. Through its ongoing activities, the Council will monitor, assess, or potentially take action on the following topics:

- The trend of high level student debt for new graduates makes managing financial risk and planning for the future more important than ever. Offering appropriate, affordable member products as well as information resources and education will help equip young professionals for success.
- The trend in dental practice away from solo practice to large group practice is likely to impact the market for insurance and retirement plans, and will require study by the Council to assess short-term and long-term implications and opportunities.
- The participation trends in the retirement plans and a few of the members insurance plans is relatively flat or slightly declining. Both the 2012 insurance financial audit and the 2013 ADA member retirement program review and benchmarking study identified opportunities for improvements to help reverse these trends.
- Implementation of the Affordable Care Act may provide for product development opportunities as well as opportunities for benefit changes in the current products to better meet members' health insurance needs.
- Emerging issues and trends related to dental malpractice and insurance risk management; cyber liability exposures; and the impact of new digital media and technology enhancements.

### **Responses to House of Delegates Resolutions**

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There were no assignments from the 2012 ADA House of Delegates.

In August 2012, the Council put forth a resolution in support of the continuation of CMIRP in opposition to Resolution 93-2012 (*Trans.*2012:425). Resolution 93-2012 resulted from the Governance Study of 2012 and proposed that CMIRP be sunset at the end of the 2013 House of Delegates. The significant contributions of the Council over the years in overseeing the members insurance and retirement programs, and most recently its 2012 accomplishments in completing a financial audit and benchmarking study of the ADA-sponsored Members Insurance Plans, were recognized by the House when it voted to defeat Resolution 93-2012 in support of CMIRP. At its March 2013 meeting, the Council discussed its structure, composition and areas of responsibility, and agreed to form a work group to further evaluate governance issues and report back at the Council's August meeting.

### **Summary of Resolutions**

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This report is informational and no resolutions are presented.

### **Council Minutes**

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For more information on recent activities, see the Council's minutes on ADA.org:  
<https://www.ada.org/members/1293.aspx#retirement>

# Council on Membership

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Bauman, Mark A., 2013, New York, chair  
Kelly, Thomas S., 2014, Ohio, vice chair  
Bainbridge, Jean E., 2013, Texas  
Bradley, Steven P., 2016, Iowa  
Cassidy, Kevin M., 2014, Kansas  
del Valle-Sepulveda, Edwin A., 2015, Puerto Rico  
Durbin, Michael G., 2013, Illinois  
Goad, Jamie Dale, 2013, New Mexico  
Ingram, William L., 2016, Alabama  
Johnson, Nicole S., 2016, Pennsylvania  
Lee, Natasha A., 2015, California  
Ogata, Randall H., 2014, Washington  
Olson, Shelley Barker, 2015, North Carolina  
Pohl, Gregory J., 2016, Kentucky  
Shoemaker, Eugene, 2015, Wisconsin  
Vakil, Shamik, Virginia, *ex officio* \*  
Wilson, Kevin Drew, 2016, New Hampshire  
Zuknick, Stephen J., 2014, Florida

Rauchenecker, Steven M., director  
Bronson, Elizabeth M., manager

The Council's 2012-2013 liaisons included: Dr. Hilton Israelson (Fifteenth District trustee, Board of Trustees), Dr. Krista Jones (Council on Communications) and Mr. Kyle Beulke (American Student Dental Association).

## Mission and Purpose

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The Council on Membership is the American Dental Association (ADA) agency composed of volunteer dentists whose responsibility it is to monitor membership trends; to collect information to assess members' needs in order to facilitate the analysis and transfer of this information throughout the ADA; to encourage the development and promotion of member benefits in order to maintain high levels of membership; and to increase membership, preserving the Association's place as the unified voice of dentistry.

The Council on Membership (CM) formulates and recommends policies related to member recruitment and retention and other related issues. The Council works closely with constituent and component dental societies to support, monitor and encourage tripartite membership activities and to enhance cooperation and communication on tripartite recruitment and retention efforts. In addition, the Council on Membership recommends, monitors and supports the development of membership benefits and services that respond to identified needs of members.

## Supporting the Strategic Plan: Activities, Results and Accomplishments

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The Council on Membership supports the ADA Strategic Plan through: the creation of strategies and resources that highlight member value; working with the tripartite to increase membership; encouraging a diverse membership; and through membership dues, contributing to a financially stable organization. Specifically, the Council's work primarily supports the 2011-2014 ADA Strategic Plan Goals 1 and 4, which follow:

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

Goal 1: Provide support to dentists so they may succeed and excel throughout their careers.

Goal 4: Ensure that the ADA is a financially stable organization that provides appropriate resources to enable operational and strategic initiatives.

The Council on Membership is focused on closing the membership market share gap between the ADA overall and lagging membership segments. In addition, it is collaborating with other agencies and stakeholders in order to increase value to members and refine its overall membership dues structure. To that end, the Council has developed plans and programs, and streamlined its efforts to achieve the following objectives:

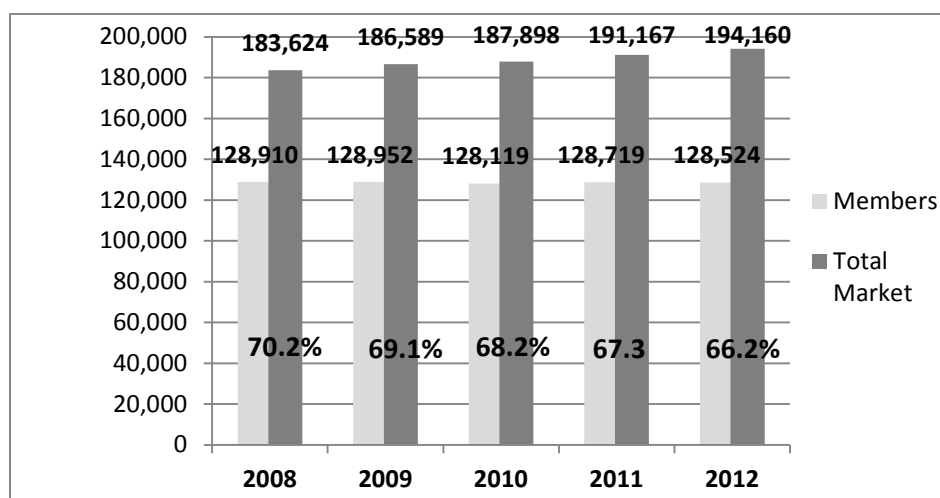
1. **Membership Recruitment:** Increase active membership to 130,900 or more by end of year 2013 for a market share of 66.3%.
2. **Membership Retention:** Maintain a 95.5% renewal rate among active licensed members at end of year 2013.
3. **Membership Conversion:** Achieve dental student membership in ASDA and ADA of 85% by end of year 2013. Convert 70% of the class of 2012 into ADA membership by end of year 2013 and convert 50% of the class of 2013 into ADA membership by end of year 2013.
4. **Membership Outreach:** Reverse the declining market share trend in each of the top five tier states (California, Florida, Illinois, New York and Texas) while influencing overall market share gains in all other constituent dental societies.
5. **Membership Experience:** Realign the ADA brand with tripartite dental societies to provide greater impact on the ADA membership experience, using key indicators such as “satisfaction” and “likelihood to recommend” to measure success.

The Council has been working on increasing the effectiveness of existing programs and implementing new strategies and initiatives to achieve these objectives and get ahead of the increasing market size. Following is a summary of the key factors influencing the objectives and the results of the Council's efforts to achieve results.

### **Membership Recruitment and Retention**

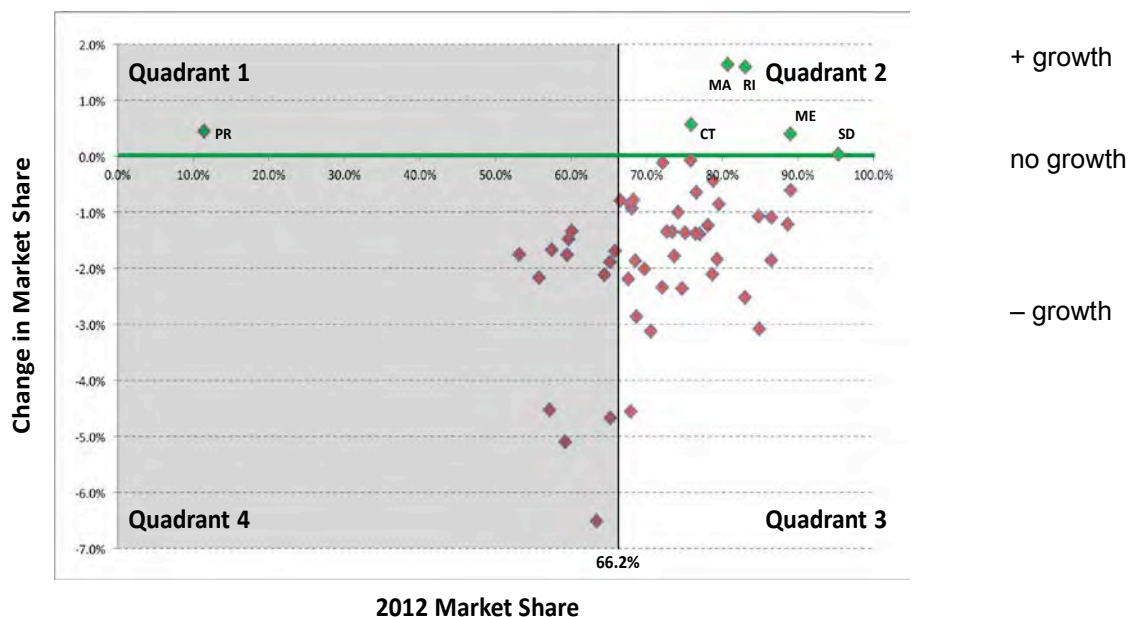
After a period of membership growth and increasing membership market share in the early 2000s, membership count has been flat even as the size of the market has increased. Over the past five years, ADA member market share has declined 4% from 70.2% in 2008 to 66.2% in 2012. During this same time, the market has grown 5.7%. In order to reverse this trend, it is anticipated that the ADA would need to experience an average net increase of over 2,100 members each year. With current efforts this is unlikely as the highest net growth in the past 10 years has been 3,814 in 2006 during the first year of the Tripartite Grassroots Membership Initiative and coinciding with lawsuits filed against insurance companies that serve dental patients.

Market share in lagging member segments, such as women and racially and ethnically diverse dentists, has also trended downward, and while there has been some erosion in the specialist market share, it has been even more pronounced among general practitioners. These trends continued in 2012 (Figure 1).

**Figure 1. Active Licensed Dentist Trends 2008–2012**

Source: 2012 ADA Dentist Masterfile.

A snapshot of changes from end of year 2011 to end of year 2012 reveals that for 95% of constituent dental societies, market share declined. Figure 2 illustrates 2012 market share versus changes in market share. Quadrant 2 includes the “good news” states. These societies have a market share above the national average, and their market share increased from 2011 to 2012. Yet, even for Connecticut, Massachusetts, Rhode Island and Maine, market share is trending down compared to the mid-2000s.

**Figure 2. Constituent Market Share vs. Change in Share**

Source: ADA Dentist Masterfile.

The ADA is not alone in facing membership challenges, and there are many societal, economic, professional and organizational factors that impact the potential to reverse the overall market share decline. However there are associations that are growing despite the environment. What has worked in the past for the ADA is not enough. The ADA Board of Trustees, led by ADA President Dr. Robert Faiella, has set enhancing member value as a key strategic priority for 2013. Each ADA council has been asked to address its contribution to building member value during 2013.

The Council on Membership has spearheaded the following programs that focus on building member value at all three levels of the tripartite, with the recognition that it is important to address needs and wants of lagging member segments as well as enhance member service across the tripartite to provide a consistent brand experience. Both constituent and component dental societies are collaborating with the ADA and each other to ensure maximum return on these efforts across the tripartite.

*Member-Get-a-Member Campaign.* This program was developed by the Council on Membership in 2012 and the implementation began with the 2013 membership year. The ADA is working in conjunction with state and local dental societies to publicize the program as well as developing joint communications with state and local dental societies that offer a member get a member program on their levels as well. As of March 31, 2013, there have been 68 new members that have been referred to membership by existing ADA members. The goals for the 2013 campaign include the following: 1) Recruit 200 new members; 2) Recognize and reward member recruiters with a variety of incentives for bringing in new members; and 3) Develop a new network of volunteer recruiters to participate in the program.

*Membership Program for Growth (MPG).* This program began in 2011, and is overseen by the Council and allocates, per a set of pre-determined criteria, \$500,000 annually to state and local dental societies to use for targeted, collaborative recruitment and retention efforts in their respective jurisdictions.

The goal of the program is to achieve a positive membership return on the MPG financial investment. From the results self-reported by the dental societies, at least 884 members are attributed to have joined or reinstated directly from 2011-2012 funded MPG efforts resulting in \$446,420 in ADA membership recruitment revenue. Further, at least 2,506 member renewals can be attributed directly to MPG funded efforts resulting in \$1,160,995 in dues revenue. In total, \$1,607,415 was generated. Less the initial investment of \$500,000, MPG generated a return of 3,390 members and \$1,107,415. More than half of the 2012 funding recipients have submitted their final reports and of those received, it was reported that 828 new members joined and 11,000 were retained as a direct result of its MPG activity. In 2013, 74 programs were selected to receive funding and 1,511 are expected to join in 2013 as a result of these efforts.

*Strategic Promotional Incentive (SPI).* The 2012 SPI was made available to nonmember full-time faculty. This promotional incentive provides a way to increase membership in specific member segments by providing a one-time reduction in dues for nonmembers in the member segment that is recommended by the Council on Membership and approved by the ADA Board of Trustees. This particular SPI provided a 50% reduction in dues at the ADA level for the 2012 membership year. Based on the response to previous SPIs offered to other tripartite membership segments, the goal for the 2012 SPI was to recruit 29 new members for a 2.4% response rate. The goal was achieved as 36 dentists joined for a 2.9% response rate. A total of 36 dentists joined for a 2.9% response rate. There are two SPIs for 2013 that are currently underway, one to nonmember non-U.S.-trained dentists and the other to nonmembers five to 10 years out of dental school (classes of 2003-2008). Each incentive offers a 50% reduction in dues for the 2013 membership year.

*Nonrenew Calling Program.* In 2012, the ADA continued an outbound calling program using an outside vendor to contact tripartite nonrenews. From a timing standpoint, this was the second year the ADA had conducted these calls earlier in the year using funds allocated by the Council from the Membership Program for Growth. These funds had been requested by Michigan to allow all constituents to participate in the spring nonrenew calling campaign. In 2010 and previously, the program was completed in the fall.



The nonrenew calling program has also provided an opportunity for states to add customized information to the scripts and lapsed members have had the option to pay their membership dues by credit card. Payment was efficient for the member because callers had the members' dues information readily available. Information on payments was shared with constituent dental societies daily via a secure, password-protected website. Overall, this reinstatement campaign had a positive impact on end-of-year membership numbers; although the parameters of this program were different from the ADA's past program, both a higher percentage and aggregate number of reinstatements occurred compared to previous years.

Highlights of the 2012 program:

- 171 pledges were made on credit cards (143 of these renewed in 2012).
- Of the 312 others who pledged to renew, 165 or 52.9% did renew their membership by end of year 2012.
- Overall, 239 of 319 (74.9%) who said they thought they had already renewed are currently members.
- Of the 955 who declined to renew over the phone, 174 (18.2%) were members by the end of 2012.

This program will be repeated in 2013. There are additional marketing touch points scheduled to take place in 2013 to encourage active life membership renewal. These are noted in the Responses to House of Delegates Resolutions section of this report.

### **Membership Conversion**

Conversion is defined as the market share rate at which new graduates join the ADA the year following graduation. This is tracked annually by graduating class. At the end of 2012, the conversion rate for the class of 2011 was 66.1%, which was a 1.7 percentage point increase over the year before, and at pace with market share overall. The rate still falls short of the goal to convert 70% of graduating dental students into ADA membership. The increase in conversion is likely due to additional marketing efforts, such as the Conversion Drive (ASDA assistance in gaining conversion information from senior dental students) and National Signing Day (dental school-based outreach by state and local societies).

At year-end 2012, conversion for the class of 2012 was well underway. Overall, 59.8% of the class of 2012 provided post-graduation plans. A total of 51.6% of new graduate members were transferred to an appropriate constituent society by the end of 2012. Of these 2,474 new graduate members, 1,980 (80%) transferred to tripartite dental societies, 392 (15.8%) to direct graduate student membership, 101 (4.1%) to federal services, and 1 (.04%) to direct ADA membership.

The Reduced Dues Program continues to be an appealing offer for recent dental school graduates whether they begin to practice or enter a graduate or residency training program following graduation or within their first few years out of school. The program allows those who enter a graduate program or residency to put their reduced dues on hold while they are in training and then pick up where they left off following completion of the program. In addition to this program, the ADA continues to promote key member benefits, such as ADA Insurance Plans. As of year-end 2012, 71% of student members were enrolled in the student term life insurance plans and 67% of student members were enrolled in the student disability insurance plan. Effective January 1, 2014, all eligible student members nationwide will be auto-enrolled in the no-cost student life and disability insurance plans. This initiative will encourage continuation of membership after graduation.

### **Membership Outreach**

Membership outreach efforts have continued to increase over the years. In 2012, Membership Opportunity Analysis Documents (MOADs) were completed for the top nine constituents (Table 1) that offer the greatest membership growth opportunities. These documents, prepared in conjunction with the

stakeholders from those constituents, serve as a starting point for the continued development of collaborative marketing plans and strategies to grow market share in those states.

**Table 1. Constituents With Greatest Opportunity for Growth  
(2011/2012 and Five Years Ago)**

	2011	2011	2011	2012	2012	2012	Five Years Ago (2008)	Five Years Ago (2008)	Five Years Ago (2008)
	Active Members	Market Share	Market Size	Active Members	Market Share	Market Size	Active Members	Market Share	Market Size
<b>ADA</b>	128,719	67.3%	191,167	128,524	66.2%	194,160	128,910	70.2%	183,624
<b>California</b>	19,193	69.0%	27,813	19,323	68.2%	28,322	18,859	69.8%	27,028
<b>Florida</b>	5,317	59.1%	8,998	5,242	57.4%	9,129	5,793	67.6%	8,572
<b>Illinois</b>	5,609	68.9%	8,137	5,585	68.0%	8,213	5,528	71.3%	7,749
<b>Maryland</b>	1,994	54.9%	3,634	2,001	53.1%	3,767	2,044	58.0%	3,525
<b>New Jersey</b>	3,762	57.9%	6,497	3,683	55.7%	6,608	3,873	60.0%	6,459
<b>New York</b>	9,549	69.7%	13,693	9,446	67.5%	13,985	9,994	73.7%	13,555
<b>Ohio</b>	4,317	74.7%	5,779	4,311	73.4%	5,877	4,438	78.1%	5,681
<b>Pennsylvania</b>	4,387	61.2%	7,167	4,384	59.5%	7,374	4,412	62.3%	7,081
<b>Texas</b>	7,696	67.0%	11,483	7,777	65.1%	11,940	7,015	69.2%	10,130

Source: ADA Dentist Masterfile.

This table identifies the change in member count and market share for the top nine states that have the greatest opportunity for growth. Key observations include:

- From 2011 to 2012, three states saw an increase in active members — California (130), Maryland (7) and Texas (81) — whereas ADA nationally saw a slight decline of 195 members in the face of a market that grew by 2,993 dentists compared to 2011.
- Overall, 2012 market share dropped for each of the nine states compared to 2011.

In 2012, the top five states identified as having the greatest opportunity for growth were California, Florida, Illinois, New York and Texas. The total nonmembers in these states combined was 24,163 at end of 2012. The Council proposed that in 2014, a 50% dues reduction be offered to the nonmember dentists in these states as a one-time strategic promotional incentive, as allowed in the ADA *Bylaws*. To increase response to the campaign, the Council on Membership maintains that the ADA could work with the states to encourage them to offer an identical 50% reduction at the state and local level. The Council has also proposed a resolution to the Board of Trustees wherein the constituent and component dental societies will be encouraged by the appropriate ADA agencies to match the incentive offered and to update their Bylaws if necessary to allow for them to match the offer.

### Membership Experience

The Council recognizes that realigning the ADA brand with tripartite dental societies will provide a greater impact on the overall membership experience. Results from the ADA's 2012 Tripartite Member Value and

Loyalty Survey have helped the ADA to identify opportunities to improve member value; to benchmark the percent of loyal, neutral and vulnerable members; and to help identify next steps in the process. The study also gave constituent dental societies an opportunity to customize questions based on their specific membership offerings and receive customized constituent reports. The results of this survey were presented to attendees of the 2013 Annual Conference on Membership Recruitment and Retention, and to constituent and component dental society staff via webinar in May 2013. By sharing the details of this research, the ADA is able to work collaboratively on action plans to increase member value throughout the tripartite and to improve the membership experience.

## **Emerging Issues and Trends**

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### **Emerging Issues**

A number of existing factors have been identified by the Council on Membership as having a direct impact on tripartite membership growth. Over the past 10 years, despite increasing membership by 7,418, ADA's market share has gone from 70.4% at the end of 2002 to 66.2% at the end of 2012. Market share for specific member segments such as women (60.4%), ethnically diverse (53.4%), new (66%) and non-U.S.-trained dentists (47.3%) is lagging behind the ADA overall. ADA's core member segment, the general practitioner (63.5%), also continues to erode. In addition, a group dental practice with 20 or more dentists continues to proliferate. The ADA Health Policy Resources Center has identified that during a two-year period between the second quarter of 2009 and 2011, the 22 largest group practices grew by nearly one-third. Although data is not currently available at the dentist level, it is believed that market share among group practice dentists lags in comparison to solo practitioners and small group practices.

Finally, the Council is continuing to look closely at the dues structure for all membership categories in order to strike an optimum balance between value provision and revenue generation. Specifically, the Council is recommending a change in dental student and graduate student member dues rates and for the ADA *Bylaws* to be amended so that future dues changes in those dues categories can be made by the ADA Board of Trustees with recommendations from the ADA's Council on Membership. The Council will continue its review of the ADA membership dues structure on an annual basis.

In order to be informed to make decisions and recommendations on the dues structure of the various membership categories, the Council has been working with McKinley Advisors, a consulting firm that was hired to conduct a study on the membership dues pricing and dues structure of the ADA. In addition, the Council's workgroup on membership categories will meet with representatives of the Committee on International Programs and Development prior to the Council's June 2013 meeting to review the results of McKinley's findings on the affiliate membership category. The outcomes from this meeting will be reported in the Council's Supplemental Annual Report to the House of Delegates.

### **Group Practice**

According to studies done by the ADA's Health Policy Resource Center (HPRC), one of the key trends identified in recent years is the decline in the percentage of dentists who are solo practitioners and an increase in the number of dentists working in a group practice setting. Many of the dentists who work in a group practice setting are working within the traditional private practice model, for example, with an owner dentist and an associate, or two or three dentists working together as partners. In this case, they are likely to be one practice location or two at the most. However, recent years have also shown significant growth in a corporate practice model that has a parent organization and multiple locations. Examples of these include Heartland, Pacific Dental Care, Great Expressions and Aspen Dental. The Council conducted the 2011 Survey of Group Practice Dentists, which addressed professional and membership issues of dentists who are not in solo practice. The Council discussion focused primarily on dentists who are affiliated with a Dental Services Organization as well as those in the large, multi-location corporate practices. Qualitative research was planned as follow-up in order to explore opportunities to develop a more robust member value proposition and to enhance membership communications to these dentists. However, this was postponed in order to collaborate with an ADA-wide research agenda focused on large group practices.

There is a belief that group practice dentists—especially those affiliated with the largest group practices—are less likely to belong to the American Dental Association. The ADA has established an inter-agency workgroup to focus on large group practice issues. The workgroup includes representatives of the Council on Dental Practice, the Council on Government Affairs, the Council on Ethics, Bylaws and Judicial Affairs, the New Dentist Committee and the Council on Membership. In addition, there have been some meetings between ADA leadership and staff and the leadership of some large group practices, initiated and facilitated by the Dental Group Practice Association. Pacific Dental has indicated a desire to encourage dentists associated with this group to become ADA members; a similar approach has been made by the leadership at Aspen Dental. In one case, these discussions have already been productive. Through ADA discussions with Great Expressions, an office group practice operating in nine states including Connecticut, Florida, Georgia, Massachusetts, Michigan, New Jersey, New York, Ohio and Virginia, the group has agreed to pay for ADA membership for each of its employed dentists. To date, 206 of their 344 dentists are ADA members. The group will also provide ADA membership to those dentists who join the firm in the future.

There is an HPRC research initiative underway to develop a database of group practices. As a starting point, the Health Policy Resources Center is analyzing a list from the National Provider Identifier database of dentists who accept dental insurance, which includes relevant information. This information will be supplemented to build a more complete picture of companies and individual dentists and will be maintained on an ongoing basis. This resource will allow the ADA to identify dentists in all sizes and types of group practices; track changes in groups over time; and chart the growth of all types of groups year by year in the future. In addition, with the implementation of Aptify, tracking interactions with group practice dentists singularly and collectively across the tripartite will help ADA's overall relationship building and the data reporting needed to support group practices. In terms of membership, it will allow the ADA to address group practice dentists as a membership segment and measure market share. This is not currently possible because data is not available at the dentist level.

### **Dues Structure**

As part of its role as outlined in the ADA *Bylaws*, the Council on Membership formulates and recommends policies related to membership recruitment and retention. As such, it has traditionally played a role in reviewing ADA dues amounts, rate percentages and membership categories in order to make dues recommendations to the Board of Trustees and House of Delegates that positively impact both market share and revenue contribution. While the House gives significant attention to the amount of full active dues in relation to the other fully privileged categories, due to the complexity of the separate dues structures and pricing methodologies that exist at the constituent and component levels it is difficult to fully consider the cost of membership to the individual dentist. The Council in concert with the administrative review committee and the Board continue to address implications and opportunities relative to this situation.

Furthermore, other categories are often reviewed every few years, in isolation from other dues categories and without full consideration to the overall financial and market impact. Typically, it is in response to a resolution that has been sent to the House of Delegates.

In 2012, the House of Delegates voted to remove the amount of Affiliate Membership dues from the ADA's *Bylaws* to allow the ADA greater price-setting flexibility when providing member value to global entities seeking ADA membership. This action was consistent with the removal of Active Member dues amounts from the ADA *Bylaws* in a previous year.

The Council discussed the flexibility that would result from removing all dues amounts and percentage structures from the ADA *Bylaws*. After reviewing the pros and cons of this approach, the Council concluded that the dollar amounts for the dues of the student and graduate student member categories should be removed from the *Bylaws* and that the Board of Trustees should be authorized to set these dues amounts with recommendations from the Council on Membership. The changes to the *Bylaws* are proposed in the following resolution offered for the consideration of the House of Delegates:

**44. Resolved**, that the ADA *Bylaws*, CHAPTER I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection E. STUDENT MEMBER, subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 1, be amended as follows (new language underscored; deletions ~~stricken through~~):

(1) PREDOCTORAL STUDENT MEMBERS: The dues of predoctoral student members shall be established by the Board of Trustees. five dollars (\$5.00) ~~Predoctoral student member dues shall be~~ due January 1 of each year. Such student members shall be exempt from the payment of any special assessment.

and be it further

**Resolved**, that the ADA *Bylaws*, CHAPTER I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection E. STUDENT MEMBER, subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 2, be amended as follows: (new language underscored; deletions ~~stricken through~~).

(2) POSTDOCTORAL STUDENTS AND RESIDENTS: The dues of dentists who are student members pursuant to Chapter I, Section 20E shall be established by the Board of Trustees. thirty dollars (\$30.00) ~~Postdoctoral students and resident dues shall be~~ due January 1 of each year. Such student members shall be exempt from the payment of any special assessment.

and be it further

**Resolved**, that the ADA *Bylaws*, CHAPTER I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection A. ACTIVE MEMBER, subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 2, be amended as follows (new language underscored; deletions ~~stricken through~~):

(2) Dentists who are engaged full-time in (a) an advanced training course of not less than one (1) academic year's duration in an accredited school or a residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall pay an amount to be established by the Board of Trustees, pay thirty and shall be dollars (\$30.00) ~~pay thirty and shall be dollars (\$30.00)~~ due on January 1 of each year until December 31 following completion of such program. For dentists who enter such a course or program while eligible for the dues reduction program, the applicable reduced dues rate shall be deferred until completion of that program. Upon completing the program, the dentist shall pay dues and any special assessment for active members at the reduced dues rate where the dentist left off in the progression. This benefit shall be conditioned on maintenance of continuous membership or payment of post-graduate student dues and active member dues and any special assessment for years not previously paid, at the rates current during the missing years. The dentist who is engaged full-time in (a) an advanced training course of not less than one (1) academic year's duration in an accredited school or residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall be exempt from the payment of any active member special assessment then in effect through December 31 following completion of such course or program.

If the House adopts the proposed Resolution 44 above, the Board of Trustees would then review the current dues structure following the close of the House to establish the dues of the predoctoral and postdoctoral dues categories. If Resolution 44 fails to be adopted by the House of Delegates, the Council offers the House the following two resolutions on setting dues amounts for these categories for its consideration. If Resolution 44 is adopted, then Resolutions 45 and 46 are moot.

### Review of Student Dues Category

Predoctoral student members of ADA pay \$5 annually. This student dues amount has not changed in 25 years. For their annual investment, student members receive essentially the same benefits as dentist members do, plus specific resources just for students. The American Student Dental Association (ASDA) collects ADA student dues concurrently with ASDA dues. In 2013, dental students pay \$70 for ASDA dues, plus \$5 for ADA dues (or \$75 in total), and any applicable local ASDA chapter dues. Student dues for both memberships are paid to the American Student Dental Association; ASDA, in turn, remits \$5 for each student member to the ADA. This arrangement demonstrates the relationship among the two organizations and allows a streamlined experience for the student. In order to maintain the data records of the student members until graduation, student market share is measured on July 1. As of July 1, 2012, there were 18,092 pre-doctoral student ADA members for a market share of 85.2% and associated dues revenue of \$90,460.

It is important to note that any change proposed for ADA student membership dues to the House of Delegates in 2013 would not go into effect until the 2016 membership year to accommodate the current dues collection process used by ASDA. In addition to updating its operational systems and dues billing communications, ASDA would be afforded the time to give appropriate notice to the dental schools that automatically bill student members, currently 38. These schools include ASDA and ADA membership dues as part of the tuition payment, which is billed in advance of the academic year, and a handful receive payment or partial payment from state and local dental societies. This timeframe is necessary to allow the dental schools and constituent and component dental societies that pay full or partial membership dues for their student members the opportunity to make their billing changes in time for the collection of ADA student dues beginning with the 2015–2016 academic year and then remittance of those ADA dues effective January 1, 2016, by ASDA. Therefore, any additional dues revenue would not be received until the 2016 ADA fiscal year. It may be helpful to know that ASDA has adopted a resolution to increase its dues by \$5 to a total \$75 for 2015. Recent conversations with ASDA regarding dues have been beneficial. ASDA recognizes that close collaboration and coordination is necessary to work through the process when ADA student dues are raised. In addition, the Council took into consideration the results of the dues pricing survey conducted by McKinley Advisors wherein the student<sup>1</sup> members responded that the student dues of the ADA are priced below common perceptions of cost compared to value. About 50% of the dental student respondents considered \$5 so cheap that the quality of the membership came into question; less than 20% considered \$30 or less to be too expensive, while the optimal range of dues landed between \$30 and \$75. The Council reviewed the pros and cons and recommends that student dues be increased by a total of \$5. Doing so accomplishes the following:

- Keeps the financial burden on the student member low;
- Doubles the revenue gained from student dues; and
- Compares favorably to ASDA's practice of raising dues.

This would bring the ASDA and ADA dues to \$85 for the 2016 membership year. This total does not include local ASDA chapter dues, which vary.

The following resolution requesting an amendment of ADA *Bylaws* regarding the dues of predoctoral dental student members is offered for consideration of the House of Delegates:

**45. Resolved**, that effective January 1, 2016, the ADA *Bylaws*, CHAPTER I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection E. STUDENT MEMBER, subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 1, be amended as follows (new language underscored; deletions ~~stricken through~~):

(1) PREDOCTORAL STUDENT MEMBERS: The dues of predoctoral student members shall be ten dollars (\$10.00) ~~five dollars (\$5.00)~~ due January 1 of each year. Such student members shall be exempt from the payment of any special assessment.

<sup>1</sup> Student members as defined in the McKinley study were composed of both predoctoral and postdoctoral students combined.

### Review of Graduate Dues Category

Graduate student member dues have not changed in 22 years. In 1991 graduate student dues increased from \$5 to \$30. Many graduate students enter their advanced dental education program in the same year they receive their DDS or DMD degrees. If recent graduates enter a postdoctoral program immediately following graduation and pay graduate student dues during that time, they will be eligible for the reduced dues schedule upon completion of their postdoctoral program. As noted previously, new dentists in the reduced dues program pay a percentage of full active dues according to the following rate schedule:

- 0% for their first year
- 25% for their second year
- 50% for their third year
- 75% for their fourth year; and
- 100% of full active dues in their fifth year and thereafter.

The Reduced Dues Program continues to be an appealing offer for recent dental school graduates who enter a graduate program or residency following graduation or within their first few years out of school. The program now allows those who enter a graduate program or residency to put their reduced dues on hold while they are in training and then pick up where they left off following completion of the program. Graduate students may hold direct or tripartite membership, and 42 constituent societies offer a special rate. All but two of these societies offer a reduced rate that is equal to or less than the ADA's \$30 rate. About half of the graduate student members hold direct membership.

### Revenue Impact of Dues Increase

Using the 2012 graduate student membership count as a base, Table 2 shows the changes in revenue contribution that could be obtained by increasing member dues by \$10 increments.

**Table 2. Potential Revenue Contributions**

<b>Dues</b>	<b>2012 Graduate Student Members</b>	<b>Potential Revenue Contribution</b>
\$30 (current)	3,379	\$101,370
\$40	3,379	\$135,160
\$50	3,379	\$168,950
\$60	3,379	\$202,740
\$70	3,379	\$236,530
\$80	3,379	\$270,320

The Council reviewed the pros and cons of raising graduate student dues, including the large amount of debt a graduate student member may have acquired. In addition, the group discussed the fact that this is a transient population and additional outreach will need to occur in order to grow the 61.8% market share. Again, the Council took into consideration the results of the dues pricing survey conducted by McKinley Advisors wherein the student<sup>2</sup> members responded that the student dues of the ADA are priced below common perceptions of cost compared to value. About 50% of the dental student respondents considered \$5 so cheap that the quality of the membership came into question; less than 20% considered \$30 or less to be too expensive, while the optimal range of dues landed between \$30 and \$75. Taking all this into consideration, the Council offers the following resolution requesting amendments of ADA *Bylaws* regarding the dues of postdoctoral dental student and resident members for the consideration of the House of Delegates:

<sup>2</sup> Student members as defined in the McKinley study were composed of both predoctoral and postdoctoral students combined.

**46. Resolved**, that the ADA *Bylaws*, CHAPTER I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection E. STUDENT MEMBER, subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 2, be amended as follows (new language underscored; deletions ~~stricken through~~):

(2) POSTDOCTORAL STUDENTS AND RESIDENTS: The dues of dentists who are student members pursuant to Chapter I, Section 20E shall be fifty dollars (\$50.00) ~~thirty dollars (\$30.00)~~ due January 1 of each year. Such student members shall be exempt from the payment of any special assessment.

and be it further

**Resolved**, that the ADA *Bylaws*, CHAPTER I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection A. ACTIVE MEMBER, subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 2, be amended as follows (new language underscored; deletions ~~stricken through~~):

(2) Dentists who are engaged full-time in (a) an advanced training course of not less than one (1) academic year's duration in an accredited school or a residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall, pay ~~thirty dollars (\$30.00)~~ fifty dollars (\$50.00) due on January 1 of each year until December 31 following completion of such program. For dentists who enter such a course or program while eligible for the dues reduction program, the applicable reduced dues rate shall be deferred until completion of that program. Upon completing the program, the dentist shall pay dues and any special assessment for active members at the reduced dues rate where the dentist left off in the progression. This benefit shall be conditioned on maintenance of continuous membership or payment of post-graduate student dues and active member dues and any special assessment for years not previously paid, at the rates current during the missing years. The dentist who is engaged full-time in (a) an advanced training course of not less than one (1) academic year's duration in an accredited school or residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall be exempt from the payment of any active member special assessment then in effect through December 31 following completion of such course or program.

### **Responses to House of Delegates Resolutions**

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The Council on Membership was assigned the following resolutions from the 2012 ADA House of Delegates.

#### **50H-2012. Downloadable ADA Member Logos (Trans.2012:511)**

Status: The downloadable ADA Member Logos have had the date removed from the logo and have been available for member download on ADA.org beginning with the 2013 membership year. Since this resolution has been adopted the logo has been downloaded 500 times (317 vertical versions of the logo and 183 horizontal versions of the logo).

#### **51H-2012. Amendment of the ADA Bylaws Regarding the Dues of Active Life Members (Trans.2012:515)**

Status: This resolution, that called for the increase of active life member dues from 50% of full active dues to 75% of full active dues, was implemented for the 2013 membership year. The Council has been monitoring the impact of the change in the dues structure on the active life member category and as of March 31, 2013, the percentage of nonrenewed members in the active life category was on



pace with the percentage of nonrenewed members in all dues categories. There is also additional outreach scheduled to take place in 2013 to encourage active life membership renewal including an outbound calling program to all nonrenewed active life members, a mailer and email communication asking to renew and a survey sent to all active life nonrenews to determine if the increase in dues was the reason for not renewing their membership. While the current revenue and member projections are on target, the Council is continuing to study the Active Life category through 2013 and will consider any further adjustments again in 2014.

**67H-2012. Amendment of the ADA Bylaws Regarding Benefits of Affiliate Members (Trans.2012:517)**

Status: This resolution was implemented and the 2013 ADA *Bylaws* have been updated accordingly. No changes have been made to the existing affiliate membership category to date, however options for the expansion of the affiliate category continue to be explored by the Council on Membership. It is expected that any recommended changes will be brought to the Board of Trustees for discussion at its August 2013 meeting.

**160H-2012. Extending New Dentist Discount Program (Trans.2012:519)**

Status: The Council, in collaboration with the New Dentist Committee, has researched the topic of extending the new graduate reduced dues program as part of the dues pricing study. The Membership Category Review Workgroup has studied the pros, cons and financial implications of extending this program. The full Council will review the findings of the workgroup at its June 2013 meeting and will forward its recommendations to the House of Delegates in its supplemental report.

## **Policy Review**

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The Council on Membership will identify and review policies in accordance with Resolution 111H-2010, Regular Comprehensive Policy Review, and Resolution 170H-2012 and recommend action to maintain, amend, rescind, or remove from *Current Policies* at its June 2013 meeting. The results will be reported in the Council's supplemental report to the House of Delegates.

## **Summary of Resolutions**

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Resolution 44. Amendment of the ADA *Bylaws* to Allow the Board of Trustees Authority to Establish Predoctoral and Postdoctoral Student Member Dues  
 Resolution 45. Amendment of the ADA *Bylaws* Regarding the Dues of Predoctoral Student Members  
 Resolution 46. Amendment of the ADA *Bylaws* Regarding the Dues of Postdoctoral Student Members

## **Council Minutes**

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For more information on recent activities, see the Council's minutes on ADA.org:  
<https://www.ada.org/members/1293.aspx#membership>.

# Joint Commission on National Dental Examinations

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Shampaine, Guy, 2013, Maryland, chair, American Association of Dental Boards  
Peterson, Lorin D., 2014, Washington, vice chair, American Dental Association  
Donahue, Jerri Ann, 2013, Wyoming, American Association of Dental Boards  
Drisko, Connie L., 2015, Georgia, American Dental Education Association  
Gerosky, Mary Lou, 2014, Ohio, American Dental Hygienists' Association  
Glass, Birgit J., 2013, Texas, American Dental Education Association  
Hersh, Robert A., 2015, New Jersey, American Dental Association  
Levitan, Marc E., 2016, South Carolina, American Dental Education Association  
McVea, Conrad, III, 2016, Louisiana, American Association of Dental Boards  
Murray, Ian R., 2013, California, American Student Dental Association  
Podruch, LeeAnn G., 2014, Wisconsin, American Association of Dental Boards  
Shannon, Kelley, 2014, Washington, DC, Public Member  
Trager, Peter S., 2013, Georgia, American Dental Association  
VanderVeen, M. Reggie, 2015, Michigan, American Association of Dental Boards  
Open, 2016, American Association of Dental Boards

Waldschmidt, David M., secretary  
Hinshaw, Kathleen J., senior manager  
Ryske, Ellen, manager

## Mission and Purpose

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The Joint Commission on National Dental Examinations (JCNDE) develops and conducts highly reliable, state of the art cognitive examinations that assist regulatory agencies in making valid decisions regarding licensure of oral health care professionals, develops and implements policy for the orderly, secure, and fair administration of its examinations, and is a leader and resource in assessment for the oral health care profession.

## Supporting the Strategic Plan: Activities, Results and Accomplishments

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### 2013 Updates

At its April 2013 meeting, the Joint Commission accomplished the following:

- *Budget Proposal and Fees.* Approved 2013 and 2014 budget proposals, including a \$55 increase to 2014 application fees for NBDE Parts I and II, a \$10 increase to NBDHE application fees, and a fifty cent increase to score report request fees. The total 2014 examination fees charged to candidates will be \$410 for Part I, \$455 for Part II, and \$400 for the Dental Hygiene Examination. In 2014, score report request fees will be \$33.
- *Intellectual Property Usage.* Approved continuing the established policies and procedures for granting permission for use of the JCNDE's intellectual property by dental educational programs and dental hygiene educational programs.
- *Development Guides.* Approved procedures for granting permission to educational programs for use of the Case Development and Test Item Development Guides by dental schools for faculty development.
- *NBDHE Materials.* Approved procedures for the sale of NBDHE 2006 and 2009 released examination materials to individuals for a fee to cover costs of production and distribution. Approved the discontinuation of sales of NBDHE 1996 released examination materials.

- *Examination Regulations.* Adopted revisions to the Joint Commission's *Examination Regulations*. This included editorial modifications to clarify language within the document, the removal of information concerning the Joint Commission's test administration vendors, the removal of references to reporting scores (i.e., in light of the Joint Commission's move to pass/fail reporting), and the inclusion of clarifying text confirming that the Joint Commission's five year/five attempt eligibility rule applies only to administrations occurring from January 1, 2012, forward. Additionally, the following two revisions were adopted:
  - In situations where an irregularity has occurred, individuals who are involved or implicated with respect to the occurrence of the irregularity, or who are reasonably believed to have witnessed the irregularity, may be asked to provide information concerning the irregularity.
  - In the case of a candidate enrolled in an accredited dental school or dental hygiene program who is involved in an irregularity, notification that test scores are not available is sent to the dean or director. While this notification does not typically provide the reason or evidence for withholding the scores, this may occur on occasion at the discretion of the Joint Commission.
- *Test Constructors.* Approved the reappointment of Dental and Dental Hygiene examination test constructors and the appointment of primary and alternate test constructors for the Dental and Dental Hygiene examinations for 2014.
- *Dental Hygiene Test Constructor Selection Criteria and Joint Commission Standing Rules.* Approved a revision to the Joint Commission's Standing Rules with respect to the selection criteria for NBDHE Test Constructors in the area of Clinical Dental Hygiene. This revision is intended to provide greater flexibility in selecting qualified test constructors, and is as follows: At least three years' experience, preferably within the last five years, teaching and practicing clinical dental hygiene; full-time or part-time in private practice or faculty practice.
- *IDEA Letters of Intent/Proposals.* Considered one letter of intent discussing potential research for submission to the Innovative Dental Assessment (IDEA) Research and Development Grants program for the 2012-2013 funding cycle. This request for funding was rejected.
- *Expenditures (Research and Development, IDEA).* Approved of a list of 2013 and 2014 research and development projects and expenditures, and expenditures pertaining to current and future projects supported by the IDEA Research and Development Grants program.
- *IDEA Grant Fund Reallocation.* Approved the reallocation of available money in the IDEA grant fund toward the Joint Commission's Research and Development fund, so that this money could also potentially be used to support research and development activities, including those involving the Integrated National Board Dental Examination.
- *Technical Reports.* Approved the 2012 editions of the NBDE and NBDHE Technical Reports.
- *Joint Commission Elections.* Elected Dr. Connie Drisko as chair and Dr. LeeAnn Podruch as vice chair of the Joint Commission. Their terms will begin in November of 2013.

### **Integrated National Board Dental Examination Update**

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 individuals who seek licensure to practice dentistry. The JCNDE is currently developing the Integrated National Board Dental Examination (INBDE) to supplant this two-part examination program. The INBDE integrates basic sciences, dental disciplines, and clinical competencies. The Committee for an Integrated Examination (CIE), an ad hoc committee of the JCNDE, has been charged with the development and validation of this examination. At its April 2013 meeting, the Joint Commission approved a number of resolutions pertaining to the INBDE and the CIE. The specific resolutions were as follows:

- *INBDE Content Domain and Test Specifications.* Approved a report outlining development of the content domain for the INBDE, including corresponding efforts to solicit and incorporate feedback from stakeholders and communities of interest. This report specified a Model of the Domain of Dentistry, including clinical competencies performed by entry level dentists and foundation knowledge areas required to successfully demonstrate those competencies. The following four deliverables were approved:
  - Model of the Domain of Dentistry
  - Statements and annotations underpinning the Foundation Knowledge for the General Dentist
  - The percentage of items to be devoted to the 10 Foundation Knowledge areas assessed by the INBDE
  - The percentage of items to be devoted to the three clinical component sections appearing within the INBDE
- *CIE Membership.* Current chairs of Joint Commission NBDE standing committees (Administration, Examination Development, Research and Development)—or their designee from the standing committee—will serve as ex-officio members of the CIE with all the rights, responsibilities, and duties of other members of the CIE, including the right to vote.
- *Standard Presentation.* A standard presentation will be developed for delivery by any Joint Commissioner, Joint Commission staff member, or the CIE chair, on behalf of the Joint Commission. This presentation could also appear on the Joint Commission's INBDE website, which will be kept current to ensure stakeholders and communities of interest have the most recent information.
- *Distribution of Communications.* INBDE communications will be distributed by the secretary of the Joint Commission to stakeholders, communities of interest, and the Joint Commission on a regular basis. These communications will replace the previous CIE chair communiqué.
- *Advance Notice of Implementation.* The Joint Commission will provide stakeholders and communities of interest with at least four years' notice prior to the full implementation of the INBDE. Previous statements regarding estimated INBDE launch dates (e.g., 2017) are no longer in effect.
- *Enhanced Commissioner Orientation.* Approved an enhanced, in-person orientation process for new Commissioners regarding their roles and responsibilities within the Joint Commission. This required meeting would take place at the beginning of their term.
- *Increased Cap on Unexpended R&D Funds.* Approved a request to the ADA Board of Trustees to permit an increase to the cap on unexpended funds within the Joint Commission's research and development fund. This increase was requested to facilitate management of funds required to develop the INBDE. The requested increase raised the cap from \$750,000 to \$2.5 million, thus enabling the Joint Commission to carryover additional funds on a year-to-year basis. This was approved by the Board of Trustees at the June 2013 Board meeting.

Test validation involves accumulating evidence to support the interpretation and use of an examination to fulfill its intended purpose. This evidence serves as the validity argument. The following summarizes the current validity argument in support of the INBDE:

- The INBDE is currently primarily supported through content related validity arguments focusing on the general appropriateness of the content domain, and the representativeness of test content relative to that content domain.

- INBDE content is currently designed to mirror the integration between foundation knowledge areas and clinical competencies, with a primary emphasis given to the clinical competencies that are necessary for successful performance as an entry-level dentist.
- The Joint Commission approved this list of 65 competencies; these competencies were regarded as defining the domain of general dentistry.
- A practice analysis was conducted with a sample of new dentists (i.e., dentists who had obtained their license within the previous five years) to empirically determine the importance of these 65 clinical competencies for entry level dentists.
- This practice analysis collected ratings concerning the frequency with which each clinical competency was utilized in entry level practice, as well as the criticality of each competency to patient care.
- All 65 clinical competencies had criticality ratings that were rated as being at least “moderately important to patient care,” thus affirming the appropriateness of each of these competencies as the content basis for the INBDE.
- Practice analysis ratings were transformed into weighted importance ratings that signify the importance of each competency as a percentage relative to the other competencies.
- Ten foundation knowledge areas adapted from medicine were regarded as prerequisites to successful performance on the clinical competencies.
- Two science review panels—involving both new dentists and dentists with strong science backgrounds—were conducted to confirm the relevance of these foundation knowledge areas to the clinical competencies.
- Panelists made ratings indicating the strength of the perceived relationship between each foundation knowledge area and each clinical competency.
- All 10 foundation knowledge areas were perceived as being related to performance on one or more of the 65 clinical competencies, thus affirming the appropriateness of this set of foundation knowledge areas for the INBDE.
- Additionally, feedback on this draft Model of the Domain of Dentistry was solicited from stakeholders and communities of interest, and was incorporated into the framework.
- Utilizing the above framework, test specifications were derived using the weighted importance of each clinical competency (i.e., as identified by the practice analysis) to determine the total number of items available for allocation to that clinical competency.
- Within a given competency, items are allocated to foundation knowledge areas based on the proportional perceived strength of the relationship between each foundation knowledge area and the competency (i.e., as identified through the science panels).
- In deriving test specifications, expert judgment occurred at every step of the process.
- The above methodology used to develop the test specifications is new, and was developed by Joint Commission staff for this specific application. A paper describing the methodology was presented at the 2013 National Council on Measurement in Education conference.
- As noted previously, at its April 2013 meeting the Joint Commission approved the INBDE content domain and the percentage of items allocated to the Foundation Knowledge areas and Clinical component sections.

- The Joint Commission is currently directing its attention toward item development in alignment with the approved test specifications.

### Additional Updates

The Joint Commission also engaged in the following efforts:

- *Aptify Conversion.* In an effort to improve the services provided by the Joint Commission, in 2005 the Department of Testing Services initiated efforts to transition its software infrastructure to a more robust platform that would improve operating efficiency and standardize application processing and score reporting activities, with corresponding benefits to candidates and dentists requesting services (e.g., delivery of reports to state boards). This effort has represented a monumental undertaking that is historic in its magnitude, since it involves decades of examination data under the purview of the JCNDE. The Joint Commission implemented the Aptify system on April 3, 2013, and Aptify is now the Joint Commission's system of record.
- *Zoomorphix Item Bank.* The Zoomorphix project involved migrating all current and historical examination items to Zoomorphix' Exam Studio item-banking software system. This migration is nearly complete. Joint Commission staff have been using this tool within Test Construction Committee meetings, and volunteers have provided positive feedback concerning its functionality.
- *National Dental Examiners' Advisory Forum (NDEAF).* The Joint Commission hosted the National Dental Examiners' Advisory Forum on April 22, 2013. Survey feedback indicated that the majority of respondents felt the information presented was very relevant to their needs.

### Emerging Issues and Trends

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The following presents trends in performance on the National Board Dental and Dental Hygiene Examinations over a 10-year period beginning in 2003. These trends are presented with respect to candidates' status as first-time or repeat test takers, and their enrollment in accredited or non-accredited programs.

#### NBDE Part I

Table 1 presents trends for National Board Dental Examination Part I (NBDE Part I) over the past 10 years, while Figure 1 provides a graphic depiction of administration volume. As shown in Table 1, the number of first-time candidates from accredited programs taking NBDE Part I was relatively stable from 2003 to 2005. From 2006 to 2007, the number fell from 5,094 to a 10-year low of 4,179. From 2008 to 2012, the numbers increased from 4,697 to 5,497, showing slow but steady growth each year. The total number of candidates from non-accredited programs taking NBDE Part I decreased from 4,161 in 2003 to 2,563 in 2012. In interpreting this table, please note that effective 2007, NBDE Part I became a comprehensive examination and was no longer administered in four sections based on subject matter. Prior to 2007, candidates had to pass all four sections in order to pass the examination.

The total number of administrations (i.e., first-time candidates and repeating candidates from accredited and non-accredited programs) fell from 9,591 in 2003 to 8,404 in 2012. This represents an overall decrease of 1,187 candidates (i.e., 14.1%). Please note that effective 2010, candidates who have passed NBDE Part I may not retake the examination unless required by a state board or relevant regulatory agency.

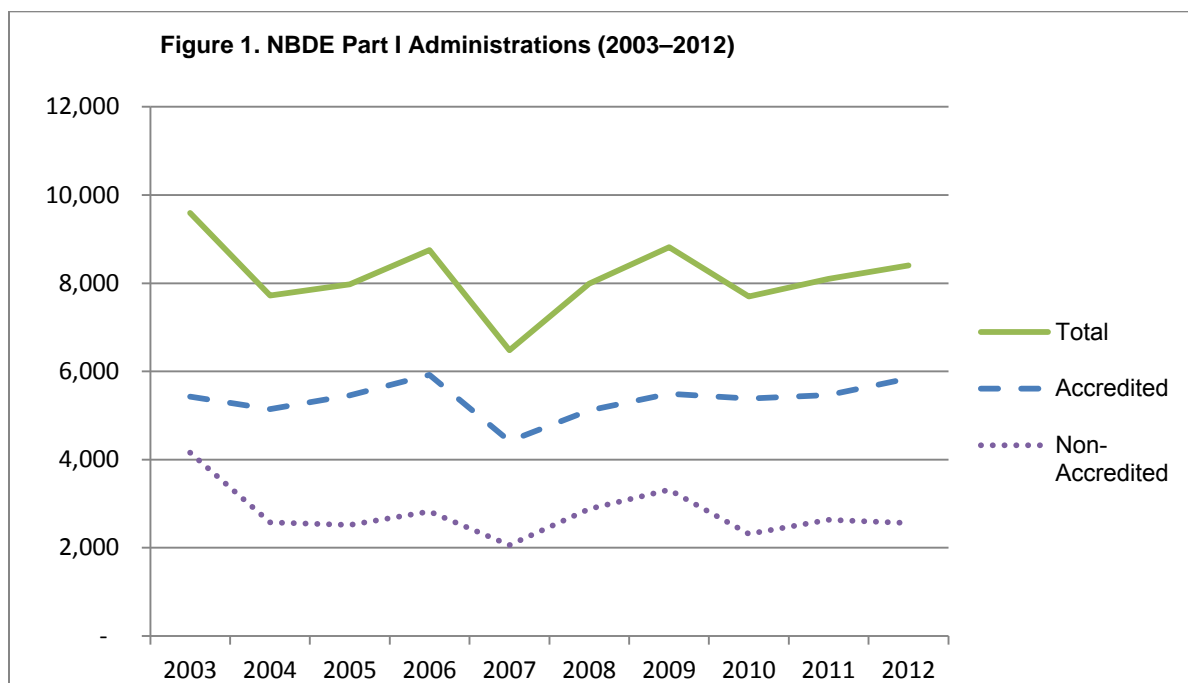
Failure rates for first-time candidates from accredited programs were higher during the earlier years, and lower in more recent years, with the lowest rate shown for 2007 (3.5%). Failure rates for candidates from non-accredited programs were relatively higher.

TABLE 1\*  
Numbers and Failure Rates for First-time and Repeating Candidates  
NBDE Part I

Year	Accredited				Non-Accredited				Total	
	First-time		Repeating		First-time		Repeating		First-time and Repeating	
	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing
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
2011	5,068	4.5	396	33.6	1,713	32.2	921	62.2	8,098	18.3
2012	5,497	6.1	344	39.2	1,721	38.3	842	68.1	8,404	20.3

\*From 2003 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.

\*\* A new standard was introduced this year, based on updated standard setting activities.



## NBDE Part II

Table 2 presents trends for National Board Dental Examination Part II (NBDE Part II) over the past 10 years, while Figure 2 provides a graphic depiction of administration volume. As shown in Table 2, the number of first-time candidates from accredited programs was relatively stable for the first three years (generally hovering just above 4,000), fell in 2006, jumped precipitously in 2007, and then showed continued growth through 2011. From 2011 to 2012, the number decreased from a 10-year high of 5,312 to 4,803. There has been quite a bit of variability since 2006, ranging from a low of 3,775 candidates in 2006 to a high of 5,312 in 2011 (i.e., a 41% increase). The total number of first-time and repeating

candidates from non-accredited programs decreased from 2,115 in 2003 to 1,626 in 2012. Comparing the number of total administrations occurring in 2003 (6,781) with 2012 (6,792) shows stability in this number at an overall level, with increases in the number of candidates from accredited programs being offset with decreases in the number of candidates from non-accredited programs.

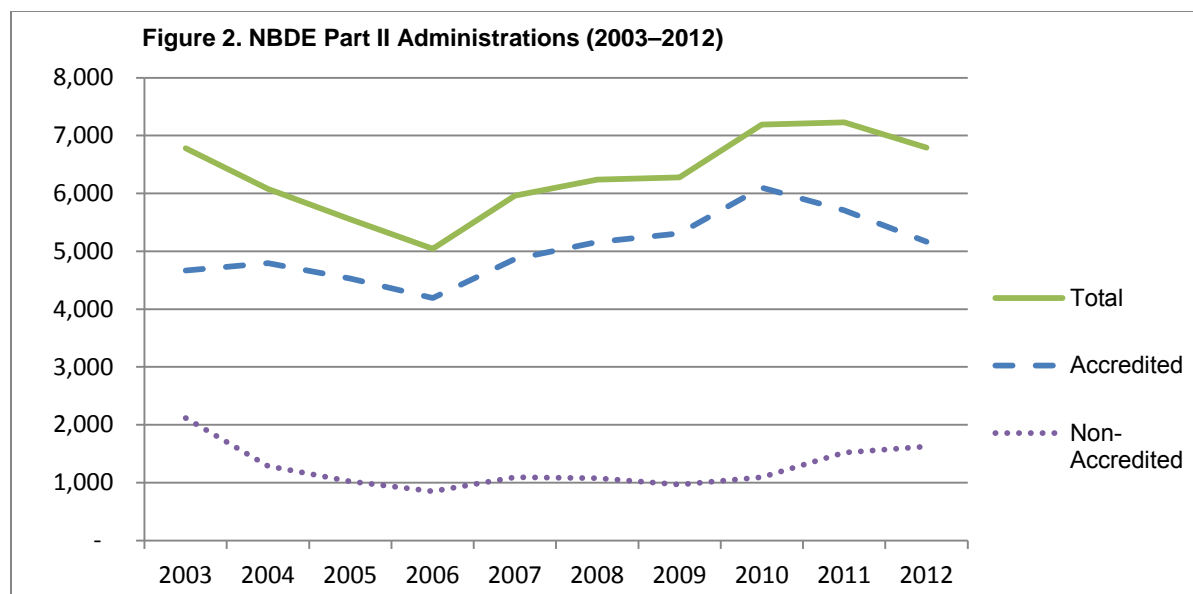
Concerning NBDE Part II failure rates, the Joint Commission recognized an increase in the failure rate starting in 2009 and carrying over to 2010. The Joint Commission reviewed procedures and protocols associated with the development of Part II examination forms, standard-setting activities conducted in 2008, and scoring. The Joint Commission also considered 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. Based on its investigation of the validity evidence relating to NBDE Part II, the Joint Commission found that the procedures utilized were appropriate. To ensure continued quality, in 2010, 2011 and 2012, Joint Commission staff conducted audits and quality control procedures, and monitored candidate performance on a weekly basis as part of the overall validation process. It is noted that the failure rate for NBDE Part II decreased from 13.7% in 2009 to 5.6% in 2012 for first-time candidates from accredited programs.

TABLE 2  
Numbers and Failure Rates for First-time and Repeating Candidates  
NBDE 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
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	5,550	12.9
2006	3,775	6.0	417	32.6	564	30.9	286	55.9	5,042	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
2011	5,312	5.1	395	28.9	1,050	29.6	471	48.4	7,228	12.8
2012	4,803	5.6	363	29.2	1,216	31.3	410	49.5	6,792	14.1

\* A new standard was introduced this year, based on updated standard setting activities.





## NBDHE

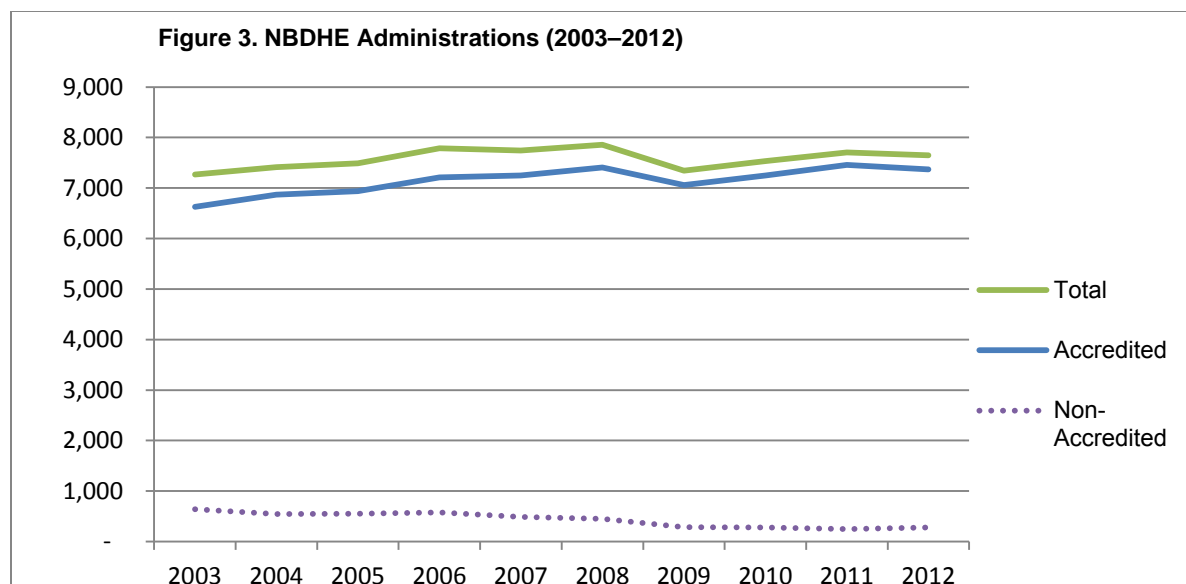
Table 3 presents failure rate trends for the National Board Dental Hygiene Examination (NBDHE) over the past 10 years, while Figure 3 provides a graphic depiction of administration volume. As shown in Table 3, the number of first-time candidates from accredited programs increased from 5,890 in 2003 to 6,882 in 2012 (i.e., a 17% increase). The total number of candidates from non-accredited programs was relatively small compared to the total number of candidates from accredited programs, representing approximately 9% of administrations occurring in 2003 and approximately 4% of administrations occurring in 2012. Comparing the number of total administrations occurring in 2003 with 2012 shows an overall increase of 380 first-time and repeating candidates from accredited and non-accredited programs (i.e., a 5% increase).

Failure rates were below 7% for all 10 years for first-time candidates from accredited programs. Failure rates for first-time candidates from non-accredited programs were substantially higher and less stable, ranging from 23.1% in 2010 to 67.3% in 2003.

TABLE 3  
Numbers and Failure Rates for First-time and Repeating Candidates  
NBDHE

Year	Accredited				Non-Accredited				Total	
	First-time		Repeating		First-time		Repeating		First-time and Repeating	
	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing
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
2011*	6,968	5.2	492	46.5	194	23.7	51	60.8	7,705	8.7
2012	6,882	4.2	486	47.1	236	26.7	42	50.0	7,646	7.9

\* A new standard was introduced this year, based on updated standard setting activities.



### Responses to House of Delegates Resolutions

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The Joint Commission did not receive any resolutions from the House of Delegates this year.

### Summary of Resolutions

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This report is informational and no resolutions are presented.

### Commission Minutes

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For more information on recent activities, see the Joint Commission's minutes on ADA.org:  
<https://www.ada.org/members/1293.aspx#examinations>.

# Council on Scientific Affairs

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Harrel, Stephen K., 2013, Texas, chair  
Truelove, Edmond L., 2014, Washington, vice chair  
Abt, Elliot G., 2016, Illinois  
Chalian, G. Garo, 2013, Colorado  
Hale, Robert G., 2016, Texas (Federal Dental Services)  
Hart, Thomas C., 2015, Illinois  
Ludlow, John B., 2016, North Carolina  
Michalowicz, Bryan S., 2014, Minnesota  
Milgrom, Peter, 2015, Washington  
Noraian, Kirk W., 2014, Illinois  
Novy, Brian B., 2014, California  
Oh, Timothy W., 2013, Maine\*  
Plemons, Jacqueline M., 2013, Texas  
Sollecito, Thomas P., 2015, Pennsylvania  
Thompson, Geoffrey A., 2015, Wisconsin  
Whitaker, Steven B., 2013, Arkansas  
Williams, Ray C., 2015, New York  
Young, Douglas A., 2016, California

Whall, Clifford W., Jr., interim senior director

The Council's 2012–13 liaisons include Dr. Steven Gounardes (Second District trustee, Board of Trustees), Dr. Alice Boghosian (Council on Communications) and Mr. Phillip A. Bell (American Student Dental Association).

The ADA president, in consultation with the Board of Trustees, appointed Dr. Peter Milgrom (University of Washington) to serve the term of Dr. John Greenspan, winner of the 2012 ADA Gold Medal Award for Excellence in Dental Research. Dr. Greenspan had previously informed the ADA president that, due to scheduling conflicts, he would be unable to serve the three-year term with CSA that is normally occupied by the Gold Medal Award recipient.

## Mission and Purpose

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The ADA Council on Scientific Affairs (CSA) serves member dentists, internal ADA agencies, the dental profession, other health professions and the public as the primary source of timely, relevant and emerging information on the art and science of dentistry and promotion of oral health. The Council provides recommendations to the ADA's policymaking bodies on scientific issues, and promotes, reviews, evaluates and conducts studies on scientific matters. This annual report highlights CSA's initiatives and accomplishments in 2012-2013 and key initiatives for 2013-2014, which are directly aligned with the ADA's strategic goals.

## Supporting the Strategic Plan: Activities, Results and Accomplishments

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The Council's primary activities include addressing emerging professional issues through the development and review of evidence-based clinical recommendations, laboratory and clinical product reviews, administration of the ADA Seal of Acceptance Program, oversight for the *ADA Professional Product Review* (PPR) program; and developing peer-reviewed journal reports, scientific policies, dental standards, CSA statements and online resources for ADA.org. Table 1 summarizes CSA's recent achievements for the reporting period.

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

**Table 1. Key Accomplishments for 2012–2013**

- Completed and published the HOD directed systematic review on alternative dental workforce models (January 2013 *JADA*)
- Published online a new clinical practice guideline for the prevention of orthopaedic implant infection in patients undergoing dental procedures, in collaboration with the American Academy of Orthopaedic Surgeons
- Published an advisory statement on the use of cone-beam computed tomography in dentistry (August 2012 *JADA*), which has been *JADA*'s most-viewed online article through the first quarter of 2013 (over 21,000 online visits through April 2013)
- Developed an updated report on dental radiographic examinations in collaboration with the U.S. Food and Drug Administration (FDA), and promoted the updated report with an ADA press release and articles in ADA e-publications and *ADA News*
- Served an advisory role in the development of an updated business plan for the ADA Center for Evidence-Based Dentistry ("EBD Center"), which proposes expanding staff resources for future EBD activities
- Launched a pilot, customized EBD workshop to educate U.S. dental school faculty
- Promoted ADA member success by facilitating scientific research of importance to the practicing dentist in accordance with the ADA Research Agenda, 2012-2013
- Implemented a targeted marketing plan to educate consumers about the value of choosing oral care products with the ADA Seal of Acceptance; the marketing plan provides kits that contain seal products and information to selected dentists, who then offer the kits to patients
- Established collaborations with Virginia Commonwealth University, A.T. Still University-Arizona School of Dentistry & Oral Health, the Department of Veterans Affairs, the University of the Pacific and the U.S. Air Force Dental Evaluation and to enhance the 2013 PPR program; developed and reviewed scientific content prior to the launch of the MouthHealthy.org website
- Developed and reviewed CSA resources that are included in the sixth edition of the *ADA/PDR Dental Therapeutics Online*, scheduled for release in fall 2013
- In cooperation with the ADA Standards Committee on Dental Products and the International Association for Dental Research, provided a symposium on the "Relevancy of *In Vitro* Testing in Predicting Clinical Behavior" to address the clinical relevance of ADA standards

### Helping Dentists Succeed and Excel

*Evidence-Based Dentistry.* Developing relevant, science-based information to help dentists succeed is at the heart of CSA's mission and programs. To meet this strategic goal, the Council collaborates with the Center for Evidence-Based Dentistry (EBD), CSA consultants and other researchers to synthesize and disseminate the best available scientific information and help practitioners implement EBD in clinical practice.

The Council and EBD Center are the ADA's primary agencies for systematic analysis of the available research evidence, a fundamental need for dentistry and all health care professions. Both CSA and the EBD Center develop resources that dentists can use in everyday clinical practice, including evidence-based clinical recommendations with accompanying chair side guides as well as critical summaries of published systematic reviews, all of which are available through the [EBD website](#) and are accessible via smartphone. These resources, plus the Center's educational programs (EBD Champions Conference, ADA Advanced EBD (formerly "ADA-Forsyth") course and customized workshops), support professional excellence in the provision of care.

*Seal of Acceptance Program.* The Seal Program provides the profession and the public with reliable information on safe and effective over-the-counter (OTC) oral health products. In 2012-2013, the Council worked to revitalize interest in the Seal of Acceptance through stronger ADA communications on the seal's value to consumers and practitioners. Specifically, CSA began implementing a pilot marketing plan to reverse a gradual decline in industry participation and public awareness. By contrast, a separate survey of ADA members found that dentists considered the Seal Program to be the fourth most valuable member benefit. Consumers also rely on the seal for product information. Combined traffic to seal pages on ADA.org and MouthHealthy has nearly tripled in the past year, while page views have increased by 41%. The value of the Seal Program is dependent on the number of Accepted products. During the past 12 months, the number of brand name products in the Seal Program has increased 2%.

One component of the ADA seal pilot marketing plan promotes awareness of the ADA seal through dental offices to a target patient population. This part of the marketing plan relied on contributions of Accepted products by companies participating in the Seal Program. The pilot program is intended to increase consumer and member awareness of, and reliance on, the seal as a trusted source of information on products to maintain oral health. A 2009 consumer survey showed that 54% of consumers were familiar with the ADA seal. Of those who were aware of the seal, 87% said that they respected or highly respected it. After being informed about what it takes to earn the seal, 73% of consumers said they preferred products with the ADA seal and were willing to pay more for them (69%). Comparative survey data is being collected now from participants in the pilot program.

*Standards Development.* The Council promotes dental excellence by developing standards and technical reports for current and emerging technologies used in clinical practice. The ADA's voluntary standards program is ANSI-accredited and manages the development of consensus standards that provide direct value to ADA members. This CSA program encourages the consideration of the dental practice perspective in the standards development process by fostering dental representation in the development of ADA standards. The Council's standards development activities help provide dentists with confidence in the purchase and use of professional products in their practice. Standards also help promote patient safety and health, product safety and efficacy, as well as product interoperability, compatibility, ease of use and accessibility.

*2013 ADA SCDP Meeting.* The annual meeting of the Standards Committee on Dental Products (SCDP) and U.S. Technical Advisory Group (TAG) for ISO/TC 106 was held in Seattle. SCDP approved the development of a technical specification to address polymerization shrinkage, shrinkage stress, and shrinkage rate in composite resins to assist member dentists and the profession to provide improved materials to their patients.

*2012 ISO/TC 106 Dentistry Meeting in Paris.* The ADA Department of Standards Administration facilitated participation by the U.S. delegation of dental professionals at the 2012 annual meeting of ISO/TC 106 Dentistry in Paris. This delegation represented the U.S. among approximately 20 countries attending this annual meeting of international standards development. The meeting resolved one issue on CSA's priority list (how to test adhesives for strength and durability) and advanced several others, including how to measure fluoride release from oral healthcare products, and new or updated standards for amalgam, dental implants and CAD/CAM systems used in dentistry.

### **Trusted Resource for Oral Health Information**

The Council works continuously to identify, anticipate and meet the oral health information needs of ADA members and the patients they serve. The following sections address recent projects of CSA and the EBD Center to develop evidence-based reports and other resources.

*Scientific Review of Alternative Dental Workforce Models.* In 2012, the Council completed a systematic review on alternative dental workforce models, which was requested by the House of Delegates through Resolution 41H-2011. The systematic review was published in the January 2013 issue of *JADA*.

*AAOS-ADA Clinical Practice Guideline—Prevention of Orthopaedic Implant Infection in Patients Undergoing Dental Procedures.* In December 2012, the ADA and the American Academy of Orthopaedic Surgeons (AAOS) posted a collaborative Clinical Practice Guideline for the Prevention of Orthopaedic Implant Infection in Patients Undergoing Dental Procedures and supporting materials (e.g., executive summary, companion editorial, and shared decision-making tool) on the websites of both organizations. As an initial step in developing this guideline, an AAOS-ADA workgroup, including three representatives from the Council on Scientific Affairs, conducted a comprehensive review of existing clinical research in the peer-reviewed published literature. Based on the findings from this evidence-based review, the workgroup concluded that there was insufficient evidence to support routine prescription of antibiotic prophylaxis for patients with orthopedic implants who undergo dental procedures.

The full-text guideline is available on ADA.org and the AAOS website. The guideline was also promoted through a joint ADA-AAOS press release, the ADA Leadership Update, articles in *ADA News* and *AAOS Now*, and at the Evidence-Based Quality and Value booth at the 2013 AAOS annual meeting. Additional promotion of the ADA-AAOS guideline included: a patient education page on ADA.org; a summary of the guideline in the March 2013 issue of the *Journal of American Academy of Orthopaedic Surgeons* (a companion editorial coauthored by CSA's Dr. Elliot Abt also appeared in the same issue); and a two-page guideline summary in the April 2013 *Journal of Bone and Joint Surgery*.

*Evidence-Based Clinical Recommendations.* Developed under the sponsorship of CSA and the EBD Center, evidence-based clinical recommendations are resources that dentists can integrate with their professional judgment and patients' needs and preferences to support evidence-based practice. In 2013, the EBD Center is conducting three evidence-based clinical recommendation projects:

- *Topical Fluoride for Caries Prevention:* The CSA convened an expert panel to update the evidence-based recommendations on topical fluoride, which were last published in the August 2006 issue of *JADA*. Pending clearance by the Centers for Disease Control and Prevention and approval by CSA, an executive summary will be submitted to *JADA* for publication consideration.
- *Nonsurgical Treatment of Chronic Periodontitis:* The CSA convened an expert panel to develop new evidence-based clinical recommendations on nonsurgical treatment of chronic periodontitis. The panel met at ADA Headquarters in early 2013 and anticipates completing this project by mid-2014.
- *Sealants for Caries Arrest and Prevention:* The CSA is convening an expert panel to update the evidence-based clinical recommendations on pit and fissure sealants. The original recommendations were published in 2008, and are to be updated every five years in accordance with EBD Center policy. This project is anticipated to begin in late 2013.

*EBD Champions Conference.* The goal of the EBD Champions Conference is to develop a network of dentists to promote the application of an evidence-based approach to patient treatment. Another successful conference was held in April 2013.

*EBD Website.* In 2012, the [EBD website](#) drew nearly 53,000 online visits and has demonstrated a consistent increase since its launch in 2009. The website currently hosts over 2,200 systematic reviews, and four new educational tutorials have been created and uploaded to the site, bringing the total number of online EBD tutorials to seven. Technologies have evolved since the EBD website's debut in 2009, and the site is not currently on a platform that can be supported by ADA information technology (IT) staff. To update the EBD website and increase functionality for a better user experience, the EBD Center is collaborating with the IT division to develop a new website in 2013, which will provide even more substantive value to ADA members and the public.

*Critical Summaries of Systematic Reviews.* The EBD Center, in conjunction with a network of volunteers with expertise in EBD, developed and posted 30 critical summaries to the EBD website over the past year. Eleven critical summaries were also published in *JADA*.

*ADA Evidence Reviewer Workshops and an Annual Session EBD Course.* ADA Evidence Reviewers (AERs) write critical summaries of dentistry-related systematic reviews that are hosted on the EBD website. Volunteers are trained via AER workshops held at dental schools, and 24 AERs were trained over the past year. Three workshops are planned in 2013, one of which was held at the University of Buffalo in spring 2013; two other workshops, funded by a Canadian grant, will also be held at the University of British Columbia and McGill University. The 2013 annual session in New Orleans will feature a course on the ADA's caries prevention clinical recommendations, offered by Dr. Domenick Zero (University of Indiana) and Dr. Julie Frantsve-Hawley (EBD Center).

*National Dental Practice-Based Research Network.* In 2013, the Council designated the National Dental Practice-Based Research Network (NDPBRN) as a liaison organization to CSA, which will foster continued communication and collaboration between the agencies. Funded by a \$66 million grant from the National Institute of Dental and Craniofacial Research, and headquartered at the University of Alabama at Birmingham (UAB) School of Dentistry, the NDPBRN is a consolidated network that includes six regional research sites across the U.S. (from Rochester, New York, and Gainesville, Florida, to Portland, Oregon). The NDPBRN aims to improve oral health by conducting practice-based research and serving dental professionals and their patients through education and collegiality. Through CSA and the EBD Center, the ADA is engaged in three projects with the NDPBRN:

- *Dissemination and Implementation Research on the ADA's Sealant Clinical Recommendations:* The EBD Center is collaborating with Dr. Wynne Norton (UAB) and Dr. Gregg Gilbert (NDPBRN network director) to conduct dissemination and implementation research on the ADA's evidence-based clinical recommendations program. As of spring 2013, the study concept is in the preliminary review stage, and the EBD Center anticipates developing a full proposal later this year.
- *Validation Study of the ADA Caries Classification System:* A preliminary study concept is planned for submission to the NDPBRN to conduct a study of a caries classification system that was developed at a 2008 international stakeholder conference at ADA headquarters. The purpose of the study would be to validate the sensitivity, specificity, and reliability of the caries classification system in real-world practice settings.
- *Multi-Method PBRN Program Evaluation:* In collaboration with Dr. Gregg Gilbert, the EBD Center will assist in evaluating the PBRN and help to evaluate if participation in the network's research increases implementation of EBD.

*Sjögren's Syndrome Foundation Guidelines.* The Sjögren's Syndrome Foundation (SSF) has invited the EBD Center to collaborate on the development of three evidence-based guidelines on caries management and restoration, caries prevention, and mucosal management of patients with Sjögren's Syndrome. The SSF anticipates that the caries management guidelines will be completed by 2014.

*CSA Statement on Bisphenol A and Dental Materials.* Council statements are reviewed and updated periodically. The CSA Statement on Bisphenol A (BPA) and Dental Materials was last updated in 2010, but new research and actions by the FDA made the statement out of date. The Council approved an updated BPA statement at its April 2013 meeting and posted it on ADA.org.

*Science and Technology E-Publication.* In collaboration with the Division of Communications, email updates on science news related to dentistry are sent in a "Science & Technology" e-publication to member dentists on a monthly basis. The e-publication provides updates on recently released reports, guidelines and systematic reviews, science in the popular press, and pertinent information from federal agencies (e.g., Centers for Disease Control and Prevention, Occupational Safety and Health Administration, National Institute of Dental and Craniofacial Research). Activities of CSA, the EBD Center, Seal Program, PPR and the standards department are also featured.

*Professional Product Review.* The [ADA Professional Product Review](#) (PPR) is CSA's quarterly online newsletter that provides unbiased evaluations of professional products used in clinical practice. The PPR



relies on a wide range of research expertise and ADA member input to promote continued clinical relevance. *PPR* also utilizes the resources of the ADA laboratory to provide scientifically sound evaluations of professional products, plus critical analysis of issues facing today's practitioners. Toward this end, the March 2013 *PPR* provided a detailed analysis of issues related to exposure to Bisphenol A in dental materials, and key points to address questions or concerns that could be raised by patients. Additionally, based on ADA member input, the *PPR* plans to address the following topics in 2013: electronic health care recordkeeping software; dental implant techniques; and Botox. Two collaborative projects between the ADA Laboratories and the ADAF Paffenbarger Research Center are on the schedule for publication in *PPR* in 2014: BPA in composites and ultrafine particulate aerosols.

*ANSI/ADA Standards Development and Proposed Technical Report.* In 2012-2013, the Standards Committee on Dental Products completed work on three new ANSI/ADA standards (Dental Base Polymers; Dental Duplicating Material Fatigue Testing for Endosseous Dental Implants; Metallic Materials for Fixed and Removable Restorations and Appliances) and five revised ANSI/ADA standards (Eugenol and Zinc Oxide-Non-Eugenol Cements; Dental Cartridge Syringes; Dental Water-Based Cements; Orthodontic Brackets and Tubes; and Manual Interdental Brushes). In addition, the Standards Committee on Dental Informatics approved a new project to develop an ADA Technical Report on Monitoring the Patient's Exposure to Ionizing Radiation in Dentistry, which will assess methods for recording and communicating a patient's exposure to ionizing radiation.

### **Ensure Financial Stability**

The Council pursues cost-effective, collaborative research and strategic partnerships to develop sound scientific information and address critical issues in a fiscally responsible manner. In 2012-2013, CSA transitioned the *ADA Professional Product Review* from a quarterly print newsletter to a digital magazine format, which reduced costs for publication design, printing and mailing.

*Updated EBD Business Plan for 2014-16.* The original business plan for the ADA Center for Evidence-Based Dentistry called for phased implementation to five full-time employees by 2009, with continued expansion in subsequent years. Yet for financial reasons, this phased implementation plan for the EBD Center was not realized, and the center currently operates at 60% of its planned staffing level with three full-time staff.

Nevertheless, the EBD Center has built an impressive structure of active volunteers that has enabled it to perform core functions with reduced staff support. The center has also been successful with innovating novel programs, including the EBD website, the Clinical Recommendations Program, the ADA Evidence Reviewer Program, the EBD Champions Conference, the ADA Advanced EBD Course held in collaboration with the Forsyth Institute and customizable EBD workshops. Since its inception, the center has also received over \$1 million in grants. However, limited staffing has significantly impacted the center's ability to achieve its full potential, and has forced the center and CSA to prioritize projects and place several key projects on hiatus. One noteworthy example was completing the recent workforce systematic review, which required significant resource reallocation and delay of multiple projects to complete within the HOD-mandated timeline.

To meet the anticipated increased demand for EBD and keep the ADA at the forefront of EBD worldwide, a considerable expansion of EBD Center staffing and programs is required. An updated EBD Center business plan has been developed that proposes expansion of the center, including the addition of five staff members, over the course of three years (2014-2016). The business plan projects significant grant revenue to cover most of the program and staff expenses, with the net increase in expenses estimated at \$220,000 annually.

### **Emerging Issues and Trends**

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The Council closely monitors emerging research and news reports on substantive issues to dental practice and patient safety. In spring 2013, two widely reported infection control breaches—one at an oral surgeon's office in Tulsa, Oklahoma, and another associated with a deceased dentist in Arkansas—called



significant attention to infection control practices across the profession. After initial reports of the Tulsa case, the Council assisted in providing information for the MouthHealthy Facebook page, and several CSA resources were cited in related *ADA News* coverage. Appropriate dental infection control remains a long-standing focus for CSA, which will continue to monitor emerging issues and promote patient and provider safety and appropriate infection control practice.

In January 2013, the ADA completed its participation in the United Nations Environment Programme (UNEP) International Negotiating Committee (INC) meetings in Geneva, Switzerland. Since 2009, the ADA has actively engaged in the negotiations through its representation in the FDI World Dental Federation and International Association for Dental Research delegations. In addition, the ADA worked with the U.S. State Department, Environmental Protection Agency, and Food and Drug Administration (FDA) to better align the U.S. position during these meetings with that advocated by the ADA, FDI and International Association for Dental Research (IADR).

Dental amalgam is an essential restorative material not only in the U.S. but for public health worldwide. The ADA was extremely concerned about the UNEP INC treaty interfering with the doctor-patient relationship by attempting to ban or phase out the use of safe and effective dental restorative materials. In response, the ADA advocated on behalf of the profession about the potentially negative consequences to public health from a legally binding mercury treaty. In the face of pressure from some special interest groups and some international delegations, the ADA upheld its belief that it would be both reckless and without precedent for the United Nations to ignore the expert advice from those oral health professionals entrusted with the health of the public and individual patients. Limiting the use of dental amalgam would be most harmful in lower income communities and countries in which access to care, field conditions and economic circumstances make the alternative restorative options less successful and less affordable.

ADA representatives, together with FDI, IADR, World Health Organization and other respected health care organizations, forcefully argued that a ban or any limitations on dental amalgam at any set future date is not feasible. Instead, the ADA negotiated for phasing down the use of restorative materials, including dental amalgam, by reducing demand for all restorative options. Demand reduction is to be accomplished by a phasing up of disease prevention efforts and support for more research into safe and effective alternative treatment options. The ADA's phase down approach also called for the use of best management practices (BMPs) to minimize the already slight environmental impact from dental amalgam. The ADA has been in the forefront of BMP development in this country and supports the use of amalgam separators as part of BMPs globally.

ADA representatives to the treaty negotiations were unwavering that an environmental treaty must not dictate and limit personal or professional health care decisions. The meeting concluded with adoption of language fully consistent with the approach advocated by the ADA.

Ratification of the treaty will be opened for signature by world governments at a fall 2013 meeting in Japan.

The CSA is monitoring the environmental safety of triclosan-containing products. The FDA is continuing an extensive review on triclosan safety, and the findings of this FDA review are expected this year. As of spring 2013, the FDA still supports the use of triclosan in consumer products, and several toothpastes with triclosan carry the ADA seal because they have met the Acceptance Program's criteria for safety and effectiveness. Similarly, CSA is continuing to monitor its November 2012 Statement on Human Papillomavirus (HPV) and Squamous Cell Cancers of the Oropharynx to provide more information on suggestive symptoms of HPV-associated oropharyngeal cancer. The CSA continues to provide guidance for advising patients about the oncogenic potential of some HPV infections. Additional information on HPV-associated oropharyngeal cancer was publicized in a 2013 article for "Science in the News" on ADA.org.

*Plans for 2013-2014.* Table 2 outlines several of CSA's primary initiatives for 2013-2014:

**Table 2. Key Initiatives and Plans for 2013–2014**

- *Improve Oral Health Outcomes by Developing Recommendations for Caries Management by Risk Assessment:* An interagency workgroup led by CSA is preparing a draft statement on caries management by risk assessment, which will outline strategies for minimizing caries risk factors, implementing evidence-based interventions for caries prevention, improving diagnostics, and reducing caries incidence and severity.
- *Establish a Science-Based Definition for the Term “Oral Health” to Provide a Useful Foundation for Measuring and Evaluating Oral Health Outcomes:* The Council is developing a science-based definition for the term “oral health” that is aligned with the needs of dentists, patients and the ADA.
- *Help Dentists Address the Oral Health Needs of Patients With Cancer and Other Chronic Conditions:* The Council is developing a “concept paper” addressing the care of dental patients across the age spectrum, and the care of oral health problems that arise in individuals with cancer and other long-standing conditions.
- *Promote Evidence-Based Practice by Updating the ADA’s EBD Website and Implementing an Updated EBD Business Plan:* The EBD Center is implementing an updated business plan in 2013-2014 to meet the increasing demand for EBD through the addition of five staff members over a three-year period (2014-2016). In 2013, the EBD Center is also updating the EBD website in collaboration with the Division of Information Technology to provide improved user experience and enhanced functionality.
- *Improve Pediatric Oral Health by Finalizing Consensus Recommendations on Fluoride Toothpaste Use in Children Under Six Years of Age:* The Council is circulating preliminary draft guidance and the findings of a draft systematic review on the incidence of dental caries and fluorosis in young children who used fluoride toothpaste to subject matter experts for further evaluation. The Council will finalize consensus recommendations on this topic in 2013.
- *Improve the Clinical Management of Patients With Xerostomia:* The Council is finalizing an updated report on the clinical management of xerostomia and hyposalivation, which will outline treatment approaches for optimal patient care.
- *Forensic Dental Data Standard Implementation Activities:* The ADA standards program is collaborating with the National Institute of Standards and Technology (NIST) to incorporate *ANSI/ADA Standard No. 1058 on Forensic Dental Data Set* into ANSI/NIST ITL 2011, a standard that deals with the transmission of biometric information between police agencies. The resulting standard will provide the specifications to forensically code dental information and exchange dental and radiographic data with national and international law enforcement agencies to assist with missing person and victim identification.
- *Support the Integrated Healthcare Enterprise (IHE) Through IHE Dental Domain:* The IHE Dental Domain is assisting ADA members in selecting digital dental information systems with full interoperability in real-world practice settings. The first IHE profile on the secure exchange of digital dental images has been completed, and testing software to demonstrate conformance is under development.

**Policy Review**

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In accordance with Resolution 111H-2010, Regular Comprehensive Policy Review, and Resolution 170H-2012, the Council will begin its review of current policy on scientific issues at its July 2013 meeting, and will provide recommendations in a supplemental report to the 2013 House of Delegates.

**Summary of Resolutions**

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This report is informational and no resolutions are presented.

**Council Minutes**

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For more information, ADA members are encouraged to review the minutes of recent CSA meetings at: <https://www.ada.org/members/1293.aspx#scientific>

# ADA Business Enterprises, Inc.

## Wholly Owned Subsidiary Annual Report and Financial Affairs

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Mercer, James, 2013, South Carolina, chairman  
Kiesling, Roger, 2013, Montana  
Kolman, Paul, 2012, Indiana  
Meckler, Edward, 2012, Ohio

Doherty, Deborah, managing vice president

### Mission and Purpose

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ADA Business Enterprises, Inc. (ADABEI) is a wholly owned subsidiary of the American Dental Association ("Association"). In 2012, the newly reconstituted ADABEI Board of Directors developed a new vision, mission, and strategic goals for the subsidiary.

#### Vision

ADABEI will be the leader in the development of non-dues revenue and member value by providing quality products and services.

#### Mission

ADABEI is to develop and manage programs that generate revenue by providing best-in-category products and services that create member value for dentists.

#### Strategic Goals

Goal 1: ADABEI will diversify revenue sources, grow revenue, and build reserves by providing best-in-category products and services for dentists.

- Foster organic growth from existing programs.
- Expand into new program and service areas.
- Coordinate with other ADA divisions to enhance the value proposition for both members and non-members.
- Set goals to grow ADABEI reserves annually, to attain long-term financial stability and position ADABEI to pursue new business opportunities.

Goal 2: ADABEI will protect the ADA Business Resources brand by ensuring that internal structures, policies, and practices support knowledge-based decision-making, prudent risk-taking, and ongoing oversight of programs.

- Develop policies and procedures, including position descriptions and interview questions, to support skill-based appointments to the board.
- Ensure that staffing levels, expertise, and compensation structures support strategic and annual goals.
- Review and refine new product adoption procedures and parameters.
- Review programs periodically and discontinue activities that do not add measureable value to members and meet stated goals of financial profit.

## Supporting the Strategic Plan: Activities, Results and Accomplishments

### ADABEI Program Revenue

ADABEI program revenue is unaudited and subject to change. In 2012, ADABEI earned \$2,408,367 in gross revenue as a result of service fees to ADABEI from the program, which is 0.9% above the budget of \$2,386,277 (Table 2).

Every product was at budget. Two products, utilities with Energy Plus and luxury cars with Mercedes Benz, were added in the fourth quarter of 2012. Interest was high for both products, which added more than \$10,000 in unbudgeted income to ADABEI.

ADABEI prepared the 2013 budget based upon positive input from ADABEI providers and some mixed economic signs and trends throughout 2012. The 2013 budget was approved, with growth of 2.3%. For the first quarter of 2013, ADABEI earned a total of \$544,000 from program service fees, which was at budget.

### ADA Royalties

In 2012, the ADA earned royalties of \$3,522,045 from endorsed providers in the program, exceeding the budget by more than \$1 million dollars. The variance was driven by the timing of the ADA budget preparation and better than expected performance, primarily from the financial products. For the first quarter of 2013, ADA earned a total of \$858,000 from endorsed providers in the program.

**Table 1. 2012 ADA Financials**

	<b>2012 Actuals (Unaudited)</b>	<b>2012 Budget</b>	<b>Variance (\$)</b>	<b>Variance (%)</b>
ADA Royalties	\$3,522,045	\$2,467,850	\$1,054,195	43%
Expenses	\$515,724	\$500,000	(\$15,724)	(3%)
<b>Net (Pre-Tax)</b>	<b>\$3,006,321</b>	<b>\$1,967,850</b>	<b>\$1,038,471</b>	<b>53%</b>

State dental societies may choose to co-endorse products and services and share in program revenue through a license agreement. In 2012, the program paid more than \$515,000 in royalties to state dental societies, the majority of which was contributed by the co-endorsements of the credit card with U.S. Bank, credit card processing with Chase Paymentech, and patient financing with CareCredit, LLC.

### ADABEI Financials

ADABEI finished 2012 with net income (pre-tax) of \$518,937, driven in large part by the strong revenue performance of the financial products.

**Table 2. 2012 ADABEI Financials**

	<b>2012 Actuals (Unaudited)</b>	<b>2012 Budget</b>	<b>Variance (\$)</b>	<b>Variance (%)</b>
ADABEI Revenue	\$2,408,367	\$2,386,277	\$22,090	0.9%
Expense	\$1,889,430	\$1,861,201	(\$28,229)	(2.0%)
<b>Net (Pre-Tax)</b>	<b>\$518,937</b>	<b>\$525,076</b>	<b>(\$6,139)</b>	<b>(1.1%)</b>

## Products

In 2012, the program included 14 products and services from 13 providers:

- Credit Card—U.S. Bank
- Credit Card Processing—Chase Paymentech, LP
- Patient Financing—CareCredit, LLC
- Practice Financing & Commercial Real Estate—Wells Fargo Practice Finance
- Luxury Vehicles—Mercedes-Benz
- Utility Benefits—Energy Plus
- Payroll Services—SurePayroll, Inc.
- Message on Hold—InTouch Practice Communications
- Staff Apparel—Lands' End Business Outfitters, Inc.
- Digital & Paper Patient Charts—The Dental Record
- Shipping—FedEx and Meridian One Corporation
- Appliances—Whirlpool VIP Program and Meridian One Corporation
- Computers—Hewlett Packard and Meridian One Corporation

## Renewed Contracts

Two endorsement relationships were renewed in 2012. InTouch Practice Communications was renewed as the endorsed provider for Message on Hold for an additional three-year term. The Dental Record, a WDA Insurances and Services Corporation, a subsidiary of the Wisconsin Dental Association, is the endorsed provider of paper and digital patient charts. After a scorecard review was completed, the agreements were renewed for five years with increased terms.

In 2013, seven of the existing agreements are slated for contract review and potential renewal. Industry scans, program scorecard reviews and contract discussions are a priority for 2013.

## New Products

Product development continued to be a key focus for ADABEI in 2012. Eighty-six companies contacted ADABEI in 2012 with an interest in a business relationship. In addition, ADABEI conducts ADA member surveys to quantify industry and product trends, as well as to gauge product interest.

In the third quarter of 2012, ADABEI added two new products offered to ADA members, including a three-year agreement with Energy Plus Holdings LLC to provide electricity and natural gas discounts, and a two-year agreement with Mercedes Benz to provide discounts to ADA members on its line of luxury automobiles.

All new products and providers are researched to ensure they are industry leaders, solid financially, solve a member need and hold a higher service standard. They must offer preferred pricing for ADA members and all providers are monitored to make sure they deliver what they promise to members.

In 2012, RFPs were conducted in the areas of marketing services, amalgam separators and banking products, and programs are being developed for possible 2013 launches.

## Marketing

Members are able to learn about the program, branded ADA Business Resources, through direct mail and digital channels, and to access the many products and services via:

- The toll-free number, 800-ADA-2308
- The website, [www.adabusinessresources.com](http://www.adabusinessresources.com)

In 2012, ADABEI made more than 6,000,000 impressions in the dental community through various marketing channels—including six direct mail pieces, four *ADA News* advertisements, 27 email newsletters and the ADA Business Resources website—with an increased focus on digital channels.

After a redesign of the ADA Business Resources email template in 2012, email open rates increased by 37% and website page views increased by 50%. The integrated marketing strategy served as the foundation for delivering relevant, effective messages that will maximize the amount of traffic sent back to the endorsed providers.

### **Summary of Resolutions**

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This report is informational and no resolutions are presented.

### **Links**

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For a complete listing of ADA Business Resources endorsements, see [www.adabusinessresources.com](http://www.adabusinessresources.com).

# ADA Foundation

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Whiston, David A., president, 2014, Virginia  
Rethman, Michael P., vice president, scientific research, 2014, Hawaii  
Szarzynski, Ronald, vice president, finance, 2014, Minnesota  
Walker, Lewis, vice president, development, 2015, Florida  
Zarkowski, Pamela, vice president, grants, 2014, Michigan

## *Members at Large*

Buckenheimer, Terry L., 2016, Florida  
Bushick, Ronald D., 2015, Pennsylvania  
Garcia, Ernest L., Jr., 2013, California  
Gounardes, Steven, 2014, New York  
Hearn, Cindy, 2016, California  
Hemmen, Pam, 2016, Illinois  
Panagakos, Fotinos S., 2012, New Jersey  
Penrose, Michele, 2016, Michigan  
Reyes, Reneida, 2016, New York  
Ross, Candy B., 2015, Georgia  
Rouse, Leo E., 2013, Maryland  
Seago, Donald L., 2013, Mississippi  
Smith, Charles L., 2013, West Virginia  
Winston, J. Leslie, 2015, Ohio  
Yonemoto, Gary S., 2015, Hawaii

## *ADA Foundation Administrative Staff*

Wurth, Gene, executive director  
Fronczak, Cynthia, chief financial officer/chief operating officer  
Haibach, Cathy, manager, grants program/communications officer  
Watson, Shirley, manager, administrative services  
Rabianski, Walter, senior accountant  
Smith, Eric, staff accountant  
Garcia, Cristina, grants program coordinator

Schumacher, Gary, director, administration, Paffenbarger Research Center  
Skrtic, Drago, director, research, Paffenbarger Research Center

## **Mission and Purpose**

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As dentistry's premier philanthropic and charitable organization, the ADA Foundation is a catalyst for uniting people and organizations to make a difference through better oral health.

## **Supporting the Strategic Plan: Activities, Results and Accomplishments**

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In 2012, the ADA Foundation made 249 grants totaling approximately \$1.3 million, every dollar of which was related to one or more of the ADA's strategic goals. This included 117 grants for disaster or financial assistance to dentists; 19 grants to support various aspects of the ADA's Give Kids A Smile program; a grant for the ADA's National Children's Dental Health Month program; a grant to support the ADA's Dental Quality Alliance program; 54 dental student scholarships and 30 allied dental student scholarships; and more than 20 grants to support various outreach and access to care programs conducted by volunteers and dental students across the country.



## Financial Matters

In 2012, the ADA grant to the ADA Foundation was reduced by more than \$2 million from 2011. The total grant in 2012 was \$1,906,533. Despite that significant reduction of more than 50%, the Foundation ended 2012 in good financial shape, primarily by reducing expenses more than \$1,760,000 compared to 2011. The Foundation realized more than \$877,000 in increased contributions from 2011, and the gain on investments was significantly higher than in 2011. However, contributions all go to the programs that donors wish to support, and cannot be used for operations. Only a very small portion of investment income can be used to cover operational costs, because income from restricted accounts must be reinvested into those restricted accounts, and nearly 95% of all ADA Foundation investments are in funds that are restricted by the donors' wishes. Therefore, consistent support from the ADA at approximately that same level will be important for the ADA Foundation's continued success in the future, since the grant covers Foundation administrative costs which cannot be met from other funds.

## Paffenbarger Research Center

The ADA Foundation made significant changes to revitalize the Paffenbarger Research Center (PRC) during 2012. Five of the research staff moved to emeritus or reduced time status, which allowed the Foundation to use most of those salaries to hire new researchers in the emerging areas of oral health science. The Foundation has hired two new microbiologists and is in the process of hiring additional staff in 2013.

The ADA Foundation has strengthened its connections to the National Institute of Standards and Technology (NIST), the federal agency on whose campus the PRC is located. A new organizational structure at NIST has demonstrated the favorable view that they have of PRC and their interest in collaborating on research projects.

The ADA Foundation will hire more researchers in 2013 and has begun submitting a number of new grants to the National Institute of Dental and Craniofacial Research (NIDCR) and other agencies.

## Give Kids A Smile Gala

The 2012 Give Kids A Smile Gala was a big success, with a net of revenue over expenses of more than \$82,000. The event, which combined the Give Kids A Smile Gala and the ADA President's Gala, had not been profitable in previous years. More than 580 people attended in 2012.

## Fund Raising

The ADA Foundation has formed a new Development Committee, with three specific subcommittees dedicated to: Individual Giving—Annual Gifts; Individual Giving—Major Gifts; and Corporate Support. There have been several new proposals for corporate support of the Foundation's scholarship and access to care programs, and in support of the PRC.

## Summary of Resolutions

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This report is informational and no resolutions are presented.

## Links

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For more information on recent activities, see <http://www.ada.org/adafoundation.aspx>.

## Notes

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## 2012 Resolutions

## Notes

# 2012 Resolutions

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## BOARD OF TRUSTEES

### AMENDMENT OF THE ADA *CONSTITUTION* AND *BYLAWS* REGARDING THE OFFICES OF FIRST AND SECOND VICE PRESIDENT

**Background:** In response to Resolution 38H-2011, the Board of Trustees directed its Governance Committee to oversee a comprehensive study of the Association's governance. After careful deliberation, the Committee selected Westman and Associates (the Consultant) to provide suggested revisions to the governance of the ADA. Based on months of data collection and collaboration with the Committee, the Consultant provided a report to the Board of Trustees setting forth 80 suggestions for change in ADA governance. Among the suggestions received from the Consultants was the following:

Westman Suggestion #44. Eliminate the two Vice President positions.

Unlike the position in many state societies, the position of ADA vice president does not automatically succeed to the office of President-elect and then President. Moreover, the stated purpose of these positions, to represent the House, is in fact served by the President and President-elect, as well as the entire Board. The Board has been well served by many very able and dedicated Vice Presidents and thanks each of them for their service. Nevertheless, the Board concludes that the positions add complexity to our governance (by increasing the size of the Board and adding additional elections). The Board is recommending that this change take place at the close of the 2013 House (both to allow a smooth transition and because of the need for an amendment to the ADA Constitution).

Accordingly, the Board proposes the following resolutions, with the suggestion that the *Bylaws* amendments be referred back to the Board to be offered again in 2013, after the Constitutional changes are addressed by the 2013 House.

#### Resolution

**95-2012. Resolved**, that ARTICLE V. OFFICERS, *Section 10*. ELECTIVE OFFICERS of the ADA *Constitution* be amended to delete references to the First and Second Vice Presidents, as shown below (deletions are ~~stricken~~):

#### ARTICLE V. OFFICERS

*Section 10*. ELECTIVE OFFICERS: The elective officers of this Association shall be a President, a President-elect, ~~a First Vice President, a Second Vice President,~~ a Treasurer and a Speaker of the House of Delegates, each of whom shall be elected by the House of Delegates.

and be it further

**Resolved**, that CHAPTER VI. CONFLICT OF INTEREST of the ADA *Bylaws* be amended as follows (deletions ~~stricken~~):

#### CHAPTER VI. CONFLICT OF INTEREST

It is the policy of this Association that individuals who serve in elective, appointive or employed offices or positions do so in a representative or fiduciary capacity that requires loyalty to the Association. 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.
- c. obtaining by a third party an improper gain or advantage.

As a condition for selection, each nominee, candidate and applicant shall complete a conflict of interest statement as prescribed by the Board of Trustees, disclosing any situation which might be construed as placing the individual in a position of having an interest that may conflict with his or her duty to the Association. Candidates for offices of President-elect, ~~Second Vice President~~, Treasurer, Speaker of the House, nominees for office of trustee, and nominees to councils and commissions shall file such statements with the Secretary of the House of Delegates to be made available to the delegates prior to election. As a condition of appointment, consultants, advisers and staff of Councils, Commissions and Special Committees, and each person nominated or seeking such positions, shall file conflict of interest statements with the executive director of this Association.

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.

The Board of Trustees shall approve any additional compliance activities that will implement the requirements of this chapter. The Board of Trustees shall render a final judgment on what constitutes a conflict of interest.

and be it further

**Resolved**, that CHAPTER VII. BOARD OF TRUSTEES, *Section 10*. COMPOSITION of the ADA *Bylaws* be amended as shown below (additions underscored, deletions ~~stricken~~):

*Section 10*. COMPOSITION: The Board of Trustees shall consist of one (1) trustee from each of the seventeen (17) trustee districts. Such seventeen (17) trustees, and the President-elect ~~and the two Vice Presidents~~ shall constitute the voting membership of the Board of Trustees. In addition, the President, the Treasurer and the Executive Director of the Association, except as otherwise provided in the *Bylaws* shall be *ex officio* members of the Board without the right to vote.

and be it further

**Resolved**, that CHAPTER VII. BOARD OF TRUSTEES, *Section 130*. OFFICERS, Subsection A. CHAIR AND SECRETARY of the ADA *Bylaws* be amended as follows (deletions ~~stricken~~):

*Section 130*. OFFICERS:

A. CHAIR AND SECRETARY. The officers of the Board of Trustees shall be the President of the Association who shall be the Chair, and the Executive Director of the Association who shall be the Secretary.

In the absence of the President, the office of Chair shall be filled by the President-elect and, in his or her absence, by ~~the First or Second Vice President in that order and, in their absence,~~ a voting member of the Board shall be elected Chair *pro tem*.

In the absence of the Secretary, the Chair shall appoint a Secretary *pro tem*.

and be it further

**Resolved**, that CHAPTER VIII. ELECTIVE OFFICERS, *Section 10*. TITLE of the ADA *Bylaws* be amended as follows (deletions ~~stricken~~):

*Section 10.* TITLE: The elective officers of this Association shall be President, President-elect, ~~First Vice President, Second Vice President,~~ Treasurer and Speaker of the House of Delegates, as provided in Article V of the *Constitution*.

and be it further

**Resolved**, that CHAPTER VIII. ELECTIVE OFFICERS, *Section 30.* NOMINATIONS, Subsection A. of the ADA *Bylaws*, be amended as follows (deletions ~~stricken~~):

*Section 30.* NOMINATIONS:

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.

and be it further

**Resolved**, that CHAPTER VIII. ELECTIVE OFFICERS, *Section 50.* TERM OF OFFICE of the ADA *Bylaws* be amended as follows (deletions ~~stricken~~):

*Section 50.* TERM OF OFFICE: The President, President-elect, ~~First Vice President, Second Vice President~~ and Speaker of the House of Delegates shall serve for a term of one (1) year, except as otherwise provided in this chapter of the *Bylaws*, or until their successors are elected and installed. The term of office of the Treasurer shall be three (3) years, or until a successor is elected and installed. The Treasurer shall be limited to two (2) consecutive terms of three (3) years each, excepting the case of a former Treasurer who has been elected Treasurer *pro tem* as provided in Chapter VIII, Section 30 of these *Bylaws*, who may serve one (1) additional year.

and be it further

**Resolved**, that CHAPTER VIII. ELECTIVE OFFICERS, *Section 60.* INSTALLATION of the ADA *Bylaws* be amended as follows (deletions ~~stricken~~):

*Section 60.* INSTALLATION: The elective officers shall be installed at the last meeting of the annual session of the House of Delegates. The President-elect shall be installed as President at the next annual session of the House following election. ~~The Second Vice President shall be installed as First Vice President at the next annual session of the House following election.~~

and be it further

**Resolved**, that CHAPTER VIII. ELECTIVE OFFICERS, *Section 80.* VACANCIES, Subsection A. VACANCY OF ELECTIVE OFFICE of the ADA *Bylaws* be amended as follows (deletions ~~stricken~~):

*Section 80.* VACANCIES:

A. VACANCY OF ELECTIVE OFFICE: In the event the office of President becomes vacant, the President-elect shall become President for the unexpired portion of the term. In the event the office of President becomes vacant for the second time in the same term or at a time when the office of President-elect is also vacant, the First Vice President Board shall select by majority vote a sitting trustee to become President for the unexpired portion of the term. ~~In the event the office of First Vice President becomes vacant, the Second Vice President shall become the First Vice President for the unexpired portion of the term. A vacancy in the office of the Second Vice President shall be filled by a majority vote of the Board of Trustees.~~ In the event of a vacancy in the office of Speaker of the House of Delegates, the President, with approval of the Board of Trustees, shall appoint a Speaker *pro tem*. In the event the office of President-elect becomes

vacant by reason other than the President-elect succeeding to the office of the President earlier than the next annual session, the office of President for the ensuing year shall be filled at the next annual session of the House of Delegates in the same manner as that provided for the nomination and election of elective officers, except that the ballot shall read "President for the Ensuing Year." A vacancy in the office of Treasurer shall be filled by a majority vote of the Board of Trustees until the process of inviting applications, screening and nominating candidates and electing a new Treasurer has been completed by the Board of Trustees and the House of Delegates. The Treasurer *pro tem* shall be eligible for election to a new consecutive three (3) year term. The newly elected Treasurer shall be limited to two (2) consecutive terms of three (3) years each, excepting the case of a former Treasurer who has been elected Treasurer *pro tem* as provided in Chapter VIII, Section 30 of these *Bylaws*, who may serve one (1) additional year.

and be it further

**Resolved**, that CHAPTER VIII. ELECTIVE OFFICERS, *Section 90*. DUTIES, Subsection C. FIRST VICE PRESIDENT of the ADA *Bylaws* be deleted in its entirety as follows (deletions ~~stricken~~):

~~C. FIRST VICE PRESIDENT. It shall be the duty of the First Vice President to:~~

- ~~a. Assist the President as requested.~~
- ~~b. Serve as an ex officio member of the House of Delegates without the right to vote.~~
- ~~c. Serve as an ex officio member of the Board of Trustees.~~
- ~~d. Succeed to the office of President, as provided in this chapter of the Bylaws.~~

and be it further

**Resolved**, that CHAPTER VIII. ELECTIVE OFFICERS, *Section 90*. DUTIES, Subsection D. SECOND VICE PRESIDENT of the ADA *Bylaws* be deleted in its entirety as follows (deletions ~~stricken~~):

~~D. SECOND VICE PRESIDENT. It shall be the duty of the Second Vice President to:~~

- ~~a. Assist the President as requested.~~
- ~~b. Serve as an ex officio member of the House of Delegates without the right to vote.~~
- ~~c. Serve as an ex officio member of the Board of Trustees.~~
- ~~d. Succeed to the office of First Vice President at the next annual session of the House of Delegates following election as Second Vice President.~~
- ~~e. Succeed immediately to the office of First Vice President in the event of vacancy not only for the unexpired term but also for the succeeding term.~~

and be it further

**Resolved**, that the remaining Subsections of *Section 90*. of CHAPTER VIII. of the ADA *Bylaws* be re-lettered accordingly.

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## BOARD OF TRUSTEES

### AMENDMENT OF THE ADA *BYLAWS* REGARDING NOTICE FOR DUES, SPECIAL ASSESSMENTS AND PROCEDURE FOR CHANGING THE DUES OF ACTIVE MEMBERS

**Background:** In response to Resolution 38H-2011, the Board of Trustees directed its Governance Committee to oversee a comprehensive study of the Association's governance. After careful deliberation, the Committee selected Westman and Associates (the Consultant) to provide suggested revisions to the governance of the ADA. Based on months of data collection and collaboration with the Committee, the Consultant provided a report to the Board of Trustees setting forth 80 suggestions for change in ADA governance. Among the suggestions received from the Consultants was the following:

Westman Suggestion #65. Change the ADA *Bylaws* to enable a 30-day notice to members of a dues increase.

The Board agrees with this suggestion and believes it will bring better order to the current budgeting process. Currently, the Board is at times forced to propose a specific dues increase in the absence of a final proposed budget. A 30 day period would eliminate that issue. Moreover, the Board notes that the existing 90 day requirement appears to be premised on the use of certified mail, a practice which no longer seems to be necessary. Accordingly, in addition to a change in the time period, the Board is proposing a change in the required manner of communication. The Board also proposes to carry over the modifications in the time period to the requirement of notice to the general membership. Finally, to be consistent, the Board is recommending a parallel change to the *Bylaws* provisions governing notice in the procedure for changing the dues of active members and in proposing special assessments. Accordingly, the Board proposes the following resolution:

#### Resolution

**99-2012. Resolved**, that CHAPTER VII. BOARD OF TRUSTEES, *Section 100. DUTIES*, Subsection F. of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

F. Prepare a budget for carrying on the activities of the Association for each ensuing fiscal year, and present for action by each House of Delegates a resolution setting forth the proposed dues of active members for the following year. Notice of such a resolution shall be sent electronically by a certifiable method of delivery to each constituent society and posted on ADA Connect or its equivalent for the House of Delegates not less than ~~ninety (90)~~ thirty (30) days before such session to permit prompt, adequate notice by each constituent society to its delegates and alternate delegates to the House of Delegates of this Association, and shall be announced to the general membership in an official publication of the Association at least ~~sixty (60)~~ fifteen (15) days in advance of the annual session.

and be it further

**Resolved**, that CHAPTER XVIII. FINANCES, *Section 40. SPECIAL ASSESSMENTS* of the ADA *Bylaws* be amended as follows:

*Section 40. SPECIAL ASSESSMENTS:* In addition to the payment of dues required in Chapter I, Section 20 of these *Bylaws*, a special assessment may be levied by the House of Delegates upon active, active life, retired and associate members of this Association as provided in Chapter I, Section 20 of these *Bylaws*, for the purpose of funding a specific project of limited duration. Such an assessment may be levied at any annual or special session of the House of Delegates by a two-thirds (2/3) affirmative vote of the delegates present and voting, provided notice of the proposed assessment has been presented ~~in writing~~ at least ~~ninety (90)~~ thirty (30) days prior to the first day of the session of the House of Delegates at which it is to be considered. Notice of such a resolution shall be sent ~~by a certifiable method of delivery~~ electronically to each constituent society and posted on ADA Connect or its equivalent for the House of Delegates not less than ~~ninety (90)~~ thirty (30) days before such session to permit prompt, adequate notice by

each constituent society to its delegates and alternate delegates to the House of Delegates of this Association, and shall be announced to the general membership in an official publication of this Association at least ~~sixty (60)~~ fifteen (15) days in advance of the session. The specific project to be funded by the proposed assessment, the time frame of the project, and the amount and duration of the proposed assessment shall be clearly presented in giving notice to the members of this Association. Revenue from a special assessment and any earnings thereon shall be deposited in a separate fund as provided in Chapter XVII, Section 30 of these *Bylaws*. The House of Delegates may amend the main motion to levy a special assessment only if the amendment is germane and adopted by a two-thirds (2/3) affirmative vote of the delegates present and voting. The House of Delegates may consider only one (1) specific project to be funded by a proposed assessment at a time. However, if properly adopted by the House of Delegates, two (2) or more special assessments may be in force at the same time. Any resolution to levy a special assessment that does not meet the notice requirements set forth in the previous paragraph also may be adopted by a unanimous vote of the House of Delegates, provided the resolution has been presented in writing at a previous meeting of the same session.

and be it further

**Resolved**, that CHAPTER XXII. AMENDMENTS, *Section 20*. AMENDMENT AFFECTING THE PROCEDURE FOR CHANGING THE DUES OF ACTIVE MEMBERS be amended as follows (additions underscoring, deletions ~~stricken through~~):

*Section 20*. AMENDMENT AFFECTING THE PROCEDURE FOR CHANGING THE DUES OF ACTIVE MEMBERS: An amendment of these *Bylaws* affecting the procedure for changing the dues of active members may be adopted only if the proposed amendment has been presented in writing at least ~~ninety (90)~~ thirty (30) days prior to the first day of the session of the House of Delegates at which it is to be considered. Notice of such a resolution shall be sent electronically ~~by a certifiable method of delivery~~ to each constituent society not less than ~~ninety (90)~~ thirty (30) days before such session to permit prompt, adequate notice by each constituent society to its delegates and alternate delegates to the House of Delegates of this Association, and shall be announced to the general membership in an official publication of the Association at least ~~sixty (60)~~ fifteen (15) days in advance of the annual session.

Amendments affecting the procedure for changing the dues of active members may also be adopted by a unanimous vote provided that the proposed amendment has been presented in writing at a previous meeting of the same session.

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**SEVENTEENTH TRUSTEE DISTRICT**  
**AMENDMENT OF THE ADA CONSTITUTION, SECTION 20. ADMINISTRATIVE BODY**

The following resolution was submitted by the Seventeenth Trustee District and transmitted on October 19, 2012, by Dr. Kim Jernigan, Seventeenth District Caucus Chair.

**Background:** Since the ADA meeting in Hawaii, many hours have been spent contemplating how best for the House to exercise its fiduciary responsibility and its supreme governing authority, especially regarding the adoption of the budget and to address the undesirable method of the Board “going behind the curtain” to balance the budget in the waning moments of the House.

To ensure that we achieve the necessary and adequate checks and balances while accomplishing strategic budgeting, the right and privilege of developing and adopting the budget should be accomplished by both the House and the Board, with the understanding that the *Bylaws* will later define more clearly the responsibilities of each.

In lieu of our repeated efforts to accomplish these goals, the roadblock has been the current Constitution which prohibits the House from performing any administrative duties. Therefore in consultation with the Speaker of the House and General Counsel, a limited exception to the administrative duties section of the Constitution is proposed. This resolution attempts to open a narrow window to allow the House and Board to work together to accomplish a budgetary process that is in the best interest of the ADA.

**Resolution**

**175-2012. Resolved,** that the ADA Constitution be amended by addition to Article IV Government, Section 20, in line 52 after the word “Board” the following: “with the exception that the Board and the House of Delegates shall have joint responsibility for development and adoption of the annual budget” so that Section 20 reads:

Section 20. ADMINISTRATIVE BODY: The administrative body of the Association shall be a Board of Trustees, which may be referred to as ‘the Board’ or ‘this Board,’ with the exception that the Board and the House of Delegates shall have joint responsibility for development and adoption of the annual budget.

## Notes

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## Appendix

## Notes

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## Notes

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# ADA 2012 Audited Financial Statements

## Notes



**AMERICAN DENTAL ASSOCIATION  
AND SUBSIDIARIES**

Consolidated Financial Statements and Supplemental Schedules

December 31, 2012 and 2011

(With Independent Auditors' Report Thereon)



**KPMG LLP**  
Aon Center  
Suite 5500  
200 East Randolph Drive  
Chicago, IL 60601-6436

## **Independent Auditors' Report**

The Board of Trustees  
American Dental Association and Subsidiaries:

### **Report on the Consolidated Financial Statements**

We have audited the accompanying consolidated financial statements of the American Dental Association and Subsidiaries (the Association), which comprise the consolidated statements of financial position as of December 31, 2012 and 2011, and the related consolidated statements of activities and cash flows for the years then ended, and the related notes to the consolidated financial statements.

### ***Management's Responsibility for the Consolidated Financial Statements***

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

### ***Auditors' Responsibility***

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

### ***Opinion***

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the American Dental Association and Subsidiaries as of December 31, 2012 and 2011, and the results of their activities and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.



***Other Matter***

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The supplementary information included in schedules 1 through 3 are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

June 10, 2013

**AMERICAN DENTAL ASSOCIATION  
AND SUBSIDIARIES**

Consolidated Statements of Financial Position

December 31, 2012 and 2011

<b>Assets</b>	<b>2012</b>	<b>2011</b>
Cash and cash equivalents	\$ 8,370,124	9,019,767
Receivables, net	7,729,198	7,368,076
Deferred taxes	128,262	430,758
Income taxes receivable	370,031	750,157
Prepaid expenses and other assets	2,115,452	1,944,706
Inventories, net	590,180	600,045
Marketable securities	108,826,964	92,608,778
Property and equipment, net	40,246,494	43,571,604
Funds held for deferred compensation	5,445,955	4,979,020
Total assets	<u>\$ 173,822,660</u>	<u>161,272,911</u>
<b>Liabilities and Net Assets</b>		
Accounts payable and accrued liabilities	\$ 13,239,922	10,186,242
Due to constituent societies	17,652	8,205
Deferred revenues	11,740,169	12,504,462
Charitable gift annuities	77,112	90,232
Liability for deferred compensation	5,445,955	4,979,020
Postretirement benefit obligation	10,533,050	9,901,103
Pension liability	56,796,206	51,134,619
Total liabilities	<u>97,850,066</u>	<u>88,803,883</u>
Net assets:		
Unrestricted	63,888,749	61,292,068
Temporarily restricted	9,945,003	9,038,118
Permanently restricted	2,138,842	2,138,842
Total net assets	<u>75,972,594</u>	<u>72,469,028</u>
Total liabilities and net assets	<u>\$ 173,822,660</u>	<u>161,272,911</u>

See accompanying notes to consolidated financial statements.



**AMERICAN DENTAL ASSOCIATION  
AND SUBSIDIARIES**

Consolidated Statements of Activities

Years ended December 31, 2012 and 2011

	2012				2011			
	Unrestricted	Temporarily restricted	Permanently restricted	Total	Unrestricted	Temporarily restricted	Permanently restricted	Total
Membership dues	\$ 54,551,655	—	—	54,551,655	56,706,335	—	—	56,706,335
Advertising	8,129,803	—	—	8,129,803	7,982,508	—	—	7,982,508
Rental income	5,458,093	—	—	5,458,093	5,283,155	—	—	5,283,155
Publication and product sales	7,448,384	—	—	7,448,384	5,773,428	—	—	5,773,428
Testing and accreditation fees	18,854,668	—	—	18,854,668	17,129,472	—	—	17,129,472
Meeting and seminar income	11,418,883	—	—	11,418,883	8,903,007	11,360	—	8,914,367
Grants, contributions, and sponsorships	2,853,102	2,547,391	—	5,400,493	2,487,363	2,192,208	—	4,679,571
Royalties and service fees	10,485,490	—	—	10,485,490	10,021,290	—	—	10,021,290
Investment income (loss)	10,256,308	1,346,359	—	11,602,667	(4,500,633)	(226,933)	—	(4,727,566)
Other income	2,777,212	45,092	—	2,822,304	1,959,839	132,754	—	2,092,593
Net assets released from restrictions	3,031,957	(3,031,957)	—	—	3,341,382	(3,341,382)	—	—
Total revenues	135,265,555	906,885	—	136,172,440	115,087,146	(1,231,993)	—	113,855,153
Expenses:								
Staff compensation, taxes, and benefits	59,798,557	—	—	59,798,557	64,096,518	—	—	64,096,518
Printing, publication, and marketing	10,815,806	—	—	10,815,806	9,861,348	—	—	9,861,348
Meeting expenses	3,237,651	—	—	3,237,651	1,772,338	—	—	1,772,338
Travel expenses	5,840,996	—	—	5,840,996	5,858,562	—	—	5,858,562
Consulting fees and outside services	9,045,600	—	—	9,045,600	9,184,879	—	—	9,184,879
Professional services	9,215,552	—	—	9,215,552	8,585,568	—	—	8,585,568
Office expenses	5,301,616	—	—	5,301,616	5,075,790	—	—	5,075,790
Facility and utility expenses	6,287,907	—	—	6,287,907	5,044,538	—	—	5,044,538
Grants and awards	4,585,040	—	—	4,585,040	4,514,992	—	—	4,514,992
Endorsement expenses	649,550	—	—	649,550	602,064	—	—	602,064
Depreciation and amortization	6,749,299	—	—	6,749,299	6,608,002	—	—	6,608,002
Bank and credit card fees	1,152,625	—	—	1,152,625	1,118,748	—	—	1,118,748
Other expenses	1,726,171	—	—	1,726,171	1,287,775	—	—	1,287,775
Total expenses	124,406,370	—	—	124,406,370	123,611,122	—	—	123,611,122
Net income (loss) from operations before income tax expense	10,859,185	906,885	—	11,766,070	(8,523,976)	(1,231,993)	—	(9,755,969)
Income tax expense	2,009,734	—	—	2,009,734	1,682,742	—	—	1,682,742
Net income (loss)	8,849,451	906,885	—	9,756,336	(10,206,718)	(1,231,993)	—	(11,438,711)
Pension – and postretirement health plan – related changes other than net periodic pension cost	(6,252,770)	—	—	(6,252,770)	7,855,195	—	—	7,855,195
Change in net assets	2,596,681	906,885	—	3,503,566	(2,351,523)	(1,231,993)	—	(3,583,516)
Net assets at beginning of year	61,292,068	9,038,118	2,138,842	72,469,028	63,643,591	10,270,111	2,138,842	76,052,544
Net assets at end of year	\$ 63,888,749	9,945,003	2,138,842	75,972,594	61,292,068	9,038,118	2,138,842	72,469,028

See accompanying notes to consolidated financial statements.

**AMERICAN DENTAL ASSOCIATION  
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Consolidated Statements of Cash Flows  
Years ended December 31, 2012 and 2011

	<u>2012</u>	<u>2011</u>
Cash flows from operating activities:		
Change in net assets	\$ 3,503,566	(3,583,516)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Pension – and postretirement health plan – related changes other than net periodic pension cost	6,252,770	(7,855,195)
Depreciation and amortization	6,749,299	6,608,002
Deferred income tax expense	302,496	244,512
Net change in unrealized depreciation (appreciation) in fair value of marketable securities	(10,122,398)	6,592,508
Net realized (gain) loss on sale of marketable securities	921,517	(444,881)
Provision for uncollectible accounts	104,800	166,196
Changes in assets and liabilities:		
Receivables, net	(465,922)	(375,728)
Income taxes receivable	380,126	(402,193)
Prepaid expenses and other assets	(170,746)	308,727
Inventories, net	9,865	132,522
Accounts payable, accrued liabilities, and other liabilities	3,063,127	72,104
Deferred revenues	(764,293)	(1,344,901)
Postretirement benefit obligation	(446,553)	2,571,252
Pension liability	487,317	(2,014,248)
Net cash provided by operating activities – continuing operations	9,804,971	675,161
Net cash used in operating activities – discontinued operations	—	(247,574)
Net cash provided by operating activities	<u>9,804,971</u>	<u>427,587</u>
Cash flows from investing activities:		
Purchase of marketable securities	(40,611,854)	(32,793,426)
Sale and maturity of marketable securities	33,601,432	36,875,886
Loan repayment	—	6,000
Acquisitions of property and equipment	(3,424,189)	(4,163,142)
Net cash used in investing activities	<u>(10,434,611)</u>	<u>(74,682)</u>
Cash flows from financing activities:		
Payments to charitable gift annuitant	(20,003)	(20,003)
Net cash used in financing activities	<u>(20,003)</u>	<u>(20,003)</u>
Net (decrease) increase in cash and cash equivalents	(649,643)	332,902
Cash and equivalents at beginning of year	9,019,767	8,686,865
Cash and cash equivalents at end of year	<u>\$ 8,370,124</u>	<u>9,019,767</u>
Supplemental disclosure of cash flow information:		
Cash paid for income taxes	\$ 835,625	1,885,357

See accompanying notes to consolidated financial statements.

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**(1) Summary of Significant Accounting Policies**

**(a) *Organization and Purpose***

The American Dental Association (Association) is organized as an association of members of the dental profession, residing primarily in the United States of America and is designed “to encourage the improvement of the health of the public and to promote the art and science of dentistry.”

The accompanying consolidated financial statements include the accounts of the Operating and Reserve Divisions of the Association, the American Dental Political Action Committee (ADPAC), ADA Foundation (ADAF), and the Association’s wholly owned for-profit subsidiary, ADA Business Enterprises, Inc. (ADABEI).

ADPAC promotes the Association’s political and legislative agenda.

ADAF was organized to operate exclusively for charitable, scientific, and educational purposes.

ADABEI manages the for-profit activities organized by the Association offering a range of products and services to Association members in conjunction with various service providers under the title of ADA Business Resources.

All significant intercompany accounts and transactions have been eliminated in consolidation.

**(b) *Basis of Accounting***

The consolidated financial statements of the Association are prepared using the accrual basis of accounting in accordance with U.S. generally accepted accounting principles.

**(c) *Use of Estimates***

The preparation of the consolidated financial statements in conformity with U.S. generally accepted accounting principles, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues, expenses, gains, and losses during the reporting period. Actual results could differ from those estimates.

**(d) *Cash and Cash Equivalents***

Cash equivalents at December 31, 2012 and 2011 consist primarily of interest bearing deposits under overnight repurchase agreements. The Association, ADPAC, ADAF, and ADABEI each maintain their cash balances in financial institutions, which at times may exceed federally insured limits. The Association, ADPAC, ADAF, and ADABEI have not experienced any losses in such accounts and believe they are not exposed to any significant credit risk on cash.

**(e) *Receivables and Allowance***

The allowance for doubtful receivables is determined after considering a number of factors, including the length of time receivables are past due, the Association’s previous loss history, the customer’s current ability to pay its obligations, and the condition of the general economy as a

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whole. Uncollectible accounts are written off, and payments subsequently received on such receivables are credited to the allowance for doubtful receivables. Receivables include pledges receivable for unconditional promises for which payment has not been received. Pledges receivable are recognized at the estimated present value of expected future cash flows, net of allowances.

**(f) Marketable Securities**

Investments in marketable securities are carried at fair value based on quoted market prices or other observable inputs. Realized and unrealized investment gains and losses are included within investment income in the accompanying consolidated financial statements. Net realized capital gains or losses on sales are calculated based on the cost of securities sold.

Marketable securities held in the Operating Division are available for current use while marketable securities held in the Reserve Division are not intended for current use. Reserve Division assets may be used for operations upon approval of the Board of Trustees, with subsequent reporting to the Association's House of Delegates. Investment expenses of \$75,023 and \$77,590 in 2012 and 2011, respectively, are included in professional services in the accompanying consolidated financial statements.

**(g) Inventories**

Inventories, consisting principally of salable educational materials and supplies, are carried at the lower of cost or market (net realizable value). Cost is primarily determined using the first-in, first-out method.

**(h) Property and Equipment**

Property and equipment are stated at cost, less accumulated depreciation and amortization. Depreciation is computed on the straight-line method once assets are put into service over the estimated useful lives of the assets, which are as follows:

Buildings	30 – 55 years
Building improvements	7 – 20 years
Furniture, equipment, and libraries	3 – 20 years

Tenant leasehold improvements are amortized over the shorter of their estimated useful lives or the remaining term of the lease.

**(i) Valuation of Long-Lived Assets**

The Association periodically evaluates the carrying value of its long-lived assets, including, but not limited to, property and equipment and other assets. The carrying value of long-lived assets are considered impaired when the undiscounted cash flows from such assets are separately identifiable and estimated to be less than their carrying value. In that event, a loss is recognized based on the amount by which the carrying value exceeds the fair value of the long-lived assets. Fair value is determined primarily using the anticipated cash flows discounted at a rate commensurate with the

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risk involved. Pursuant to Accounting Standards Codification (ASC) Topic 360, *Property, Plant, and Equipment-Overall*, long-lived assets that are to be disposed of are to be written down to their fair value if such fair value is less than carrying value.

**(j) Charitable Gift Annuities**

The ADAF enters into agreements with donors in which the donor contributes assets in exchange for an annuity to be paid to the donor or their designee for a specified period of time. Annually, the liability is readjusted based upon actuarial projections of future payments over the remaining life expectancy of the donor. Upon termination, any residual amount is recognized as revenue.

**(k) Contributed Facilities**

ADAF occupies, without charge, certain premises located in government-owned research facilities. No amounts have been reflected in the consolidated financial statements for their use as no objective basis is available to measure the value of such facilities.

**(l) Deferred Compensation**

The Association has a deferred compensation plan. Participation is limited to ADA officers, trustees, and certain upper management employees whose compensation rate is at least \$100,000 per year. This is a nonqualified plan governed by Section 457 of the Internal Revenue Code (the Code). Investments held for deferred compensation are carried at market value and are not available for current use.

**(m) Revenue and Expense Recognition**

Membership dues and assessments are recognized as revenue during the membership year, which ends on December 31. Amounts received in advance are deferred to the subsequent year. Unearned membership dues and assessments, which have been included in deferred revenues in the accompanying consolidated financial statements, amounted to approximately \$6,888,000 and \$7,574,000 at December 31, 2012 and 2011, respectively.

Periodical subscriptions are recognized as revenue over the terms of the subscriptions. Subscriptions paid in advance are recorded as deferred revenue. Advertising revenue and direct publication costs are recognized in the period the related publication is issued. Rental income from the Association's headquarters building and Washington, D.C. office building is recorded as revenue when earned. Testing fees are recognized as revenue when the related examinations are administered.

Contributions are considered to be available for unrestricted use unless specifically restricted by the donor. Amounts received that are designated for future periods or are restricted by the donor for specific purposes are reported as temporarily restricted. Amounts required to be maintained in perpetuity by the donor are reported as permanently restricted net assets. Contributions, including unconditional pledges, are recognized in the period received. Conditional pledges are not recognized until the conditions on which they depend are substantially met. A donor restriction expires when a time restriction ends or when the purpose for which it was intended is attained. Temporarily restricted net assets are reclassified to unrestricted net assets upon expiration of donor restrictions.

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and are reported in the consolidated statements of activities as net assets released from restrictions. Unconditional promises are recognized at the estimated present value of expected future cash flows, net of allowances.

Corporate grants that do not constitute contributions are recognized as revenue when costs of the related programs or projects are incurred. Corporate grants received but not yet expended are reported as deferred revenues. Grants to other organizations are recorded as expense when authorized by the Board of Trustees.

Royalties and service fees are recognized when earned

**(n) Pension and Other Postretirement Benefits.**

Pension costs are determined under the projected unit credit cost method. This method determines the present value of benefits projected to retirement with increases in salary and service, and allocates (attributes) pension costs to prior and current periods based upon the relationship of service to date versus service projected to retirement. Pursuant to ASC Subtopic 715-10, *Compensation – Retirement Benefits-Overall*, the Association is required to fully recognize and disclose an asset or liability for the overfunded or underfunded status of its benefit plans in its consolidated financial statements and to recognize changes in that funded status as a change in unrestricted net assets in the year in which the changes occur.

**(o) Income Taxes**

Deferred taxes are established for temporary differences between the financial reporting basis and the tax basis of assets and liabilities. Deferred taxes are based upon enacted tax rates, which would apply during the period in which taxes become payable or recoverable, and the adjustment of cumulative deferred taxes for any changes in the tax rate.

The Association accounts for uncertain tax positions in accordance with ASC Topic 740, *Income Taxes*. ASC Topic 740 addresses the determination of how tax benefits claimed or expected to be claimed on a tax return should be recorded in the consolidated financial statements. Under ASC Topic 740, the Association must recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such a position are measured based on the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement. ASC Topic 740 also provides guidance on derecognition, classification, interest, and penalties on income taxes and accounting in interim periods and requires increased disclosures.

**(p) Net Assets**

Net assets subject to donor-imposed stipulations are classified as temporarily or permanently restricted net assets while net assets not subject to such restrictions are classified as unrestricted net assets. If a restriction is fulfilled in the same time period in which the contribution is received, the Association reports the support as unrestricted.

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ASC Section 958-205-45, *Not-for-Profit Entities: Other Presentation Matters, Endowments for Not-for-Profit Organizations: Net Asset Classification of Funds Subject to an Enacted Version of the Uniform Prudent Management of Institutional Funds Act of 2006 (UPMIFA)*, and *Enhanced Disclosures for All Endowment Funds*, provides guidance on the net asset classification of donor-restricted endowment funds for a not-for-profit organization that is subject to an enacted version of UPMIFA. ASC Subtopic 958 enhances disclosures related to both donor-restricted and board-designated endowment funds, whether or not the organization is subject to UPMIFA.

**(q) Fair Value Measurements**

The Association applies the provisions of ASC Topic 820, *Fair Value Measurement*, for fair value measurements of financial assets and liabilities and for fair value measurements of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis. ASC Topic 820 defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC Topic 820 also establishes a framework for measuring fair value and expands disclosures about fair value measurements.

This pronouncement did not require any new fair value measurements and its adoption did not affect the results of operation or financial position of the Association. ASC Topic 820 establishes a fair value hierarchy that prioritizes the inputs to valuation technique used to measure fair value (note 4).

The Association also applies the provisions of Accounting Standards Update (ASU) No. 2010-06, *Improving Disclosures about Fair Value Measurements*. ASU No. 2010-06 amends ASC Subtopic 820-10, *Fair Value Measurement – Overall*, to provide additional disclosure requirements for transfers in and out of Levels 1 and 2 and for activity in Level 3 and to clarify certain other existing disclosure requirements.

The Association applies the provisions of ASC Subtopic 825-10, *Financial Instruments – Overall*. ASC Subtopic 825-10 provides the Association with an option to elect fair value as the initial and subsequent measurement attribute for most financial assets and liabilities and certain other items. The fair value option election is applied on an instrument-by-instrument basis (with some exceptions), is irrevocable, and is applied to an entire instrument. The fair value option election may be made as of the date of initial adoption for existing eligible items. Subsequent to initial adoption, the Association may elect the fair value option at initial recognition of eligible items, on entering into an eligible firm commitment, or when certain specified reconsideration events occur. Unrealized gains and losses on items for which the fair value option has been elected will be reported in the consolidated statements of activities. The Association did not elect any changes to fair value measurements upon the adoption of ASC Subtopic 825-10 in 2012 and 2011.

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**(2) Receivables**

Receivables at December 31, 2012 and 2011 consist of the following:

	<u><b>2012</b></u>	<u><b>2011</b></u>
Trade receivables	\$ 3,649,307	3,629,224
Royalties receivable	2,298,244	2,078,249
Grants and contracts receivable	210,609	138,548
Tenant receivables	1,920,997	2,032,255
Pledges receivable	38,810	35,960
Other	<u>64,142</u>	<u>133,392</u>
Total	8,182,109	8,047,628
Less allowance for doubtful receivables	<u>(452,911)</u>	<u>(679,552)</u>
Net receivables	<u><u>\$ 7,729,198</u></u>	<u><u>7,368,076</u></u>

Unconditional promises for which payment has not been received are recorded in the consolidated financial statements as pledges receivable and revenue of the appropriate net asset category.

Unconditional promises are expected to be realized in the following periods from December 31, 2012 and 2011:

	<u><b>2012</b></u>	<u><b>2011</b></u>
In one year or less	\$ 18,810	1,250
Between one year and five years	<u>20,000</u>	<u>34,710</u>
	38,810	35,960
Less allowance for uncollectible pledges	<u>(1,250)</u>	<u>(1,250)</u>
	<u><u>\$ 37,560</u></u>	<u><u>34,710</u></u>

Changes in the Association's allowance for doubtful receivables for the years ended December 31, 2012 and 2011 are as follows:

	<u><b>2012</b></u>	<u><b>2011</b></u>
Beginning balance	\$ 679,552	529,899
Provision for uncollectible accounts	104,800	166,196
Accounts written off	<u>(331,441)</u>	<u>(16,543)</u>
Ending balance	<u><u>\$ 452,911</u></u>	<u><u>679,552</u></u>

A fundraising moratorium, self-imposed by the Board, was in effect during 2011. The Give Kids A Smile (GKAS) gala was the only fundraising event during 2011.



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The moratorium was lifted by the Board at its September 23, 2011 meeting; however, fundraising activities did not commence until 2012. Certain unsolicited funds were received by the Foundation during 2012 and 2011.

**(3) Marketable Securities**

Marketable securities at December 31, 2012 and 2011 consisted of the following:

	<b>2012</b>	
	<b>Cost</b>	<b>Market</b>
Money market funds	\$ 34,296	34,296
Bonds and bond funds	39,323,782	40,253,018
Equities and equity funds	64,425,815	68,539,650
	<u>\$ 103,783,893</u>	<u>108,826,964</u>

	<b>2011</b>	
	<b>Cost</b>	<b>Market</b>
Money market funds	\$ 13,369	13,369
Bonds and bond funds	30,263,286	30,352,708
Equities and equity funds	67,418,334	62,242,701
	<u>\$ 97,694,989</u>	<u>92,608,778</u>

The fair value of marketable securities held in the Reserve Division amounted to \$69,553,388 and \$61,117,876 at December 31, 2012 and 2011, respectively.

Investment income (loss) is included in the accompanying consolidated statements of activities for the years ended December 31, 2012 and 2011 as follows:

	<b>2012</b>	<b>2011</b>
Interest and dividends	\$ 1,853,370	1,623,831
Change in net unrealized appreciation (depreciation) in fair value of marketable securities	10,122,398	(6,592,508)
Net realized gain (loss) on sale of marketable securities	(921,517)	444,881
Net unrealized appreciation (depreciation) on funds held for deferred compensation	548,416	(203,770)
Total investment income (loss)	<u>\$ 11,602,667</u>	<u>(4,727,566)</u>

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**(4) Fair Value Measurements**

**(a) Fair Value of Financial Instruments**

The following methods and assumptions were used by the Association in estimating the fair value of its financial instruments:

- The carrying amount reported in the consolidated statements of financial position for the following approximates fair value because of the short maturities of these instruments: cash equivalents, accounts payable and accrued liabilities.
- Fair values of the Association's investments held as marketable securities are estimated based on prices provided by its investment managers and its custodian bank. Fair value for money market funds, equities and equity funds, alternative investment funds, fixed income mutual funds, and quoted corporate bonds and U.S. government bonds are measured using quoted market prices at the reporting date multiplied by the quantity held.

**(b) Fair Value Hierarchy**

The Association follows ASC Topic 820 for fair value measurements of financial assets and liabilities and for fair value measurements of nonfinancial items that are recognized or disclosed at fair value in the financial statements on a recurring basis. ASC Topic 820 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 – Quoted prices are available in active markets for identical assets or liabilities as of the report date. A quoted price for an identical asset or liability in an active market provides the most reliable fair value measurement because it is directly observable to the market.
- Level 2 – Pricing inputs are other than quoted prices in active markets, which are either directly or indirectly observable as of the report date. The nature of these securities include investments for which quoted prices are available but which are traded less frequently and investments that are fairly valued using other securities, the parameters of which can be directly observed.
- Level 3 – Securities that have little to no pricing observability as of the report date. These securities are measured using management's best estimate of fair value, where the inputs into the determination of fair value are not observable and require significant management judgment or estimation.

Inputs are used in applying the various valuation techniques and broadly refer to the assumptions that market participants use to make valuation decisions, including assumptions about risk. Inputs may include price information, volatility statistics, specific and broad credit data, liquidity statistics, and other factors. A financial instrument's level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. However, the determination of

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what constitutes “observable” requires significant judgment by the Association. The Association considers observable data to be that market data that is readily available, regularly distributed or updated, reliable and verifiable, not proprietary, and provided by independent sources that are actively involved in the relevant market. The categorization of a financial instrument within the fair value hierarchy is based upon the pricing transparency of the instrument and does not necessarily correspond to the Association’s perceived risk of that instrument. The Association’s policy is to recognize transfers between levels of the fair value hierarchy on the actual date of the event or change in circumstances that caused the transfer.

The following table sets forth by level, within the fair value hierarchy, the Association’s assets at fair value as of December 31, 2012 and 2011:

		<b>2012</b>			<b>Total</b>
		<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>	
Cash and cash equivalents	\$	8,370,124	—	—	8,370,124
Marketable securities:					
Money market funds		34,296	—	—	34,296
Fixed income mutual funds		40,185,291	—	—	40,185,291
Equity mutual funds		59,728,034	—	—	59,728,034
Corporate bonds		—	67,727	—	67,727
Alternative investment funds:					
Common Sense Offshore Fund		—	5,468,449	—	5,468,449
Blackstone Partners Offshore Fund		—	3,343,167	—	3,343,167
Total alternative investment funds		—	8,811,616	—	8,811,616
Total marketable securities		99,947,621	8,879,343	—	108,826,964

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		<b>2012</b>			
		<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>	<b>Total</b>
Funds held for deferred compensation:					
Money market funds	\$	801,768	—	—	801,768
Equity mutual funds		2,931,004	—	—	2,931,004
Fixed income mutual funds		707,077	—	—	707,077
Corporate bonds		—	1,006,106	—	1,006,106
Total funds held for deferred compensation		4,439,849	1,006,106	—	5,445,955
Total assets at fair value	\$	112,757,594	9,885,449	—	122,643,043

There were no significant transfers in or out of Level 1, Level 2, or Level 3 assets during the year ended December 31, 2012.

		<b>2011</b>			
		<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>	<b>Total</b>
Cash and cash equivalents	\$	9,019,767	—	—	9,019,767
Marketable securities:					
Money market funds		13,369	—	—	13,369
Fixed income mutual funds		30,244,848	—	—	30,244,848
Equity mutual funds		53,400,588	—	—	53,400,588
Corporate bonds		—	107,860	—	107,860
Alternative investment funds:					
Common Sense Offshore Fund		—	5,742,859	—	5,742,859
Blackstone Partners Offshore Fund		—	3,099,254	—	3,099,254
Total alternative investment funds		—	8,842,113	—	8,842,113
Total marketable securities		83,658,805	8,949,973	—	92,608,778

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		2011			
		Level 1	Level 2	Level 3	Total
Funds held for deferred compensation:					
Money market funds	\$	528,604	—	—	528,604
Equity mutual funds		2,846,553	—	—	2,846,553
Fixed income mutual funds		622,006	—	—	622,006
Corporate bonds		—	981,857	—	981,857
Total funds held for deferred compensation					
		3,997,163	981,857	—	4,979,020
Total assets at fair value					
	\$	96,675,735	9,931,830	—	106,607,565

There were no significant transfers in or out of Level 1, Level 2, or Level 3 assets during the year ended December 31, 2011.

The Association is invested in two alternative investment funds at December 31, 2012 and 2011 for which the net asset value is used as a practical expedient to determine fair value in accordance with ASC Paragraph 820-10-65-6. The Association has no contractual commitments to fund the alternative investment funds. The redemption frequencies of the alternative investment funds are 25% of the net asset value can be redeemed at June 30, or any and all can be redeemed as of December 31 with 100 days notice given prior to the redemption date. The balances in these funds were \$8,811,616 and \$8,842,113 at December 31, 2012 and 2011, respectively, and have been reflected as Level 2 assets in the fair value table presented above.

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**(5) Property and Equipment**

Property and equipment at December 31, 2012 and 2011 consisted of the following:

<b>2012</b>			
	<b>Chicago, IL</b>	<b>Washington, D.C.</b>	<b>Total</b>
Land	\$ 712,113	3,030,000	3,742,113
Building	12,381,169	9,602,195	21,983,364
Building improvements	70,029,903	2,773,458	72,803,361
Furniture and equipment	44,332,824	1,196,667	45,529,491
Tenant leasehold improvements	1,743,423	2,099,484	3,842,907
	<u>129,199,432</u>	<u>18,701,804</u>	<u>147,901,236</u>
Less accumulated depreciation and amortization	<u>96,565,400</u>	<u>11,089,342</u>	<u>107,654,742</u>
	<u>\$ 32,634,032</u>	<u>7,612,462</u>	<u>40,246,494</u>
<b>2011</b>			
	<b>Chicago, IL</b>	<b>Washington, D.C.</b>	<b>Total</b>
Land	\$ 712,113	3,030,000	3,742,113
Building	12,381,169	9,602,195	21,983,364
Building improvements	68,922,517	2,764,023	71,686,540
Furniture and equipment	43,427,622	1,182,848	44,610,470
Tenant leasehold improvements	1,580,229	2,026,449	3,606,678
	<u>127,023,650</u>	<u>18,605,515</u>	<u>145,629,165</u>
Less accumulated depreciation and amortization	<u>91,721,717</u>	<u>10,335,844</u>	<u>102,057,561</u>
	<u>\$ 35,301,933</u>	<u>8,269,671</u>	<u>43,571,604</u>

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The Association leases portions of both the headquarters building in Chicago, Illinois, and the Washington, D.C. office building to unrelated parties under operating leases with varying terms. These amounts may be adjusted upon renewal of the leases. Minimum future rentals to be earned from leases currently in effect as of December 31, 2012 are:

2013	\$	4,346,263
2014		2,820,554
2015		2,595,420
2016		2,472,853
2017		2,022,392
Thereafter		<u>3,770,426</u>
	\$	<u><u>18,027,908</u></u>

Building expenses include the cost of facilities occupied by the Association, as well as those costs related to other tenants.

**(6) Deferred Compensation**

Pursuant to agreements between the Association and certain officers and employees of the Association and its affiliates, portions of their compensation have been retained by the Association and invested as directed by those participants. The assets are owned by the Association until distributed to the participants after termination of employment or services.

**(7) Income Taxes**

The Association and ADAF have received favorable determination letters from the Internal Revenue Service (IRS) stating that they are exempt from taxation on income related to their exempt purposes under Section 501(a) of the Code as organizations described in Sections 501(c)(6) and 501(c)(3), respectively. As exempt organizations, the Association and ADAF are subject to federal and state income taxes on income determined to be unrelated business taxable income. ADPAC is exempt from federal income taxes under Section 527 of the Code, except on net investment income. The income of the Association's for-profit subsidiary, ADABEI, determined separately, is also subject to federal and state income taxes.

The Association accounts for income taxes using the provisions of ASC Topic 740. Under ASC Topic 740, deferred tax assets and liabilities are recognized for future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates and laws expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date. A valuation allowance is provided when it is more likely than not that some portion of deferred tax assets will not be realized.

A deferred tax asset of \$128,262 and \$430,758 as of December 31, 2012 and 2011, respectively, is attributable primarily to carryforwards for state net operating losses and other timing differences. The

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Association has set up a valuation allowance of its net deferred tax assets related to a carryover of the capital losses, as it has determined it will not meet the more likely than not threshold for recovery of these assets. Based upon the level of historical taxable income and projections for future taxable income over the periods in which the deferred tax assets are deductible, management believes it is more likely than not that the Association will realize the benefits of these deductible differences, net of the existing valuation allowance at December 31, 2012 of \$162,221. The amount of the deferred tax assets considered realizable, however, could be reduced in the near term if estimates of future taxable income during the carryforward period are reduced.

Income tax expense differs from the amount computed by applying the statutory federal income tax rate of 34% to loss before income tax expense primarily because a significant portion of consolidated income is exempt from income tax. Income tax expense is computed by applying the statutory federal and state income tax rate to net unrelated business income earned for the years ended December 31, 2012 and 2011. Income tax expense for the years ended December 31, 2012 and 2011 is as follows:

	<u>2012</u>	<u>2011</u>
Current:		
Federal	\$ 984,107	1,033,224
State	327,900	405,006
Creation of income tax reserve	395,231	—
Current income tax expense	<u>1,707,238</u>	<u>1,438,230</u>
Deferred:		
Federal	132,900	241,025
State	7,375	3,487
Creation of valuation allowance	162,221	—
Deferred income tax expense	<u>302,496</u>	<u>244,512</u>
Income tax expense	<u>\$ 2,009,734</u>	<u>1,682,742</u>



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Net deferred tax assets at December 31, 2012 and 2011 consisted of:

	<u>2012</u>	<u>2011</u>
Deferred tax assets (liabilities) resulting from:		
Postretirement health benefits	\$ 80,590	80,590
Charitable contributions	18,467	26,645
Capital loss carryforward	162,221	162,221
Furniture and equipment	—	(1,079)
Net operating loss carryforward	29,205	129,782
AMT credit carryforward	—	32,599
	<u>290,483</u>	<u>430,758</u>
Total deferred tax assets, net		
Valuation allowance	<u>(162,221)</u>	<u>—</u>
Total deferred tax assets, net of valuation allowance	<u>\$ 128,262</u>	<u>430,758</u>

As of December 31, 2012 and 2011, net operating loss carryforwards totaling \$0 and \$277,375, respectively, are available to offset future taxable income of ADABEI for federal tax purposes. As of December 31, 2012 and 2011, net operating loss carryforwards totaling \$465,788 and \$565,788, respectively, are available to offset future taxable income of ADABEI for state tax purposes. As of December 31, 2012, these carryforwards expire as follows for state tax purposes: \$4,715 in 2020 and \$461,073 in 2021.

As of December 31, 2012 and 2011, liabilities related to uncertain tax positions for federal and state income taxes, including interest and penalties, which are included in other liabilities in the accompanying consolidated balance sheets totaled \$452,844 and \$0, respectively. The Association records uncertain tax positions in income tax expense in the accompanying consolidated financial statements.

**(8) Employee Benefit Plans**

**(a) Defined Benefit Plan and Supplemental Plan**

The Association sponsors a noncontributory defined benefit pension plan (the Plan) covering substantially all employees of the Association, its subsidiaries and affiliates meeting certain eligibility requirements. Generally, the Association's funding policy is to make annual contributions to the Plan equal to an amount calculated by an outside consulting actuary in accordance with the funding requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Retirement benefit payments are based on years of credited service, average compensation during the five years of employment that produce the highest average, and the average Social Security limit at employment termination date.

The minimum funding contributions for 2012 and 2011 were \$5,081,578 and \$6,738,620, respectively. The Association contributed \$1,200,352 to the Plan in 2012 related to the 2011 Plan

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year. The assets of the Plan are held in various investment manager funds and comprised of mutual funds and a guaranteed investment contract.

The Association recognizes the cost related to employee service using the unit credit cost method. Gains and losses, calculated as the difference between estimates and actual amounts of plan assets and the projected benefit obligation, and prior service costs are amortized over the expected future service period.

The Association accounts for the defined benefit pension plan in accordance with ASC Topic 715, *Compensation – Retirement Benefits*. ASC Topic 715 requires recognition in the consolidated statements of financial position of the funded status of defined benefit pension plans and other postretirement benefit plans, including all previously unrecognized actuarial gains and losses and unamortized prior service cost, as a component of unrestricted net assets.

Pursuant to agreements between the Association and a certain prior employee, the Association also maintains a frozen unfunded supplemental retirement income plan funded through Association general assets. Investments designated for the supplemental plan of \$44,210 and \$143,060 at December 31, 2012 and 2011, respectively, are carried at fair value and included in prepaid expenses and other assets.

The IRS has informed the Employees' Retirement Trust administration that the plan is qualified under provisions of the Code and, therefore, the related trust is exempt from federal income taxes. The Employees' Supplemental Trust is a nonqualified plan and as such is not exempt from federal income taxes.

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The following table sets forth the plans' funded status and amounts recognized in the Association's consolidated financial statements:

	<b>2012</b>		
	<b>Employees' Retirement Trust</b>	<b>Employees' Supplemental Trust</b>	<b>Total</b>
Change in projected benefit obligation:			
Projected benefit obligation, beginning of year	\$ 160,846,151	1,422,334	162,268,485
Service cost	1,632,460	—	1,632,460
Interest cost	8,267,583	71,152	8,338,735
Actuarial loss	18,620,750	112,538	18,733,288
Benefits paid	<u>(6,936,226)</u>	<u>(92,796)</u>	<u>(7,029,022)</u>
Projected benefit obligation, end of year	<u>\$ 182,430,718</u>	<u>1,513,228</u>	<u>183,943,946</u>
Change in plan assets:			
Fair value of plan assets, beginning of year	\$ 111,133,866	—	111,133,866
Actual return on plan assets	16,668,170	—	16,668,170
Employer contributions	6,281,930	92,796	6,374,726
Benefits paid	<u>(6,936,226)</u>	<u>(92,796)</u>	<u>(7,029,022)</u>
Fair value of plan assets, end of year	<u>\$ 127,147,740</u>	<u>—</u>	<u>127,147,740</u>
Funded status, end of year:			
Fair value of plan assets	\$ 127,147,740	—	127,147,740
Benefit obligation	<u>182,430,718</u>	<u>1,513,228</u>	<u>183,943,946</u>
Funded status	<u>\$ (55,282,978)</u>	<u>(1,513,228)</u>	<u>(56,796,206)</u>

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	<b>2012</b>		
	<b>Employees' Retirement Trust</b>	<b>Employees' Supplemental Trust</b>	<b>Total</b>
Amounts recognized in the accompanying consolidated statements of financial position:			
Pension liability	\$ 55,282,978	(1,513,228)	53,769,750
Accumulated benefit obligation	182,255,362	1,513,228	183,768,590
Amounts not yet reflected in net periodic benefit expense and included as accumulated charges to unrestricted net assets:			
Prior service cost	\$ (11,412,908)	—	(11,412,908)
Net actuarial loss	81,307,025	—	81,307,025
Net amounts included as an accumulated charge to unrestricted net assets	\$ 69,894,117	—	69,894,117
Components of net periodic benefit cost:			
Service cost	\$ 1,632,460	—	1,632,460
Interest cost	8,267,583	71,152	8,338,735
Expected return on plan assets	(8,870,150)	—	(8,870,150)
Prior service cost	(1,491,883)	—	(1,491,883)
Recognized net loss	7,252,881	—	7,252,881
Net periodic benefit cost	\$ 6,790,891	71,152	6,862,043

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	<b>2012</b>		
	<b>Employees' Retirement Trust</b>	<b>Employees' Supplemental Trust</b>	<b>Total</b>
Calculation of change in unrestricted net assets:			
Accumulated unrestricted net assets, end of year	\$ 69,894,117	—	69,894,117
Reversal of accumulated unrestricted net assets, prior year	<u>(64,719,847)</u>	<u>—</u>	<u>(64,719,847)</u>
Change in unrestricted net assets	<u>\$ 5,174,270</u>	<u>—</u>	<u>5,174,270</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:			
Net loss experienced during the year	\$ 10,935,268	—	10,935,268
Amortization of prior service cost due to plan amendments	1,491,883	—	1,491,883
Amortization of unrecognized net loss	<u>(7,252,881)</u>	<u>—</u>	<u>(7,252,881)</u>
Net amounts recognized in unrestricted net assets	<u>\$ 5,174,270</u>	<u>—</u>	<u>5,174,270</u>
Estimate of amounts that will be amortized out of unrestricted net assets into net pension expense in 2013:			
Net loss	\$ 7,157,296	—	7,157,296
Prior service cost	(1,491,883)	—	(1,491,883)
Weighted average assumptions as of December 31:			
Discount rate	5.16%	4.56%	
Expected return on plan assets	8.00	8.00	
Rate of compensation increase	3.00	3.00	

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	<b>2011</b>		
	<b>Employees' Retirement Trust</b>	<b>Employees' Supplemental Trust</b>	<b>Total</b>
Change in projected benefit obligation:			
Projected benefit obligation, beginning of year	\$ 149,168,534	871,163	150,039,697
Service cost	4,979,215	—	4,979,215
Interest cost	8,426,105	74,510	8,500,615
Actuarial loss	16,081,296	569,457	16,650,753
Benefits paid	(4,904,208)	(92,796)	(4,997,004)
Plan amendments	<u>(12,904,791)</u>	<u>—</u>	<u>(12,904,791)</u>
Projected benefit obligation, end of year	<u>\$ 160,846,151</u>	<u>1,422,334</u>	<u>162,268,485</u>
Change in plan assets:			
Fair value of plan assets, beginning of year	\$ 101,268,953	—	101,268,953
Actual return on plan assets	1,965,156	—	1,965,156
Employer contributions	12,803,965	92,796	12,896,761
Benefits paid	<u>(4,904,208)</u>	<u>(92,796)</u>	<u>(4,997,004)</u>
Fair value of plan assets, end of year	<u>\$ 111,133,866</u>	<u>—</u>	<u>111,133,866</u>
Funded status, end of year:			
Fair value of plan assets	\$ 111,133,866	—	111,133,866
Benefit obligation	<u>160,846,151</u>	<u>1,422,334</u>	<u>162,268,485</u>
Funded status	<u>\$ (49,712,285)</u>	<u>(1,422,334)</u>	<u>(51,134,619)</u>

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	<b>2011</b>		
	<b>Employees' Retirement Trust</b>	<b>Employees' Supplemental Trust</b>	<b>Total</b>
Amounts recognized in the accompanying consolidated statements of financial position:			
Pension liability	\$ 49,712,285	(1,422,334)	48,289,951
Accumulated benefit obligation	160,745,303	1,422,334	162,167,637
Amounts not yet reflected in net periodic benefit expense and included as accumulated charges to unrestricted net assets:			
Prior service cost	\$ (12,904,791)	—	(12,904,791)
Net actuarial loss	77,624,638	—	77,624,638
Net amounts included as an accumulated charge to unrestricted net assets	\$ 64,719,847	—	64,719,847
Components of net periodic benefit cost:			
Service cost	\$ 4,979,215	—	4,979,215
Interest cost	8,426,105	74,510	8,500,615
Expected return on plan assets	(8,226,465)	—	(8,226,465)
Recognized net loss	5,629,148	—	5,629,148
Net periodic benefit cost	\$ 10,808,003	74,510	10,882,513

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	<b>2011</b>		
	<b>Employees' Retirement Trust</b>	<b>Employees' Supplemental Trust</b>	<b>Total</b>
Calculation of change in unrestricted net assets:			
Accumulated unrestricted net assets, end of year	\$ 64,719,847	—	64,719,847
Reversal of accumulated unrestricted net assets, prior year	<u>(60,341,724)</u>	<u>—</u>	<u>(60,341,724)</u>
Change in unrestricted net assets	<u>\$ 4,378,123</u>	<u>—</u>	<u>4,378,123</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:			
Net loss experienced during the year	\$ 22,912,062	—	22,912,062
Prior service cost established due to plan amendments	(12,904,791)	—	(12,904,791)
Amortization of unrecognized net loss	<u>(5,629,148)</u>	<u>—</u>	<u>(5,629,148)</u>
Net amounts recognized in unrestricted net assets	<u>\$ 4,378,123</u>	<u>—</u>	<u>4,378,123</u>
Estimate of amounts that will be amortized out of unrestricted net assets into net pension expense in 2012:			
Net loss	\$ 7,098,010	—	7,098,010
Prior service cost	(1,491,883)	—	(1,491,883)
Weighted average assumptions as of December 31:			
Discount rate	5.16%	5.16%	
Expected return on plan assets	8.00	8.00	
Rate of compensation increase	3.00	3.00	

The discount rate is determined each year as of the measurement date, based on a review of interest rates associated with long-term high quality corporate bonds. The discount rate determined on each measurement date is used to calculate the benefit obligation as of that date, and is also used to calculate the net periodic benefit cost for the upcoming plan year.



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The Plan's expected return on assets assumption is derived from a review of actual historical returns achieved by the Plan and anticipated future long-term performance of individual asset classes with consideration given to the appropriate investment strategy. While the method gives appropriate consideration to recent trust performance and historical returns, the assumption represents a long-term prospective return. The expected return on plan assets determined on each measurement dates is used to calculate the net periodic benefit cost for the upcoming plan year.

On September 23, 2011, the Plan sponsor resolved that starting January 1, 2012 the Plan will define "Average Monthly Compensation" for benefits accrued as "Career Average Monthly Compensation," will require calculation of the "Normal Retirement Benefit" for all benefits earned as the sum of (1) the amount accrued by the participant in the Plan as of December 31, 2012 and (2) 1% of "Career Average Monthly Compensation" multiplied by total "Years of Benefit Service" at normal retirement date to a maximum of 30 such years, will define Normal Retirement Date for retirements to be the date on which a participant attains the age of 65 and meets the vesting requirements, and will eliminate the early retirement calculation based on attaining age 62 and at least 25 years of vesting.

The Association expects to contribute approximately \$7,517,796 to the Plan in 2013 of which, the entire amount relates to Plan year 2013.

The table below reflects the total pension benefits expected to be paid in each of the next five years and in the aggregate for the five years thereafter:

2013	\$ 7,018,797
2014	7,747,234
2015	8,338,159
2016	8,874,675
2017	9,447,797
Thereafter	<u>54,642,844</u>
	<u>\$ 96,069,506</u>

The expected benefits are based on the same assumptions used to measure the Association's benefit obligations at December 31 and include estimated future employee service.

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The actual allocations for the pension assets as of December 31, 2012 and 2011, and target allocations by asset category, are as follows:

<b>Asset category</b>	<b>2012</b>	
	<b>Actual allocation</b>	<b>Target allocation</b>
Fixed income	40%	40%
Equity:		
Domestic small cap	10	11
Domestic large cap value	15	14
Domestic large cap growth	15	14
International	20	21
	<u>100%</u>	<u>100%</u>

<b>Asset category</b>	<b>2011</b>	
	<b>Actual allocation</b>	<b>Target allocation</b>
Fixed income	43%	40%
Equity:		
Domestic small cap	10	11
Domestic large cap value	14	14
Domestic large cap growth	15	14
International	18	21
	<u>100%</u>	<u>100%</u>

Pension assets are allocated with a goal to achieve diversification between and within various asset classes. The target asset allocations are expected to earn an average annual rate of return of approximately 8% measured over a planning horizon of 20 years with a reasonable and acceptable level of risk. Actual allocation percentages will vary from target allocation percentages based upon short-term fluctuations in cash flows and benefit payments.

Domestic equity includes securities of domestic companies listed on the U.S. exchanges or traded OTC, diversified across industry, and individual holdings. International equity includes securities primarily of companies located outside the U.S. diversified across countries and industries. Fixed income refers to a diversified portfolio of marketable debt instruments with an average quality rating of at least AA or equivalent.

**(b) Fair Value of Financial Instruments**

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2012 and 2011.

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Guaranteed investment contract: Valued at contract value, which approximates fair value. The guaranteed investment contract is included in the consolidated financial statements at fair value, which represents contributions made under the contract plus earnings, less withdrawals, and expenses.

Equity and fixed income mutual funds: Mutual funds are valued at the net asset value of shares held by the Plan at year-end at the closing price reported in the active market in which the individual securities are traded.

The preceding methods may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

**(c) Fair Value Hierarchy**

The Plan has adopted ASC Section 715-20-50 for fair value measurements of financial assets and liabilities and for fair value measurements of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis. ASC Section 715-20-50 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value.

The Plan's policy is to recognize transfers between levels of the fair value hierarchy on the actual date of the event or change in circumstances that caused the transfer. There were no significant transfers into or out of Level 1, Level 2, or Level 3 during the years ended December 31, 2012 and 2011, respectively.

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The following table sets forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2012 and 2011:

	<b>2012</b>			
	<b>Total</b>	<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>
Guaranteed investment contract	\$ 438,755	—	—	438,755
Equity mutual funds:				
Dodge & Cox Stock Fund	19,329,004	19,329,004	—	—
INTECH Growth Fund	18,762,449	18,762,449	—	—
Wells Fargo Small Cap Value Fund	12,653,883	12,653,883	—	—
Templeton Institutional Funds, Inc. International Equity Series	13,470,111	13,470,111	—	—
RS Investments (Baillie Gifford) International Equity Fund	12,422,822	12,422,822	—	—
Total equity mutual funds	<u>76,638,269</u>	<u>76,638,269</u>	<u>—</u>	<u>—</u>
Fixed income mutual funds:				
PIMCO Long Duration Total Return Fund	11,576,986	11,576,986	—	—
PIMCO Long-Term Credit Fund	12,195,544	12,195,544	—	—
Vanguard Long-Term Investment-Grade Fund	26,298,186	26,298,186	—	—
Total fixed income mutual funds	<u>50,070,716</u>	<u>50,070,716</u>	<u>—</u>	<u>—</u>
Total	<u>\$ 127,147,740</u>	<u>126,708,985</u>	<u>—</u>	<u>438,755</u>

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		<b>2011</b>			
		<b>Total</b>	<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>
Guaranteed investment contract	\$	783,910	—	—	783,910
Equity mutual funds:					
Dodge & Cox Stock Fund		15,893,630	15,893,630	—	—
INTECH Growth Fund		16,474,739	16,474,739	—	—
Wells Fargo Small Cap Value Fund		11,186,124	11,186,124	—	—
Templeton Institutional Funds, Inc. International Equity Series		11,362,594	11,362,594	—	—
Artio Global International Equity Fund		8,781,429	8,781,429	—	—
Total equity mutual funds		<u>63,698,516</u>	<u>63,698,516</u>	<u>—</u>	<u>—</u>
Fixed income mutual funds:					
PIMCO Long Duration Total Return Fund		10,735,373	10,735,373	—	—
PIMCO Long-Term Credit Fund		10,943,157	10,943,157	—	—
Vanguard Long-Term Investment-Grade Fund		24,972,910	24,972,910	—	—
Total fixed income mutual funds		<u>46,651,440</u>	<u>46,651,440</u>	<u>—</u>	<u>—</u>
Total	\$	<u><u>111,133,866</u></u>	<u><u>110,349,956</u></u>	<u><u>—</u></u>	<u><u>783,910</u></u>

The following table presents a reconciliation for all Level 3 assets measured at fair value on a recurring basis for the period from January 1, 2012 to December 31, 2012.

	<b>Investment contract</b>
Investment contract:	
Balance, beginning of year	\$ 783,910
Interest income	11,683
Purchases	7,258,570
Sales	<u>(7,615,408)</u>
Balance, end of year	<u><u>\$ 438,755</u></u>

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The following table presents a reconciliation for all Level 3 assets measured at fair value on a recurring basis for the period from January 1, 2011 to December 31, 2011.

	<u>Investment contract</u>
Investment contract:	
Balance, beginning of year	\$ 497,599
Interest income	24,302
Purchases	5,700,000
Sales	<u>(5,437,991)</u>
Balance, end of year	<u>\$ 783,910</u>

**(d) 401(k) Plan**

The Association has a savings and retirement plan for all eligible employees. The Association, at its discretion, contributes a predetermined amount to the plan. The plan was amended during 2012 whereby the Association may contribute to the accounts of eligible employees in lieu of the matching contributions provisions, which are suspended. For 2012, the plan contributed 4% of each eligible employee's base salary. For 2011, 50% of contributed amounts up to a maximum of \$500 per participant were made. The Association's contributions under the Plan were \$1,484,529 and \$218,890 in 2012 and 2011, respectively.

The IRS has informed the Savings Plan administrator that the plan is qualified under provisions of the Code and, therefore, the related trust is exempt from federal income taxes.

**(e) Executive Parity Plan**

The Association has established the Executive Parity Plan, which compensates executives of the Association and its subsidiaries who suffered restrictions in their pension benefits beginning in 1994 as a result of the Omnibus Budget Reconciliation Act. This is a deferred compensation arrangement, which allows the Compensation Committee of the Board of Trustees to set aside, on an annual basis, a specified cash amount for those individuals who suffered a benefit loss during the year, to be paid upon vesting. Awards of \$113,489 were earned and payments totaling \$212,099 were made to participants in 2012. Awards of \$329,017 were earned and payments totaling \$243,485 were made to participants in 2011.

**(f) Postretirement Health Plan**

The Association sponsors a contributory defined benefit postretirement health plan, which covers substantially all employees of the Association, its subsidiaries, and affiliates. The plan provides both medical and dental benefits.

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The following table sets forth the Plan's funded status:

	<u>2012</u>	<u>2011</u>
Change in benefit obligation:		
Benefit obligation, beginning of year	\$ 9,901,103	19,563,169
Service cost	359,019	1,209,908
Interest cost	463,052	1,147,899
Actuarial loss	213,337	2,490,995
Benefits paid	(403,461)	(445,204)
Plan amendments	—	(14,065,664)
Benefit obligation, end of year	<u>\$ 10,533,050</u>	<u>9,901,103</u>
Change in plan assets:		
Employer contributions	\$ 817,471	738,574
Benefits paid	<u>(817,471)</u>	<u>(738,574)</u>
Plan assets, end of year	<u>\$ —</u>	<u>—</u>
Funded status, end of year:		
Benefit obligation	\$ 10,533,050	9,901,103
Accumulated benefit obligation	10,533,050	9,901,103
Components of net periodic benefit cost:		
Service cost	\$ 359,019	1,209,908
Interest cost	463,052	1,147,899
Amortization of transition obligation	—	182,302
Amortization of prior service cost	(1,459,910)	—
Recognized net loss	<u>594,747</u>	<u>476,347</u>
Net periodic benefit cost	<u>\$ (43,092)</u>	<u>3,016,456</u>
Amounts recognized in the accompanying consolidated statement of financial position:		
Postretirement benefit obligation	\$ 10,533,050	9,901,103
Amounts not yet reflected in net periodic benefit expense and included as accumulated charges to unrestricted net assets:		
Net actuarial loss	\$ 7,305,840	7,687,250
Prior service cost	<u>(12,058,853)</u>	<u>(13,518,763)</u>
Net amounts included as an accumulated charge to unrestricted net assets	<u>\$ (4,753,013)</u>	<u>(5,831,513)</u>

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	<u>2012</u>	<u>2011</u>
Calculation of change in unrestricted net assets:		
Accumulated unrestricted net assets, end of year	\$ (4,753,013)	(5,831,513)
Reversal of accumulated unrestricted net assets, prior year	<u>5,831,513</u>	<u>(6,401,805)</u>
Change in unrestricted net assets	<u>\$ 1,078,500</u>	<u>(12,233,318)</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net loss experienced during the year	\$ 213,337	2,490,995
Amortization of transition obligation	—	(182,302)
Amortization of net loss	(594,747)	(476,347)
Amortization of prior service cost	1,459,910	—
Prior service cost established due to plan amendments	<u>—</u>	<u>(14,065,664)</u>
Net amounts recognized in unrestricted net assets	<u>\$ 1,078,500</u>	<u>(12,233,318)</u>
Estimate of amounts that will be amortized out of unrestricted net assets into net postretirement benefit expense in 2013 and 2012:		
Net loss	\$ 605,866	651,473
Prior service cost	(1,459,910)	(1,459,910)
Weighted average assumptions used to determine obligations at December 31:		
Discount rate	4.56%	5.16%
Weighted average assumptions used to determine net periodic benefit cost for the years ended December 31:		
Discount rate	5.16%	5.65%
Healthcare cost trend rate	6.00	6.00
Dental care trend rate	4.00	4.00
Assumed healthcare cost trend rates at December 31:		
Healthcare cost trend rate assumed next year	6.00%	6.00%
Ultimate trend rate	6.00	6.00
Year that trend reached ultimate rate	2013	2012

The Association expects to contribute approximately \$642,424 to the postretirement health plan in 2013.

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (the Act) became law on December 8, 2003. The Act adds a prescription drug benefit under Medicare (Medicare Part D) and provides a federal subsidy to retiree healthcare benefit plan sponsors that provide a benefit that is at least actuarially equivalent to Medicare Part D. The Association currently provides postretirement



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benefits to retirees under three plans. The Association compared the Medicare Part D plan to its retiree prescription drug coverages using actuarial equivalencies and reflecting the retiree premiums and cost sharing provisions of the various plans. The Association concluded that the prescription drug benefit provided under these plans is actuarially equivalent to the benefit provided under the Act, and is and will be entitled to the employer subsidy available under the Act.

The employer contribution under the Association's retiree health plan is limited to increases of not more than 6% per year, cumulative from 1993/1994. The Association has chosen the application of ASC Subtopic 715-60, *Defined Benefit Plans – Other Postretirement*, at December 31, 2012 and 2011 to reflect the effects of the Medicare Act upon the accounting for the Association's postretirement health plan. Because the Association's employer contribution is limited by a cumulative increase of not more than 6% per year, the impact of the Medicare subsidy upon the accounting for the plan for 2012 and 2011 is \$0. The total premium cost exceeds the cap, but with the reflection of the Medicare D subsidy, the Association's employer contribution remains at the 6% capped trend level. Therefore, for 2012 and 2011, the measurement of the Medicare D subsidy does not reduce the capped employer obligation as measured by the APBO, and does not impact the expense determination. The remeasurement for the subsidy of the APBO related to benefits attributed to past service would be \$0 at year-end. The effect of the subsidy on the measurement of net periodic postretirement cost for 2012 and 2011 would be \$0.

The table below reflects the postretirement health payments expected in each of the next five years and in the aggregate for the five years thereafter:

	<b>Gross payments</b>	<b>Net payments after Medicare Part D adjustment</b>
2013	\$ 722,544	642,424
2014	361,052	361,052
2015	378,575	378,575
2016	405,009	405,009
2017	438,589	438,589
2017 – 2021	2,805,206	2,805,206

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**(9) Net Assets**

Temporarily restricted net assets at December 31, 2012 and 2011 were available for the following purposes:

	<u>2012</u>	<u>2011</u>
Campaign for innovation in dental education	\$ 598,680	551,213
Trusts	987,345	909,061
Extramural programs	113,520	113,520
Research	50,643	32,169
Awards	190,548	163,158
Education	162,126	162,837
Access	2,032,586	1,309,872
Political and legislative	182,253	855,813
Relief program	5,627,302	4,940,475
	<u>\$ 9,945,003</u>	<u>9,038,118</u>

Temporarily restricted trusts include funds restricted by donors for periodontal research, public education in dental health, and memorial commemoration.

Temporarily restricted net assets were released from donor restrictions during 2012 and 2011 by incurring expenses satisfying the restricted purposes as follows:

	<u>2012</u>	<u>2011</u>
Campaign for innovation in dental education	\$ 230	2,385
Trusts	380	499
Extramural programs	—	177,489
Research	3,131	218,437
Awards	10,060	35,290
Education	10,145	434,533
Access	631,857	680,838
Political and legislative	2,300,724	1,603,201
Relief program	75,430	188,710
	<u>\$ 3,031,957</u>	<u>3,341,382</u>

Permanently restricted net assets at December 31, 2012 and 2011 totaled \$2,138,842 for both years. Earnings on these net assets are restricted by donors for children's oral health and education in dental entrepreneurship and leadership.

**(10) Endowment Funds**

The Association's endowments consist of various individual funds to support access to care and educational activities within the ADAF. Net assets related to the ADAF endowments are donor-restricted

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funds, classified and reported based upon the donor-imposed restrictions. The ADAF does not have board-designated endowment funds.

The ADAF accounts for endowment net assets by preserving the fair value of the original gift as of the gift date of the donor-restricted endowment fund absent explicit donor stipulations to the contrary. As a result, the ADAF classifies as permanently restricted net assets the original value of gifts donated to the permanent endowment and the original value of subsequent gifts to the permanent endowment. Earnings on the permanent endowments are classified as temporarily restricted net assets in accordance with the direction of the applicable donor gift instrument. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets, according to donor stipulations. Temporarily restricted net assets are released from restriction when appropriated for expenditure by ADAF for the donor-stipulated purpose.

To make a determination to expend or accumulate donor-restricted endowment funds, the ADAF considers a number of factors, including the duration and preservation of the fund, purposes of the donor-restricted fund, general economic conditions, the possible effects of inflation and deflation, the expected total return from income and the appreciation of investments, other resources of the ADAF, and the investment policies of the ADAF.

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or UPMIFA requires the ADAF to retain permanently.

The ADAF has adopted investment and spending policies for endowment assets that attempt to enhance its ability to support activities, provide long-term real, inflation-adjusted growth in assets, and support financial flexibility and liquidity. Under this policy, as approved by its Board of Directors, the ADAF's assets are to be adequately diversified to provide a high degree of stability of principal in order to maintain the ability to provide financial assistance to support education and access to care programs. The assets are to be invested in a manner that is intended to grow in real, inflation-adjusted terms, and maintain its ability to support spending needs. In addition, the assets are to be efficiently structured to provide the highest level of return within the risk parameters established by its Board of Directors.

There are distinct asset pools and the asset allocation of the pools is the major determinant of investment risk exposure, real return levels, and current income generation. The endowments have variable spending needs, and the related asset pools are structured to support the spending needs.

The ADAF has an active finance committee that meets regularly to ensure the objectives of the investment policy are being met, and the strategies used to meet the objectives are in accordance with the investment policy.

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During 2012 and 2011, the ADAF had the following activities related to endowment net assets:

		<b>2012</b>		
		<b>Unrestricted</b>	<b>Temporarily restricted</b>	<b>Permanently restricted</b>
				<b>Total</b>
Endowment net assets, beginning of year	\$	—	135,817	2,138,842
Investment returns:				
Interest and dividends		—	54,029	—
Realized gain on sale of investments		—	35,134	—
Net unrealized appreciation on investments		—	258,028	—
Total investment returns		—	347,191	—
Investment management fee		—	(933)	—
Appropriation of endowment assets for expenditures		—	(84,930)	—
Total change in endowment net assets		—	261,328	—
Endowment net assets, end of year	\$	—	397,145	2,138,842

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		2011			
		Unrestricted	Temporarily restricted	Permanently restricted	Total
Endowment net assets, beginning of year	\$	—	251,611	2,138,842	2,390,453
Investment returns:					
Interest and dividends		—	42,104	—	42,104
Realized gain on sale of investments		—	38,957	—	38,957
Net unrealized depreciation on investments		—	(133,885)	—	(133,885)
Total investment returns		—	(52,824)	—	(52,824)
Investment management fee		—	(1,278)	—	(1,278)
Appropriation of endowment assets for expenditures		—	(61,692)	—	(61,692)
Total change in endowment net assets		—	(115,794)	—	(115,794)
Endowment net assets, end of year	\$	—	135,817	2,138,842	2,274,659

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**(11) Functional Expenses**

The following table summarizes the costs of providing various programs and activities on a functional basis for the years ended December 31, 2012 and 2011:

	<u>2012</u>	<u>2011</u>
General fund:		
Administrative services	\$ 7,187,875	5,965,132
Legal affairs	4,004,954	3,323,226
Government affairs	8,969,342	7,671,497
Communications	4,196,857	3,021,337
Membership and dental society services	8,648,262	6,444,600
Global affairs	1,331,571	951,154
Conference and meeting services	9,616,611	6,314,754
Finance and operations	4,352,665	2,974,631
Headquarters building	6,025,679	4,490,871
DC building	1,086,870	904,992
Salable materials	4,205,301	3,269,752
Central administration	9,814,972	31,373,846
Information technology and standards	8,995,432	6,698,412
Dental practice	3,406,383	2,441,792
Health policy resources center	2,507,280	1,584,359
Education	14,360,646	12,680,802
Science	6,491,976	5,008,805
Publishing	8,900,921	7,550,991
Corporate relations	590,199	415,314
Activities funded from reserves	1,895,967	2,154,174
Grant from ADA to ADAF	1,906,533	3,925,382
	<u>118,496,296</u>	<u>119,165,823</u>
Reserve division investment account	1,168,006	981,955
Eliminations of intercompany activities:		
Grant from ADA to ADAF	(1,906,533)	(3,925,382)
Reserve division earnings transfer	(1,168,006)	(981,955)
Headquarters building management office rent expense	(31,392)	(31,392)
	<u>116,558,371</u>	<u>115,209,049</u>
Total expenses of general fund including income tax expense	116,558,371	115,209,049
ADPAC total expenses including income tax expense	3,091,198	2,383,583
ADAF total expenses	5,794,585	7,890,184
ADABEI total expenses including income tax expense (benefit)	2,553,975	1,902,474

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	<u>2012</u>	<u>2011</u>
Eliminations of intercompany activities:		
ADABEI rental charges	\$ (89,336)	(87,501)
Professional services	(65,930)	(19,550)
Printing, publication, and marketing	(26,500)	(270,421)
Meeting expenses	(160)	(140)
Research expenses	(493,981)	(343,701)
Other expenses	(10,000)	(10,000)
Overhead recovery	(105,644)	(579,730)
In-kind administrative expenses	(790,474)	(780,383)
Total expenses including income tax expense	<u>\$ 126,416,104</u>	<u>125,293,864</u>

**(12) Commitments and Contingencies**

Although management is not aware of any pending or threatened litigation, the Association may be subject to legal actions, claims, and proceedings arising in the ordinary course of business. The ultimate resolution of these matters, including any related financial effects on the Association, would be addressed if and when they are known. The Association has not provided for any potential future losses arising from the resolution of these matters in the accompanying consolidated financial statements. Despite the inherent uncertainties of litigation, management does not believe that the lawsuits would have a material adverse impact on the financial condition of the Association at this time.

Certain tax returns of the Association and ADABEI were selected for audit by the IRS. As of the date of this report, the Association has received information document requests from the IRS, which included the request of certain reports, communications, and other documentation. Management has responded to all requests made. The Association has not received notice from the IRS asserting any deficiencies in federal income taxes paid for those years as a result of these audits.

ADABEI has received from the IRS a 30-day letter with the accompanying forms 870, 886A, and 4549-A adjusting ADABEI's income for each of the years under audit (2007-2011). ADABEI will be filing a protest with IRS Appeals. In regards to this notice, management estimates that these matters will be resolved without material adverse impact on the financial position or results of operations of ADABEI.

**(13) Subsequent Events**

In connection with the preparation of the consolidated financial statements and in accordance with ASC Topic 855, *Subsequent Events*, the Association evaluated subsequent events after the statement of financial position date of December 31, 2012 through June 10, 2013, which was the date the consolidated financial statements were available to be issued.

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Consolidated Statement of Financial Position with Supplementary Consolidating Information

December 31, 2012

	General fund					ADPAC	ADAF	ADABEI	Eliminations	Total
	Operating division	Reserve division			Total general fund					
	Operating account	Capital formation account	Technology account	Investment account	Total general fund					
<b>Assets</b>										
Cash and cash equivalents	\$ 6,685,671	—	—	—	6,685,671	247,930	313,228	1,123,295	—	8,370,124
Receivables, net	6,190,911	—	—	—	6,190,911	—	984,368	553,919	—	7,729,198
Due from affiliates	455,449	—	—	(1,399,360)	(943,911)	—	671,348	272,563	—	—
Deferred taxes	—	—	—	—	—	—	—	128,262	—	128,262
Income taxes receivable	—	—	—	—	—	—	—	370,031	—	370,031
Prepaid expenses and other assets	2,084,650	—	—	—	2,084,650	30,725	77	—	—	2,115,452
Inventories, net	590,180	—	—	—	590,180	—	—	—	—	590,180
Marketable securities	13,771,214	—	—	69,553,388	83,324,602	—	24,498,648	1,003,714	—	108,826,964
Investment in subsidiaries	—	2,726,316	—	—	2,726,316	—	—	—	(2,726,316)	—
Property and equipment, net	40,082,198	—	—	—	40,082,198	—	164,296	—	—	40,246,494
Funds held for deferred compensation	5,445,955	—	—	—	5,445,955	—	—	—	—	5,445,955
Total assets	\$ 75,306,228	2,726,316	—	68,154,028	146,186,572	278,655	26,631,965	3,451,784	(2,726,316)	173,822,660
<b>Liabilities and Net Assets</b>										
Accounts payable and accrued liabilities	\$ 11,562,831	—	—	214,121	11,776,952	96,402	641,100	725,468	—	13,239,922
Due to constituent societies	—	—	—	—	—	—	17,652	—	—	17,652
Deferred revenues	11,763,437	—	—	—	11,763,437	—	—	—	(23,268)	11,740,169
Charitable gift annuities	—	—	—	—	—	—	77,112	—	—	77,112
Liability for deferred compensation	5,445,955	—	—	—	5,445,955	—	—	—	—	5,445,955
Postretirement benefit obligation	—	—	—	10,533,050	10,533,050	—	—	—	—	10,533,050
Pension liability	56,796,206	—	—	—	56,796,206	—	—	—	—	56,796,206
Total liabilities	85,568,429	—	—	10,747,171	96,315,600	96,402	735,864	725,468	(23,268)	97,850,066
Net assets:										
Common stock	—	—	—	—	—	—	—	100,100	(100,100)	—
Additional paid-in capital	—	—	—	—	—	—	—	500,000	(500,000)	—
Unrestricted	(10,262,201)	2,726,316	—	57,406,857	49,870,972	—	13,994,509	2,126,216	(2,102,948)	63,888,749
Temporarily restricted	—	—	—	—	—	182,253	9,762,750	—	—	9,945,003
Permanently restricted	—	—	—	—	—	—	2,138,842	—	—	2,138,842
Total net assets	(10,262,201)	2,726,316	—	57,406,857	49,870,972	182,253	25,896,101	2,726,316	(2,703,048)	75,972,594
Total liabilities and net assets	\$ 75,306,228	2,726,316	—	68,154,028	146,186,572	278,655	26,631,965	3,451,784	(2,726,316)	173,822,660

See accompanying independent auditors' report.



**AMERICAN DENTAL ASSOCIATION  
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Consolidated Statement of Activities with Supplementary Consolidating Information

Year ended December 31, 2012

	General fund									
	Operating division	Reserve division			Total general fund	ADPAC	ADAF	ADABEI	Eliminations	Total
	Operating account	Capital formation account	Technology account	Investment account						
Revenues:										
Membership dues	\$ 54,551,655	—	—	—	54,551,655	—	—	—	—	54,551,655
Advertising	8,156,303	—	—	—	8,156,303	—	—	—	(26,500)	8,129,803
Rental income	5,578,821	—	—	—	5,578,821	—	—	—	(120,728)	5,458,093
Publication and product sales	7,448,384	—	—	—	7,448,384	—	—	—	—	7,448,384
Testing and accreditation fees	18,854,668	—	—	—	18,854,668	—	—	—	—	18,854,668
Meeting and seminar income	11,314,893	—	—	—	11,314,893	—	104,150	—	(160)	11,418,883
Grants, contributions, and sponsorships	2,037,055	—	—	—	2,037,055	1,584,786	2,331,670	—	(553,018)	5,400,493
Grant from ADA	—	—	—	—	—	—	1,906,533	—	(1,906,533)	—
Royalties and service fees	6,609,435	—	—	—	6,609,435	—	1,494,628	2,391,427	(10,000)	10,485,490
Investment income (loss)	2,362,084	(145,608)	—	7,358,910	9,575,386	378	3,045,137	4,164	(1,022,398)	11,602,667
Other income	2,933,985	—	—	—	2,933,985	42,000	5,114	12,776	(171,571)	2,822,304
In-kind services	—	—	—	—	—	790,474	—	—	(790,474)	—
Total revenues	119,847,283	(145,608)	—	7,358,910	127,060,585	2,417,638	8,887,232	2,408,367	(4,601,382)	136,172,440
Expenses:										
Staff compensation, taxes, and benefits	55,971,988	—	—	—	55,971,988	6,895	3,488,054	331,620	—	59,798,557
Printing, publication, and marketing	9,689,930	—	—	—	9,689,930	418,000	20,397	713,979	(26,500)	10,815,806
Meeting expenses	3,054,443	—	—	—	3,054,443	46,874	116,689	19,805	(160)	3,237,651
Travel expenses	5,668,521	—	—	—	5,668,521	6,983	132,495	32,997	—	5,840,996
Consulting fees and outside services	8,627,407	—	—	—	8,627,407	250,772	156,627	10,794	—	9,045,600
Professional services	8,672,142	—	—	—	8,672,142	33,609	332,966	242,765	(65,930)	9,215,552
Office expenses	5,132,558	—	—	—	5,132,558	57,310	93,247	18,501	—	5,301,616
Facility and utility expenses	6,317,778	—	—	—	6,317,778	—	329	90,528	(120,728)	6,287,907
Grants and awards	2,603,917	—	—	—	2,603,917	1,467,899	982,205	25,000	(493,981)	4,585,040
Grant to ADA Foundation	1,906,533	—	—	—	1,906,533	—	—	—	(1,906,533)	—
Endorsement expenses	659,550	—	—	—	659,550	—	—	—	(10,000)	649,550
Depreciation and amortization	6,562,777	—	—	—	6,562,777	—	185,456	1,066	—	6,749,299
Bank and credit card fees	1,136,354	—	—	—	1,136,354	11,447	3,391	1,433	—	1,152,625
Other expenses	1,382,948	—	—	1,168,006	2,550,954	—	282,729	166,138	(1,273,650)	1,726,171
In-kind administrative expenses	—	—	—	—	—	790,474	—	—	(790,474)	—
Total expenses	117,386,846	—	—	1,168,006	118,554,852	3,090,263	5,794,585	1,654,626	(4,687,956)	124,406,370
Net income (loss) from operations before income tax expense	2,460,437	(145,608)	—	6,190,904	8,505,733	(672,625)	3,092,647	753,741	86,574	11,766,070
Income tax expense	1,109,450	—	—	—	1,109,450	935	—	899,349	—	2,009,734
Net income (loss)	1,350,987	(145,608)	—	6,190,904	7,396,283	(673,560)	3,092,647	(145,608)	86,574	9,756,336
Pension – and postretirement health plan – related changes other than net periodic pension cost	(5,174,270)	—	—	(1,078,500)	(6,252,770)	—	—	—	—	(6,252,770)
Increase (decrease) in net assets	(3,823,283)	(145,608)	—	5,112,404	1,143,513	(673,560)	3,092,647	(145,608)	86,574	3,503,566
Net assets (deficit) at beginning of year	(8,773,731)	2,871,924	1,649,215	52,980,051	48,727,459	855,813	22,803,454	2,271,824	(2,189,522)	72,469,028
Equity transfers	2,334,813	—	(1,649,215)	(685,598)	—	—	—	—	—	—
Net assets (deficit) at end of year	\$ (10,262,201)	2,726,316	—	57,406,857	49,870,972	182,253	25,896,101	2,126,216	(2,102,948)	75,972,594

See accompanying independent auditors' report.

**AMERICAN DENTAL ASSOCIATION  
AND SUBSIDIARIES**

Consolidated Statement of Cash Flows with Supplementary Consolidating Information  
Year ended December 31, 2012

	General fund					ADPAC	ADAF	ADABEI	Eliminations	Total
	Operating division	Reserve division			Total general fund					
	Operating account	Capital formation account	Technology account	Investment account						
Cash flows from operating activities:										
Increase (decrease) in net assets	\$ (3,823,283)	(145,608)	—	5,112,404	1,143,513	(673,560)	3,092,647	(145,608)	86,574	3,503,566
Adjustments to reconcile change in net assets to net cash provided by (used in) operating activities:										
Pension – and postretirement health plan – related changes other than net periodic pension cost	5,174,270	—	—	1,078,500	6,252,770	—	—	—	—	6,252,770
Depreciation and amortization	6,562,777	—	—	—	6,562,777	—	185,456	1,066	—	6,749,299
Deferred income tax expense	—	—	—	—	—	—	—	302,496	—	302,496
Net unrealized (appreciation) depreciation in fair value of marketable securities	(293,628)	—	—	(7,434,361)	(7,727,989)	—	(2,395,321)	912	—	(10,122,398)
Net realized loss (gain) on sale of marketable securities	(135,277)	—	—	1,243,457	1,108,180	—	(186,663)	—	—	921,517
Provision for uncollectible accounts	104,800	—	—	—	104,800	—	—	—	—	104,800
Equity in net income of other investments	—	145,608	—	—	145,608	—	—	—	(145,608)	—
Changes in assets and liabilities:										
Receivables, net	(256,657)	—	—	—	(256,657)	—	(307,961)	98,696	—	(465,922)
Income taxes receivable	418,503	—	—	—	418,503	—	—	(38,377)	—	380,126
Prepaid expenses and other assets	(195,331)	—	2,284	—	(193,047)	14,802	7,499	—	—	(170,746)
Inventories, net	9,865	—	—	—	9,865	—	—	—	—	9,865
Due from/to affiliated organizations	(2,968,947)	—	138,655	3,475,370	645,078	—	(445,129)	(199,949)	—	—
Accounts payable, accrued liabilities, and other liabilities	2,563,357	—	(89,798)	(98,611)	2,374,948	89,086	297,771	301,322	—	3,063,127
Deferred revenues	(818,327)	—	—	—	(818,327)	—	(5,000)	—	59,034	(764,293)
Postretirement benefit obligation	—	—	—	(446,553)	(446,553)	—	—	—	—	(446,553)
Pension liability	487,317	—	—	—	487,317	—	—	—	—	487,317
Net cash provided by (used in) operating activities	6,829,439	—	51,141	2,930,206	9,810,786	(569,672)	243,299	320,558	—	9,804,971
Cash flows from investing activities:										
Purchase of marketable securities	(24,221,002)	—	—	(13,459,007)	(37,680,009)	—	(1,927,219)	(1,004,626)	—	(40,611,854)
Sale and maturity of marketable securities	20,500,000	—	—	11,214,399	31,714,399	—	1,887,033	—	—	33,601,432
Acquisitions of property and equipment	(5,022,263)	—	1,598,074	—	(3,424,189)	—	—	—	—	(3,424,189)
Net cash provided by (used in) investing activities	(8,743,265)	—	1,598,074	(2,244,608)	(9,389,799)	—	(40,186)	(1,004,626)	—	(10,434,611)
Cash flows from financing activities:										
Payments to charitable gift annuitant	—	—	—	—	—	—	(20,003)	—	—	(20,003)
Net cash used in financing activities	—	—	—	—	—	—	(20,003)	—	—	(20,003)
Net increase (decrease) in cash and cash equivalents	(1,913,826)	—	1,649,215	685,598	420,987	(569,672)	183,110	(684,068)	—	(649,643)
Cash and equivalents at beginning of year	6,264,684	—	—	—	6,264,684	817,602	130,118	1,807,363	—	9,019,767
Equity transfers funded with cash	2,334,813	—	(1,649,215)	(685,598)	—	—	—	—	—	—
Cash and cash equivalents at end of year	\$ 6,685,671	—	—	—	6,685,671	247,930	313,228	1,123,295	—	8,370,124

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