

2014

Annual Reports and Resolutions

155th Annual Session
San Antonio, Texas
October 10–14, 2014

Copyright 2014
American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611

Table of Contents

Councils and Commissions	1	Access, Prevention and Interprofessional Relations, Council on
	10	ADA Sessions, Council on
	20	Communications, Council on
	33	Dental Accreditation, Commission on
	80	Dental Benefit Programs, Council on
	96	Dental Education and Licensure, Council on
	127	Dental Practice, Council on
	143	Ethics, Bylaws and Judicial Affairs, Council on
	176	Government Affairs, Council on
	188	Members Insurance and Retirement Programs, Council on
	196	Membership, Council on
	211	National Dental Examinations, Joint Commission on
	283	Scientific Affairs, Council on
 ADA Business Enterprises, Inc.	 291	 ADA Business Enterprises, Inc.
 ADA Foundation	 294	 ADA Foundation
 Appendix	 296	 Annual Reports Index of Resolutions
 ADA 2013 Audited Financial Statements	 299	 ADA and Subsidiaries, Consolidated Financial Statements and Supplemental Schedules

Officers

Charles H. Norman, president
Maxine Feinberg, president-elect
Brian E. Scott, first vice president
Jonathan D. Shenkin, second vice president
Ronald P. Lemmo, treasurer
Glen D. Hall, speaker of the House of Delegates
Kathleen T. O'Loughlin, executive director and secretary

Board of Trustees

Terry L. Buckenheimer, Seventeenth District
Jeffrey M. Cole, Fourth District
Joseph P. Crowley, Seventh District
Jeffrey D. Dow, First District
Julian Hal Fair, III, Sixteenth District
Steven Gounardes, Second District
Joseph F. Hagenbruch, Eighth District
Hilton Israelson, Fifteenth District
Gary E. Jeffers, Ninth District
Roger L. Kiesling, Eleventh District
Andrew J. Kwasny, Third District
Gary L. Roberts, Twelfth District
Alvin W. Stevens, Fifth District
Carol Gomez Summerhays, Thirteenth District
Gary S. Yonemoto, Fourteenth District
James K. Zenk, Tenth District
Mark R. Zust, Sixth District

Senior Staff

Jerome K. Bowman, chief of governance and strategy management
J. Craig Busey, general counsel
Helen McK. Cherrett, senior director, Global Affairs
James S. Goodman, managing vice president, Conferences and Continuing Education
Michael A. Graham, senior vice president, Government and Public Affairs
Sabrina A. King, chief of people management
Toni Mark, chief technology officer
Daniel M. Meyer, senior vice president, Science/Professional Affairs
Clayton B. Mickel, managing vice president, Corporate Relations and Strategic Marketing Alliances
Kenneth Ohr, chief communications officer
David M. Preble, vice president, Practice Institute
Paul Sholty, chief financial officer
Michael D. Springer, senior vice president, Business and Publishing
Marko Vujicic, chief economist and vice president, Health Policy Institute
James L. Willey, senior director, Practice Institute
Anthony J. Ziebert, senior vice president, Education/Professional Affairs

Council on Access, Prevention and Interprofessional Relations

Thompson, W. Roy, 2014, Tennessee, chair
Gillette, E. Jane, 2015, Montana, vice chair
Chase, Timothy D., 2014, Arkansas
Crystal, Yasmi O., 2016, New Jersey
Fisher, John P., 2015, Massachusetts
Jones, Shelly F., 2017, Michigan
Lang, Melanie S., 2014, Washington, American Hospital Association
Logan, Bernadette A., 2015, Pennsylvania
Mitchell, G. Lewis, 2016, Alabama
Napier, Rocky L., 2014, South Carolina
Nunokawa, Neil C., 2017, Hawaii
Pankratz, Todd A., 2014, Nebraska, American Medical Association
Peckosh, Valerie B., 2017, Iowa
Roberts, Matthew B., 2014, Texas
Sabates, Cesar R., 2016, Florida
Schirmer, David C., 2015, New York
Soderstrom, Andrew P., 2017, California
Watson-Lowry, Cheryl D., 2016, Illinois
Wynn, Mary Ellen, 2016, Ohio
Yanase, Rex, 2014, California, *ex officio**

Grover, Jane S., director, Council on Access, Prevention and Interprofessional Relations
Geiermann, Steven P., senior manager, Access, Community Oral Health Infrastructure and Capacity
McGinley, Jane S., manager, Fluoridation and Preventive Health
Smith, Barbara J., manager, Geriatrics and Special Needs
Clough, Sharon R., manager, Preventive Health Services
Heitner, Kimberly, coordinator, Action for Dental Health
Radosevich, Amy, coordinator, Council Programs and Administrative Activities

The Council's 2013-14 liaisons include: Dr. Hilton Israelson (Fifteenth District trustee, ADA Board of Trustees); Dr. Michael Maihofer (Council on Communications); and Ms. Lauren Vitkus (American Student Dental Association).

Purpose

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.

* New Dentist Committee member without the power to vote.

Supporting the Strategic Plan Activities, Results and Accomplishments

Action for Dental Health

In keeping with the strategic plan objective that refers to promoting oral health through advocacy and science, CAPIR has been primarily focused on the continued activities of the Action for Dental Health (ADH) campaign. All initiatives of ADH below highlight member involvement coupled with local advocacy. (Supports Goals 1, 2 and 3)

Community Dental Health Coordinator (CDHC). When the pilot program ended in 2012, there were no states with CDHC implementation plans. At this time, there are 20 states focused on implementing the program, some in 2015. The ADH established goal is to have 15 states by 2015.

ER Referral. The ER Referral initiative of the ADH continues to prompt design of new models and highlight dental school interactions with local hospitals. UMKC in Missouri and NOVA School of Dental Medicine are just two examples of how successfully these projects motivate dental students in interprofessional care. At least 30 states have reported some model of ER Referral, increasing public awareness of this oral health need. The ADA is building a database to incorporate results of all models, which save hospital ERs millions of dollars each year. Each model in operation at this time measures success with several metrics, which include patients referred and decrease in ER visits.

Contracting Between FQHCs and Private Dentists. CAPIR staff discussed contracting between Federally Qualified Health Centers (FQHCs) and private dentists with the chief operating officer and medical director of the National Association of Community Health Centers (NACHC), which has requested that CAPIR staff discuss the community benefits of contracting at their August Community Health Institute meeting and provide sample contracts on the ADA website for NACHC members to utilize. There are eight states now contracting with health centers, with a goal to increase by 10% in 2015.

Reducing Medicaid Burdens. The ADA, American Association of Pediatric Dentistry and CAPIR's Medicaid Provider Advisory Committee (MPAC) continue to investigate the extent to which program integrity and RAC (Recovery Audit Contractors) audits affect dental practitioners, both individually and within the context of the whole healthcare team. Complying with requested documentation of an audit costs time and money. Yet increasing Medicaid participation is an initiative of ADH. CAPIR has set a goal of a 10% increase over three to four years in Medicaid services provided.

The MPAC is revising its 2013 course entitled "Maintaining Your Sanity and Practice Viability as a Medicaid Provider" for ADA 2014 – America's Dental Meeting for use as a template for anticipated regional and online educational opportunities to educate both current and future dental practitioners of the requirements and expectations of participating as a Medicaid provider. Implementation of a scrubbing algorithm prior to submission of claims is an anticipated tool for use by participating providers.

Direct Care Programs. The Council seeks to increase programs where dentists can directly provide care to those who are suffering from lack of dental care today. Over 20 more MOM projects were conducted in 2013 and first quarter 2014 than in previous years. Give Kids A Smile programs report a decrease in events (1,600 vs 1,800 in 2013) with 350,000 kids seen in the screening events.

Strengthen Collaborations With Other Health Professionals and Organizations. CAPIR continues to seek greater collaboration among national organizations who advocate for oral health as an integral component of overall health, which includes the ADA's continued endorsement of [Smiles for Life: A National Oral Health Curriculum](#). The American Academy of Family Practitioners has formally agreed to partner with CAPIR on medical residency education.

Prevention

Choosing Wisely Dental Website. The American Board of Internal Medicine Foundation (ABIMF) and Robert Wood Johnson Foundation (RWJF) invited ADA to collaborate to develop the Choosing Wisely Dental Website. RWJF is the funding agent for this project. The initiative is focused on encouraging

physicians, patients and other health care stakeholders to talk about medical tests that may be unnecessary, or could cause harm. The website content is developed by leading specialty societies who have created lists of “[Things Physicians and Patients Should Question](#)”—evidence-based recommendations that should be discussed to help patients make wise decisions about the most appropriate care based on a patient’s individual situation. ADA will be the first “non-medical” association to provide content for the website. CAPIR has convened a group of 10 ADA volunteers and representatives of dental specialty organizations for the purpose of drafting 10 recommended questions that dentists want patients to ask so they can make informed decisions about their dental treatment. The expected launch date is December 2014.

Health Literacy in Dentistry. The Oral Health Literacy Advisory Committee, idle since November 2012, reconvened by teleconference in May 2013. A follow up in-person meeting is planned for November 2014. The group plans on designing a literacy “toolkit” for members by the end of 2014.

Sweetened Beverage Consumption. CAPIR held a discussion about the many types of sweetened beverages that may contribute to caries risk across the lifespan. The Council also noted that the consumption of sweetened beverages begins at a very early age, which may be a contributing factor to the increasing incidence of early childhood caries.

After some discussion, CAPIR adopted the following resolution:

The Council on Access, Prevention and Interprofessional Relations recommends that the Council on Scientific Affairs, with assistance from other appropriate ADA agencies, consider developing appropriate clinical practice guidelines for nutritional counseling related to beverage consumption for children 0-3.

In April 2014, the Council on Scientific Affairs (CSA) reviewed CAPIR’s resolution and adopted a resolution to develop a committee to investigate the issue and report back to the Council at their July 2014 CSA meeting regarding CSA developing the requested guidelines.

2013 Prevention Summit. The 2013 Prevention Summit – Advancing America’s Oral Health was held at ADA headquarters from November 18-20. Approximately 121 participants met to develop a framework for action that leverages today’s opportunities, represents strategic choices, takes full advantage of multi-stakeholder engagement and includes plans for sustainability and accountability. The final document outlining the proceedings is nearly ready for distribution. Additional outcomes are a linkage to a texting prompt for moms to engage in oral health practices for their children.

Fluoridation

Status of Fluoridation in the United States. According to the CDC 2012 Fluoridation Census, 74.6% of the U.S. population on public water systems, nearly 211 million people, has access to optimally fluoridated water. At the state level, 20 states currently meet or exceed the 80% goal established for Action for Dental Health. Twenty-six states meet or exceed the Healthy People 2010 Goal of 75%. However, there is disparity between the states as eight states provide less than half of their population on public water systems with fluoridated water. In 2013, 85 water systems in 29 states were recognized for 50 years of fluoridation.

Challenges to current and proposed community water fluoridation programs continue at an unabated rate. Three communities in three states voted to initiate community water fluoridation in 2013 while 30 communities in 13 states voted to retain community water fluoridation. It should be noted that as recently as six years ago, these numbers would have been reversed between the categories with the vast majority of efforts being to initiate rather than retain fluoridation programs. In the past three years, while fluoridation activity does not always end with a vote, every state (with the exception of Delaware, Kentucky and Rhode Island) has had either state legislative activity or communities that have discussed fluoridation that required the local/state coalitions and the dental societies to take action, respond to

charges, and/or testify before decision makers. There were a record number of fluoridation bills introduced into state legislatures in the 2013-2014 legislative session.

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 ADA Fluoridation Toolkit, revised in April 2014, is available online for use by all state dental associations and state oral health programs via ADA Connect. (Supports Strategic Goals 1, 2 and 3)

Fluoridation Training. In support of the fluoridation initiative of the Action for Dental Health, the “CAPIR Track” at ADA’s 2013 Annual Session included a CE program, “Fluoridation: The Science and the Challenges.” Approximately 250 registrants reviewed scientific responses to fluoridation challenges and successful campaign strategies to initiate and retain fluoridation programs. In the past year, CAPIR staff also participated in fluoridation training at the annual meetings of the Illinois, Kansas and Missouri state oral health coalitions and returned to participate in a second fluoridation spokesperson training event sponsored by the New York State Dental Foundation and the New York State Department of Health. Since a CDC census is done every two years, it won’t be until late in 2015 that progress would be noted. (Supports Strategic Goal 2)

Access, Community Oral Health Infrastructure and Capacity

Collaboration With Dental Public Health. The 2014 National Oral Health Conference, the premier dental public health conference, sponsored by the American Association of Public Health Dentistry ([AAPHD](#)) and the Association of State and Territorial Dental Directors ([ASTDD](#)), was held in Fort Worth, Texas from April 26-30 with about 800 attendees. The ADA is also a major sponsor of this conference and organized dentistry has become a welcome and familiar participant.

CAPIR facilitated Dr. Marko Vujicic, ADA Health Policy Institute director, as the opening keynote speaker with his presentation: “Looking Back, Looking Forward: An Empirical Look at Access to Dental Care Issues in the U.S.” Dr. Vujicic was well received, with references to his comments appearing in subsequent presentations. Dr. Jane Grover and Mr. Calvin Hoops participated in a CDHC presentation.

Dr. Charles Norman, ADA president, Dr. Kathleen O’Loughlin, ADA executive director, and Dr. W. Roy Thompson, CAPIR chair, met with the leadership of AAPHD and ASTDD to discuss current initiatives and to further collaboration with the ADA and dental public health.

Seventh Leadership Colloquium: Developing the Alliance Framework for Action. CAPIR continues to support and engage the U.S. National Oral Health Alliance, which arose from the 2009 ADA-convened Access to Dental Care Summit. Approximately 150 individuals representing many of the diverse stakeholder groups originally represented at the 2009 aforementioned summit participated in this 7th colloquium of the [U.S. National Oral Health Alliance](#).

CAPIR-Sponsored Continuing Education Courses: Six courses were accepted for ADA 2014 – America’s Dental Meeting:

- New Partners in Prevention: Making the Medical-Dental Connection in Your Practice
- The ABCs of Federally Qualified Health Centers (FQHCs)
- Sports Dentistry Update: Prevention, Treatment, Education and Policy
- Fighting Dry Mouth in Your Practice
- Maintaining Your Sanity and Practice Viability as a Medicaid Provider
- Help! I Have a One-Year-Old in My Chair! (minimal fee charged)

Five of these courses will be offered free of charge as they are seen as a member benefit. (Supports Strategic Goals 1, 2 and 3)

Increasing Collaboration Between Private Practitioners and Dentists Working Within Health Centers. CAPIR staff provided technical assistance to state dental associations and/or state oral health coalitions

in New Hampshire, Indiana, Missouri and at the 2014 Yankee Dental Congress 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)

ADA and Center for Medicare/Medicaid Services (CMS) Leadership. In March 2014, Dr. O'Loughlin and ADA staff met with principals within the CMS leadership to talk about the importance of discussing members concerns with the CMS structure. Quarterly calls are scheduled for 2014.

Engaging Native American Communities. In early 2014, the Navajo Nation embarked on a major initiative to improve health outcomes for their people. The New Mexico and Arizona Dental Associations and the ADA were "invited in" to participate actively in the development of a 10-year health and wellness plan and to strategize with the Navajo leadership on its implementation. This was a revolutionary development in Indian Country and a major achievement for organized dentistry.

The ADA provided a simple, but comprehensive oral health plan for the Navajo Nation, which was well received by Navajo Nation officials. To test the acceptance of the oral health draft, Navajo Nation Health officials organized a full day workshop on oral health on March 13 attended by about 35 senior staffers from across the spectrum of Navajo health programs. Drs. Grover and Luciana Sweis provided an overview of the CDHC program, while Ms. Angela Black, CDHC from the Chickasaw Nation, described how the incorporation of CDHCs among [community health representatives](#) (CHRs) could produce significant health outcomes on the Navajo reservation.

ADA staff shared the foundational elements of the draft oral health plan, emphasizing the importance of building infrastructure, capacity, community and partnerships. The Navajo plan on starting three students in a CDHC program in 2015. The oral health plan was accepted by Navajo leadership and is in the process of implementation.

Geriatric and Special Needs Populations

In continuing efforts to address the ambitious agenda of initiatives set forth by Resolution 5H-2006 (*Trans.2006:317*), the National Elder Care Advisory Committee (NECAC) serves to assist and advise the Council in efforts to improve the oral health of elders. NECAC adopted goal statements echoing those set forth in ADA's 2011-2014 Strategic Plan, but with a specific focus on the vulnerable elderly.

Action for Dental Health Long-Term Care Initiative. With the 2013 launch of the Action for Dental Health initiatives, the focus of activity has been on the two long-term care initiative goals, closely aligned with Strategic Plan 2011-2014 Goal 1—providing support to dentists so they may succeed and excel throughout their careers.

- Goal 1: At least 10 state dental associations committed to implementing a long-term care program to improve the oral health of nursing home residents by 2015.
State associations in Idaho, Maryland and Virginia have initiated long-term care program planning and/or pilots. Illinois and California associations received staff/volunteer presentations on the incurred medical expense reimbursement mechanism and long-term care Initiative.
- Goal 2: Through ADA continuing education, train at least 1,000 dentists to provide care in nursing homes by 2020, and increase the number of dentists serving on advisory boards or as dental directors of long-term care facilities.
An online modular CE series entitled "Dentistry in Long-Term Care: Creating Pathways to Success" is being offered through ADA's Center for Professional Success. NECAC members served as faculty for the eight module series scheduled for an August 2014 release.

Interprofessional Relations

The American Academy of Family Physicians (AAFP) requested an opportunity to discuss further collaboration beyond the Smiles for Life Oral Health Curriculum. The initial call with AAFP leadership developed into a template for common ground and a mutual interest to design projects that have measurable outcomes benefiting patients. AAFP has requested a CAPIR presentation to the 1000 residency directors in 2015.

The relationship between the ADA and the American Academy of Physician Assistants (AAPA) continues to strengthen, with the Academy desiring a role in Give Kids A Smile events for 2015, as oral health is an integral part of overall health. Discussions on such participation will continue at the Physician Assistant Leadership Forum later this summer. AAPA has a goal of participating actively in GKAS events.

The American College of Emergency Physicians (ACEP) is considering a presentation by CAPIR staff at an ACEP board meeting to discuss models of ER Referral.

The relationship between the ADA and American Academy of Pediatricians (AAP) remains strong, with CAPIR pediatric dentist members preparing articles for future editions of the AAP newsletter on oral health. AAP will continue to look to ADA to educate current and future Community Oral Health Advocates (COHAs).

Emerging Issues and Trends

- As water fluoridation nears its 70th anniversary, ADA supports fluoridation at the national, state and local levels, supplying technical assistance and participating in collaborative efforts to increase the number of individuals who receive the benefits of fluoridated water. In January 2011, the U.S. Department of Health and Human Services published a notice of intent to establish a single target number for the level of fluoride (0.7 ppm) to be used in drinking water across the U.S. The final recommendation has yet to be published, but is anticipated by the close of 2014. A spike in anti-fluoridation activity is expected when the final recommendation is released later this year. It is imperative that constituents and members prepare now for challenges to come. CAPIR offers training programs that can be tailored to meet specific constituent needs. CAPIR strongly encourages constituents to consider scheduling training programs to assist members in facing these anticipated challenges.
- Due to increased marketing efforts, an increased use of smokeless tobacco products by adolescents has been noted. The tobacco industry continues to introduce new smokeless tobacco products, such as Snus, electronic cigarettes and dissolvable tobacco products, which are marketed aggressively to the younger population.
- The increasing awareness of RAC audits and their perceived negative impact upon dental practices has threatened participation in Medicaid by current and future dental providers.
- Though ADA councils and volunteers are becoming more mindful of the importance of medical/dental collaboration, the need to increase awareness about the potential benefits of this type of collaboration with the general membership is heightened.
- There is heightened awareness of the importance of the older dental patient to private practice as the population age 65 and over is the only population group whose utilization has increased.
- The Council is currently reviewing the new Strategic Plan, Members First 2020, and is in the process of assessing and aligning the Council's priorities to fully support the new plan.

Responses to House of Delegates Resolutions

The Council will report on the status of Resolutions 82-2013, 93H-2013, and 94-2013 in a supplemental report to the House.

Self-Assessment

A customized Council survey was designed by CAPIR staff and shared with volunteers. The response rate was 84%. The results are in Appendix 1.

Policy Review

In accordance with Resolution 170H-2012, Reaffirming Existing ADA Policy, the Council will submit a policy review in a supplemental report to the 2014 House of Delegates.

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.

Appendix 1. Council on Access, Prevention and Interprofessional Relations 2014 Self-Assessment

In response to Resolution 1H-2013 (*Trans.2013:339*), the Council undertook a thorough self-assessment. The Council survey was customized to record feedback on key issues from the volunteers.

CAPIR Bylaws Duties

1. Evaluate for the ADA trends in dental public health and access to care that enhance community oral health.
2. Recommend policies, advise other ADA agencies and develop programs relating to access to care; population-based prevention, including community water fluoridation; and inter-professional relations.
3. Provide advice and technical assistance to constituencies and communities to assess community oral health needs; develop coalitions and partnerships; and design, implement and evaluate programs to meet community oral health needs.
4. Recommend policies, advise constituencies and communities, provide technical assistance and develop programs focused on building community oral health infrastructure and capacity, reducing oral health disparities and increasing access to care.
5. Collaborate with internal and external stakeholders to create advocacy strategies regarding access to care, population-based prevention and inter-professional relations.
6. Promote community outreach, cultural competence and oral health literacy.
7. Foster and maintain liaisons with external stakeholders regarding population-based strategies and intervention strategies to improve oral health.
8. Serve as liaison for the ADA with The Joint Commission and with The Joint Commission's corporate members and other national health care organizations.
9. Recommend policies and formulate programs on issues pertaining to the relationship of dentistry to medicine, including interdisciplinary patient management, dentist-physician relations, oral health needs of patients with complex medical conditions and the oral-systemic relationship.
10. Conduct activities to improve the health outcomes of patients requiring cooperative dental-medical management in hospitals, including active medical staff membership and clinical privileges, in ambulatory care centers, long-term care facilities and other interdisciplinary health care settings.
11. Plan, develop, implement and evaluate programs that support the ADA's commitment to optimal oral health for all.

The ADA Board of Trustees gave each Council a topical outline for the purposes of assessment. Since customization of the outline was permitted, CAPIR staff designed a unique instrument for the goal of Council self-assessment.

There are 19 members on CAPIR; 17 selected by ADA districts, one physician member and one member who is an administrator of a health care facility. The survey return total was 16 responses, for an 84% response rate. The results are summarized below in Table 1 and correspond to the above listed Council duties.

Table 1. Council Survey per Bylaws Duty

Duty	Excellent	Good	Fair
#1	75%	25%	
#2	75%	25%	
#3	50%	43.8%	6.2%
#4	43.8%	43.8%	12.5%
#5	68.8%	31.2%	
#6	37.5%	56.2%	6.2%
#7	68.8%	31.2%	
#8	68.8%	31.2%	
#9	47.5%	43.8%	8.7%
#10	43.8%	31.2%	25%
#11	68.8%	31.2%	

Council members were asked to rate the top three duties accomplished by CAPIR that benefit ADA members. Those were duties #2, 11 and 1 (in order of priority).

Council members were asked if any duties should be discontinued and 62% answered “No.” Comments from the 6.2% “Yes” respondents referred to the number of groups with which CAPIR collaborates. “Some collaborations may need to be discontinued especially if there are no definitive accomplishments that benefit members.” Those will be discussed at the upcoming Council meeting.

Members were also asked if the structure of CAPIR effectively accomplishes the work of the Council. The response was 87.5% “Yes.”

Another question asked if the subcommittees facilitated the business of CAPIR. Over 81% said “Yes.” On the subject of Council meeting structure, members were asked if the Council agenda enabled strategic discussions to the extent that members would like and 62.5% answered “Yes.”

Conclusions

The CAPIR self-assessment yielded unique information about the Council structure, purpose and activities. Also evident from the personal comments made in the survey, members feel passionate about the role the ADA plays in the oral health of the public.

One member stated that “CAPIR is the cornerstone of the ADA” and another member stated “CAPIR is the heart and soul of the ADA.” Members clearly feel that the duties of CAPIR correlate with the Bylaws authority and are gratified by the work the Council accomplishes. As Action for Dental Health continues to build nationwide, these activities are viewed as member benefits with public outcomes at the forefront of professional discussion.

Responses from CAPIR members indicate that the current duties should be continued. There is clear indication that the ADA member benefit of this Council includes advocating for oral health for the public and the development of programs which promote population based prevention strategies.

Council on ADA Sessions

Galati, James E., 2014, New York, chair
Roesch, Robert E., 2015, Nebraska, vice chair
Cohen, Barry I., 2015, Pennsylvania
Cram, Sally J., 2015, Washington, DC, *ex officio*
Curcuro, Grace A., 2016, Michigan
Doniger, Sheri B., 2015, Illinois, *ex officio*
Foster, James R., 2014, Texas
Foy, Jr., Charles B., 2017, Louisiana
Fulton, Jr., David J., 2017, Illinois
Hasty, Christopher M., 2014, Georgia, *ex officio**
LaMorte, Gregory, 2017, New Jersey
Lancaster, T. Harold, 2016, North Carolina
Lum, Calbert M., 2016, Hawaii
Martin, Risé L., 2014, Texas, *ex officio*
Parker, Steven E., 2015, Ohio
Pietrasik, John P., 2014, Massachusetts
Samy, S. Shane, 2014, Oregon
Torgerson, Neil E., 2015, Florida
Tourial, Sidney R., 2016, Georgia
Van Sicklen, Jr., James H., 2016, California
Wyckoff, Douglas A., 2017, Missouri

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

The Council's 2013-14 liaisons included: Dr. Gary L. Roberts (Twelfth District trustee, Board of Trustees) and Ms. Onika R. Patel (American Student Dental Association).

Purpose

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

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

The council set tactics and quantifiable measures for these goals. Last year, as a result of both quantifiable and qualitative data on members who both attend and don't attend the annual meeting, the "Experience Design Project," the Council voted to rebrand the meeting. The rebranding had a "soft launch" during the 2013 meeting in New Orleans. This year the meeting is no longer referred to as the ADA 155th Annual Session but rather *ADA 2014 – America's Dental Meeting*. The results of the

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

“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. These marketing and experience strategies began to be rolled out in 2013 and will continue to be rolled out and built upon for ADA 2014 in San Antonio and ADA 2015 in Washington, DC.

The other main achievement in 2013 was the very first ADA MOM event. This folded into the ADA’s Action for Dental Health and Power of 3 (Tripartite Alignment in 2013) initiatives. The ADA worked closely with the Louisiana Dental Association and America’s Dentists Care Foundation to promote, raise funds and execute the event. Below are the final numbers from the event:

1,119 volunteers from 42 states
 785 patient visits
 755 patients treated
 \$352,498.50 total care provided = \$466.89 per patient
 2,688 procedures consisting of:
 752 exams
 266 x-rays
 553 surgical procedures
 393 fillings
 270 cleanings
 35 sealants
 205 fluoride treatments
 17 endodontic procedures
 24 partials
 2 denture repairs
 5 upper and 3 lower dentures
 1 enamelplasty
 1 palliative (emergency) treatment of dental pain
 269 medications delivered onsite

154th Annual Session, New Orleans, Louisiana, October 31–November 3, 2013

The ADA’s 154th Annual Session was held at the Ernest N. Morial Convention Center under the direction of the Council on ADA Sessions. Total actual registration for the meeting was 23,669 attendees. There were 7,225 dentists and 5,587 professional staff at the meeting, totaling 54% of all meeting registrants. The exhibit hall featured 1,285 booths from 560 companies during a three-day exhibition period. The number of courses taken per professional attendee was 3.17 courses. This was an increase of 42% over the number of courses taken in 2012, which was 2.24. In 2013, the Council also started tracking the number of continuing education (CE) hours taken per professional attendee, which was 7.30 hours.

Table 1. Financial Overview			
2012 Actuals*		2013 Actuals*	
<i>Revenue</i>		<i>Revenue</i>	
Exhibit	\$6,929,920	Exhibit	\$5,244,928
Registration	\$1,610,833	Registration	\$1,222,821
Sponsorship/Advertising	\$961,423	Sponsorship/Advertising	\$860,250
CE Tickets	\$1,323,049	CE Tickets	\$1,088,038
Housing Rebate	\$735,198	Housing Rebate	\$908,718
Other	\$21,693	Other	\$40,417
<i>Gross Revenue</i>	<i>\$11,582,116</i>	<i>Gross Revenue</i>	<i>\$9,365,172</i>
<i>Total Expenses</i>	<i>\$7,329,529</i>	<i>Total Expenses</i>	<i>\$5,668,720</i>
<i>Net Revenue</i>	<i>\$4,252,587</i>	<i>Net Revenue</i>	<i>\$3,696,452</i>
<i>*All figures above are unofficial and unaudited.</i>		<i>*All figures above are unofficial and unaudited.</i>	

Emerging Issues and Trends

At its May 2014 meeting, the Council started to look at the annual meeting's role going forward in light of the new 2015-2019 strategic plan, Members First 2020, and the Power of 3. Based on survey data, the Council looked at getting an understanding of the ADA's current place and role in the dental meeting environment as well as starting to look at what the ADA's place and role should be by 2020.

Responses to House of Delegates Resolutions

There were no assignments from the 2013 ADA House of Delegates.

Self-Assessment

The Council on ADA Sessions self-assessment report is attached as Appendix 1.

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.

Appendix 1. Council on ADA Sessions 2014 Self-Assessment

Council on ADA Sessions 2014 Self-Assessment

I. Threshold Issues

A. State the primary value of your council or commission to a member.

The Council on ADA Sessions (CAS) represents the member dentist when developing the annual meeting for the ADA. It plans, organizes and operates the ADA's annual meeting – America's Dental Meeting. The experience of CAS members is what allows the meeting to take place. CAS members deliver content expertise to the meeting's continuing education (CE) program.

The Council looks for ways to grow the meeting by collaborating with other organizations to hold their meetings in conjunction with the ADA annual meeting. It looks to meet the changing needs of the membership by creating a variety of opportunities that will appeal to the diverse membership of the organization.

The meeting brings value to ADA members through the social aspects of the meeting, showcasing innovative new products through the exhibit hall, networking opportunities and bringing in non-dues revenue. The highlight of the meeting is the phenomenal CE provided. The ADA annual meeting continues to provide the leading edge of innovative CE which is often copied around the country at other dental meetings. Over 50% of CE seats are included in the registration cost at no additional fee.

B. Should your council or commission continue to exist?

Yes. CAS is a fundamental part of the ADA governance structure. The Council is needed to ensure there is dentist input and expertise when planning the meeting. It is needed to ensure there is grassroots and diverse representation both geographically and demographically; to ensure the products shown are relevant and to provide continuity to the annual meeting.

C. Is your council or commission effective in carrying out its bylaws authority? If not, why?

This question will be answered in two parts per the *ADA Bylaws*, Revised January 1, 2013:

COUNCIL ON ADA SESSIONS. The duties of the Council shall be to:

a. Have responsibility for conducting the annual session of this Association, except the House of Delegates, subject to approval by the Board of Trustees as provided in these *Bylaws*.

- The Council upholds this part of its bylaws duties. It follows a strategic plan developed in 2012 and executed for 2013–2015.

b. Plan and coordinate other Association sessions or regional meetings.

- This portion of the bylaws was more difficult in answering as up until 2013, there have been very few "other Association sessions or regional meetings". Based on the structure of the tripartite, most "other" meetings are conducted through the component and constituent organizations.
- With the focus on "The Power of 3," CAS sees where its expertise can be lent to the tripartite in holding, managing and /or executing other meetings.
- One way this is being done today is through providing meeting space to many affiliate groups that meet during the ADA's annual meeting such as the American College of Diplomates, International College of Diplomates, alumni groups and many others. These groups are able to take advantage of all the work ADA has done in securing hotel contracts, taking advantage of the ADA negotiated hotel rates and often negotiated discounts on A/V and catering within those contracts.

- This is seen even more so with the move of the American Association of Women Dentists' annual meeting which will meet in conjunction with the ADA's meeting starting in 2014 and the continued relationship with the American Dental Assistants Association, now in its seventh year.

D. What are the top three goals to be accomplished by CAS annually?

CAS has a business plan which includes our three strategic goals (Appendix 2).

1. How are these related to member value?
The annual meeting is a source of non-dues revenues; provides innovative, high quality CE; brings the ADA to members "backyards" as the meeting rotates throughout the country creating brand awareness and a perceived value to members.
2. How successful has CAS been with respect to these goals?
CAS has increased the profitability of the meeting over the past four years (2010–2013) by over 50% net per attendee over the previous four years (2006–2009), and this during the downturn in the economy. Although attendance appears to be down over the past few years, professional attendance has remained flat (aside from 2013, with dates over Halloween). Per our strategic plan, we do have a strategy to build loyalty but since the meeting only takes place once a year, it will take a few years to see the results of increased professional attendance. Even though CAS has been successful over the past few years, it continues to look for ways to elevate experience and improve upon itself each year.

E. How do you define/measure success for the Council on ADA Sessions annually?

1. We look to the success measures of the Strategic Plan (Appendix 2).

II. Structure

Should your council or commission be skills based, or elected at large?

It is the responsibility of the trustee to appoint an able member from their district to the Council that has the background and experience of planning local and state/regional meetings. CAS suggests that the trustee appointing the replacement, contact the current member holding the position on CAS for specific experience and skills needed to fill the position. The Council feels that skills-based, geographic representation is an important makeup of the Council.

B. Do you have an agenda that enables strategic discussion to the extent you would like?

Through this exercise, efficiencies were identified for the agendas of the Council and subcommittee meetings:

- All subcommittees need to focus on Vision and Strategic Planning (VSP), not just the VSP subcommittee.
- The question, "what would it look like if we did not have this subcommittee?" was asked. The Council agreed that the functions of this subcommittee could be incorporated into the other subcommittees starting with the 2015 Council, with strategic direction to be discussed within all remaining subcommittees and the Council as a whole.
- There is redundancy in having a VSP subcommittee which has often created inefficiencies, redundancies and inconsistencies in the planning process.
- By incorporating VSP into the goals of the other subcommittees, the focus should be for everyone to think and act strategically, rather than just a subset of the Council. This will help the whole Council focus in a more strategic, less tactical mode of operation.

C. Do you have the optimal number of members to conduct business well and efficiently?

Yes, one member from each district (17), two committee on local arrangements chairs (current year and upcoming year), a new dentists liaison and an ASDA liaison for a total of 21. Each member is integral to planning the meeting.

D. Is the manner of member selection ideal (e.g. geographic vs. skills based)?

Yes, see answer for II. A.

1. Should you use standing committees or ad hoc task forces?

Already have five subcommittees – will be four starting in 2015.

F. Would a task force structure as opposed to a council structure be better? Worse?

A task force in definition is short lived/short term to accomplish a limited goal and disband. This would not be an optimal vehicle for planning an annual meeting.

III. Efficiencies

A. Is the decision making process efficient? If not, why?

CAS is very efficient based on the scope and amount of work. The Council moved to using a consent calendar during their February 2013 meeting and it has shortened the meeting by a half day.

B. How can you reduce the time spent by volunteers on your work, while still doing what needs to be done?

The Council discussed how we could incorporate video conferencing and better use conference calls. Subcommittees can explore video calls/using Skype and are already doing conference calls which are working well for the time being.

This May, CAS will be adjusting its meeting schedule to help eliminate time out of the office for the Council members. This is possible due to the implementation of the consent calendar.

CAS also discussed if the May subcommittee meetings could take place via conference call. Exhibit Relations and Local Arrangements and Meeting Logistics will explore this further. Continuing Education does need to meet face to face.

Time and roles during the annual meeting can be more efficiently used. This will be explored before the meeting this year in San Antonio.

C. Do you meet in person enough? Too much? Too little?

CAS meetings are the right number.

D. What work done by volunteers could be handled by staff?

By nature of planning a meeting, CAS focuses on a lot of tactics and details. Content is where the Council's experience is most needed. Other items like traffic builders in the exhibit hall are tactics that can be handled better by staff.

With the advent of the strategic plan in place in 2013, direction from the ADA executive director to be more strategic and less "in the weeds," the Council will continue to improve on how it conducts business with focus on strategy and less on tactics that should be handled by staff.

E. Are issues brought to your council in an efficient or appropriate manner?

For the most part. There are improvements that can be made when an electronic/ADA Connect vote is needed. These are being worked on.

F. Are you provided with sufficient information to address and decide issues?

Yes.

G. Is the discussion of issues efficient and effective?

People can tend to be passionate around topics that mean a lot to them. Time will be spent in May by the chair, vice chair and all committee chairs going over parliamentary procedure and duty of care to help in these types of conversation at both the subcommittee and Council levels.

H. Are there matters left to the council or commission that should be handled by a smaller group?

No additional comments.

I. Do you effectively use conference calls and web-based meeting time? Can you do so more or better?

See answer to III. B.

J. Are you aware of the staff time devoted to your activities? Can that staff time be directed to other activities?

The Council is aware of the time staff puts into executing the Council's direction for our world class annual meeting.

K. Is your staff support sufficient?

Yes.

IV. Areas of Responsibility

A. Based on a review of the bylaws, should some responsibilities be placed elsewhere or discontinued?

No. All duties in the bylaws should remain with CAS.

B. Are you addressing each area of responsibility? If not, should you, or should you change the bylaws?

No other comments for this area.

C. Can your responsibilities be consolidated with those of another entity or be done better by another entity?

No other comments for this area.

V. Agenda Review

As you consider a self-assessment, use your agenda as a tool in the assessment:

A. Is each item an efficient use of your time?

Yes.

B. Which items can be handled in other ways, conference calls, consent, etc.?

Consent agenda has been implemented.

C. What are you doing which is “down in the weeds,” operational as opposed to directional?

As discussed in III. D., the Council needs to do a better job of framing the start of the conversation with big picture items/objectives and hand the tactics over to staff. CAS can do a better job of looking at what we are trying to accomplish vs. how we should accomplish it. We are moving in the right direction with the help of staff in getting here.

We will be focusing on what we want our meeting to look like in the future. This will *have* to start with strategy. We have the flexibility to try new things based on our overall (ADA) structure with focus being on member value and the Power of 3.

D. What can you ask staff to take over?

See III. B. & D.

VI. Are you spending time on big issues and strategic direction?

As noted through this report, CAS has been building the structure in order to do this. Again, with the nature of what we are tasked to do through the *Bylaws*, “a. Have responsibility for conducting the annual session of this Association, except the House of Delegates...”, details and tactics are a natural and easy place to go. It is also where we are comfortable going.

We understand the motivation and direction coming from the Board and House to focus on the bigger picture and believe we are moving in the right direction to make that happen.

Appendix 2. 2014 Council on ADA Sessions Strategic Plan

2014 Council on ADA Sessions							
Strategic Plan Tracking							
Goal	Tactics & Initiatives	Success Measure	Target	Range	Actual	Comments	Status
1. Make the ADA annual meeting the first meeting the professional dental community and exhibitors select for participation.	Create new attendee experiences for networking and entertainment.	Implement 2-3 new experiences.	ADA 2014	October 9-14			
	Create year-round engagement by building an annual meeting community.	Enhance social media strategy, particularly on Facebook, YouTube and LinkedIn.	December 31, 2014	October - December 2014			
	Provide exhibitors with information to help plan booth staffing for the ADA annual meeting.	Send buying habits survey insights to exhibitors as part of their monthly updates via email. Include information on what the ADA has done to help exhibitors. Post edited "full" results to exhibitor webpage.	Monthly	January - October 2014			
	Enhance communications strategy to better communicate with exhibitors and tell our story, particularly via video.	Create and/or provide from other sources 3-5 short videos to help exhibitors get better ROI from their booth.	ADA 2014	February - October 2014			
2. Attract new and diverse attendees and create brand loyalty among current and new attendees, as well as exhibitors.	Continue to pursue other dental organizations and invite them to co-locate their annual meeting with the ADA annual meeting.	Signed contracts with 1-2 organizations to co-locate meeting in 2016 or 2017.	December 15, 2014	November 2014 - July 2015			
	Continue to enhance ADA365 and expand its reach beyond ADA members (ADA database) and internationally.	Reach 780-850 unique users (10-20% increase above 2013 unique users).	ADA 2014	October - December 2014			
	Create more areas on the show floor dedicated to specific products or services (example: dental laboratories).	Create one new area for ADA 2014	July 30, 2014	July 17 - August 15			

3. Add value to our membership by maintaining a profitable meeting to drive future success and yearly expansion, increasing the perceived benefits of ADA membership.	Enhance our communications strategy to let non-attendee members know what they are missing; for members who do attend, reminding them of the great experience they had—tell our story better, particularly via video.	Create 3-5 short videos to help attendees get the most out of various aspects of the meeting, such as registration, CE planning, CE verification, mobile app, etc.	ADA 2014	February - October 2014			
	Work with membership to include enhanced information about the benefits of annual meeting in all membership marketing materials.	Plan 1-3 presentations in the Member Value Theater on-site	ADA 2014	March - October 2014			

Council on Communications

Hewett, Sally J., 2014, Washington, chair
Shepley, George R., 2015, Maryland, vice chair
Austin, Joshua A., 2016, Texas
Boghosian, Alice G., 2015, Illinois
Campbell, Jeffrey A., 2014, Ohio
Chesser, William E., 2014, Alabama
Childs, Eric, 2014, Michigan *ex officio**
Herre, Craig W., 2017, Kansas
Hight, James R., 2017, Tennessee
Howell, Ralph L., 2016, Virginia
Jenkins, James F., 2014, Nebraska
Maihofer, Michael G., 2015, Michigan
Malon, Carolyn J., 2017, Connecticut
Manzanares, Robert J., 2016, New Mexico
Patel, Minerva, 2015, New York
Paul, John H., 2016, Florida
Sahota, Ruchi K., 2016, California
Tauberger, James A. H., 2017, Pennsylvania

MacLachlan, Janine, director
Cebula, Marcia, coordinator

The Council's 2013-14 liaisons include: Dr. Gary S. Yonemoto (Fourteenth District trustee, Board of Trustees) and Ms. Elizabeth T. Kalliath (American Student Dental Association).

Purpose

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

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 House of Delegates adopted Resolution 75H-2012 (*Trans.*2012:493) to engage a national public relations firm and implement an initiative to enhance the ADA image and advance its reputation and brand.

Now in its second year, the ADA, in conjunction with public relations agency FleishmanHillard, focused the initiative on expanding awareness and coverage of the ADA's Action for Dental Health: Dentists Making a Difference movement launched in May 2013 at a National Press Club event. Action for Dental Health (ADH) strives to target the "dental divide" via three key areas: 1) Provide care now to people suffering with untreated dental disease, 2) Strengthen and expand the public/private safety net to provide more care to more Americans, and 3) Deliver dental health education and disease prevention to communities.

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

Action for Dental Health programs include:

- Emergency room dental referrals
- Nursing home, long-term care facilities
- Give Kids A Smile, Missions of Mercy (MOM) events
- Community Dental Health Coordinator expansion
- Water fluoridation expansion
- Medicaid reform
- Private contracting with Federally Qualified Health Centers
- Collaborations with other health professionals and organizations

With input from leaders from the Councils on Access, Prevention and Interprofessional Relations, Government Affairs and Communications, a series of Action for Dental Health goals were developed to reflect key oral health goals in Healthy People 2020. The overarching goal of Action for Dental Health is to reduce the proportion of adults and children with untreated dental decay via multiple interventions, early diagnosis and risk assessment, disease management and health education, and preventing dental disease before it starts.

Progress toward the achievement of these goals will be measured through a variety of data mechanisms and self-reported metrics from dental societies.

State dental societies were encouraged to commit to at least one Action for Dental Health program when the movement launched in May 2013. Less than one year later, all 50 states have launched at least one Action for Dental Health program.

Communications goals for Action for Dental Health include:

- Assert ADA leadership and change the conversation about access to dental health
- Broaden awareness and boost belief in ADA's approach among influencers, media and policymakers
- Position ADA as the leading advocate for dental health by putting forth a nationally coordinated plan to address the dental health crisis in America
- Generate understanding of campaign programs among state dental societies
- Provide tools and resources to dental societies to successfully build, launch and promote campaign programs

During the first two quarters of 2014, Action for Dental Health communication activities focused on: health care reform; the national launch of Give Kids A Smile day at Howard University; the design and fielding of a baseline quantitative survey of key opinion leaders/stakeholders on their perceptions of ADA leadership on access to dental health issues; a series of Action for Dental Health toolkits for dental societies; and the production and distribution of Action for Dental Health Year One: A Report to Congress. This report was also offered to state dental societies to use as an advocacy tool to help advance their state legislative agenda.

Ongoing media analyses and annual key opinion leader surveys are key metrics in assessing the achievement of the Action for Dental Health communications goals. Since ADA began working with FleishmanHillard midway through the first quarter of 2013, Communications has tracked top-tier media sentiment (coverage that is either positive, neutral, or negative about the ADA).

A media analysis measuring coverage of dental issues and the ADA during the second through fourth quarters of 2013, which is when work with FleishmanHillard began in earnest, is generally positive to neutral. This is true with both top-tier media coverage and overall media coverage, with top-tier coverage trending more neutral and overall coverage trending more positive. Negative media coverage in the fourth quarter is primarily a result of two articles critical of the ADA's position on so-called "mid-level providers."

Notable national media placements over the past year include The New York Times, CNN.com, Wall Street Journal, Huffington Post, U.S. News and World Report, ABC Radio and ABC.com.

A key metric of the ADA's work with FleishmanHillard during 2014 is a targeted 18% positive sentiment in top-tier media stories on Action for Dental Health and other oral health issues that cite the ADA. In the first quarter of 2014, positive media sentiment reached an all-time high at 59% positive. Positive press coverage in the first quarter included the ADA's position on dental X-rays; the ADA's updated recommendations for children regarding use of fluoride toothpaste; and thought leadership commentary on CNN.com by ADA President Dr. Charles H. Norman about the state of dental health in the United States.

In the first quarter of 2014, the ADA worked with FleishmanHillard on the design of a quantitative survey intended to serve as a baseline of key opinion leaders' perceptions of the ADA as a leader on access to dental health issues and solutions. Topline results of the survey indicate ADA is favored as the leading organization to help solve the lack of access to dental care over any other organization by a factor of four to one. Less than a year after launch (May 2013), 14% of respondents are aware of Action for Dental Health. This is an extremely strong measure considering Action for Dental Health does not include any paid advertising to boost awareness.

A comprehensive report on Action for Dental Health, including more detailed metrics of top-tier media coverage and sentiment and results of the baseline key opinion leader survey, will be included in the Council's supplemental report.

The Council on Communications will continue to provide volunteer oversight to the public relations initiative.

The Action for Dental Health Goals are detailed in Appendix 1.

Subcommittee on Social and Digital Media

The Council's subcommittee advises on implementation of the Social Media Plan, including planning for long-term expansion across the Association. This year, the subcommittee aimed to offer more social media resources to state and local societies. In February 2014, the ADA launched a new subscription service that feeds ADA-authored social media content to state and local dental societies providing them a menu of weekly social media content items for their Facebook, Twitter, and LinkedIn channels. Currently 55 dental societies use this feature. The most popular content to date has been posts about the ADA Seal Program and Action for Dental Health—each of which has been shared on more than 40 social state and local channels.

The subcommittee also completed the development, review and publication of the *ADA Practical Guide to Social Media Planning, Second Edition*, published as an e-book in October 2013 and subsequently made available in a print version. Both versions are offered for sale in the ADA online store. A total of 683 units have been sold, netting roughly \$6,000. 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 developed the ADA Social Media Posting Protocol for ADA trustees slated to go to the Board in June. This document is designed to ensure that the ADA is prepared to manage its reputation in the social media space. All the ADA's social media channels continue to grow in following and engagement quarter over quarter.

Subcommittee members include Dr. Ruchi Sahota, chair; Dr. Joshua Austin; Dr. Jeffrey Campbell; Dr. James Jenkins; Dr. Minerva Patel; Dr. John Paul; Dr. Craig Herre and Ms. Elizabeth T. Kalliath, American Student Dental Association consultant.

Reputation Management Advisory 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. In 2014, the subcommittee reviewed and proposed updates to the ADA Issues Management Plan.

In support of the ADA Issues Management Plan and to serve as a communications resource for dental societies, the subcommittee continues to develop issues management resource toolkits. Toolkits currently available on ADA Connect include water fluoridation, dental amalgam, and launched in June 2014, dental anesthesia and sedation. The toolkits include credible information on these issues that dental societies can use with key audiences such as the public, media and legislators to help protect and promote the reputation of dentistry. Along with the Subcommittee, Communications staff worked with staff in the divisions of Science, Education, Government Affairs and Legal to develop content for the kits. According to best available tracking metrics, the amalgam toolkit has been viewed 85 times since its launch in September 2013, and the fluoridation toolkit 218 times since its launch in September 2012.

Subcommittee members include Dr. Jeffrey Campbell, chair; Dr. Alice Boghosian; Dr. Ralph Howell; Dr. Michael Maihofer; and New Dentist Committee ex officio Dr. Eric Childs.

Advocacy Communications Subcommittee

The Advocacy Communications Subcommittee is focusing on two major areas: increasing member value by communicating ADA's effective advocacy on behalf of its members, and communications support for relevant parts of Action for Dental Health.

Recognizing the need to communicate the value of membership, and members' continued statements that advocacy is among the most vital functions of the ADA, the subcommittee is working to develop new methods of using existing resources to deliver advocacy information to members. Under consideration are:

- Broadening the use of Engage (formerly CapWiz) beyond its current function of distributing action alerts and facilitating communications to lawmakers. Engage reaches more than 50,000 ADA members and has strong potential to deliver advocacy information in very brief "bites" to this large portion of ADA members who have self-selected as having a particular interest in this area.
- Putting advocacy information in context for members who might not otherwise pay special attention to it. As a recent example, a recent "Practice and Thrive" e-newsletter included a brief item on the ADA's opposition to a proposed Medicare rule change that would have required dentists to register with that program in order to write prescriptions to Medicare beneficiaries.
- Increased use of existing ADA social media channels.

The challenge is to demonstrate that ADA advocacy is a *member* benefit, not just an activity that benefits all dentists, whether they are members or not. Providing relevant, concise, timely information through channels like Engage, to which only ADA members have access, is one way to accomplish this.

Subcommittee members include Dr. Michael Maihofer, chair; Dr. William Chesser; Dr. Sally Hewett; Dr. Ralph Howell; Dr. Carolyn Malon; Dr. Robert Manzanares; 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. Over the past year, the workgroup has begun an examination of current perceptions of the ADA brand and strategies to

strengthen it. Part of this work included identifying further opportunities to streamline the branding experience across the dental societies and enhance the member experience. To broaden the scope of oversight, two members of the Council on Membership were also invited to participate in the workgroup. As a first step, the workgroup assessed gaps in past brand research to define knowledge needs going forward. A four-part research plan was then approved and is currently underway. It includes surveys to ADA members and non-members, ADA state and local volunteer and staff leaders, consumers, and opinion leaders.

Workgroup members include: Dr. William Chesser, chair; Dr. Sally Hewett; Dr. Jay Hight; Dr. James Jenkins; Dr. Nicole Johnson (Council on Membership); Dr. Shelley Olson (Council on Membership); Dr. Ruchi Sahota; and Dr. James Tauberg.

MouthHealthy.org

MouthHealthy.org promotes oral health content to the public, as well as ADA member dentists through the Find-a-Dentist feature, which includes the most frequently viewed pages on the site. Since the launch of MouthHealthy.org in mid-2012, 19 state society websites now link directly to the Find-a-Dentist resource, and 25 state sites link to content on MouthHealthy.org. Advertising on the site has continued to lag behind projections, but expenses have been reduced to offset the variance to achieve a budget neutral bottom line. Visits to the site have continued to increase, with the site reaching its one millionth visitor in December 2013, and delivering 143,706 hours of oral health education to the public. Since then, 2014 traffic has continued to grow. In the first quarter of 2014, the site received an average of 2,609 daily visitors (a 20% increase over 2013), and an average of 8,746 daily page views (a 24% increase over 2013). Visitors also spend an average of 6:05 minutes on the site.

MouthHealthy Analytics	2013	2014: Jan-March
Page Views	2,567,781	786,306
Visits	792,926	234,321
Visitors	693,002	205,394
Avg. Visit duration	5:56	6:05
Visits/Day	2,173	2,609
Page Views/Day	7,048	8,746

Ad Council Public Service Campaign on Children's Oral Health

The ADA continues to play a lead role in the Partnership for Healthy Mouths Healthy Lives, a coalition of 37 dental and health-related organizations that created "[Kids' Healthy Mouths](#)," an Ad Council public service campaign to improve children's oral health. The key message is that parents should have their children brush their teeth for two minutes, two times a day (2min2x), with the [2min2x.org](#) website serving as a robust hub for interactive information.

A 2012 benchmark study (wave 1) at the launch of the campaign and the wave 2 tracking study in 2013 were conducted to measure shifts in both English and Spanish speaking parents' behaviors and attitudes. Specifically, the studies measured overall awareness; awareness of the campaign Public Service Announcements; knowledge of 2min2x; attitudes regarding the importance and efficacy of regular brushing; and relevant behaviors (number of times brushing, time spent brushing and monitoring children's brushing).

Increased Frequency of Brushing

Most parents in 2013 continue to understand that their child should brush their teeth two or more times per day.

However, since the launch of the Children's Oral Health PSA Campaign, significantly more English-speaking parents report that their child is actually doing this (48% in 2012 to 55% in 2013).

Ideally – Monday -Friday (% whose kids brush 2 or more times per day)		
	English-speaking Parents	Spanish-speaking Parents
Benchmark 2012	87%	98%
Wave 2 -2013	87%	97%

Actual Brushing Behavior (Monday – Friday) Twice a day or more everyday		
	English-speaking Parents	Spanish-speaking Parents
Benchmark - 2012	48%	63%
Wave 2 - 2013	55%*	66%

Significant Increase among English-speaking parents

47



Increased Duration of Brushing

Since the launch of the Children's Oral Health PSA campaign more parents report:

that their child children should be brushing for 2 or more minutes and their children are actually brushing for 2 minutes or more

Ideally (% whose kids brush 2 minutes or more each time)		
	English-speaking Parents	Spanish-speaking Parents
Benchmark 2012	80%	72%
Wave 2 -2013	84%*	79%*

Actual Brushing Behavior 2 minutes or more each time they brush		
	English-speaking Parents	Spanish-speaking Parents
Benchmark - 2012	60%	69%
Wave 2 - 2013	64%*	77%*

Significant Increases among all parents

48



Results demonstrate the campaign has exceeded its benchmark goals and is driving awareness and behavior change. General awareness among parents about making sure children brush two times per day for two minutes has significantly increased since the launch. More parents report an increased frequency and duration of brushing, and more parents are actively involved in the brushing process, making sure their kids are doing a good or very good job brushing.

One year post-launch, new consumer touch points of the campaign include an in-school toolkit with Scholastic, Inc., to extend the program to teachers and a social media pledge rallying families around National Brush Day, observed on November 1 (the day after Halloween).

The Scholastic Toolkit “Two Minutes, Twice a Day” was delivered to 125,000 teachers nationwide and reached 3.75 million children and their families. Nearly all teachers surveyed (96%) have used the kit or plan, as they believe it will impact dental health behaviors at home.

National Brush Day outreach yielded an estimated 53.1 million impressions from press coverage and social media traction. The pledge announcement, asking families to commit to brushing for two minutes twice a day, was Tweeted nearly 1,800 times and The National Brush Day pledge received 510 names, reaching an estimated audience of 500,000.

Leaders of the coalition recently convened to discuss future efforts, agreeing that one key campaign message must focus solely on parents, relating to their busy lives and appealing to their yearn for small, everyday wins (such as their kids brushing for two minutes, twice a day).

Media Relations Activities

Since the last annual report, media reports from third and fourth quarter 2013 and first quarter 2014 have indicated that the ADA’s comprehensive communications campaigns successfully increased dental-related consumer stories in the news.

Media coverage of ADA issues management topics such as amalgam, infection control, fluoridation and sedation, rose over the last three quarters due to the release of a scientific research paper on oral cancer, a research paper mention of fluoride, and legal issues involving infection disease control and dental amalgam.

Following is a topline summary of audience impressions, indicating circulation, viewership and online visitors:

- Quarter 3, 2013: 83 million consumer topic impressions & 107 million issues topic impressions
- Quarter 4, 2013: 640 million consumer topic impressions & 56 million issues topic impressions
- Quarter 1, 2014: 452 million consumer topic impressions & 159 million issues topic impressions

Targeted Consumer Outreach—Diabetes and Oral Health

In November 2013, the ADA Communications team coordinated outreach to media and the public to make sure people better understand the connection between diabetes and oral health issues. By promoting a recent *JADA* study that found one in five cases of total tooth loss in the U.S. is linked to diabetes, the team conducted strategic outreach efforts.

Tailored media pitching resulted in three placements to date, while a satellite media tour featuring ADA Consumer Advisor Dr. Maria Lopez-Howell booked 21 broadcast interviews. Ten of the interviews were conducted in Spanish with Latino media, a target audience greatly affected by diabetes. The team also distributed a multimedia news release to heighten our efforts and promote a video about diabetes and oral health with ADA Consumer Advisor Dr. Alice Boghosian. A press release was also posted to ADA.org for extended visibility to membership and media.

To ensure the campaign was also engaging from a social perspective, the Communications team created Facebook posts, Tweets and an infographic about diabetes and oral health as content to share in the digital world. The ADA also joined a November 19 Mayo Clinic and Everyday Health Twitter Chat about managing diabetes during the holiday season. The ADA took this opportunity to remind people with diabetes to take care of their teeth and gums—directing them to resources on the Mouth Healthy website—an important facet of the topic that would have been entirely overlooked without the ADA’s participation.

Campaign Results:

- 24 million readers and counting MAT release (ADA press release written as a news story)
- 4 million viewers to date (Satellite Media Tour reach)
- More than 27 million unique online visitors

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. Communications staff works on media outreach and communications planning to support this initiative, which plays a role in the Action for Dental Health initiative, including Give Kids A Smile Day, held each year on the first Friday in February.

Since 2011, in tandem with GKAS sponsors, Give Kids A Smile worked 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 sported the GKAS logo on his car and jersey during the Texas race weekend in April. In addition, the program features 10 educational events at elementary schools in five race cities. 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. Sponsors include 3M ESPE Dental, Henry Schein Cares, CareCredit, Church and Dwight, and Oral Health America. The program is funded in part by the ADA Foundation.

Council member Dr. James Jenkins serves on the Give Kids A Smile advisory committee.

Emerging Issues and Trends

With the launch of the new strategic plan Members First 2020, the Council will develop a new strategic communications plan to support it.

Self-Assessment

In accordance with Resolution 1H-2013 (*Trans.*2013:339), the Council conducted a self-assessment, which is included as Appendix 2 to this report. The priorities for the Council include collaborating with the Council on Membership and other councils to support Members First 2020.

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.

Appendix 1. Action for Dental Health Goals



Action for Dental Health: Dentists Making a Difference Progress Report Goals

OVERARCHING GOAL:

Reduce the proportion of adults and children with untreated dental decay through multiple interventions, early diagnosis and risk assessment, disease management and health education, and by preventing dental disease before it starts.

Initiative: Lead Collaborations to Achieve and Exceed the Healthy People 2020 Goals

Dedicate resources to collaborations, public/private partnerships and community-based interventions defined locally to achieve and exceed the Healthy People 2020 oral health goals adopted by U.S. Department of Health and Human Services.

- Goal: Reduce the proportion of adults with untreated dental decay 15% by 2020, exceeding the 10% HP 2020 goal by 50%
- Goal: Reduce the number of children under 18 with untreated dental decay 15% by 2020, exceeding the 10% HP 2020 goal by 50%
- Goal: Increase the proportion of low income children who received any preventive dental services during the past year by 15% by 2020, exceeding the 10% HP 2020 goal by 50%

Initiative: Get People the Right Care, in the Right Setting – Emergency Department to Dental Chair

The utilization of emergency departments for dental conditions burdens the hospital, drains resources and becomes a cycle of care that does not treat and solve the underlying patient problem.

Baseline: Total dental emergency room visits 2.1 million (2010). Estimated 830,000 visits for preventable dental conditions and 390,000 visits for caries (cavities) as primary diagnosis (2009).

- Goal: Institute ER interception programs in 25 states by 2015 and 50 states and District of Columbia by 2020
- Goal: Reduce ER dependency for patients with dental caries (cavities) and the pain associated with dental emergencies 50% by 2020
- Goal: Reduce the total proportion of ER visits for dental-related issues by 35% by 2020

Initiative: Community Based Contracting Between Local Dentists and Federally Qualified Health Centers

Increase the capacity of the Federally Qualified Health Center (FQHC) Dental Programs through the contracting of private practices to accept publicly insured patients in the private practice setting, while the administrative burden of state insurance programs remains with the FQHC, reducing the barrier for private practice participation in public dental programs.

Baseline: 17.5% of FQHC patients received oral health services (2007)

Goal: Increase patients receiving oral health services 175% by 2020 – target 50% of all FQHC patients to receive oral health services, such as risk assessments, preventive measures, dental referrals and direct treatment

Initiative: Dentists Providing Care to Nursing Home Residents – Establish the Long-Term Care Dental Campaign

Dentists are to participate in nursing home care and prevention programs through local community outreach, continuing education and training to work in long-term care.

Baseline: Currently, there is insufficient data at a national level to accurately understand how many nursing home residents are receiving regular dental care. Therefore, one goal of this initiative is to gain a better understanding and measurement of the extent of the problem. Ultimately, our goal is to ensure every nursing home resident who wants and needs dental care is able to get it.

Goal: At least 10 state dental associations committed to implementing a long-term care program to improve the oral health of nursing home residents by 2015

Goal: Through ADA continuing education, train at least 1,000 dentists to provide care in nursing homes by 2020, and increase the number of dentists serving on advisory boards or as dental directors of long-term care facilities

Initiative: Expansion of Give Kids A Smile Local Community Screening and Treatment Efforts

The Give Kids A Smile mission is that as a public/private partnership, to serve as a catalyst for community-based children's oral health and wellness programs that are expandable, sustainable and innovative. Each year, dentists and dental team members in communities around the country conduct free screenings and provide preventive care, such as fluoride varnish and sealant applications, as well as offer treatment to children in need while getting them into continuity of care.

Baseline: 400,000 children screened and treated in 2012. Fact: National Health and Nutrition Examination Survey reports 23.8% of children aged three-five years had untreated dental decay in at least one primary tooth.

Goal: The Vision Statement of Give Kids a Smile calls for the elimination of cavities in U.S. five year-olds by 2020

Goal: ADA supports the Healthy People 2020 objectives that call for a 10% increase in children three to 15 who receive sealants. Sealants have been proven effective in reducing dental decay on the chewing surfaces of children's teeth

Initiative: Expansion of Community Water Fluoridation – Tap Into Your Health

The Centers for Disease Control and Prevention have proclaimed community water fluoridation as one of the 10 great public health achievements of the 20th Century. Community Water Fluoridation is one public health program that actually saves money. An individual can have a lifetime of fluoridated water for less than the typical cost of one dental filling.

Baseline: As of 2010, 74% of people on public water systems enjoy the cavity-prevention benefits of fluoridated water.

Goal: Provide fluoridated water to 80% of Americans on public water systems by 2020

Initiative: Improve Utilization of the Existing Safety Net Through the Use of Community Dental Health Coordinators: Working With Patients in 15 States by 2015

Expand the number of community dental health coordinators (CDHC) working as patient navigators, preventive specialists, and oral health screening workforce within the community health center environment and the private practice environment to reduce barriers to access (socio-economic, cultural, geographic, educational and psychological), while increasing capacity of the community health center dental programs and private practices.

Baseline: As of April 2013, 34 Community Dental Health Coordinators are actively working in seven states. A CDHC pilot project evaluation found one CDHC working just one day a week was able to provide services to 114 patients over a nine-month period.

Goal: Increase the number of states with active Community Dental Health Coordinators to 15 states by 2015

Initiative: Educating All Americans to be Mouth Healthy for Life

Continue to provide public education outreach programs and to improve oral health literacy among the general public through direct investment and collaborations.

Baseline: The ADA's MouthHealthy.org website launched in July 2012. The ADA is a founding and executive member of the Partnership for Healthy Mouths, Healthy Lives and the Ad Council developed Children's Oral Health campaign.

Goal: Establish MouthHealthy.org as the most respected and trusted online resource for oral health information and as one of the top five most visited websites for oral health information

Goal: Support and expand the efforts of the Partnership for Healthy Mouths, Healthy Lives and the Ad Council campaign through ADA member dentists in the local community

Initiative: Reducing the Barriers to Provider Participation in Medicaid/CHIP Through Reductions in Administrative Burdens and State Developed Solutions for Sustainable Reimbursement

Many states are cutting adult dental Medicaid. Six states provide no adult dental benefits through Medicaid and 18 states provide benefits for emergency dental care only. There are no states providing full coverage at this time. Each year, only \$143 per Medicaid patient is spent on dental treatment. Across the U.S., Medicaid spending for dental care is approximately 1% of total Medicaid spending.

Goal: Increase the number of states that have streamlined their credentialing process to less than one month by 10%

Goal: Increase the number of states that have a dental Medicaid advisory committee by 25%

#

Appendix 2. Council on Communications 2014 Self-Assessment

Background

In response to Resolution 1H-2013 (*Trans*.2013:339), the Council on Communications has undertaken a self-assessment to be included as an addendum in the 2014 annual report.

To establish a platform for its self-assessment, the Council reviewed its bylaws to assess its work:

Bylaws of the Council on Communications

The duties of the Council shall be to:

- a. Identify, recommend, and maintain a strategic communications plan for the Association.
- b. Advise on the reputation management of the Association, provide strategic oversight and advise the Association on the image and brand implications of its plans, programs, services and activities.
- c. Provide counsel to the Association on the priority and allocation of communication resources, to advise on their implications, and to identify the areas where the greatest strategic communications impact can be achieved.
- d. Identify, recommend, articulate and maintain strategies for significant communications campaigns across the Association.
- e. Serve as a strategic communications and brand management resource to other Association agencies.
- f. Serve as a resource and to support communications and reputation management strategies for the constituent and component dental societies.

Threshold issues

As the Council that advises the Board on reputation management and strategic communications, the Council's goals are driven by issues facing the Association. For example, as the ADA embarks on a new strategic plan, the Council will create an updated strategic communications plan that supports ADA goals. Since the theme is Members First 2020, we anticipate collaborating with the Council on Membership to create a strong member communications plan. In recent years, as advocacy communications issues generated significant media attention, and the Council on Communications helped to address it along with other ADA councils, which became the Action for Dental Health initiative.

To fulfill its bylaws responsibilities, the Council on Communications created subcommittees and workgroups to enable it to be flexible enough to adapt to concerns and priorities that may impact the ADA. These subgroups are described in the next section about structure.

Structure

The Council supports the current geographic representation by trustee district, which allows for a diversity of voices from large and small states, as well as the opportunity to share perspectives on issues that impact different regions of the country.

Much of the work of the Council is conducted by subcommittees and workgroups in between Council meetings to provide for a more productive meeting twice a year. The Council has three subcommittees:

- Advisory subcommittee on reputation management
- Subcommittee on social and digital media
- Subcommittee on advocacy communications

In addition, the chair activates select workgroups as necessary, such as the Interagency Workgroup on Brand Management (with the Council on Membership), which is currently working on a branding platform for the Association. Other workgroups address Golden Apple awards and policy review and the spokesperson program.

The Council also maintains a liaison program with five other councils to help identify emerging communications issues throughout the ADA. The Council on Communications liaison attends council meetings to provide an update on communications activities, as well as to represent a communications point of view as the host councils conduct their business. Host councils include:

- Council on Access, Prevention and Interprofessional Relations
- Council on Dental Practice
- Council on Government Affairs
- Council on Membership
- Council on Scientific Affairs

Efficiencies

Conference calls for subcommittees and workgroups address Council business between meetings to ensure the Council achieves its desired results. These smaller teams work productively and make thoughtful recommendations to the full Council.

Areas of Responsibility

As mentioned, the Council believes that the renewed commitment to member value indicates a need for deeper collaboration with the Council on Membership to identify opportunities to educate existing and potential members on the value delivered by the ADA. Currently, a workgroup on Brand Management includes two members from the Council on Membership, and the Council on Communications sends a liaison to Membership meetings. This may be sufficient on an ongoing basis, with additional collaboration during key times that require strategic discussions.

Agenda Review

The Council believes the meeting agendas are strategic and a good use of the Council's time. The chair, vice chair and staff plan the meeting agenda to reflect priorities for the Council and the ADA. The agenda typically reflects sufficient time for strategic discussion rather than hearing a series of reports. As with the Board of Trustees, most reports are on the consent calendar to allow maximum time for strategic discussion.

Are you spending time on big issues and strategic direction?

The Council operates at a strategic level by providing volunteer insights into programs such as the public relations initiative, the SPA oversight committee and through the liaison program. For the upcoming Strategic Plan, Members First 2020, the Council chair will appoint a workgroup to work with staff on a strategic communications plan to support ADA goals.

#

Commission on Dental Accreditation

Williams, John N., 2014, Indiana, chair, American Dental Education Association
Schonfeld, Steven E., 2014, California, vice chair, American Dental Association
Benson, Byron, 2015, Texas, American Academy of Oral and Maxillofacial Radiology
Burr, Kristi, 2014, Ohio, Public Member
Campbell, Stephen, 2017, Illinois, American College of Prosthodontists
Cangialosi, Thomas, 2015, New Jersey, American Association of Orthodontists
Dodge, William, 2015, Texas, American Dental Education Association
Donly, Kevin, 2015, Texas, American Association of Pediatric Dentists
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
Kahn, Richard, 2016, New Jersey, American Dental Association
Kassebaum, Denise, 2017, Colorado, American Dental Education Association
Kolstad, James, 2015, Wisconsin, American Student Dental Association and American Dental Education Association
Lanier, Dennis, 2017, Georgia, National Association of Dental Laboratories
Leffler, William, 2014, Ohio, American Association of Dental Boards
Livingston, Harold Mark, 2017, Mississippi, American Association of Hospital Dentists and American Dental Education Association
Mascarenhas, Ana Karina, 2016, Florida, American Association of Public Health Dentistry
Neville, Brad Wesley, 2014, South Carolina, American Academy of Oral and Maxillofacial Pathology
Royeen, Charlotte, 2015, Missouri, Public Member
Schindler, William, 2016, Texas, American Association of Endodontists
Shepherd, Kathi, 2015, Michigan, American Dental Hygienists' Association
Sherman, Robert, 2017, Hawaii, American Association of Dental Boards
Sherrard, James, 2015, Connecticut, Public Member
Surabian, Stanley, 2017, California, American Dental Association
Tiner, B.D., 2017, Texas, American Association of Oral and Maxillofacial Surgeons
Torres-Nazario, Ivan, 2017, Puerto Rico, American Association of Dental Boards
Tuneberg, Perry K., 2015, Illinois, American Dental Association
West, Karen, 2016, Nevada, American Dental Education Association

Tooks, Sherin, director
Baumann, 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 2013-2014 Board of Trustees liaisons included: Dr. Dennis Engel (Ninth District trustee) and Dr. Joseph Hagenbruch (Eighth District trustee).

Mission

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 2013 through February 2014 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 2013 and February 2014 meetings, for a total of 619 accreditation actions. Applications for initial accreditation of education programs were reviewed. During this time, one predoctoral dental education program, two advanced education in general dentistry, one advanced education in general practice residency, one advanced general dentistry in orofacial pain, one oral and maxillofacial pathology, one pediatric dentistry, one endodontics, three dental assisting, and three dental hygiene programs were granted accreditation. As indicated in Table 2, the total number of educational programs accredited is 1,452. This represents a decrease of one program from the previous reporting period. Of the 1,452 accredited programs, 47 (3.2%) hold the status of "Initial Accreditation" and 1,350 programs (92.9%) are in compliance with all requirements and have been awarded "Approval *Without* Reporting Requirements." During this reporting period, 55 programs (3.8%) were found to have deficiencies or areas of noncompliance and hold the status of "Approval *With* Reporting Requirements." Each of the 55 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, no education programs 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, 13 programs voluntarily discontinued their participation in the Commission's accreditation program.

Table 1. Selected Accreditation Actions: Two Meetings—August 2013 and February 2014

	Dental	Specialty	Advanced General Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Initial Accreditation Granted	1	3	4	3	3	0	14
Initial Accreditation—Continuing	3	5	4	0	0	0	12
Approval Without Reporting Requirements	25	167	89	81	105	5	472
Approval With Reporting Requirements	7	10	14	33	29	2	95
Accreditation Denied	0	0	0	0	0	0	0
Discontinued Programs	0	1	6	3	3	0	13
Intent to Withdraw	0	3	2	6	2	0	13
Accreditation Withdrawn	0	0	0	0	0	0	0
Decision Appealed	0	0	0	0	0	0	0
Number of Accreditation Actions	36	189	119	126	142	7	619

Table 2. Total Number of Accredited Programs as of February 2014

	Dental	Specialty	Advanced General Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Initial Accreditation	7	16	12	2	10	0	47
Approval Without Reporting Requirements	55	438	280	250	308	19	1,350
Approval With Reporting Requirements	3	7	6	22	17	0	55
Number of Accredited Programs	65	461	298	274	335	19	1,452

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 Advanced General Dentistry Education Programs in Oral Medicine, 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 Specialty Education Programs in Oral and Maxillofacial Surgery, for circulation to the communities of interest until December 1, 2014 for consideration at the February 2015 meeting of the Commission;
- Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery, for circulation to the communities of interest until December 1, 2014 for consideration at the February 2015 meeting of the Commission; and
- Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics, for circulation to the communities of interest until June 2, 2014 for consideration at the July/August 2014 meeting of the Commission.

Adoption of Accreditation Standards

The Commission adopted revisions to the following Accreditation Standards:

- Accreditation Standards for Dental Hygiene Education Programs (Standards 2-20 and 3-7), with immediate implementation;
- Accreditation Standards for Dental Laboratory Technology Education Programs, with implementation January 1, 2014;
- Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Radiology, with implementation July 1, 2014;
- Accreditation Standards for Advanced Education Programs in General Dentistry, with implementation July 1, 2014;
- Accreditation Standards for Advanced Education Programs in General Practice Residency, with implementation July 1, 2014;
- Accreditation Standards for Advanced General Dentistry Education Programs in Oral Medicine, with implementation July 1, 2014; and
- Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery, with implementation July 1, 2014.

Dental Therapy Accreditation Standards

The Commission's Task Force on Development of Accreditation Standards for Dental Therapy Education Programs conducted a thorough review of comments received on the proposed Dental Therapy

Standards, which had been circulated during 2013. Five open hearings were conducted in 2013 at the annual meetings of the American Dental Education Association, American Dental Hygienists' Association, American Dental Assistants Association, and American Dental Association (two hearings). The Task Force identified several themes among the comments received on the draft dental therapy standards, including the degree track and program length, the scope of training, the level of supervision, the program director requirements, and advanced standing. Beyond the key themes addressed within the comments received, the Task Force made additional changes for clarification or editorial purposes. The Task Force believed the proposed revisions provided clarity and flexibility for the development of quality training programs that address the minimal entry level requirements for dental therapy practice but could also be expanded to incorporate additional training experience and competence development for other duties that may be allowed under the state dental practice acts and regulatory authority.

Due to the nature of the changes made to the proposed Accreditation Standards for Dental Therapy Education Programs, the Task Force recommended, and the Commission concurred, that the proposed standards should be circulated for an additional one year (until December 1, 2014) for further consideration and public comment, including open hearings. An open hearing was conducted at the American Dental Education Association annual session in March 2014; additional hearings will be scheduled during the 2014 annual sessions of the American Dental Hygienists' Association, American Dental Assistants Association, and American Dental Association. The Commission will consider all comments received during its winter 2015 meeting. 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/en/coda/accreditation/accreditation-news/open-hearings-comments-due>.

Policy Review

The Commission adopted the following revised policies, as published in the Evaluation and Operational Policies and Procedures Manual of the Commission:

- Policy on Reporting Program Changes in Accredited Programs and related supplemental Guideline document; providing further clarification on categories of changes, how changes must be reported to the Commission, and potential Commission actions.
- Policy on Accreditation of Off-Campus Sites with supplemental Guideline document; providing further clarification on categories of off-campus sites and how sites must be reported to the Commission.
- Accreditation Status Definition "Intent to Withdraw;" inserting language that states "The Commission reserves the right to require a period of non-enrollment for programs that have been issued the Intent to Withdraw warning."
- Annual Fee Policy; noting that the fee is doubled in the year of the program's regular interval site visit (CODA Action: 2/2013) and clarifying the Commission's actions when a program fails to pay the annual fee.
- Policy on Electronic Submission of Accreditation Materials and Conversion Fee and Policy and Procedures Related to Compliance with the Health Insurance Portability and Accountability Act (HIPAA); noting that CODA will not accept any program documentation which includes Protected Health Information (PHI) or Personally Identifiable Information (PII). A \$1,000 penalty fee will be assessed when programs submit documentation that does not comply with the policy. A resubmission that continues to contain PHI or PII will be assessed an additional \$1,000 fee.
- Application for Accreditation for Fully Operational Programs With Enrollment and Without Accreditation; inserting language on the process for accreditation, ability to withdraw the application, and required fee.
- Application for Initial Accreditation for Developing Programs; inserting the application review steps which mirror those elsewhere in the Evaluation and Operational Policies and Procedures document.
- Policies and Procedures for Accreditation of Programs in Areas of Advanced Training in General Dentistry; to remove the term "The Joint Commission or its equivalent" and replace it with

terminology used in the Accreditation Standards regarding institutional accreditation by an agency recognized by the U.S. Department of Education or accredited by “an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).”

- Policy on Third Party Comments; updating the language on the method by which CODA announces site visits.
- Policy on Special Site Visits; updating the language on current practice and fee.
- Policy on Silent Observers on Site Visits; adding a statement on the expected role of the observer during a site visit.
- Policy on Institutions Offering Both Accredited and Non-Accredited Programs; revisions to apply the policy to all disciplines under the Commission’s purview.
- Policy on Conflict of Interest and the Policy on Consultants/Site Visitors; providing further clarification on the role of the Commission consultant/site visitor, Review Committee member, and Commissioner.
- Policy and Procedure for Development and Revision of Accreditation Standards; providing further clarification on document preparation prior to circulation of proposed changes.
- Policy on Site Visits; removing the policy on dental education programs for graduates of international schools, as this policy is no longer relevant.
- Policy on Request for Transfer of Sponsorship of Accredited Programs; updating the language to clarify the type of information that should be provided in the request.
- Policy on Requests for Contact Distribution Lists; clarifying language to define a commercial interest and changing the fee structure for this type of request.
- Policy and Procedure Regarding Investigation of Complaints Against Educational Programs; enhancing the definition of an “anonymous comment/complaint” and the process for review of this type of complaint.
- Policy Statement on Accreditation of Off-Campus Sites; incorporating exclusionary language for dental public health regarding reporting off-sites used for field experiences, and updating the potential actions that could be recommended by the Review Committee and taken by the Commission.
- Recognition Chronology; updating actions of the Commission’s re-recognition by the United States Department of Education.
- Policy on Review Committees; providing guidance for temporary appointment of an additional discipline-specific expert when an inadequate number of experts are available due to a recusal.

The Commission adopted the following new policy:

- Policy on CODA Research and Development Fund (R&D Fund); providing clarity on the potential uses of the fund and criteria guidelines for disbursement of the funds.

Quality Assurance and Strategic Planning

The Commission approved and forwarded for signature a Memorandum of Understanding (MOU) between the Commission and the American Dental Association outlining agreed upon duties and expectations of each party. The MOU was executed in fall 2013. The Commission also directed that the Quality Assurance and Strategic Planning Committee meet every six weeks to facilitate ongoing work toward achieving the Commission’s strategic plan. Additionally, the Commission established a Research and Development Fund, including a program administrative fee of \$25 in 2014, to provide the Commission with funds to support projects that are not planned during the regular budget planning cycle. The Research and Development Fund was approved by the American Dental Association Board of Trustees in fall 2013. The Commission plans to conduct comparative analysis and technology needs studies with the Research and Development Fund. The Commission also directed that the Quality Assurance and Strategic Planning Committee review and update data on a benchmarking study of structure models and cost implications of those models toward the development of a policy on initiation of new review committees and/or Commissioner positions. The Commission will consider the draft policy in summer 2014.

Accreditation Fees

The Commission directed an increase in the 2015 accreditation fees assessed to programs in an effort to ensure greater fiscal responsibility within the Commission. The increase in 2015 fees will allow the Commission to assume a greater portion of direct and indirect expenses associated with its accreditation program. In 2015, the Commission will increase annual accreditation fees to \$6,480 for predoctoral programs; \$1,620 for dental assisting, dental hygiene, and all advanced education programs; and \$1,140 for dental laboratory technology programs. The Commission's application fees will remain constant in 2015 at \$50,000 for predoctoral programs and \$15,000 for all other programs. The Commission also will increase the Research and Development Fund Administrative Fee to \$35.

Further, the Commission directed implementation of a fee structure for international predoctoral programs that apply for Commission accreditation, as follows: a) \$50,000 application fee; b) international programs pay all site visit expenses (actual expenses) for all site visits during the application and regular site visit schedule; c) implement an administrative fee of 25% of the total site visit cost to the program for coordination of each site visit; and d) assess a \$10,000 annual fee in 2015 for international predoctoral programs. All fees must be paid in U.S. Dollars. The Commission believed this fee structure would assure that the costs associated with international accreditation would not adversely affect the U.S.-based accreditation program. The Commission will continue to monitor the international fee structure.

Rules of the Commission on Dental Accreditation

In winter 2014, the Commission directed that references made in the *Rules* and Evaluation and Operational Policies and Procedures of the Commission to the "American Association of Hospital Dentists" be changed to the "Special Care Dentistry Association" and that the American Dental Association be notified of this requested change, which is supported by the Council on Dental Education and Licensure.

1. Resolved, that the *Rules* of the Commission on Dental Accreditation be revised to replace the name "American Association of Hospital Dentists" with "Special Care Dentistry Association" as shown in Appendix 1 of the Commission's 2014 annual report.

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 and programs to become eligible for federal funds, accreditors 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 recognition 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 were considered at the June 2013 meeting of the NACIQI. On July 23, 2013, the Commission received correspondence from the U.S. Department of Education Assistant Secretary for Postsecondary Education that the Commission's recognition had been renewed for four years.

Joint Advisory Committee on International Accreditation (JACIA) Activities

Mission and Purpose

The Joint Advisory 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 included Dr. Roger Kiesling, chair; Dr. Steven Bruce, ADA; Dr. Gary Herman, ADA; Dr. Yilda Rivera-Nazario, CODA; and Dr. Karen West, CODA. Then ADA president, Dr. Robert Faiella, and the CODA chair, Dr. Kent Knoernschild, served as *ex officio* members of this committee. Dr. Michael Reed served 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 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. Eleven international programs have submitted PACV surveys since 2007. Following review and discussion, JACIA approved each of the programs to attend a U.S. comprehensive visit and submit a PACV self-study.

Since 2009, six international predoctoral programs have submitted PACV self-studies 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 Leon, 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. Two programs, one in Istanbul, Turkey and one in Seoul, South Korea, submitted the PACV self-study in 2013, and will receive a comprehensive PACV consultative site visit in 2014.

No international predoctoral dental education programs have been accredited by the Commission on Dental Accreditation at this time. Currently, only the program in Jeddah, Saudi Arabia has been notified by the JACIA of its potential to pursue accreditation by the Commission on Dental Accreditation.

Activities, Results and Accomplishments

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

- The JACIA approved revisions to the Guidelines for International Consultation and Preliminary Accreditation Consultation Visit (PACV) Survey (Guidelines) identifying that a six (6) month extension for submission of the PACV self-study could be granted for just cause, with flexibility for extenuating circumstances, which would be brought to the Committee.
- The JACIA approved consultative report terminology to more clearly reflect the nature of a preliminary accreditation consultative visit outcomes and, at the same time, not be confused with the terminology used in the Commission's accreditation process. The JACIA terms are "strongly advise" and "advise" compared to the Commission's terms "recommend" and "suggest." The JACIA terms were placed in the "Definitions" section of the Guidelines and staff was directed to use these terms in each future consultative site visit report.
- The JACIA approved inclusion of the Commission's international accreditation fees to the appropriate section of the Guidelines.
- The JACIA approved language for the Guidelines that requires a program to acknowledge receipt of the consultative site visit report within 60 days of receipt and requires the program to notify

JACIA as to whether the program plans to submit a response, including a timeline for the expected date or submission of the response.

- The JACIA modified the International Accreditation Process Flow Chart in the Guidelines to accurately identify the Commission's accreditation review process.
- The JACIA reviewed the PACV self-studies submitted by Yonsei University College of Dentistry, Seoul, Korea and Yeditepe University, Faculty of Dentistry, Istanbul, Turkey. Following discussion, JACIA determined that a preliminary accreditation consultation visit should be scheduled to both of these programs in 2014.
- The JACIA reviewed the PACV survey submitted by King Saud University, Riyadh, Saudi Arabia. The JACIA determined that the program addressed the broad eligibility requirements and a PACV self-study could be submitted as the next step of the application process. There were four areas of the PACV survey for which the JACIA will seek more information in the self-study: 1) travel conditions for site visitors (travel restrictions, for example); 2) cultural or legal restrictions which may affect the site visit team composition; 3) clarification on the centralized admission process of the program; and 4) information on the facilities of the program, including floor plans and availability of learning resources.
- Dr. Steven Bruce, ADA, and Dr. Yilda Rivera-Nazario, CODA, completed their terms on JACIA and will be succeeded by Dr. Steven Tonelli, ADA, and Dr. Denise Kassebaum, CODA.

Emerging Issues and Trends

To support informed decision-making, the Commission monitors trends in the dental education and practice arenas, as well as in higher education. During this reporting period, the Commission, the discipline-specific review committees, 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;
- Trends in the National Advisory Committee on Institutional Quality and Integrity (NACIQI) evaluation of accreditors for USDE recognition;
- Activities of other specialized accreditors and the Association of Specialized and Professional Accreditors;
- Requests from the communities of interest; and
- Reports of accreditation standard frequency of citations for all disciplines.

Responses to House of Delegates Resolutions

57H-2013. Revision of Accreditation Standards (Trans.2013:334)

Commission Response: The Commission directed that the Predoctoral Dental Education Review Committee consider Resolution 57H-2013 with a report to the Commission in summer 2014.

Self-Assessment

1H-2013. Task Force to Study Councils Resolution 1 – Council, Commission and Committee Self-Assessment (Trans.2013:339)

Commission Response: In accord with Resolution 1H-2013, the Commission conducted a self-assessment based on the topical outline developed by the Board of Trustees. At its winter 2014 meeting, the Commission directed that an Ad Hoc Committee be formed to complete the 2014 CODA self-assessment. Members of the Ad Hoc Committee included the following Commissioners: Dr. Steven Schonfeld (chair), Dr. Denise Kassebaum, Dr. William Leffler, Dr. Mark Livingston, Ms. Kathi Shepherd, Dr. James Sherrard, and Dr. B.D. Tiner. The Ad Hoc Committee met on March 24, April 10 and April 21, 2014, to prepare the Commission's 2014 self-assessment. Dr. Joseph Hagenbruch, American Dental Association trustee liaison to the Commission attended the meetings on March 24 and April 21, 2014 as an ex-officio member.

The Commission reviewed each of the six areas of the self-assessment, which included threshold issues, structure, efficiencies, areas of responsibility, agenda review, and strategic direction. The Commission made the following conclusions as a result of the self-assessment:

- As the only nationally recognized accrediting agency for dental and dental related education programs, there would be a profound impact on the profession and dental education if the Commission on Dental Accreditation ceased to exist.
- The duties of the Commission should be revised to reflect contemporary terminology for dental and dental related professions (see associated resolution).
- The Commission should have authority to make editorial changes to its *Rules*, which do not alter its context or meaning (see associated resolution).
- The Commission continues to offer a strong accreditation program, as evidenced through continued compliance with the United States Department of Education criteria for recognition and continuous benchmarking of the Commission against similar accreditors.
- The Commission's agenda enables strategic discussion; however, two areas for improvement are: 1) enhancing the level of trust between the Commission and its committees, and 2) addressing the increased workload and complexity of issues which come before the Commission by considering other meeting structures.
- The number of staff dedicated to this agency is insufficient to support long-term growth and sustainability of this agency.
- Responsibilities of the Commission on Dental Accreditation cannot be placed with another agency or discontinued, nor can the responsibilities of the Commission be consolidated beyond the current structure of the Board of Commissioners, its committees, appeal board, and staff support.

The complete assessment is presented as Appendix 2 of this report.

As a result of the assessment, the Commission presents the following resolutions to the House of Delegates:

2. Resolved, that Chapter XV. COMMISSIONS, *Section 130. DUTIES*, Subsection A. COMMISSION ON DENTAL ACCREDITATION, of the ADA *Bylaws*, be amended as follows (additions are underscored; deletions are ~~stricken~~):

Section 130. DUTIES:

- A. COMMISSION ON DENTAL ACCREDITATION. The duties of the Commission on Dental Accreditation shall be to:
- a. Formulate and adopt requirements and guidelines for the accreditation of dental, advanced dental ~~educational~~ and ~~dental auxiliary~~ allied dental educational programs.
 - b. Accredit dental, advanced dental, ~~educational~~ and ~~dental auxiliary~~ allied dental educational programs.
 - c. Provide a means for appeal from an adverse decision of the accrediting body of the Commission to a separate and distinct body of the Commission whose membership shall be totally different from that of the accrediting body of the Commission.
 - d. Submit an annual report to the House of Delegates of this Association and interim reports, on request, and the Commission's annual budget to the Board of Trustees of the Association.
 - e. Submit the Commission's articles of incorporation and rules and amendments thereto to this Association's House of Delegates for approval by majority vote either through or in cooperation with the Council on Dental Education and Licensure.

3. Resolved, that Chapter XV. COMMISSIONS, *Section 120. POWER TO ADOPT RULES*, of the ADA *Bylaws*, be amended as follows (additions are underscored):

Section 120. POWER TO ADOPT RULES: Any commission of this Association shall have the power to adopt rules for such commission and amendments thereto, provided such rules and amendments thereto do not conflict with or limit the *Constitution and Bylaws* of this Association. Rules and amendments thereto, adopted by any commission of this Association, shall not be effective until submitted in writing to and approved by majority vote of the House of Delegates of this Association, except the Joint Commission on National Dental Examinations shall have such bylaws and amendments thereto as the House of Delegates of this Association may adopt by majority vote for the conduct of the purposes and management of the Joint Commission on National Dental Examinations. The Commission on Dental Accreditation shall have the authority to make corrections in punctuation, grammar, spelling, name changes, gender references, and similar editorial corrections to the *Rules* of the Commission on Dental Accreditation which do not alter its context or meaning without the need to submit such editorial corrections to the House of Delegates. Such corrections shall be made only by a unanimous vote of the Commission on Dental Accreditation members present and voting.

Summary of Resolutions

Resolution 1. Revision of the *Rules* of the Commission on Dental Accreditation to Replace the Name “American Association of Hospital Dentists” With “Special Care Dentistry Association”

Resolution 2. Amendment of the ADA *Bylaws* Regarding the Duties of the Commission on Dental Accreditation

Resolution 3. Amendment of the ADA *Bylaws* to Give the Commission on Dental Accreditation Authority to Make Editorial Corrections to Its *Rules*

Commission Minutes

For more information on recent activities, see the Commission’s [minutes](#) on ADA.org.

Appendix 1. Rules of the Commission on Dental Accreditation

Article I. MISSION

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.

Article II. BOARD OF COMMISSIONERS

Section I. LEGISLATIVE AND MANAGEMENT BODY: The legislative and management body of the Commission shall be the Board of Commissioners.

Section 2. COMPOSITION: The Board of Commissioners shall consist of:

Four (4) members shall be selected from nominations open to all trustee districts from the active, life or retired members of this association, no one of whom shall be a faculty member working more than one day per week of a school of dentistry or a member of a state board of dental examiners or jurisdictional dental licensing agency. These members shall be nominated by the Board of Trustees and elected by the American Dental Association House of Delegates.

Four (4) members who are active, life or retired members of the American Dental Association shall be selected by the American Association of Dental Boards from the active membership of that body, no one of whom shall be a member of a faculty of a school of dentistry.

Four (4) members who are active, life or retired members of the American Dental Association shall be selected by the American Dental Education Association from its active membership. These members shall hold positions of professorial rank in dental schools accredited by the Commission on Dental Accreditation and shall not be members of any state board of dental examiners.

The remaining Commissioners shall be selected as follows: one (1) certified dental assistant selected by the American Dental Assistants Association from its active or life membership, one (1) licensed dental hygienist selected by the American Dental Hygienists' Association, one (1) certified dental laboratory technician selected by the National Association of Dental Laboratories, one (1) student selected jointly by the American Student Dental Association and the Council of Students of the American Dental Education Association, one (1) dentist for each ADA recognized dental specialty who is board certified in the respective special area of practice and is selected by the respective specialty sponsoring organization, one (1) dentist representing postdoctoral general dentistry who is jointly appointed by the American Dental Education Association and the Special Care Dentistry Association ~~American Association of Hospital Dentists~~ and four (4) consumers who are neither dentists nor allied dental personnel nor teaching in a dental or allied dental education institution and who are selected by the Commission, based on established and publicized criteria. In the event a Commission member sponsoring organization fails to select a Commissioner, it shall be the responsibility of the Commission to select an appropriate representative to serve as a Commissioner. A member of the Standing Committee on the New Dentist (when assigned by the ADA Board of Trustees) and the Director of the Commission shall be ex-officio members of the Board without the right to vote.

Section 3. TERM OF OFFICE: The term of office of the members of the Board of Commissioners shall be one four (4) year term except that the member jointly selected by the American Dental Education Association and the American Student Dental Association shall serve only one two (2) year term.

Section 4. POWERS:

- A. The Board of Commissioners shall be vested with full power to conduct all business of the Commission subject to the laws of the State of Illinois, these *Rules* and the *Constitution and Bylaws* of the American Dental Association.

- B. The Board of Commissioners shall have the power to establish rules and regulations not inconsistent with these *Rules* to govern its organization and procedures.

Section 5. DUTIES:

- A. The Board of Commissioners shall prepare a budget at its winter meeting each year for carrying on the activities of the Commission for the ensuing fiscal year and shall submit said budget to the Board of Trustees of the American Dental Association for funding in accordance with Chapter XIV of the *Bylaws* of the American Dental Association.
- B. The Board of Commissioners shall submit an annual report of the Commission's activities to the House of Delegates of the American Dental Association and interim reports, on request, to the Board of Trustees of the American Dental Association.
- C. The Board of Commissioners shall appoint special committees of the Commission for the purpose of performing duties not otherwise assigned by these *Rules*.
- D. The Board of Commissioners shall appoint consultants to assist in developing accreditation standards and conducting accreditation evaluations, including on-site reviews of predoctoral, advanced dental educational and allied dental educational programs and to assist with other duties of the Commission from time to time as needed.

Section 6. MEETINGS:

- A. REGULAR MEETINGS: There shall be two (2) regular meetings of the Board of Commissioners each year.
- B. SPECIAL MEETINGS: Special meetings of the Board of Commissioners may be called at any time by the Chairman of the Commission. The Chairman shall call such meetings on request of a majority of the voting members of the Board provided at least ten (10) days notice is given to each member of the Board in advance of the meeting. No business shall be considered except that provided in the call unless by unanimous consent of the members of the Board present and voting.
- C. LIMITATION OF ATTENDANCE DURING MEETINGS: In keeping with the confidential nature of the deliberations regarding the accreditation status of individual educational programs, a portion of the meetings of the Commission, and its committees shall be designated as confidential, with attendance limited to members, the American Dental Association Trustee Liaison, selected staff of the Commission and affiliated accreditors. During this part of the meeting, only confidential accreditation actions may be considered.

Section 7. QUORUM: A majority of the voting members of the Board of Commissioners shall constitute a quorum.

Article III. APPEAL BOARD

Section 1. APPEAL BOARD: The appellate body of the Commission shall be the Appeal Board which shall have the authority to hear and decide appeals filed by predoctoral and advanced dental educational and allied dental educational programs from decisions rendered by the Board of Commissioners of the Commission denying or revoking accreditation.

Section 2. COMPOSITION: The Appeal Board shall consist of four (4) permanent members. The four (4) permanent members of the Appeal Board shall be selected as follows: one (1) selected by the Board of Trustees of the American Dental Association from the active, life or retired membership of the American Dental Association giving special consideration whenever possible to former members of the Council on Dental Education and Licensure, one (1) member selected by the American Association of Dental Boards from the active membership of that body, one (1) member selected by the American Dental Education

Association from the active membership of that body and one (1) consumer member who is neither a dentist nor an allied dental personnel nor teaching in a dental or allied dental educational program and who is selected by the Commission, based on established and publicized criteria. In addition, a representative from either an allied or advanced education discipline would be included on the Appeal Board depending upon the type and character of the appeal. Such special members shall be selected by the appropriate allied or specialty organization. Since there is no national organization for general practice residencies and advanced education programs in general dentistry, representatives of these areas shall be selected by the American Dental Education Association and the Special Care Dentistry Association ~~American Association of Hospital Dentists~~. One (1) member of the Appeal Board shall be appointed annually by the Chairman of the Commission to serve as the Chairman and shall preside at all meetings of the Appeal Board. If the Chairman is unable to attend any given meeting of the Appeal Board, the other members of the Appeal Board present and voting shall elect by majority vote an acting Chairman for that meeting only. The Director of the Commission shall provide assistance to the Appeal Board.

Section 3. TERM OF OFFICE: The term of office of members on the Appeal Board shall be one four (4) year term.

Section 4. MEETINGS: The Appeal Board shall meet at the call of the Director of the Commission, provided at least ten (10) days notice is given to each member of the Appeal Board in advance of the meeting. Such meetings shall be called by the Director only when an appeal to the appellate body has been duly filed by a predoctoral or advanced dental educational or allied dental educational program.

Section 5. QUORUM: A majority of the voting members of the Appeal Board shall constitute a quorum.

Section 6. VACANCIES:

- A. In the event of a vacancy in the membership of the Appeal Board of the Commission, the Chairman of the Commission shall appoint a member of the same organization, or in the case of a consumer of the general public, possessing the same qualifications as established by these Rules, to fill such vacancy until a successor is selected by the respective representative organization.
- B. If the term of the vacated position has less than fifty percent (50%) of a full four-year term remaining at the time the successor member is appointed, the successor member shall be eligible for a new, consecutive four-year term. If fifty percent (50%) or more of the vacated term remains to be served at the time of the appointment, the successor member shall not be eligible for another term.

Article IV. ACCREDITATION PROGRAM

Section 1. ACCREDITATION STANDARDS: The Commission, acting through the Board of Commissioners, shall establish and publish specific accreditation standards for the accreditation of predoctoral and advanced dental educational and allied dental educational programs.

Section 2. EVALUATION: Predoctoral and advanced dental educational and allied dental educational programs shall be evaluated for accreditation status by the Board of Commissioners on the basis of the information and data provided on survey forms and secured by the members of, and consultants to, the Board of Commissioners during site evaluations.

If the Board of Commissioners decides to deny, for the first time, accreditation to a new educational program or to withdraw accreditation from an existing program, the Board of Commissioners shall first notify the educational program of its intent to deny or withdraw accreditation. Such notice, together with announcement of the date of the next meeting of the Board of Commissioners, shall be sent to the educational program by certified mail, return receipt requested, within fourteen (14) days following the intent to deny or withdraw decision of the Board of Commissioners. Within thirty (30) days after receipt of such notice, the educational program may, in writing, request a hearing before the Board of

Commissioners at its next meeting. Within fifteen (15) days after receipt of the request, the Board of Commissioners shall schedule a hearing and notify the educational program of the date, time and place of such hearing. A request for a hearing due to the Board of Commissioner's decision to deny for the first time, accreditation to a new program, shall automatically stay the decision to deny accreditation. In the event the educational program that has been denied initial accreditation for the first time does not make a timely request for a hearing, the Board of Commissioners' findings and proposed decision to deny accreditation shall become final.

Section 3. HEARING: Upon completion of an evaluation for accreditation status, the Board of Commissioners shall notify the predoctoral, advanced or allied dental educational program (hereinafter called "educational program") of its findings and decision regarding the program's accreditation status. Two types of hearings can be held to review the appropriateness of the decision made by the Commission:

- A. **CHALLENGE:** This type of hearing is available to a program/institution that wishes to challenge the decision of the Commission to change its accreditation status or to a new program that wishes to challenge the decision of the Commission to deny, for the first time, initial accreditation. When an institution/program believes that the Commission has made an error in judgment, a hearing may be requested. The hearing before the Commission would be held at the next regularly scheduled meeting. Representatives of the institution/program may present arguments that the Commission, based on the information available when the decision was made, made an error in judgment in determining the accreditation status of the program. The educational program need not appear in person or by its representatives at the hearing. Legal counsel may represent the educational program at the hearing. During the hearing, the educational program may offer evidence and argument in writing or orally or both tending to refute or overcome the factual findings of the Board of Commissioners. The Director of the Board of Commissioners must receive any written evidence or argument at least thirty (30) days prior to the hearing. No new information regarding correction of the deficiencies may be presented.
- B. **SUPPLEMENT:** An institution/program may request a hearing in order to supplement written information, which has already been submitted to the Commission. A representative of the institution would be permitted to appear in person before the Commission to present this additional information.

When a hearing to provide supplemental information is desired, a written request is to be made to the Director of the Commission thirty (30) days prior to the meeting. The chairman and the Director of the Commission determine the disposition of the request and inform the requestor of the date, hour and amount of time which will be allocated for the hearing.

Section 4. APPEAL: In the event the final decision of the Board of Commissioners is a denial or withdrawal of accreditation, the educational program shall be informed of this decision within fourteen (14) days following the Commission meeting. Within fourteen (14) days after receipt of the final decision of the Board of Commissioners, the educational program may appeal the decision of the Board of Commissioners by filing a written appeal with the Director of the Board of Commissioners. The filing of an appeal shall automatically stay the final decision of the Board of Commissioners. The Appeal Board of the Commission shall convene and hold its hearing within sixty (60) days after the appeal is filed. The educational program filing the appeal may be represented by legal counsel and shall be given the opportunity at such hearing to offer evidence and argument in writing or orally or both tending to refute or overcome the findings and decision of the Board of Commissioners. No new information regarding correction of the deficiencies may be presented with the exception of review of new financial information if all of the following conditions are met: (i) The financial information was unavailable to the institution or program until after the decision subject to appeal was made. (ii) The financial information is significant and bears materially on the financial deficiencies identified by the Commission. The criteria of significance and materiality are determined by the Commission. (iii) The only remaining deficiency cited by the Commission in support of a final adverse action decision is the institution's or program's failure to meet

the Commission's standard pertaining to finances. An institution or program may seek the review of new financial information described in this section only once and any determination by the Commission made with respect to that review does not provide a basis for an appeal. The educational program need not appear in person or by its representative at the appellate hearing. The Appeal Board may make the following decisions: to affirm, amend, remand, or reverse the adverse actions of the Commission. A decision to affirm, amend or reverse the adverse action is implemented by the Commission. In a decision to remand the adverse action for further consideration, the Appeal Board will identify specific issues that the Commission must address. The Commission must act in a manner consistent with the Appeal Board's decisions or instructions. The Appeal Board shall advise the appellant educational program of the Appeal Board's decision in writing by registered or certified mail. The decision rendered by the Appeal Board shall be final and binding. In the event the educational program does not file a timely appeal of the Board of Commissioners' findings and decision, the Board of Commissioners' decision shall become final.

Section 5. HEARING AND APPEAL COSTS: If a hearing is held before the Board of Commissioners, the costs of the Commission respecting such hearing shall be borne by the Commission. If an appeal is heard by the Appeal Board, the costs of the Commission respecting such appeal shall be shared equally by the Commission and the appellant educational program filing the appeal except in those instances where equal sharing would cause a financial hardship to the appellant. However, each educational program shall bear the cost of its representatives for any such hearing or appeal.

Article V. OFFICERS

Section 1. OFFICERS: The officers of the Commission shall be a Chair, Vice-Chair and a Director and such other officers as the Board of Commissioners may authorize. The Chair and Vice-Chair shall be elected by the members of the Commission. The Chair and Vice-Chair shall be active, life or retired member of the American Dental Association.

Section 2. DUTIES: The duties of the officers are as follows:

- A. CHAIR: The Chair shall preside at all meetings of the Board of Commissioners.
- B. VICE-CHAIR: If the Chair is unable to attend any given meeting of the Board of Commissioners, the Vice-Chair shall preside at the meeting. If the Vice-chair is unable to attend the meeting, the other members of the Board of Commissioners present and voting shall elect by majority vote an acting chair for the purpose of presiding at that meeting only.
- C. DIRECTOR: The Director shall keep the minutes of the meetings of the Board of Commissioners, prepare an agenda for each meeting, see that all notices are duly given in accordance with the provisions of these *Rules* or as required by law, be the custodian of the Commission's records, and in general shall perform all duties incident to the office of Director.

Article VI. MISCELLANEOUS

The rules contained in the current edition of "Sturgis Standard Code of Parliamentary Procedures" shall govern the deliberations of the Board of Commissioners and Appeal Board in all instances where they are applicable and not in conflict with the *Rules* or the previously established rules and regulations of the Board of Commissioners.

Article VII. AMENDMENTS

These *Rules* may be amended at any meeting of the Board of Commissioners by majority vote of the members of the Board present and voting subject to the subsequent approval of the House of Delegates of the American Dental Association.

Reaffirmed: 8/12; Revised: 8/10, 10/02, 10/97, 10/87, 11/82

Adopted by the Commission on Dental Accreditation, February 1, 2002. Approved by the ADA House of

Delegates, October 2002. Revisions adopted by the Commission on Dental Accreditation, August 2010. Approved by the ADA House of Delegates, October 2010. Revision of Mission Statement adopted by the Commission on Dental Accreditation, August 2012. Approved by the ADA House of Delegates, October 2012.

Appendix 2. Commission on Dental Accreditation 2014 Self-Assessment

Background: In 2002, the American Dental Association (ADA) House of Delegates passed a resolution requiring all ADA Councils and Commissions to complete a self-assessment in 2003, with a report to the House of Delegates in Fall 2003. Based on the outcomes of the 2003 self-assessment process, the ADA Board of Trustees determined that a five-year self-assessment cycle was warranted to provide an opportunity for agencies to review their relevancy, productivity efficiency, mission and duties. Reports were not requested for reporting year 2008, nor were they requested for 2009; the Board of Trustees requested reports of self-assessment for the 2010 House of Delegates. In 2010, the Commission on Dental Accreditation (CODA) submitted a self-assessment.

In 2013, the ADA House of Delegates passed the following resolution:

1H-2013. Resolved, that each council and commission undertake a thorough self-assessment based on a topical outline to be developed by the Board of Trustees and submit a report to the 2014 House of Delegates (in time for the Board to consider the report at its June 2014 meeting) on the process and its results, including any proposed resolutions to implement those results, and be it further **Resolved,** that following 2014, each council and commission undertake a thorough self-assessment on a rotating basis over every five years based on a schedule and outline to be developed by the Board of Trustees, and within the Annual Report include information on the process followed and results to the next session of the House, including any proposed resolutions to implement those results, and be it further **Resolved,** that the Board be urged to require the New Dentist Committee and the Committee on International Programs and Development to undertake a self-assessment, with reports to the Board, and to be included in the schedule applicable to councils and commissions, and be it further **Resolved,** any council which has undertaken a thorough self-assessment in 2013 as determined by the Board and reported on that self-assessment to the 2013 House of Delegates is exempted from the requirement to conduct a self-assessment in 2014, and be it further **Resolved,** that 118H-2002 (*Trans.2002:374*) be rescinded.

Similar to the self-assessment process of 2002, the Board of Trustees has requested that all Councils and Commissions complete a self-assessment report for the June 2014 meeting of the Board and the 2014 House of Delegates meeting in San Antonio, Texas. At its Winter 2014 meeting, the Commission on Dental Accreditation reviewed Resolution 1H-2013 and directed that an Ad Hoc Committee be formed to complete the CODA self-assessment. Members of the Ad Hoc Committee included the following Commissioners: Dr. Steven Schonfeld (chair), Dr. Denise Kassebaum, Dr. William Leffler, Dr. Mark Livingston, Ms. Kathi Shepherd, Dr. James Sherrard, and Dr. B.D. Tiner. The Ad Hoc Committee met on March 24, April 10, and April 21, 2014 to prepare the Commission's 2014 Self-Assessment. The self-assessment was approved by the Commission on Dental Accreditation in May 2014.

Commission on Dental Accreditation Self-Assessment: All Councils and Commissions were required to address the following six (6) areas and supporting questions:

1. Threshold Issues

a. State the primary value of your council or commission to a member.

The Mission of the Commission on Dental Accreditation states "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." The Vision statement of the Commission states "The Commission on Dental Accreditation will be a globally recognized leader for accrediting dental and dental related educational programs and will accomplish this by establishing quality standards that reflect the ever changing delivery of oral health care." The scope of the Commission on Dental Accreditation encompasses dental, advanced dental, and allied dental education programs.

The Commission is the only nationally recognized accrediting body for dentistry and the related dental fields. The Commission receives its authority as a programmatic accreditor by the United States Department of Education (USDE), a governmental agency. Accreditation agencies are required to petition for recognition every five years. In 2012 and 2013, the Commission participated in the USDE's re-recognition process, which included an extensive self-assessment and submission of a self-study document with supporting documentation that addressed the recognition criteria for accreditors. In July 2013, the Commission received re-recognition for a period of four (4) years with the following scope of recognition: "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 "Initial Accreditation" status, including programs offered via distance education."

The Commission on Dental Accreditation provides value to the membership of the American Dental Association, the dental community, students, and the public in a number of ways. The value of the Commission includes:

- Ensuring quality education programs in dental and dental related professions.
- Ensuring that skilled and knowledgeable members of the dental workforce graduate from programs that have achieved a nationally accepted level of quality as monitored through CODA accreditation
- Assuring that practitioners in dental and dental related professions have graduated from educational programs that reflect the state of the art of dentistry.
- Playing a unique role in protecting the safety of the public through accreditation standards that support educational requirements for entry to practice.
- Fostering the dental team concept by assuring that all dental and dental related educational programs are accredited by one agency with input from the profession.
- Providing meaningful and reliable data regarding the number and types of programs accredited across the country.

b. Should your council or commission continue to exist? If not, why?

The Commission on Dental Accreditation should continue to exist. As the only nationally recognized accreditation agency for dental and dental related education programs, there would be a profound impact on the profession and dental education if the Commission on Dental Accreditation ceased to exist. The negative impact may include:

- A potential fragmenting of the concept of the "dental team" which is currently served through accreditation under the auspices of one organization.
- The compromise of professional self-regulation of educational requirements. The profession may have a limited role in developing accreditation standards and assessing the continued quality of educational programs.
- The influence of outside interest groups with limited knowledge of the profession and dental education, through attempts to initiate dental and dental related accreditation activities and influence the standards of dental education.
- Diminished protection of the public, students, and profession.
- Outside influence from individuals not associated with the dental profession (e.g. federal government, state legislature, other health related interest groups) in scope of practice issues.

c. Is your council or commission effective in carrying out its bylaws authority? If not why?

In accord with the *Bylaws* of the American Dental Association, the duties of the Commission on Dental Accreditation shall be to:

- Formulate and adopt requirements and guidelines for the accreditation of dental educational and dental auxiliary educational programs.
- Accredite dental educational and dental auxiliary educational programs.

- Provide a means for appeal from an adverse decision of the accrediting body of the Commission to a separate and distinct body of the Commission whose membership shall be totally different from that of the accrediting body of the Commission.
- Submit an annual report to the House of Delegates of this Association and interim reports, on request, and the Commission's annual budget to the Board of Trustees of the Association.
- Submit the Commission's articles of incorporation and rules and amendments thereto to this Association's House of Delegates for approval by majority vote either through or in cooperation with the Council on Dental Education and Licensure.

The Commission on Dental Accreditation has a long history of effectively carrying out its bylaws authority to formulate and adopt requirements and guidelines for accreditation of dental education programs and provide accreditation services to these programs. Success is evidenced through the Commission's continued recognition by the USDE as the national accrediting agency for dental and dental related educational programs.

Additionally, the Commission provides extensive due process opportunities for programs, including the opportunity to appeal adverse decisions of the accrediting body. In 2010, the Commission submitted revisions to the ADA House of Delegates to address changes in recognition criteria of the USDE. At that time, the Commission similarly modified its appeal board process to ensure continued compliance with changing USDE regulations.

The Commission provides annual reports to the ADA House of Delegates, provides updates to the Council on Dental Education and Licensure at its semiannual meetings, provides a report to each June meeting of the ADA Board of Trustees, and provides ongoing communication to its communities of interest through its website and online newsletter.

The Commission prepares and submits an annual budget to the ADA Board of Trustees as prescribed by the budget process of the Association. In accord with the ADA *Bylaws*, the Commission submits changes to its Rules to the ADA's House of Delegates for approval either through or in cooperation with the ADA's Council on Dental Education and Licensure.

The Commission on Dental Accreditation will propose a change to the Commission's *Rules* and the ADA's *Standing Rules for Councils and Commissions* regarding the nomenclature used for one organization appointing the postdoctoral general dentistry representative; specifically, substituting "American Association of Hospital Dentists" with the "Special Care Dentistry Association."

The Commission will also propose a change to the ADA *Bylaws* to reflect contemporary terminology used for dental and dental-related professions. The proposed changes are noted below:

Bylaws of the American Dental Association, the duties of the Commission on Dental Accreditation shall be to:

- f. Formulate and adopt requirements and guidelines for the accreditation of dental, advanced dental educational and dental auxiliary allied dental educational programs.
- g. Accredit dental, advanced dental, educational and dental auxiliary allied dental educational programs.

Further, the Commission, through its Standing Committee on Quality Assurance and Strategic Planning, will continue to assess CODA's effectiveness and long-term strategic goals as they relate to the current *Bylaws* structure of the American Dental Association. Proposed changes may be forwarded to the ADA House of Delegates at a future date.

d. What are the top three goals to be accomplished by your council or commission annually? How are these related to member value? How successful has your council or committee been with respect to these goals?

The Commission on Dental Accreditation's top three goals:

1. Foster educational excellence, support programmatic self-improvement and assure the general public of the ongoing quality of dental education through a nationally accepted and United States Department of Education (USDE) recognized accreditation program.
2. Enhance communication between the Commission on Dental Accreditation and its communities of interest.
3. To enhance fiscal responsibility within the Commission and position the Commission to continue to be a recognized leader for accreditation of dental and dental related education programs.

Goal #1: The Commission on Dental Accreditation (CODA) is the national accrediting agency for dentistry and dental related fields recognized by the USDE. The Commission has maintained ongoing USDE recognition since the first recognition list was published in 1952. The CODA is responsible for the accreditation activities for all dental and dental-related education programs in the U.S. Through the Commission's accreditation process, students are assured the necessary educational preparation to meet state board and certifying board licensure/certification requirements. The Commission on Dental Accreditation provides a critical service to the public and profession, protecting public health by providing assurance to state boards, certifying boards, and the public that the educational programs which the Commission accredits have met nationally accepted standards for education and accreditation. In order to be licensed, individuals must be graduates of a Commission-accredited educational program. When accreditation standards are revised, key stakeholders are notified and accepting of the changes due to the credibility of the Commission on Dental Accreditation.

Goal #2: The Commission continues to strive to enhance communication with its communities of interest. In 2010, the Commission established a Standing Committee on Communication and Technology. Since its establishment, the Standing Committee has worked to enhance communication with the ADA membership as well as other communities of interest of the Commission. In 2012, the Commission conducted a Communications Plan Survey of ADA Members and other communities of interest to gauge overall perceptions of the Commission's communication activities, including areas of strength and weakness. As a result of the communication survey, in Summer 2013 the Commission adopted a communication plan. The Commission views the communication activities as an ongoing priority with emphasis on enhanced communication through the Commission's *CODA Communicator* newsletter, restructuring the Commission's website to enhance utilization, and increasing touch points for interaction with the communities of interest through webinar trainings, for example.

Goal #3: The Commission has worked diligently in the past few years to increase fiscal responsibility within the agency. At the 2010 ADA annual session, the House of Delegates endorsed the 50-50% split with the Commission for expenses, achieved through a 7.2% increase in annual fees per year for six years. For 2011, the CODA-ADA expense ratio was 53%-47%. With the approved increase in annual fees, application fees, and other fees assessed by the Commission, the Commission noted that in 2014 it would assume responsibility for approximately 95% of its direct expenses and 69% of its total expenses. With budget projections for 2015, the Commission expects to assume responsibility for 100% of its direct expenses and 84% of indirect expenses (using the current ADA formula for indirect expenses at 37.5%).

e. How do you define/measure success for the council or commission annually?

The Commission on Dental Accreditation uses several success measures. The Commission's operational goals serve one important measure for success. In 2013, the Commission initiated strategies delineated in its communication and strategic plans, including development of a

Memorandum of Understanding with the ADA. The Commission conducts approximately 150-200 accreditation site visits annually and reviews feedback on the site visit process from programs and site visitors. Implementation of Commission directives through CODA's standing committees provides a measure of success for the agency. Further, through the Commission's Standing Committee on Quality Assurance and Strategic Planning (QASP), the Commission will assess its effectiveness in attaining strategic goals and objectives. The QASP is currently developing a monitoring tool and success measures to track continuous progress toward meeting the objectives of the Commission's strategic plan. Finally, ongoing compliance with the United States Department of Education's criteria for recognition and continuous benchmarking of the Commission against similar accreditors provide additional measures to determine CODA's success.

2. Structure

a. Should your council or commission be skills based, or elected at large?

The Commission on Dental Accreditation membership is and should remain both skills based and elected. The Commission relies heavily on the skills and content expertise of its members to fulfill the mission of CODA. The members of the Commission serve in various capacities; the Commission has specific nomination and appointing requirements for its positions. The Commission consists of the CODA Board, fourteen (14) Review Committees, Standing or Ad Hoc Committees, and the Appeal Board.

The Commission's thirty (30) member Board of Commissioners represents a broad community of interest. Members of the Board are appointed by sponsoring organizations in dentistry and the Commission. The Commission's membership includes four (4) members appointed by the American Dental Association, four (4) members appointed by the American Association of Dental Boards, four (4) members appointed by the American Dental Education Association, one (1) certified dental assistant selected by the American Dental Assistants Association, one (1) licensed dental hygienist selected by the American Dental Hygienists' Association, one (1) certified dental laboratory technician selected by the National Association of Dental Laboratories, one (1) student selected jointly by the American Student Dental Association and the Council of Students of the American Dental Education Association, one (1) dentist for each ADA recognized dental specialty who is board certified in the respective special area of practice and is selected by the respective specialty sponsoring organization, one (1) dentist representing postdoctoral general dentistry who is jointly appointed by the American Dental Education Association and the American Association of Hospital Dentists (now known as the Special Care Dentistry Association) and four (4) consumers who are neither dentists nor allied dental personnel nor teaching in a dental or allied dental education institution and who are selected by the Commission, based on established and publicized criteria. A member of the Standing Committee on the New Dentist (when assigned by the ADA Board of Trustees) and the Director of the Commission are *ex-officio* members of the Commission without the right to vote. The Commission Board membership is found in Appendix 2a.

The Commission also consists of fourteen (14) standing Review Committees that are advisory to the Commission. The Commissioner in each discipline area serves as chair of the respective review committee. Review committee members are appointed by the Commission. Sponsoring dental organizations are requested to submit names of nominees who have both knowledge and skill in the respective discipline. The review committee structure, composition and current membership is found in Appendix 2b.

The Commission includes five (5) Standing Committees and four (4) Ad Hoc Committees. Membership of the Standing Committees is composed of current Commissioners. Ad Hoc committee membership may include Commissioners or other individuals appointed for their knowledge, skills, or expertise. Appendix 2c lists the function of each Standing Committee as well as the membership of each Standing and Ad Hoc Committee.

Finally, the Appeal Board consists of four (4) permanent members: one (1) representative selected by the American Dental Association, one (1) representative selected by the American Association of Dental Boards, one (1) representative selected by the American Dental Education Association and one (1) consumer representative selected by the Commission on Dental Accreditation. Representatives from allied or advanced education areas may also be included on the Appeal Board, depending on the nature of the appeal. Appeal Board members do not concurrently serve on the Commission. The Appeal Board is an autonomous body, separate from the Commission. The composition of the Appeal Board is found in Appendix 2d.

b. Do you have an agenda that enables strategic discussion to the extent you would like?

The meetings of the Commission on Dental Accreditation include extensive discussion on program accreditation, as well as review of accreditation standards and Commission policy. The Commission on Dental Accreditation conducts two, 1.5-day meetings each year. The Commission has a full agenda for each meeting. Each CODA meeting begins with a closed (confidential), one-half day session in which the Commission takes accreditation actions on approximately 250-300 dental and dental-related education programs. Additionally, in the subsequent one-day open (public) session, the Commission considers reports from its fourteen (14) Standing Review Committees on dental education, its five (5) Standing Committees, and any additional ad hoc committees of the Commission. The Commission also considers items brought only before the Commission either as new items for discussion or items that require ongoing consideration.

There are two areas where the Commission could improve to enhance strategic discussion during its meetings. First, the Commission should trust that the individuals who serve on the dental education review committees and standing committees have done due diligence in review of accreditation matters brought before them. These committees are advisory to the Commission, and the Commission makes the final accreditation decisions based upon recommendations of these committees. During review reports, the Commission often spends too much time editing the work of its committees.

The second area for improvement focuses on the length of the Commission meeting. In the past, the Commission meetings were two full days, which appeared to allow more time to engage in strategic discussions and long-term planning for the Commission. The Commission's workload and complexity of issues has increased over the past several years. The Commission may wish to consider another structure for its meetings, including but not limited to increasing the meeting length back to two full days or conducting business electronically on an on-going basis rather than primarily at two in-person meetings.

c. Do you have the optimal number of members to conduct business well and efficiently?

As stated earlier, the Commission on Dental Accreditation consists of a 30-member Board of Commissioners. Discipline-specific Commissioners also serve as chair of the Commission's fourteen (14) education Review Committees. Commissioners may also serve on one of the Commission's five (5) standing committees or the Commission's ad hoc committees. In addition to the Commissioners, CODA utilizes 82 volunteers to serve on Review Committees and approximately 550 volunteers to serve as site visit evaluators.

The current complement of volunteers utilized by the Commission is sufficient to conduct the business of this agency. While the 30-member Commission may be considered large when compared to other accrediting agencies, the Commission accredits a broader scope of dental and dental related education program when compared to other accrediting agencies. As a result, it is important that the Commission include sufficiently broad representation and input from a wide community of interest in the dental and dental related community to ensure adequate peer involvement and inclusivity in the accreditation process, including the development of policies and standards for dental education accreditation.

Separate from the Board of Commissioners, CODA has an Appeal Board that consists of four (4) permanent members of the Appeal Board: one (1) representative selected by the American

Dental Association, one (1) representative selected by the American Association of Dental Boards, one (1) representative selected by the American Dental Education Association and one (1) consumer representative selected by the Commission on Dental Accreditation. Representatives from allied or advanced education areas may also be included on the Appeal Board, depending on the nature of the appeal. Appeal Board members do not concurrently serve on the Commission.

As noted in the 2008 Final Report of the ADA Task Force on the Commission on Dental Accreditation, "Research indicated expected increases in the number of dental related and advanced practice programs, as well as potential changes in practice scope and increases in the number of international programs applying for international accreditation, which may increase the workload of CODA." The Commission's Standing Committee on Quality Assurance and Strategic Planning (QASP) is currently considering a Policy on Changes to the Composition of Review Committees and the Board of Commissioners, which will provide guidelines and procedures by which the Commission may expand or restructure its composition. Further, as part of the Commission's strategic plan, CODA will conduct a comparative analysis study to benchmark financial and operating ratios of the Commission to ensure current and future resources are sufficient to support CODA in meeting its mission. Results of this study will be discussed to determine whether the Commission should consider a revised structure to allow more efficient business practices.

d. Is the manner of member selection ideal (e.g. geographic vs. skills based)?

Commission on Dental Accreditation volunteer membership consists of four categories: 1) Commissioners, 2) Appeal Board Members, 3) Review Committee Members, and 4) Consultants/Site Visitors. Because of the complexity of the work of the Commission, this agency expects that members who serve as volunteers will have suitable skills and expertise to perform the required duties in order to carry out the Commission's mission. In all cases, the Commission encourages organizations to consider appointments and nominations of under-represented racial and ethnic groups and women, and makes every effort to achieve a pool of volunteers with broad geographic diversity. The current processes for member selection allows for input from varied communities of interest.

The *Rules* of the Commission on Dental Accreditation dictate the membership composition requirements of the Board of Commissioners and the Appeal Board. With both groups, the Commissioner or Appeal Board Member is appointed to the Commission by the respective sponsoring organization that represents the discipline. The Commission appoints public members to the Board of Commissioners and Appeal Board. The criteria for appointment to these two positions are prescribed in the *CODA Rules*, and may be supplemented by the sponsoring organization. In many cases, the sponsoring organization appoints an individual with both technical expertise in the discipline and experience in dental or dental related education.

Review Committee members are appointed to the Commission through the Standing Committee on Nominations. Review Committee positions not designated as specialty or discipline specific are appointed by the Commission. Specialty or discipline specific positions on Review Committees are filled by appointment by the Commission of an individual from a small group of qualified nominees (at least two) submitted by the relevant national organization, specialty organization or certifying board. Appendix 2b provides a detailed description of the various Review Committee composition requirements.

Finally, the Commission uses site visitors with education and practice expertise in the discipline or areas being evaluated to conduct its accreditation program. Nominations for consultants/site visitors and other consultants are requested from national dental and dental-related organizations representing the areas affected by the accreditation process. The Commission reviews nominations with subject matter expertise received from each specialty organization and certifying board. Individuals may also self-nominate. The Criteria for Nomination of Consultants/Site Visitors is found in Appendix 2e.

e. Do you have the right number of committees and members on committees? Should you use standing committees or ad hoc task forces?

The Commission on Dental Accreditation consists of a 30-member Board of Commissioners, fourteen (14) education Review Committees, five (5) standing committees, ad hoc committees, and an Appeal Board.

In 2010, the Commission restructured its standing committees to the current five based upon the changing needs of the Commission. The current number of standing committees and ad hoc committees adequately serve the needs of the Commission. The composition of these committees is approved on an annual basis by the chair of the Commission and includes membership that is representative of the Commission as a whole.

The Commission's Review Committees were restructured in 2006. The composition of each Review Committee was modified to include public members, general dentists, and an adequate number of content experts based upon the workload issues of the committee. Review Committees may request that the Commission expand membership based upon increasing workload issues. Since initial restructuring, several Review Committees have increased membership to accommodate increased workload.

At this time, the Commission has the correct number of committees and members on committees. The Commission continues to monitor trends in dental education to address future needs in this area. As noted previously, the Commission's Quality Assurance and Strategic Planning Committee is in the process of developing a policy on expansion or restructure of the Review Committee or Commissioner composition within the CODA.

f. Would a task force structure as opposed to a council structure be better? Worse?

Due to the nature of its work and as the only nationally recognized accrediting agency for dental and dental related education programs, the Commission on Dental Accreditation must function as an autonomous agency with multiple layers of volunteer interaction. Best practices in accreditation require separation between site visit teams and the decision making body granting the accreditation status to programs. As such, the Commission's structure, which includes site visitors, Review Committees, the Commission, and an Appeal Board serves the Commission's needs as well as the needs of the accreditation program and community this agency serves. The current structure of the Commission has been approved by the United States Department of Education (USDE). Modification to the structure that results in changes to the decision-making authority of the agency must be reported to and approved by the USDE.

3. Efficiencies

a. Is the decision making process efficient? If not why?

The Commission's decision making process can be viewed through two lenses; efficiency in access to data and efficiency in conducting meetings. First, decisions must be made based upon adequate and appropriate documentation and evidence. The Commission and its various sub-committees use a wide range of information to formulate decisions on accreditation matters, policy, and procedures. At the site visit level, the Commission's site visit teams utilize the Accreditation Standards, and Commission policies and procedures to assess program compliance with accreditation requirements. The format of site visit reports and consultant evaluation documents is standardized to provide a consistent framework on which review and analysis occurs. At the Review Committee level, Commission staff ensures that program reports and accreditation materials adhere to required formatting and documentation guidelines. Review Committees also use the Standards and CODA policies in decision making. This assures a consistent review by the Review Committee. Similarly, at the Commission level, materials are presented in a standardized format, with sufficient background information, to ensure that Commissioners have all the necessary materials to make informed decisions. Adequate resources are made available to Commissioners and Review Committee members to help these individuals manage their work. Additionally, through the use of technology, the Commission

publishes all meeting materials on ADA Connect, which has reduced the burden of paper files retained by the Commission and programs.

Second, efficiencies in the decision making process may be assessed through the method by which the Commission conducts its business during meetings. As noted previously, the Review Committees and standing committees of the Commission serve as advisory committees to the Commission which retains the ultimate decision making authority. One area of improvement recently identified by the Commission is the amount of time spent by the Commission in editing the work of its standing and Review Committees. To facilitate the work of the Commission in an efficient manner, the Commission should focus more on substantive issues rather than recreating the work of its standing and review committees.

b. How can you reduce the time spent by volunteers on your work, while still doing what needs to be done?

Volunteers drive the entire accreditation process, from setting accreditation standards, to on-site peer review of educational programs, to ultimately determining the accreditation status of educational programs. The Commission has reduced time spent by volunteers by providing materials electronically through ADA Connect, which enables volunteers to access the information as their schedules permit. The Commission's agenda and meeting materials are streamlined and hyperlinked to provide ease of access to the Commissioners. Additionally, increased training of volunteers, including the Commission's "Red Shirt" training year, one year prior to active appointment to the Commission has enabled Commissioners to observe the Commission's meeting and decision making process in order to understand how CODA functions, thereby reducing time for volunteers to complete their work. Finally, since some meetings of the Commission are a short duration (2-3 hours), the flexibility in conducting meetings by conference call allows volunteers to maximize their time on Commission work without having to expend additional time on travel or time out of the office.

c. Do you meet in person enough? Too much? Too little?

The meeting schedule and modality currently meet the needs of the Commission and its subcommittees. The Commission on Dental Accreditation and its education Review Committees meet twice per year. These meetings occur in Winter (January/February) and Summer (July/August). Based upon workload, the Commission's Review Committees may meet in person at the Chicago headquarters or by telephone conference call. The staff of the Commission works with the Review Committee chair to determine the most suitable forum for each meeting. The Commission's meetings are always held at the Chicago headquarters building. When the Commission needs to consider a matter between meetings, the Commission fully utilizes the mail ballot option to conduct its work through ADA Connect. Mail ballots may be required for important matters that must be handled swiftly, such as a review of a complaint against a program. Additionally, the standing committees of the Commission conduct meetings by telephone conference call on an as needed basis. Some standing committees meet one to two times per year, while others meet every six (6) weeks. The use of technology such as ADA Connect, and webinar and conference call capabilities allow the Commission to stay well connected and conduct business using the most appropriate tools available.

d. What work done by volunteers could be handled by staff?

There is no work completed by volunteers that could be handled by staff. Volunteers and staff of the Commission have very distinct roles. The accreditation program must be a peer-review process; therefore, decisions of the Commission must be made by peer volunteers. Recommendations, as defined by the role of the volunteer, are made directly to the Commission. The Commission retains the final decision making authority for this agency. Separate to this authority, the Appeal Board has independent authority over the appeal process. Volunteers of the Commission on Dental Accreditation are not overburdened by unnecessary activities or Commission work that could be handled by staff.

Staff of the Commission on Dental Accreditation does not have decision making authority within the Commission. The Commission staff does an excellent job of providing resources and appropriate guidance on accreditation matters. The staff also serves as a resource to programs and the general public related to questions about accreditation processes or program accreditation status, for example.

e. Are issues brought to your council in an efficient or appropriate manner?

Accreditation matters must be managed in a reasonable amount of time and with minimal delay; therefore, issues are brought before the Commission in an efficient and appropriate manner. The Commission and its Review Committees meet twice per year. Reports related to accreditation site visits that occur from May 1 through October 31 are considered by the Commission at its Winter meeting, while reports of site visits that occur November 1 through April 30 are considered by the Commission at its Summer meeting. Other types of program reports are considered at the next regularly scheduled meeting of the Commission based upon the Commission prescribed policies and procedures for the conduct of program reports. Similarly, policy items are placed on the Review Committees' and Commission's next meeting agendas following their submission to the Commission office. Commission staff works closely with the Review Committee chairs related to these matters. The Director of the Commission works with the CODA chair and vice chair on matters for the Commission as a whole. Items that are urgent are considered between meetings via a mail ballot process.

f. Are you provided with sufficient information to address and decide issues?

The Commission and its committees have sufficient information to address and decide issues. Commission staff prepares agenda materials for review by the Commission's Review Committees and the Commission. Policy reports are prepared to ensure that sufficient historical background information is provided on the topics, along with the present issues for which the Commission will need to make decisions. Program materials are presented using a prescribed system by which the program materials and Commission materials are submitted to CODA volunteers for review and decision. When standing committee materials are prepared, the Commission staff works with the chair of the standing committee to ensure a sufficient amount of information is provided. Should more information be requested on a particular topic, staff quickly retrieves the information and forwards it to the Commission volunteers.

g. Is the discussion of issues efficient and effective?

Commission discussions are effective. Based upon the makeup of the Commission, its Review Committees, Standing Committees, and the Appeal Board, there is a wide representation of varying communities of interest. This wide scope of representation of the dental education community assures the Commission of conducting a comprehensive, thorough and effective assessment of all issues that come before the agency. Decisions of this agency are well thought out. Input is sought from communities of interest through open hearings on accreditation standards. The Commission may also refer items to its Review Committees or Standing Committees for further study and analysis prior to the Commission taking final action.

The Commission can improve on efficiency of its decision making process. As stated earlier, the Review Committees and Standing Committees of the Commission are advisory to this agency. These committees conduct an extensive review of issues brought before them prior to making recommendations to the Commission for final action. The Commission could enhance its efficiency by entrusting the Review Committees and Standing Committees to perform due diligence and by not repeating the extensive work conducted by these committees through editorial work which may have limited additional benefit to the final outcome. Upcoming training of new Commission volunteers will emphasize this philosophy.

h. Are there matters left to the council or commission that should be handled by a smaller group?

The current structure of the Commission on Dental Accreditation is appropriate. All matters before the Commission which should be examined by a smaller group are forwarded to Review

Committees and Standing Committees of the Commission. The fourteen (14) dental education Review Committees and five (5) Standing Committees of the Commission address matters related to a specific discipline or topic. These committees serve in an advisory role to the Commission and conduct detailed and extensive analysis of topics that are brought before the Commission. Ad hoc committees are created by the Commission, as necessary, to study issues that will require one-time review. The Commission should retain final decision making authority as the nationally recognized accrediting agency for dental and dental related programs. In the future, as the dental profession and dental education changes, the Commission may consider a revised structure model to allow more efficient business practice.

i. Do you effectively use conference calls and web-based meeting time? Can you do so more or better?

The Commission makes full and effective use of the technology resources available to the agency. There are no further improvements to be made related to the Commission's current use of technology to conduct meetings. All meeting materials for all committees and the Commission are placed on ADA Connect. Depending upon workload issues, the Review Committees of the Commission conduct meetings by telephone conference call or in person. Generally, the predoctoral, allied, and postdoctoral general dentistry review committees meet in person while the nine (9) specialty education review committees generally meet once per year by teleconference and once in person. Alterations to the modality for meetings can be modified based upon the specific needs of the committee. Commission staff works with the committee chair to establish the meeting forum. All standing committees of the Commission meet by telephone. Additionally, any business conducted between meeting cycles by the Commission or one of its Review Committees is conducted using technology. Due to the nature of the appeal process, meetings of the Appeal Board would be conducted in person.

j. Are you aware of the staff time devoted to your activities? Can that staff time be directed to other activities?

The Commission is well aware of the amount of time that Commission staff expends on the activities of the Commission. The activities of Commission staff are essential to the Commission and cannot be directed to other activities. Commission staff serves as the liaison between the Commission and the communities of interest. Staff guides programs on the requirements for submission of reports, reporting program changes, and other accreditation matters. Staff serves as a resource and liaison to the various communities of interest on behalf of the Commission. Commission staff directly supports the activities of all Commission Review Committees, Standing Committees and the Commission as a whole. Staff additionally provides training to all Commission volunteers through multiple training programs throughout the year. The staff of the Commission spends a significant amount of time to ensure the activities of the Commission adhere to best practices in accreditation.

k. Is your staff support sufficient?

Support is sufficient given the current number of staff within the Commission. However, the Commission believes that the number of staff dedicated to this agency is insufficient to support long term growth and sustainability of this agency. At least one additional full-time staff position is needed within the Commission on Dental Accreditation.

In the past ten (10) years, the Commission has reduced its manager-level staff by two, with the most recent reduction of one manager position in 2012. At the same time, the workload of the Commission has increased while staff positions have decreased. The number of accredited programs has increased from 1,338 in 2006 to 1,452 in spring 2014, an increase of 114 programs. The complexity of the dental education system, changes in educational delivery models, and changes in higher education require staff to provide more assistance to programs than ever before. Since 2006, the Commission has staffed the Joint Advisory Committee on International Accreditation (JACIA) as a joint committee between the American Dental Association and Commission that provides consultation to international dental education programs seeking accreditation by the Commission. In 2007 the Commission began to accredit

advanced general dentistry education programs in oral medicine and dental anesthesiology. In 2010, the Commission began to accredit advanced general dentistry education programs in orofacial pain. The Commission previously requested but was not approved for a communications staff position to enhance communications with the communities of interest, as recommended in the Report of the ADA Task Force on the Commission on Dental Accreditation. None of these activities, which resulted in an increased workload led to an increase in staff support. The heavy workload could be one factor that has led to a high turnover of staff in the past. The Commission has requested an additional full-time staff position be added to the 2015 operating budget. Appendix 2f provides information on the current composition of Commission staff and the number of programs accredited 2006-2014.

4. Areas of Responsibility

a. Based on a review of the bylaws, should some responsibilities be placed elsewhere or discontinued?

As noted in the *Bylaws*, the Commission is duty-bound to formulate and adopt requirements and guidelines for accreditation of programs, operate an accreditation process for dental and dental related programs, and provide a means for appeal from adverse decisions of the accrediting body. Administratively, the Commission must also provide an annual report to the House of Delegates of the American Dental Association, submit its annual budget to the Board of Trustees, and submit articles of incorporation and Rules and amendments thereto to the House of Delegates. Based on a review of the Bylaws, no responsibility should be placed elsewhere, nor should any responsibility of the Commission be discontinued. The Commission on Dental Accreditation serves as the only nationally recognized accrediting body for dentistry and the related dental fields. The Commission receives its accreditation authority from acceptance of the dental community and by being recognized by the United States Department of Education. Responsibilities of the Commission on Dental Accreditation cannot be placed with another agency or discontinued.

b. Are you addressing each area of responsibility? If not, should you, or should you change the bylaws?

The Commission fully addresses each area of responsibility within the *Bylaws*. However, one area of concern is the Commission's inability to amend its *Rules* or fully manage its budget. The Commission is unable to move efficiently when changes to the *Rules* are necessary, because the Commission must obtain approval from the House of Delegates prior to making changes to its *Rules*. For example, the Commission changed the name "American Association of Hospital Dentists" to "Special Care Dentistry Association" in all of its materials in January 2014 to reflect the name change adopted by that organization; however, CODA is unable to change this nomenclature in its *Rules* until the House of Delegates approves the change in October 2014. This process is cumbersome and inhibits CODA's ability to maintain current procedures and protocols. Similarly, if the Commission approves funding for a new project or study, it must request funds through the House of Delegates for the next calendar year; funds are typically not available for the current calendar year beyond those previously budgeted over one year in advance. The Commission recently initiated a Research and Development Fund to collect a nominal fee from programs which would support research projects and other activities not budgeted in a particular calendar year. While the Commission has established a disbursement policy and procedure for the Research and Development Fund, CODA must report to and gain approval from the ADA Board of Trustees prior to accessing these funds.

c. Can your responsibilities be consolidated with those of another entity or be done better by another entity?

The Commission on Dental Accreditation is a unique agency within the American Dental Association as the only nationally recognized accrediting agency for dental education programs. Since the Commission holds its authority as an accrediting body through the United States Department of Education, there is no other agency within or outside the ADA that should assume

the responsibilities of the Commission. The Commission's responsibilities cannot be consolidated beyond the current structure of the Commission, its committees, appeal board, and staff support.

5. Agenda Review: As you consider a self-assessment, use your agenda as a tool in the assessment:

a. Is each item an efficient use of your time?

Each item on the Commission's agenda as well as the agendas of its fourteen (14) Review Committees and five (5) standing committees is important. These agenda items relate to the accreditation of programs, consideration of accreditation standards, or adoption of policy. While the items themselves are important, the manner in which the Commission considers some agenda items could be more efficient. As noted previously, the Commission considers between 250-300 accreditation status actions on programs. These programs are considered in closed session of the Commission meeting. Efficiencies are under consideration to enhance Commissioner access to these materials in advance of the Commission meeting. Additionally, the Commission will discuss its members' roles related to consideration of Review Committee and Standing Committee reports, so that the Commission is not repeating the work already completed by its subcommittees.

b. Which items can be handled in other ways—conference calls, consent, etc.?

The Commission maximizes its use of conference calls, consent calendars, webinars, and other forms of technology. Consent calendars are used in review of accreditation status actions for those programs that are without reporting requirements. Similarly, consent calendars are used for Review Committee reports that are informational only. Conference calls are used to facilitate the work of the Commission's Standing Committees and Review Committees, if workload permits this meeting format. Items that are retained on the Commission agenda for discussion are matters that require a dialogue among the Commissioners and final directive action from the Commission.

c. What are you doing which is "down in the weeds", operational as opposed to directional?

Most of the Commission's work focuses on directional strategies. The program accreditation reviews, accreditation standards revisions, and policy matters brought before the Commission, its Review Committees, and Standing Committees require a directional approach to move the Commission's accreditation program forward. As noted earlier in this report, the Commission has identified a weakness related to its review of work completed by standing committees and review committees. On occasion, the Commission may get "down in the weeds" of the work produced by its subcommittees when the focus should be on global initiatives that provide direction to the Commission based upon the work of its subcommittees. The Commission has discussed several opportunities to enhance efficiency of the meeting, particularly with regard to its review process for program accreditation statuses. The Commission also noted that enhanced training for Commissioners, specifically related to the work of subcommittees and the role of the Commissioner in reviewing reports, should be emphasized with current and incoming Commissioners.

d. What can you ask staff to take over?

The accreditation program must be a peer review process; therefore, the Commissioners should retain decision-making authority. There are no additional activities or duties that the Commission can ask staff to take over. It should be noted that the staff of the Commission currently provides as much oversight and guidance to the accreditation system as they are able, given their roles. Staff facilitates the day-to-day operations of the Commission, using the policies and procedures set forth by the Commission. Staff works diligently to provide consistency in the operation of accreditation program, appropriate background and materials for meetings, and support to the volunteers and communities of interest. Staff also works very closely with the chair of each committee to ensure that materials are available to the Commission volunteers. Staff are fully and appropriately utilized by the Commission to carry out the operational activities of this agency.

6. Are you spending time on big issues and strategic direction?

A large portion of the Commission's work focuses on big issues and strategic direction. As dental education and the profession evolve, the Commission must ensure that the accreditation program continues to meet the needs of the community through established accreditation standards and protocols for accreditation that represent the current state of the profession and best practices. Commission meetings often include policy matters related to evolving issues in dental education, for which a strategic direction is required by the Commission. Similarly, for the Commission to maintain its relevance in the accreditation community, CODA must focus on strategic directions and best practices. The Commission's Standing Committee on Quality Assurance and Strategic Planning ensures that the strategic direction of the Commission is in the forefront of the Commission's focus. This standing committee plans to facilitate in two large studies (a comparative analysis study and a technology needs assessment) to ensure that the Commission move forward with the most appropriate resources it needs to ensure the sustained quality and excellent reputation that the Commission currently enjoys.

Appendix 2a. 2014 Commission on Dental Accreditation Membership Roster

2014 Commission on Dental Accreditation Membership Roster (Staff: Sherin Took)		
DATES OF MEETINGS January 29-30, 2014 July 31-August1, 2014		
MEMBER	APPOINTED BY	TERM EXPIRES
*Williams, John (Chair)	ADEA	2014
Benson, Byron "Pete"	AAOMR	2015
Burr, Kristi	Public	2014
Campbell, Steven	ACP	2017
Cangialosi, Thomas	AAO	2015
Dodge, William	ADEA	2015
Donly, Kevin	AADP	2015
Gagliardi, Lorraine (Lori)	ADAA	2016
Giasolli, Robert	Public	2014
Glicksman, Milton	AADB	2016
Greenwell, Henry	AAP	2014
Kahn, Richard	ADA	2016
Kassebaum, Denise	ADEA	2017
Kolstad, Jospeh	ASDA	2015
Lanier, Dennis	NADL	2017
Leffler, William	AADB	2014
Livingston, Harold (Mark)	AAHD/ADEA	2017
Mascarenhas, Ana Karina	AAPHD	2016
Neville, Brad	AAOMP	2014
Royeen, Charlotte	Public	2015
Schindler, William	AAE	2016
Shepherd, Kathi	ADHA	2015
Sherman, Robert	AADB	2017
Sherrard, James	Public	2015
Schonfeld, Steven (Vice-Chair)	ADA	2014
Surabian, Stanley	ADA	2017
Tiner, B.D.	AAOMS	2017
Torrez-Nazario, Ivan	AADB	2015
Tuneburg, Perry	ADA	2015
West, Karen	ADEA	2016

2014 Commissioner Trainees (Term 2015-2018)		
MEMBER	APPOINTED BY	TERM EXPIRES
Blanton, Patricia	ADA	2018
Leffler, William	AADB	2018
Lerman, Mark	AAOMP	2018
Lobb, William	ADEA	2018
Mills, Michael	AAP	2018
Stergar, Cindy	Public	2018
Wheeler, Matthew	Public	2018

Appendix 2b. Review Committees

1. **Structure:** The chairperson of each Review Committee will be the appointed Commissioner from the relevant discipline.
 - i. The Commission will appoint all Review Committee members.
 - a. Review Committee positions not designated as specialty or discipline specific will be appointed from the Commission where feasible, e.g. a public representative on the Commission could be appointed to serve as the public member on the Dental Laboratory Technology Review Committee; an ADA appointee to the Commission could be appointed to the Dental Assisting Review Committee as the general dentist practitioner.
 - b. Specialty or discipline specific positions on Review Committees will be filled by appointment by the Commission of an individual from a small group of qualified nominees (at least two) submitted by the relevant national organization, specialty organization or certifying board. Nominating organizations may elect to rank their nominees, if they so choose. If fewer than two (2) qualified nominees are submitted, the appointment process will be delayed until such time as the minimum number of required qualified nominations is received.
 - ii. Consensus is the method used for decision making; however if consensus cannot be reached and a vote is required, then the Chairperson may only vote in the case of a tie (per Sturgis, Standard Code of Parliamentary Procedure).
 - iii. Member terms will be staggered, four year appointments; multiple terms may be served on the same or a different committee, with a one-year waiting period between terms. A maximum of two (2) terms may be served in total.
 - iv. One public member will be appointed to each committee.
 - v. The size of each Review Committee will be determined by the committee's workload.
 - vi. As a committee's workload increases, additional members will be appointed while maintaining the balance between the number of content experts and non-content experts. Committees may formally request an additional member through New Business at Review Committee/Commission meetings. If an additional member is approved, this member must be a joint nomination from the professional organization and certifying board, as applicable.
 - vii. Conflict of interest policies and procedures are applicable to all Review Committee members.
 - viii. Review Committee members who have not had not been on a site visit within the last two (2) years prior to their appointment on a Review Committee should observe at least one site visit within their first year of service on the Review Committee.
 - ix. In the case of less than 50% of discipline-specific experts available for a review committee meeting, for specified agenda items or for the entire meeting, the Review Committee Chair may temporarily appoint an additional discipline-specific expert(s) with the approval of the CODA Director. The substitute should be a previous Review Committee member or an individual approved by both the Review Committee Chair and the CODA Director. The substitute would have the privileges of speaking, making motions and voting.
 - x. Consent agendas may be used by Review Committees, when appropriate; however, more than 50% of the discipline-specific members must be present to evaluate the consent agenda.

Revised: 1/14, 2/13, 8/10, 7/09; 7/08; 7/07; Adopted: 1/06

2. Composition

Predocutorial Education Review Committee (7 members)

- 1 discipline-specific Commissioner appointed by American Dental Education Association
 - 1 public member
 - 2 dental educators who are involved with a predoctoral dental education program (one of whom is a general dentist)
 - 1 general dentist
 - 1 specialty dentist
 - 1 dental assistant, hygienist, or dental laboratory technology professional educator
- } (One of whom is a practitioner and the other an educator)

Three (3) Advanced Specialty Education Review Committees (DPH, OMP, OMR) (5 members each. At least one member must be a dental educator.)

- 1 discipline-specific Commissioner appointed by specialty sponsoring organization
- 1 public member
- 1 specialty organization representative
- 1 specialty certifying board representative
- 1 general dentist

Six (6) Advanced Specialty Education Review Committees (ENDO, OMS, ORTHO, PERIO, PED, PROS) (6 members each. At least one member must be a dental educator.)

- 1 discipline-specific Commissioner appointed by specialty sponsoring organization
- 1 public member
- 1 specialty organization representative
- 1 specialty certifying board representative
- 1 specialty certifying board or specialty organization representative
- 1 general dentist

Postdoctoral General Dentistry Education Review Committee (12 members. At least one member must be a dental educator)

- 1 discipline-specific Commissioner, jointly appointed by American Dental Education Association (ADEA) and Special Care Dentistry Association (SCDA)
- 1 public member
- 2 current General Practice Residency (GPR) educators nominated by the SCDA
- 2 current Advanced Education in General Dentistry (AEGD) educators nominated by ADEA
- 1 oral medicine educator nominated by the American Academy of Oral Medicine
- 1 dental anesthesiology educator nominated by the American Society of Dentist Anesthesiologists
- 1 orofacial pain educator nominated by the American Academy of Orofacial Pain
- 1 general dentist graduate of a GPR or AEGD
- 1 specialty dentist
- 1 higher education or hospital administrator with past or present experience in administration in a teaching institution

Dental Assisting Education Review Committee (10 members. At least one member must be a dental educator)

- 1 discipline-specific Commissioner appointed by American Dental Assisting Association
- 1 public member
- 2 general dentists (practitioner or educator)
- 5 dental assisting educators
- 1 dental assisting practitioner who is a graduate of a Commission accredited program

Dental Hygiene Education Review Committee (11 members. At least one member must be a dental educator)

- 1 discipline-specific Commissioner appointed by American Dental Hygiene Association
- 1 public member
- 4 dental hygienist educators
- 2 dental hygiene practitioner
- 1 dentist (general or specialist)
- 1 dentist educator
- 1 higher education administrator

Dental Laboratory Technology Education Review Committee (5 members. At least one member must be a dental educator)

- 1 discipline-specific Commissioner appointed by National Association of Dental Laboratories
- 1 public member

- 1 general dentist
 1 dental laboratory technology educator
 1 dental laboratory owner nominated by National Association of Dental Laboratories
 Reaffirmed: 8/10; Revised: 2/13, 7/09, 7/08, 1/08; Adopted: 1/06

REVIEW COMMITTEE ON PREDOCTORAL DENTAL EDUCATION (Staff: Catherine Horan)		
DATES OF MEETINGS		
January 6-7, 2014		
July 7, 2014		
MEMBER	STRUCTURE CATEGORY	TERM EXPIRES
*Williams, John	(Commissioner-ADEA)	2014
D'Ambrosio, Joseph	Predoc educator	2017
Geurs, Nicolas	Specialty dentist (educator)	2016
Royeen, Charlotte	Public	2015
Titus, Marshall	General dentist (practitioner)	2014
Oberhaus, Stephanie	Predoc educator	2017
Mauriello, Sally	Allied educator	2014

* Committee Chair

REVIEW COMMITTEE ON POSTDOCTORAL GENERAL DENTISTRY EDUCATION		
(Staff: Peggy Soeldner)		
DATES OF MEETINGS		
January 9-10, 2014		
July 10-11, 2014		
MEMBER	STRUCTURE CATEGORY	TERM EXPIRES
* Livingston, Harold (Mark)	(Commissioner ADEA/AAHD)	2017
Tom, James	Dent Anes educator	2014
Futterman, Marlene	Public	2014
Coke, John	GPR educator	2015
Hicks, Jeffrey	Gen. dentist (AEGD/GPR grad)	2017
Ciancio, Sebastian	Specialty dentist	2014
Fedor, Kenneth	GPR educator	2016
Wong, Allen	AEGD educator	2017
Halligan, Timothy	AEGD educator	2016
Brennan, Michael	Oral med educator	2014
Young, Stephen	Higher ed/hosp administrator	2014
Gremillion, Henry	Orofacial Pain educator	2014

* Committee Chair

REVIEW COMMITTEE ON DENTAL ASSISTING EDUCATION		
(Staff: Patrice Renfrow & Alyson Ackerman)		
DATES OF MEETINGS		
January 9-10, 2014		
July 10-11, 2014		
MEMBER	STRUCTURE CATEGORY	TERM EXPIRES
*Gagliardi, Lorraine	(Commissioner ADAA)	2016
Stentiford, Deanna	DA educator	2014
Cronick, Cynthia	DA educator	2016
Friedman, Paula	General dentist	2016
Lepkoski, Donna	DA educator	2015
Roberts, Cathy	DA practitioner	2014

Faddoul, Fady	General dentist	2015
Campbell, Ethel	DA educator	2015
Kelber, Gene	Public	2014
Kracher, Connie	DA educator	2017

* Committee Chair

REVIEW COMMITTEE ON DENTAL HYGIENE EDUCATION (Staff: Patrice Renfrow & Alyson Ackerman)		
DATES OF MEETINGS January 7-8, 2014 July 8-9, 2014		
MEMBER	STRUCTURE CATEGORY	TERM EXPIRES
* Shepherd, Kathi	(Commissioner ADHA)	2015
Peterson, Melanie	Higher ed administrator	2014
Grimes, Ellen	DH educator	2015
Rogalski, Alan	Public	2015
Austin, Lynn	DH Educator	2014
Tuneberg, Perry (Commissioner)	Dentist (General or Specialist)	2015
Jones, James	Dentist Educator	2015
Duley, Susan	DH educator	2014
Dixon, Barbara	DH practitioner	2014
Breen, Carolyn	DH educator	2016
Haldemann, Karen	DH practitioner	2016

* Committee Chair

REVIEW COMMITTEE ON DENTAL LABORATORY TECHNOLOGY EDUCATION (Staff: Patrice Renfrow & Alyson Ackerman)		
DATES OF MEETINGS January 6, 2014 July 7, 2014		
MEMBER	STRUCTURE CATEGORY	TERM EXPIRES
* Lanier, Dennis	(Commissioner NADL)	2017
Budny, Renata	DLT educator	2017
McClemens, Charles	DLT owner	2014
vacant	Public	2017
Bender, Steven	General dentist	2016

* Committee Chair

REVIEW COMMITTEE ON DENTAL PUBLIC HEALTH EDUCATION (Staff: Cathy Baumann)		
DATES OF MEETINGS January 10, 2014 July 11, 2014		
MEMBER	STRUCTURE CATEGORY	TERM EXPIRES
*Mascarenhas, Ana Karina	(Commissioner AAPHD)	2016
Patton, Lauren	General dentist	2016
Kuthy, Raymond	AAPHD rep	2016
Tomar, Scott	ABDPH rep	2017
Leonard, James	Public	2016

REVIEW COMMITTEE ON ENDODONTICS EDUCATION (Staff: Jennifer Snow)		
DATES OF MEETINGS		
January 6, 2014		
July 7, 2014		
MEMBER	STRUCTURE CATEGORY	TERM EXPIRES
*Schindler, Bill	(Commissioner AAE)	2016
Bergeron, Brian	AAE rep	2017
Hatton, John	ABE rep	2016
Neefe, Diane	Public	2015
Casada, Jane	General dentist	2014
Ludington, John	AAE/ABE nom.	2015

* Committee Chair

REVIEW COMMITTEE ON ORAL AND MAXILLOFACIAL PATHOLOGY EDUCATION (Staff: Cathy Baumann)		
DATES OF MEETINGS		
January 9, 2014		
July 10, 2014		
MEMBER	STRUCTURE CATEGORY	TERM EXPIRES
*Neville, Brad	(Commissioner AAOMP)	2014
Roeder, Leslie	General dentist	2015
Summersgill, Kurt	AAOMP rep	2017
Burr, Kristi (Commissioner)	Public	2015
Kratochvill, Frank	ABOMP rep	2016

* Committee Chair

REVIEW COMMITTEE ON ORAL AND MAXILLOFACIAL RADIOLOGY EDUCATION (Staff: Cathy Baumann)		
DATES OF MEETINGS		
January 6, 2014		
July 7, 2014		
MEMBER	STRUCTURE CATEGORY	TERM EXPIRES
*Benson, Byron "Pete"	(Commissioner AAOMR)	2015
Gander, Debra	AAOMR rep	2016
Massler, Charles	General dentist	2015
Lemont, Paul	Public	2014
Parashar, Vijay	ABOMR rep	2017

* Committee Chair

REVIEW COMMITTEE ON ORAL AND MAXILLOFACIAL SURGERY EDUCATION (Staff: Jennifer Snow)		
DATES OF MEETINGS		
January 7, 2014		
July 8, 2014		
MEMBER	STRUCTURE CATEGORY	TERM EXPIRES
*Tiner, B.D.	(Commissioner AAOMS)	2017
Giasolli, Robert (Commissioner)	Public	2014
Cuccaro, Mary Ellen	General dentist	2014
Perciaccante, Vincent	AAOMS rep	2017

Herford, Alan	ABOMS rep	2016
Bennett, Jeffery	AAOMS/ABOMS nom	2015

* Committee Chair

REVIEW COMMITTEE ON ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS EDUCATION (Staff: Jennifer Snow)		
DATES OF MEETINGS January 10, 2014 July 11, 2014		
MEMBER	STRUCTURE CATEGORY	TERM EXPIRES
* Cangialosi, Thomas	(Commissioner AAO)	2015
Kiser, James	General dentist	2016
Hershey, H. Garland	AAO rep	2015
Jamieson, Scott	ABO rep	2017
Cushing, David	Public	2015
Will, Leslie	AAO/ABO nom.	2016

* Committee Chair

REVIEW COMMITTEE ON PEDIATRIC DENTISTRY EDUCATION (Staff: Cathy Baumann)		
DATES OF MEETINGS January 7, 2014 July 8, 2014		
MEMBER	STRUCTURE CATEGORY	TERM EXPIRES
* Donly, Kevin	(Commissioner AAPD)	2015
Bohaty, Brenda	AAPD rep	2016
Hochstein, Jeffrey	General dentist	2014
Ng, Man Wai	ABPD rep	2017
DeVries, Renee	Public	2015
Udin, Richard	AAPD/ABPD nom.	2016

* Committee Chair

REVIEW COMMITTEE ON PERIODONTICS EDUCATION (Staff: Jennifer Snow)		
DATES OF MEETINGS January 9, 2014 July 10, 2014		
MEMBER	STRUCTURE CATEGORY	TERM EXPIRES
* Greenwell, Henry	(Commissioner AAP)	2014
Rheinberger, John	Public	2017
Mills, Michael	ABP rep	2015
Kerns, David	AAP rep	2016
Talentowski, Dianne	General dentist	2014
Paquette, David	AAP/ABP nom.	2014

* Committee Chair

REVIEW COMMITTEE ON PROSTHODONTICS EDUCATION (Staff: Cathy Baumann)		
DATES OF MEETING		
January 8, 2014		
July 9, 2014		
MEMBER	STRUCTURE CATEGORY	TERM EXPIRES
* Campbell, Steven	(Commissioner ACP)	2017
Sherrard, James (Commissioner)	Public	2015
Garcia, Lily	ABP rep	2014
Rutt, Martin	General dentist	2015
Holloway, Julie	ACP rep	2016
Felton, David	ACP/ABP nom.	2016

* Committee Chair

Appendix 2c. Standing and Ad Hoc Committees of the Commission on Dental Accreditation

The Commission on Dental Accreditation has five (5) standing committees: Quality Assurance and Strategic Planning, Documentation and Policy Review, Finance, Nomination and Communication and Technology. Additionally, ad hoc committees and other committees and task forces may be formed to address specific issues or concerns. An ad hoc committee functions until the issue is resolved or until it becomes a standing committee of the Commission.

Occasionally, a Commissioner may be asked to serve on other task forces or joint committees that could include representatives from the American Dental Association, the American Dental Education Association or other organizations.

The charge to each of the Commission's standing committees follows:

Quality Assurance and Strategic Planning

- Develop and implement an ongoing strategic planning process;
- Develop and implement a formal program of outcomes assessment tied to strategic planning;
- Use results of the assessment processes to evaluate the effectiveness of the Commission and make recommendations for appropriate changes, including the appropriateness of its structure;
- Monitor USDE, and other quality assurance organizations i.e. Council on Higher Education Accreditation (CHEA), American National Standards Institute/International Organization for Standardization (ANSI/ISO), and International Network for Quality Assurance Agencies in Higher Education (INQAAHE) for trends and changes in parameters of quality assurance; and
- Monitor and make recommendations to the Commission regarding changes that may affect its operations, including expansion of scope and international issues.

Documentation and Policy Review

- Ensure all Commission documents reflect consistency in application of Commission policies, and that relevant sections of accreditation standards are consistent across disciplines;
- Review and consolidate the recommendations of all review committees into standard language for the Commission's consideration for adoption, when new or revised standards are proposed and will impact more than one discipline; and
- Periodically review current Commission policies and procedures to ensure that they are current and relevant.

Nomination

- Review nominations and make recommendations for appointment of consumer/public members to the Commission;
- Review nominations and make recommendations for appointment of individuals to Review Committees of the Commission;
- Ensure the pre-nomination education process provides information regarding expectations and duties of commissioners, review committee members, and site visitors; and
- Periodically review nomination and selection criteria and make recommendations for changes if necessary, consistent with the Commission's strategic plan and policies.

Finance

- Monitor, review and make recommendations to the Commission concerning the annual budget.

Communication and Technology

- Evaluate and recommend alternative methods, including the use of enhanced technology, for monitoring programs' continuous compliance with the standards;
- Evaluate and recommend new technological advances in accreditation for reporting and management of information, allowing accreditation to move toward the concepts of continuous assessment, data collection, and readiness;

- Monitor technological trends in alternative site visit methods;
- Develop and implement strategies to increase the effectiveness, quality, content, and processes of communication with all the Commission's communities of interest;
- Ensure that Commission communications strategies allow for transparency and accountability; and
- Oversee the publication of the e-newsletter, the CODA Communicator, with emphasis on communicating the value/outcomes of accreditation.

STANDING COMMITTEE ON QUALITY ASSURANCE AND STRATEGIC PLANNING (Staff: Catherine Horan)		
DATE OF MEETING TBA		
MEMBER	APPOINTED BY	TERM EXPIRES
*Schonfeld, Steven	ADA	2014
Glicksman, Milton	AADB	2016
Sherrard, James	Public	2015
Gagliardi, Lorraine	Allied (DA)	2016
Neville, Brad	Advanced (OMP)	2014
Cangialosi, Thomas	Advanced (Ortho)	2015
West, Karen	ADEA	2016
Livingston, Harold (Mark)	AAHD/ADEA	2017

* Committee Chair

STANDING COMMITTEE ON FINANCE (Staff: Sherin Tookes)		
DATE OF MEETING TBA		
MEMBER	APPOINTED BY	TERM EXPIRES
*Williams, John	ADEA	2014
Tuneberg, Perry	ADA	2015
Burr, Kristi	Public	2014
Campbell, Steven	Advanced (PROS)	2017
Lannier, Dennis	Allied (DLT)	2017
West, Karen	ADEA	2016

* Committee Chair

STANDING COMMITTEE ON COMMUNICATION AND TECHNOLOGY (Staff: Jennifer Snow)		
DATES OF MEETINGS TBA		
MEMBER	APPOINTED BY	TERM EXPIRES
* Schindler, Bill	Advanced (Endo)	2016
Giasolli, Robert	Public	2014
Shepherd, Kathi	Allied (DH)	2015
Benson, Pete	Advanced (OMR)	2015
Surabian, Stanley	ADA	2017
Sherman, Robert	AADB	2017
Kolstad, Joseph	Student	2015
Kassebaum, Denise	ADEA	2017

* Committee Chair

STANDING COMMITTEE ON NOMINATIONS (Staff: Patrice Renfrow)		
DATES OF MEETINGS TBA		
MEMBER	APPOINTED BY	TERM EXPIRES
*Mascarenhas, Ana Karina	Advanced (DPH)	2016
Kahn, Richard	ADA	2016
Tiner, B.D.	Advanced (OMS)	2017
Burr, Kristi	Public	2014
Neville, Brad	Advanced (OMP)	2014
Torrez-Nazario, Ivan	AADB	2017
Gagliardi, Lorraine	ADAA	2016
Dodge, William	ADEA	2015

* Committee Chair

STANDING COMMITTEE ON DOCUMENTATION AND POLICY REVIEW (Staff: Peggy Soeldner)		
DATES OF MEETINGS TBA		
MEMBER	APPOINTED BY	TERM EXPIRES
*Donly, Kevin	Advanced (Ped)	2015
Leffler, William	AADB	2014
Shepard, Kathi	Allied (DH)	2015
Dodge, William	ADEA	2015
Tuneberg, Perry	ADA	2015
Sherrard, James	Public	2015
Greenwell, Henry	Advanced (Perio)	2014
Livingston, Harold (Mark)	AAHD/ADEA	2017

* Committee Chair

JOINT ADVISORY COMMITTEE ON INTERNATIONAL ACCREDITATION (Staff: Catherine Horan)		
DATES OF MEETINGS TBA		
MEMBER	APPOINTED BY	TERM EXPIRES
*Kiesling, Roger	ADA	(2011) 2012-2014
Tonelli, Steven	ADA	(2013) 2014-2016
Herman, Gary	ADA	(2012) 2013-2015
Kassebaum, Denise (Commissioner)	CODA	2017
West, Karen (Commissioner)	CODA	2016
**Dr. Charles H. Norman	ADA President	2014
**Dr. John N. Williams	CODA Chair	2014
Reed, Michael (consultant)	Former Commissioner	NA

* Committee Chair

** Ex Officio

ADA/ADEA/CODA Liaison Committee on Surveys and Reports (Staff: Sherin Took, Director, CODA & Catherine Horan, Manager, Predoctoral Dental Education)		
DATES OF MEETINGS TBA		
MEMBER	APPOINTED BY	TERM EXPIRES
*Williams, John	CODA	2014
Tuneberg, Perry	CODA	2014
Feldman, Cecile	CDEL	2014
Simonian, Roger	CDEL	2014
Knight, William	ADEA	2014
Brown, Timothy	ADEA	2014
Drisko, Connie	JCNDE	2014

* Committee Chair

CODA Subcommittee on ADA Report and Recommendations (Staff: Sherin Took)		
DATES OF MEETINGS TBA		
MEMBER	APPOINTED BY	TERM EXPIRES
* Williams, John	ADEA	2014
Nissen, Larry (former Commissioner)	ADA	NA
Livingston, Harold (Mark)	AAHD/ADEA	2017
Gann, Gary (former Commissioner)	Allied (DLT)	NA
Giasoli, Robert	Public	2014
Schonfeld, Steven	ADA	2014
Kassebaum, Denise	ADEA	2017
Greenwell, Henry	Advanced (Perio)	2014

* Committee Chair

Task Force on Development of Accreditation Standards for Dental Therapy Education Programs (Staff: Sherin Took)		
DATES OF MEETINGS TBA		
MEMBER	APPOINTED BY	TERM EXPIRES
* Tuneberg, Perry	ADA	2015
D'Ambrosio, Joseph	Predoc	2017
Oberhaus, Stephanie	Predoc	2017
Kinney, George	CDEL	NA
Koelbl, James	Former Commission Chair	NA
Royeen, Charlotte	Public	2015
Schonfeld, Steven	ADA	2014
Shepherd, Kathi	ADHA	2015
McConnell, Thomas	Predoc	NA
Biermann, Michael	Consultant (Former ADA Commissioner)	NA

* Committee Chair

Appendix 2d. Appeals Board

Appeals Board
Staff: Sherin Took, Director, CODA
Meetings as Needed

AGENCY	MEMBER	TERM EXPIRES
+AADB	Dr. Bruce Kinney	2014
+ADA	Dr. Stanwood Kanna	2014
+Public	Dr. Patricia Petrozza	2015
+ADEA	Dr. Eric Hovland	2015
GPR (ADEA/AAHD)	Dr. Tracy Dellinger	2016
OMP	Dr. Susan Zunt	2014
PED	Dr. John Liu	2017
AAE	Dr. Sandra Madison	2014
ORTHO	Dr. William Gaylord	2015
PERIO	Dr. John Ducar	2015
OMS	Dr. George M. Kushner	2014
PROS	TBD (vacant 10/29/13)	2014
DPH	Dr. Gina Thornton-Evans	2017
ADAA	Ms. Angela Swatts	2015
NADL	TBD (vacant 8/8/13)	2016
ADHA	Ms. Hope Oliver	2014
OMR	Dr. Maria Alejandra Mora	2017

+ Permanent Appeals Board Positions (at every appeal)

Appendix 2e. Criteria for Nomination of Consultants/Site Visitors

Criteria for Nomination of Consultants/Site Visitors: For predoctoral dental education programs, the Commission solicits nominations for consultants/site visitors from the American Dental Education Association to serve in five of six roles on dental education program site visits. The consultant/site visitor roles are Chairperson, Basic Science, Clinical Science, Curriculum, and Finance. Nominations for the sixth role, national licensure consultant/site visitor, are submitted by the American Association of Dental Boards.

For advanced specialty education programs, the Commission solicits nominations for consultants/site visitors from the recognized dental specialty organizations and their certifying boards. Dentist consultants must be members of the ADA and their ADA-recognized specialty organizations.

For allied education programs, the American Dental Education Association is an additional source of nominations that augments, not supersedes, the nominations from the Commission's other participating organizations, American Dental Assistants Association (ADAA), American Dental Hygienists' Association (ADHA) and National Association of Dental Laboratories (NADL).

Revised: 8/12; Reaffirmed: 8/10, 7/07, 7/01; CODA: 05/93:6-7

- A. Predoctoral Dental Education: The accreditation of predoctoral dental education programs is conducted through the mechanism of a visiting committee. Membership on such visiting committees is general dentistry oriented rather than discipline or subject matter area oriented. The composition of such committees shall be comprised, insofar as possible, of at least one Commission member, consultants/site visitors having broad expertise in dental curriculum, basic sciences, clinical sciences, finance, national licensure (practitioner) and one Commission staff member. The evaluation visit is oriented to an assessment of the educational program's success in training competent general practitioners.

Although a basic science or clinical science consultant/site visitor may have training in a specific basic science or dental specialty area, it is expected that when serving as a member of the core committee evaluating the predoctoral program, the consultant serves as a general dentist. Further, it is expected that all findings, conclusions or recommendations that are to be included in the report must have the concurrence of the visiting committee team members to ensure that the report reflects the judgment of the entire visiting committee.

In appointing consultants/site visitors, the Commission takes into account a balance in geographic distribution as well as representation of the various types of educational settings and diversity. Because the Commission views the accreditation process as one of peer review, predoctoral dental education consultants/site visitors, with the exception of the national licensure consultant/site visitor, are affiliated with dental education programs.

All predoctoral dental education consultants/site visitors, who are eligible, must be members of the American Dental Association.

The following are criteria for the six roles of predoctoral dental education consultants/site visitors:
Chairperson:

- Must be a current dean of a dental school or have served as dean within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education program being site visited or as a previous consultant/site visitor.

Basic Science:

- Must be an individual who currently teaches one or more biomedical science courses to dental education students or has done so within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education program being site visited or as a previous consultant/site visitor.

Clinical Science:

- Must be a current clinical dean or an individual with extensive knowledge of and experience with the quality assurance process and overall clinic operations.
- Has served in the above capacity within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education program being site visited or as a previous consultant/site visitor.

Curriculum:

- Must be a current academic affairs dean or an individual with extensive knowledge and experience in curriculum management.
- Has served in the above capacity within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education program being site visited or as a previous consultant/site visitor.

Finance:

- Must be a current financial officer of a dental school or an individual with extensive knowledge of and experience with the business, finance and administration of a dental school.
- Has served in the above capacity within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education program being site visited or as a previous consultant/site visitor.

National Licensure:

- Should be a current clinical board examiner or have served in that capacity within the previous three (3) years.
- Should have an interest in the accreditation process.

Reaffirmed: 8/10, 7/07, 7/01; Revised: 1/99; CODA: 07/05, 05/77:4

- B. Advanced Specialty Education: Specialty organizations are advised 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 and must have experience in advanced education as teachers or administrators. Each specialty Review Committee will determine if board certification is required. Some specialty organizations have established additional criteria for their nominations to the Commission.

The Commission requests all agencies nominating consultants/site visitors to consider regional distribution, gender and minority representation and previous experience as a consultant/site visitor. Although consultants/site visitors are nominated by a variety of sources, the Commission carefully reviews the nominations and appoints consultants/site visitors on the basis of need in particular areas of expertise. The pool of consultants/site visitors is utilized for on-site evaluations, for special consultations and for special or Review Committees.

All consultants/site visitors are appointed for a one-year term and may be re-appointed annually for a total of six consecutive years. Appointments are made at the January Commission meeting and become effective with the close of the ADA annual session in the Fall.

Revised: 8/12, 7/09, 7/07, 7/01; Reaffirmed: 8/10; Revised: 7/09, 7/07, 7/01; Adopted: 7/98

- C. Allied Education in Dental Hygiene: In appointing consultants/site visitors, the Commission takes into account a balance in geographic distribution, representation of the various types of educational settings, and diversity. Because the Commission views the accreditation process as one of peer review, the dental hygiene education consultants/site visitors are affiliated with dental hygiene education programs.

The following are criteria for selection of dental hygiene consultants/site visitors:

- a full-time or part-time appointment with an accredited dental hygiene program;
- a baccalaureate or higher degree;
- background in educational methodology;

- accreditation experience through an affiliation with a dental hygiene education program that has completed a site visit; and
- accreditation experience within the previous three (3) years.

Reaffirmed: 8/10; Adopted: 7/09

D. Allied Education in Dental Assisting: The following are criteria for selection of dental assisting consultants/site visitors:

- certification by the Dental Assisting National Board as a dental assistant;
- full-time or part-time appointment with an accredited dental assisting program;
- equivalent of three (3) years full-time dental assisting teaching experience;
- baccalaureate or higher degree;
- demonstrated knowledge of accreditation; and
- current background in educational methodology.

Reaffirmed: 8/10, 7/08; Revised: 2/13, 1/08, 1/98, 2/02; CODA: 07/95:5

E. Allied Education in Dental Laboratory Technology: The following are criteria for selection of dental laboratory technology consultants/site visitors:

- background in all five (5) dental laboratory technology specialty areas: complete dentures, removable dentures, crown and bridge, dental ceramics, and orthodontics;
- background in educational methodology;
- knowledge of the accreditation process and the Accreditation Standards for Dental Laboratory Technology Education Programs;
- Certified Dental Technician (CDT) credential through the National Board of Certification (NBC); and
- full or part-time appointment with a dental laboratory technology education program accredited by the Commission on Dental Accreditation or previous experience as a Commission on Dental Accreditation consultant/site visitor.

Appendix 2f. Staff Data and Number of Accredited Programs**STAFF DATA**

CODA	2009	2010	2011	2012	2013	2014
Director	1	1	1	1	1	1
Managers	6	6	6	5	5	5
Support staff	8	8	8	8	8	8
Total Staff	15	15	15	14	14	14

TRENDS IN THE NUMBER OF ACCREDITED PROGRAMS

Year	Predoctoral	Postdoc Gen Dent	Specialty	DH	DA	DLT	Total
2006	56	276	432	286	268	20	1,338
2007	56	273	440	293	275	20	1,357
2008	57	286	437	301	274	20	1,375
2009	58	285	441	310	277	20	1,391
2010	61	276	445	325	285	20	1,412
2011	62	299	449	331	289	20	1,450
2012	64	297	457	335	281	19	1,453
2013	65	298	460	332	274	19	1,447
2014 (spring)	65	298	461	335	274	19	1,452

Council on Dental Benefit Programs

Vorrasi, Andrew G., 2014, New York, chair
Jurkovich, Mark W., 2014, Minnesota, vice chair
Blaisdell, Mark H., 2015, Utah
Brady, Thomas V., 2016, Connecticut
Bruce, Daniel S., 2014, Idaho, *ex officio**
Eder, B. Scott, 2017, West Virginia
Gordon, Douglas J., 2017, California
Harrell, Gavin G., 2014, North Carolina
Hill, Steven J., 2017, Texas
Hoffman, Charles W., 2015, Florida
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., 2017, Illinois
Rives, Robert W., 2016, Mississippi, *ad interim*
Wood, C. Rieger, III, 2014, Oklahoma

Aravamudhan, Krishna, director
Pokorny, Frank, senior manager
McHugh, Dennis, manager
Ojha, Diptee, senior manager

The Council's 2013-14 liaisons include: Dr. Steven Gounardes (Second District trustee, Board of Trustees) and Mr. Seth R. Brooks (American Student Dental Association).

Purpose

The purpose 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

The activities of the Council on Dental Benefit Programs (CDBP) are consistent with and continue to support the ADA Strategic Plan 2011-2014. Council activities support Goal 1—provide support to dentists so they may succeed and excel throughout their careers and 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 is accomplished in accordance with protocols established by the Council's *CDT Code* Maintenance Committee (CMC). The process is a broad-based collaborative and efficient effort that is responsive to member dentist needs, as well as those of dental specialty organizations and third-party payers. This collaboration is exemplified by the CMC's unanimous decision to immediately implement the Council's simplified process for editorial actions.

Summary statistics on substantive and editorial actions taken during the 2014 CMC meeting are in Table 1. *CDT Code* action requests submitted by CDBP are shown as a subset of all submissions. This

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

separation reveals that the CMC was receptive to the Council's requests. Several CDBP submissions were withdrawn in favor of similar requests submitted by member dentists. Accepted changes will be effective January 1, 2015.

Table 1. Action Requests for CDT 2015—Summary Statistics

Substantive (all types submitted by dentists, CMC members, etc.)									
	Action	Submitted		Accepted		Declined		Other (e.g. withdrawn)	
All Requests		#	%	#	%	#	%	#	%
	Add	47	47.00%	14	29.79%	28	59.57%	5	10.64%
	Revise	48	48.00%	21	43.75%	20	41.67%	7	14.58%
	Delete	5	5.00%	2	40.00%	0	0.00%	3	60.00%
	Total	100	100.00%	37	37.00%	48	48.00%	15	15.00%
ADA/CDBP Subset									
	Add	17	53.13%	7	41.18%	8	47.06%	2	11.76%
	Revise	12	37.50%	8	66.67%	4	33.33%	0	0.00%
	Delete	3	9.38%	1	33.33%	0	0.00%	2	66.67%
	Subtotal	32	100.00%	16	50.00%	12	37.50%	4	12.50%
Editorial (limited to revisions submitted by CMC member organizations)									
		Submitted		Accepted		Declined		Other (e.g. withdrawn)	
		#	%	#	%	#	%	#	%
All CMC		22	100.00%	18	81.82%	0	0.00%	4	18.18%
ADA/CDBP Subset		20	90.91%	17	85.00%	0	0.00%	3	15.00%

Information about the maintenance process, including the CMC's membership, action request submission and evaluation guidelines, and reports on action requests to be considered and in queue for implementation, is available online at <http://www.ada.org/en/publications/cdt/>. The next closing date for *CDT Code* action requests is November 1, 2014. All submissions will be on the CMC agenda when the Committee convenes March 5-7, 2015. Those accepted will be incorporated into CDT 2016.

The Council's continuing efforts to foster member awareness of the *CDT Code* maintenance process is manifest in the third annual *CDT Code* Open Forum at ADA 2014. This meeting also features delivery of the Council's 16th *CDT Code* Workshop, an educational program directed towards member dentists, practice staff and others throughout the dental community.

The Council continues to engage with third-party payers to communicate member concerns and identify mutually agreeable solutions. In 2014, the Council met with representatives from United Concordia Companies, Inc. (UCCI), DentaQuest and the National Association of Dental Plans. These meetings revealed a number of emerging issues and prompted a strategic discussion by the Council as noted in the section below.

Providing individual assistance to member dentists continues to be a valuable member benefit. Through the first quarter of 2014, staff has responded to nearly 1,500 requests for assistance and it is anticipated that by year end staff will have responded to over 6,000 requests specific to *CDT Code* and third-party issues. Please see Table 2 below for the number of requests by month and average monthly volume in the first quarter of 2014. For reference, Aptify records show that the total number of calls received in 2013 was 6,750, with a monthly average of 562 calls. Over 98% of the calls are consistently resolved within two business days.

Table 2. Member Requests for CDT Code and Third-Party Payer Assistance Recorded on Aptify

	Number of Service Requests
January	508
February	477
March	513
1st Quarter Total	1,498
Average: January-March	499

Staff continues to provide information to the broader membership on evolving plan designs and the effect of the ACA on dentistry through the Center for Professional Success, *ADA News* and various eNewsletters.

The Dental Quality Alliance (DQA) was established by the Association to develop performance measures for oral health care. It is an organization of major stakeholders in oral health care delivery that uses a collaborative approach to develop oral health care measures. The ADA is represented by one representative from CDBP, Council on Dental Practice (CDP), Council on Government Affairs (CGA), Council on Access, Prevention and Interprofessional Relations (CAPIR) and the Board of Trustees. The DQA continues to move forward with efforts to develop quality measures in dentistry. Six of the measures from the pediatric measure set were submitted to the National Quality Forum (NQF) for endorsement. These measures will be useful to evaluate Medicaid/CHIP programs as well as compare care quality among dental plans participating in exchanges. The DQA is currently validating additional measures for the pediatric population. This effort is supported in part through a grant from the ADA Foundation. The DQA received a grant from the Office of the National Coordinator for Health IT (ONC) to develop two eMeasures for implementation in the 2016 Meaningful Use program. New efforts are currently underway to identify quality measures for the adult population and the DQA has drafted a request for proposals (RFP) to facilitate testing of measures. The goal of testing is primarily to establish feasibility, reliability and validity of DQA measures using administrative data sources at the plan and program level. The DQA is beginning the planning of a second Quality Measurement conference that will take place on May 1-2, 2015, at the ADA headquarters in Chicago.

The Council continues to support webinars and workshops on peer-review. Staff collaborated with various state societies to collectively provide comments to the revised draft of the National Practitioner Data Bank Guidebook. The Council is also exploring options to improve peer-review program support for states that need such assistance. The Council is gathering information on different state programs and is using this information to develop best practices and identify strategies to provide enhanced program support.

Emerging Issues and Trends

Commercial Sector

The commercial dental benefits sector is evolving at a rapid pace promoted in large part by the Affordable Care Act. The establishment of federally facilitated and state-based marketplaces is expanding the market for benefit plan products targeted to individuals. Market trends also indicate that employers are increasingly interested in private exchanges as a means of limiting their healthcare costs while at the same time improving employee choice. Four important trends to highlight are:

- **Consumerism:** The benefit industry is moving towards individual plans and employee choice. Consumers often do not have the necessary information to purchase an optimum benefit plan. Price competition will increase as payers compete on the individual markets. There will be greater emphasis on in-network services and discounts and increasing patient co-insurance.
- **Increased complexity of benefit design:** Practices will see an increasing number of “individual” plans. Current software systems are not positioned to handle data recording. Patients will increasingly look to dentists to help them understand what they purchased as their benefit. Coordination of benefits issues will also increase. As more dental benefits are offered through “embedded” plans, new issues with claims submissions may arise.
- **“Right-sizing” of plans:** “Risk-based” plans are emerging with different levels of benefit based on patient risk status. Questions remain on who will assess risk and how plans will be designed based on predetermined risk status.
- **Clinician profiles and data analytics:** Plans are increasing their data analysis capabilities. Dentist “profiles” are common. These “profiles” are typically based on metrics such as the frequency a procedure is delivered, and may compare an individual dentist’s activity over time as well as with peers. The focus will increase on clinical outcomes and patterns of retreatment/increasing complexity of treatment. Such data will be used within pay for performance programs, separating clinicians/practices into tiers based on performance and building selective networks. Utilization reviews to monitor claims will increasingly influence network inclusion.

The Council has discussed these emerging trends and identified tactics to help members succeed in this changing environment. Tools and educational resource materials are being developed for dentists to help them educate patients on plan design. Attention is also being given to consumer guides for use by emerging private exchanges, and public marketplace administrators and regulators, to improve transparency for consumers. The Council emphasizes the need to ensure that the DQA remains the leading source for quality measures in dentistry. Efforts are underway to promote the work of the DQA among marketplace regulators and Medicaid administrators. The Council will continue to monitor this evolving sector and provide information to members as the impact of the new benefit plan designs emerges.

Medicaid

The latest research from the Health Policy Institute supports an expanding Medicaid sector. Low income children and adults are two growth sectors in terms of increasing utilization and practice revenue. The Council has noted several barriers to improving access to Medicaid, including the recent recovery audits, and reiterated the need for the ADA to take the lead in resolving these issues. The Council is working to develop best practices for planning, administration and financing of Medicaid programs.

Responses to House of Delegates Resolutions

Recommendations—Policies to be Amended

Closed Panel Dental Benefit Plans

A resolution (Resolution 10) on the policy on Closed Panel Dental Benefit Plans (*Trans.*1989:545) was originally submitted to the 2013 House of Delegates with a recommendation from CDBP that the policy be rescinded. Resolution 10 was referred to the appropriate agency for review with a report to the 2014 House. After further review, the Council recommends that this policy be amended and presents the following new resolution.

- 4. Resolved**, that the ADA policy on Closed Panel Dental Benefit Plans (*Trans.*1989:545) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

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 delivering and financing dental services, closed panel plans have not been shown demonstrated themselves to be more economical, efficient or otherwise better than other forms of dental 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 contracted dentists, this benefit concept has the potential to reduce the patient's access to comprehensive any dental care.

In view of these concerns, the Association opposes this approach as the only dental benefit plan available to subscribers patients. 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 under a fee-for-service arrangement.
2. ~~Equal premium dollars should be allocated between the freedom of choice plan and the closed panel plan.~~ There should be equal premium dollars per subscriber available for all dental plans being offered.
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 and updated semi-annually.
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.~~

Policy on Medically Necessary Care

In 2013, CDBP suggested amendments to the policy titled Medically Necessary Care (*Trans. 1988:474; 1996:686*). The 2013 House of Delegates referred to the appropriate agency Resolutions 20 and 20S-1 for study and report to the 2014 House. Additionally, the 2013 House requested responses to specific questions raised by the reference committee. The Council's responses follow.

Why was this activity discontinued?

The Council did not find any historical records indicating when or why this activity was discontinued.

Upon review of the resolution, at this time, the Council continues to strongly support the original amendment to the policy on Medically Necessary Care as proposed by CDBP in 2013 with minor changes. The Council recommends that employers not be contacted due to privacy provisions of the

Health Insurance Portability and Accountability Act (HIPAA) and the resulting business associate agreements that would need to be signed. This may expose the ADA to risk of being found in violation of HIPAA rules which could result in substantial civil monetary penalties. This requirement was not in place when the original resolution was passed in 1988.

What was the original purpose of the allocated funds?

A review of the Resolution Worksheets from 1988 (Resolution 36) and 1996 (Resolution 13) and the Reference Committee reports found that the financial implication was marked as “None.” There was no documented allocation of funds associated with these resolutions.

If the funds were budgeted on an ongoing basis, were those funds discontinued or reallocated?

See above.

After further review, CDBP recommends that parts of both Resolution 20-2013 (*Trans.*2013:317) and Resolution 20S-1-2013 (*Trans.*2013:318) be combined into a revised and updated policy and is presenting a new Resolution 5.

5. 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~~ advocate on behalf of patients to ~~see that~~ ensure the language specifying treatment coverage in health insurance plans is 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 make benefit determinations based on medical necessity with 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.~~

Self-Assessment

In accordance with Resolution 1H-2013 (*Trans.*2013:339), the Council on Dental Benefit Programs conducted a self-assessment based on the topic outline developed by the Board of Trustees. The Council conducted its review through conference calls as well as full Council discussion at its in-person meeting. Overall, the Council believes that it serves an important purpose within the ADA. Its activities are in alignment with stated bylaws and the ADA's strategic plan. The Council has established efficient processes to conduct its business. The complete assessment is presented as Appendix 1 to this report.

Policy Review

In accordance with House Resolution 170H-2012, Reaffirming Existing ADA Policy, all Association policies are to be reviewed every five years. The Council on Dental Benefit Programs did a comprehensive review of all its policies in 2013; therefore, no additional review was necessary for inclusion in this report.

Summary of Resolutions

Resolution 4. Amendment of the Policy, Closed Panel Dental Benefit Plans
Resolution 5. Amendment of the Policy, Medically Necessary Care

Council Minutes

For more information on recent activities, see the Council's [minutes](#) on ADA.org.

Appendix 1. Council on Dental Benefit Programs 2014 Self-Assessment

1. Threshold Issues

The Council on Dental Benefit Programs (CDBP) is the ADA agency dedicated to:

- Recommending policies on dental benefit programs, quality assessment issues, peer review, and coding taxonomies.
- Advocating appropriate dental benefit program administration, financing, and quality assessment mechanisms.
- Maintaining the *CDT Code*, a highly valued ADA intellectual property.
- Providing staff support for the Dental Quality Alliance.
- Developing and disseminating information on coding taxonomies for the dental profession.
- Advocating effective professional review processes for use among dentists, patients and payers.

Given this charge, the Council on Dental Benefit Programs remains an important ADA agency. This Council provides expert volunteer input to the Board of Trustees and House of Delegates, staff, membership, and external communities on matters related to dental benefits, coding and vocabulary for recording treatment and electronic transactions, and quality assessment and improvement.

Council Activities

Third-party issues are a major concern for members. The Council promotes autonomy of members in dealing with third-party payers through negotiation and advocacy. In addition, staff works with insurance carriers on an individual basis to assist member dentists with third-party concerns. This personal assistance is provided to member dentists and used effectively to recruit nonmembers. Survey results have proven this to be a favorable member value. Staff handles approximately 7,500 code and third-party issues telephone calls, email requests and letters on an annual basis.

The Council also has the responsibility of maintaining standardized diagnostic and procedural coding taxonomies for the dental profession. In this realm, the Council safeguards the ADA intellectual property in the *CDT Code* through an appropriate maintenance process that satisfies governmental entities and prevents interference. Through its leadership role within the Code Maintenance Committee (CMC) the Council ensures that the *CDT Code* remains responsive to member needs for appropriately reporting services rendered through use of standard codes. The *CDT Code* is also a significant non-dues revenue source for the ADA. In addition, the Council oversees the maintenance of the Systematized Nomenclature of Dentistry (SNODENT). SNODENT is a clinical diagnostic terminology that is designed for use in the electronic health and dental records environment. In addition to maintaining SNODENT, the Council assists in developing mapping products that support dental practice management decision support applications, and potential preparation of HIPAA standard electronic dental claim transactions.

Through its leadership role in the Dental Quality Alliance (DQA), the Council provides the voice of member dentists to enable development of appropriate quality measures in dentistry. The Council is apprised of measures under consideration by the DQA and thus far deems these measures as appropriate.

Metrics

The Council uses a post meeting survey to capture feedback on meeting logistics, discussions, preparation, and business performance.

ADA member satisfaction with staff specific to the Council's work areas, e.g., third-party issues, code inquiries, benefits information, is assessed using automated reports from the ADA Online Survey

program. Negative comments prompt an immediate follow-up response by staff to acknowledge and address the concern.

2. Structure

CDBP Membership

CDBP is composed of 17 regular members, one member from each trustee district whose terms of office are staggered. The Council also has non-voting members from the New Dentist Committee, American Student Dental Association (ASDA) and a trustee liaison.

The Council believes that it has the optimal number of members for efficient conduct of business. For CDBP, members should be selected at large with representation from all districts. Members at large typically have the required knowledge to deal with topics discussed within CDBP.

However, the Council notes the lack of diversity with the current composition of CDBP and believes that it does not adequately reflect ADA membership demographics. In reviewing the criteria used by the Board to appoint members to each Council, CDBP agrees with the criteria and reiterates that trustees should be aware of the Council's current demographics, bylaws responsibilities, as well as criteria for volunteer appointment ("Criteria for Nominations to ADA Councils, Commissions and the New Dentist Committee").

The Council also discussed the need to find a mechanism to allow Council members with unique experience and expertise to continue in leadership positions so that the ADA might benefit from their input in a meaningful manner.

CDBP Committee Structure

CDBP currently has three standing Council subcommittees:

1. Dental Benefit Information Services (DBIS) Subcommittee
2. Subcommittee on the Code
3. Quality Assessment and Improvement (QA&I) Subcommittee (includes representatives from other Councils with interest in this area)

The Council administers several standing committees. These committees include representatives of other Councils and external agencies that include dental specialty organizations, federal agencies (e.g., Centers for Medicare and Medicaid Services (CMS)), and third-party payer organizations (e.g., National Association of Dental Plans (NADP)). Each of these committees has a specific charge that helps the Council fulfill its bylaws responsibilities.

The Council administered standing committees include:

1. Dental Claim Form Advisory Committee
2. Dental Quality Alliance
3. Code Maintenance Committee

The details of each standing committee's charge is noted in Table 1 of this Appendix.

The Council has established a subcommittee structure that enables it to fulfill its bylaws responsibilities and conduct business in an effective and timely manner. There is no known need to either expand or contract this supporting structure.

An ad-hoc task force cannot replace a Council for reasons that include: recurring need to assemble a group of volunteers to address a matter of ADA interest, followed by disbandment upon completion of work; unpredictable meeting expenses, and possible delay in formation of an ad-hoc group if

supplemental funding is required; loss of long-term volunteer memory, which is now exchanged between current and incoming Council members.

However, even with the current structure, the Council has established ad-hoc workgroups or task forces to fulfill specific needs. Subcommittees of the Council have also used a subset of its members or appointed ad-hoc workgroups when specific needs arise. For example, the Subcommittee on the Code recently saw the need to establish a group dedicated to addressing issues related to diagnostic coding. This group was populated by the current subcommittee members and includes other subject matter experts and specialty group representatives. This group works on diagnostic coding issues under the oversight of the subcommittee and reports through the Code Subcommittee to CDBP.

3. Efficiencies

As noted above, the Council uses its subcommittee structure as well as establishing standing and ad-hoc committees to support fulfillment of CDBP's ADA *Bylaws* responsibilities.

Discussions on emerging issues are frequently held on ADA Connect. Examples of issues addressed by the Council between in-person meetings are:

- SNODENT Commercial License recommendation from the Department of Product Development and Sales (PDS) – Council determination is that this is a substantive licensing action that requires Board of Trustees consideration
- Review and approval of substitute resolutions prepared for the 2013 House of Delegates, "Principles for Pay-for-Performance or Other Third-Party Financial Incentive Programs"

When prompt action is required between meetings, the Council elects to discuss such matters via ADA Connect and via conference call. Further, the Council has voted on motions when they are a conference call agenda item, and by electronic ballot via ADA Connect. All three subcommittees convene conference calls as needed.

The Council believes that it has an efficient decision-making process that makes continual use of in-person meetings and electronic communication (e.g. ADA Connect, Genesys Voice/Web conference calls). There is a significant demand on volunteer time for Council and subcommittee activities. Apart from the Council director working closely with the chair and vice chair, the Council has a weekly meeting with the Council leadership group. This group includes the CDBP chair, CDBP vice chair, the chairs of all three subcommittees and staff. Staff keeps this group updated on all Council activities. The Leadership group also serves as the decision-making body for urgent issues.

Staff support is sufficient, as is the technology (Genesys) that supports work done via conference call. ADA Connect is used for dissemination of information on issues to be addressed, for posting of other material pertaining to Council business, and electronic balloting. The Council sees ADA Connect as a maturing technical application that is expected to support robust and clear discussion of Council matters between in-person meetings. The Council noted the need for ongoing training of ADA Connect.

The Council noted that properly identified "pre-reading material" issued prior to the Council meeting supports effective use of volunteer time for strategic discussions at the meeting. During the discussion, some Council members suggested that staff host an optional "orientation call" one week prior to the in-person meeting to provide an overview of the agenda and reports to assist effective preparation by volunteers. Council members also suggested using recorded presentations as resource materials prior to the Council meeting so that in-person time can be used more effectively during informed discussions.

4. Areas of Responsibility

Periodic review of Council *Bylaws* responsibilities has not identified any that should be transferred or discontinued. The most recent change resulted in clarification and expansion of the dental coding taxonomies that are within CDBP's purview. In 2009, the Council's responsibility was revised to read as follows:

Formulate and maintain coding taxonomies, including but not limited to procedural and diagnostic codes that dentists can use to document patient care and to explore applications and opportunities for new coding taxonomies.

The overview of CDBP activities as they relate to the *Bylaws* is noted in Table 2 of this Appendix.

The Council believes that it is adequately addressing and fulfilling all of its *Bylaws* responsibilities. The inter-relationships between these responsibilities preclude parsing them to other ADA agencies.

5. Agenda Review

The Council believes that the CDBP agendas are well structured to allow efficient use of Council time. As noted above, use of electronic technology, conference calls between meetings, pre-reading material and the new orientation call prior to each in-person meeting, allows the Council to efficiently conduct business.

6. Are you spending time on big issues and strategic direction?

The Council believes that CDBP spends sufficient time for strategic discussion given the methods used for communication of "routine" programmatic updates, use of a consent calendar for straightforward items of business and pre-reading materials to prepare for strategic discussions at the in-person meeting.

Appendix Table 1. Duties of Council on Dental Benefit Programs Committees

COUNCIL SUBCOMMITTEES	
Subcommittee on the Code	<ul style="list-style-type: none"> • Prepare recommendations on <i>CDT Code</i> content and maintenance. • Provide guidance to CDBP staff on technical content for the suite of <i>CDT Code</i> salable products (e.g., CDT Manual; CDT Companion). • Deliver the Code Workshop at sessions sponsored by state and local dental societies, and other dental organizations. • Serve as a reference for questions on the <i>CDT Code</i> received by Council staff from member dentists, their staff and others in the dental community. • Recommend revisions to the ADA Dental Claim Form content and completion instructions, in conjunction with the Dental Benefit Information Service Subcommittee, and with information provided by the Dental Claim Form Advisory Committee. • Support development of code taxonomies that are ADA intellectual property (e.g., SNODENT) or HIPAA standards that affect dentistry (e.g., ICD diagnosis codes). • Prepare recommendations on licensing structures, fees and strategies for commercial and non-commercial use of code sets that are ADA intellectual property, in conjunction with the Department of Product Development and Sales.
Dental Benefit Information Service (DBIS) Subcommittee	<ul style="list-style-type: none"> • Analyze, review and assist in the resolution of third-party issues reported by dental offices. • Develop educational resources to promote fee-for-service freedom of choice dental plans. • Maintain a liaison relationship with payer organizations in an effort to address key issues of concern. • Educate the membership, dental professionals, patients and general public about third-party payer issues. • Evaluate the changing third-party environment, projecting how it impacts members and develops tools to assist membership.
Subcommittee on Quality Assessment and Improvement (QA&I)	<ul style="list-style-type: none"> • Analyze and implement policy and programs that incorporate quality assessment and improvement and risk assessment in collaboration with other internal and external stakeholders, particularly in conjunction with the ADA's activities related to the Dental Quality Alliance (DQA). • Review issues regarding the development of performance measures, quality assessment criteria and audit criteria. • Analyze peer review policies of the ADA, constituent and component dental societies. • Disseminate ADA policy on peer review. • Provide peer review and mediation workshops and webinars for constituent and component dental societies, and other interested dental organizations.
COUNCIL ADMINISTERED COMMITTEES	
Dental Claim Form Advisory Committee (DeCFAC)	<ul style="list-style-type: none"> • Convened on an "as need" basis. • Considers changes to ADA Dental Claim Form content or completion instructions to address new business needs (e.g., new data on the HIPAA standard electronic dental claim).

Dental Quality Alliance (DQA)	<ul style="list-style-type: none">• Meets twice a year and has broad membership from the profession, third-party payers and federal agencies.• Develops appropriate quality measures for oral health.• The Board of Trustees approved Operating Rules for the DQA in June 2010. CDBP, as the lead agency within the ADA, administers the DQA.• The ADA has an authoritative leadership role in the DQA through representation from CDBP, CGA, CDP, CAPIR and the Board.
Code Maintenance Committee (CMC)	<ul style="list-style-type: none">• Meets annually and votes to accept, amend or decline requests to update the <i>CDT Code</i>.• Broad membership body that ensures all stakeholders have an active role in evaluating and voting on <i>CDT Code</i> changes.• Conducts business in open session and in a manner that meets or exceeds the requirements for maintenance of a named HIPAA code set.

Appendix Table 2. Council on Dental Benefit Programs Bylaws and Relation to Activities

<i>Bylaws Responsibilities: The Duties of the Council Shall be to:</i>	<i>Examples of Activity (Previous 3 Years)</i>
a. Formulate and recommend policies relating to the planning, administration and financing of dental benefit programs.	<p>The Council has been active in review of existing ADA policies regarding third-party payers and has updated many of these policies accordingly. In addition, the Council has drafted new policies that have been adopted by the House of Delegates.</p>
b. Study, evaluate and disseminate information on the planning, administration and financing of dental benefit programs.	<p>The Council, through its DBIS Subcommittee, meets separately with representatives from two dental benefits carriers annually. The purpose of these meetings is to discuss issues of mutual concern and to discuss how we can work together to better assist ADA member dentists and the carrier's network providers.</p> <p>Staff works with insurance carriers on an individual basis to assist member dentists with third-party concerns. This personal assistance is only provided to member dentists and survey results have proven this to be a favorable member value. Staff handles approximately 7,500 code and third-party issues telephone calls, email requests and letters on an annual basis.</p> <p>Staff has had success working with insurance carriers and getting them to change policies that were detrimental to dental offices and patients. For example, ADA was informed that Dentist Direct was "down-coding" D0150 to D0120 unless a narrative report was submitted. This issue was successfully resolved.</p> <p>Staff has been successful in convincing many carriers to change explanation of benefits language that may have negatively impacted the dentist-patient relationship.</p> <p>The Council provides content for the Center for Professional Success website in the areas of frequently asked questions on code and third-party issues; basic information on dental benefits (Dental Benefits: An Introduction); information on claim resolution (Responding to Claim Rejections); online complaint form; continuing education courses on the <i>CDT Code</i> and dental benefit plans.</p> <p>Articles on the code and third-party issues are published in <i>ADA News</i> and the online publication <i>Practice and Thrive</i>.</p>
c. Assist the constituent societies and other agencies in developing programs for the planning, administration and financing of dental benefit programs.	<p>Council staff consults with constituent society staff on a weekly basis regarding third-party issues and legislation pertaining to state regulated dental benefit plans.</p> <p>Constituent societies consult with the ADA on issues such as new pay for performance programs emerging in the states. The most recent example is the assistance provided by staff to the Texas Dental Association regarding administration of their Medicaid dentist incentive program.</p> <p>Another example is the support provided by ADA to the Michigan Dental Association (MDA) regarding the new Delta Dental of Michigan RightSize dental plan. ADA worked collaboratively with MDA to address this issue.</p>

<p>d. Provide assistance, guidance and support to constituent and component societies in the development and management of professional review systems.</p>	<p>Peer-review guidelines maintain assistance to the tripartite in supporting high quality care at the patient level and provide a strong dispute resolution mechanism.</p> <p>ADA guidelines assist states in maintaining a robust peer-review system.</p> <p>ADA offers states assistance to support peer-review by conducting webinars and a workshop at annual session. ADA also has a seat at the Executive Committee of the National Practitioner Data Bank to ensure that reportability policies at the federal level are appropriate for the practice of dentistry.</p> <p>Council staff routinely consults with constituent society staff regarding peer-review program administration. In addition there have been 10 in-person workshops and six webinars over the past three years.</p> <p>Council staff collaborated with various state societies to collectively provide comments to the revised National Practitioner Data Bank Guidebook.</p>
<p>e. Encourage the inclusion of dental benefits in health benefit plans and to promote dental benefit plans in accordance with Association policy.</p>	<p>The Council continues to work with other ADA agencies, e.g., Council on Government Affairs (CGA) and the Department of State Government Affairs to promote the inclusion of dental benefits in health plans. ADA policies on federal programs have also been reviewed by CDBP and appropriate suggestions have been provided to CGA.</p>
<p>f. Conduct activities and formulate and recommend policies concerning the assessment and improvement of the quality of dental care relating to dental benefit plans.</p>	<p>The Council administers the work of the DQA. The DQA is an alliance of 30 stakeholders including specialty societies, other provider organizations, the dental benefits and health plan industry, federal agencies, non-dental stakeholders and a public member. The mission of the Dental Quality Alliance is “to advance performance measurement as a means to improve oral health, patient care and safety through a consensus-building process”. The DQA was formed pursuant to House Resolution 34H-2008 and Board Resolution B-120-2008.</p> <p>The DQA's intent is to be the leading source for appropriate quality and performance measures to support a high-quality healthcare delivery system. The DQA offers a direct member benefit by providing a mechanism by which ADA members have an authoritative voice in the development of quality measures. As the only comprehensive multi-stakeholder collaborative for the development of dental quality measures, the DQA is well positioned to collaborate, coordinate, and lead these efforts through its members' experience, expertise and support. The work of the DQA will be used by federal and state programs as well as health plans across the country, thus impacting a large segment of our population.</p> <p>As more mandates to measure quality arise in both the public and the private financing sector, the ADA strives to ensure that these entities use appropriate quality measures. The first set of measures was approved in 2013 and efforts are underway to educate the membership about the value of the DQA work. A recent occurrence in Georgia highlighted by the Georgia Dental Association clearly demonstrated the value of the work of the DQA and resulted in passage of House resolution 89H-2013.</p>

	<p>The Council has been active in review of existing ADA policies regarding quality assessment and improvement and has updated many of these policies. In addition, the Council has drafted new policies that have been adopted by the House of Delegates.</p>
<p>g. Formulate and maintain coding taxonomies, including but not limited to procedural and diagnostic codes that dentists can use to document patient care and to explore applications and opportunities for new coding taxonomies.</p>	<p>The suite of <i>CDT Code</i> related activities under this program generates non-dues revenue, and its deliverables are recognized standards for health care electronic health records and electronic commerce by federal (e.g., HIPAA) and state (e.g., Medicaid) government agencies.</p> <p>The <i>CDT Code</i>, through licenses for commercial use and inclusion in ADA publications, generates approximately \$2 million (gross) non-dues revenue per year. This code set is on an annual review and revision cycle, with updated versions effective January 1 of each calendar year.</p> <p>SNODENT has gained recognition as ADA intellectual property that enables codified documentation of patient descriptive and diagnostic information in electronic dental (aka health) records.</p> <p>In 2013, Practice Institute staff created a SNODENT to ICD to CDT mapping product that supports dental practice management decision support applications, and potential preparation of HIPAA standard electronic dental claim transactions. This is a licensed product offered at \$5,000 per year.</p>

Council on Dental Education and Licensure

Dolan, Teresa A., 2014, Pennsylvania, chair, American Dental Education Association
Boyle, James M., III, 2015, Pennsylvania, vice chair, American Dental Association
Brysh, L. Stanley, 2016, Wisconsin, American Dental Association
Feldman, Cecile A., 2016, New Jersey, American Dental Education Association
Gesek, Daniel, 2017, Florida, American Association of Dental Boards
Hoelscher, Diane C., 2015, Michigan, American Dental Education Association
Holm, Steven J., 2016, Indiana, American Dental Association
Manning, Dennis E., 2016, Illinois, American Association of Dental Boards
Miller, Jade A., 2014, Nevada, American Association of Dental Boards
Price, Jill M., 2017, Oregon, American Dental Association
Raman, Prabu, 2017, Missouri, American Dental Association
Ritchie, Ryan, 2014, Minnesota, *ex officio**
Sarrett, David C., 2017, Virginia, American Dental Education Association
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
Venezie, Ronald, 2014, North Carolina, American Dental Association

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

The Council's 2014 liaisons include: Dr. James K. Zenk (Tenth District trustee, Board of Trustees) and Mr. Tyler Rumble (American Student Dental Association).

Purpose

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.

* 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

The Council continues to implement action plans and tactics which complement the ADA Strategic Plan 2011-2014 and are relevant to its *Bylaws* duties. Activities for 2013-2014 included:

- Defining the parameters for a comprehensive study of the current dental education model in response to Resolution 56H-2013.
- Improving the quality and integrity of continuing education for all members by pursuing the establishment of a separate ADA agency to approve domestic and international continuing education providers.
- Establishing new ways to inform students/parents about the costs of dental education.
- Supporting the Joint Survey Committee on Dental Education Information in collecting, analyzing and disseminating trend data on dental education.
- Promoting best practices in the national clinical licensure arena.

Emerging Issues and Trends

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 attends Commission on Dental Accreditation (CODA) meetings and provides the Council 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 Oral and Maxillofacial Surgery and the Accreditation Standards for Clinical Fellowship Training Programs Oral and Maxillofacial Surgery.
- Supported the majority of proposed changes to Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics, but noted concern regarding the proposed preface to the Clinical Program section of Standard 4. Curriculum and Program Duration. Specifically, the Council questioned the intent of the second and third sentences and the use of the terms “comprehensive care” and “leadership role.” After careful discussion, the Council transmitted to CODA the following proposed revision (suggested deletions are indicated with ~~striketroughs~~):

“Prosthodontics is the dental specialty pertaining to the diagnosis, treatment planning, rehabilitation and maintenance of the oral function, comfort, appearance and health of patients with clinical conditions associated with missing or deficient teeth and/or oral and maxillofacial tissues using biocompatible substitutes (CDEL Approved 2003). At the specialty level, Prosthodontics embraces its ~~interactive, leadership~~ role as part of a therapy team. ~~At the specialty level, Prosthodontics also embraces comprehensive care as part of its responsibility.~~ To support this definition and vision, programs will provide appropriate clinical experiences for students/residents to develop the following competencies:”

The Council determined that the term “sole providers” may be misleading and urged that the proposed Standard 4-21 be revised to read (suggested deletions are indicated with a ~~striketrough~~):

“Students/Residents **must** be competent in the ~~comprehensive~~ application of principles of esthetic dentistry ~~as sole providers and as members of a treatment team.~~”

The Council also concluded that the proposed accreditation standards do not support proposed Standard 4-22, “Students/Residents must be competent in the placement of dental implants,” noting that required didactic instruction in the biomedical areas (Standard 4-12), clinical areas (Standard 4-13) and in diagnostic and treatment planning (Standard 4-14) at the “understanding level” is not sufficient to support the proposed requirement for students/residents to achieve competency in the placement of dental implants.

Additionally, the Council determined that the approved definition of prosthodontics does not exclude the placement of implants from the scope of practice for prosthodontists.

- Supported the Commission on Dental Accreditation’s housekeeping amendment to its *Rules*, changing the name of the “American Association of Hospital Dentists” to the “Special Care Dentistry Association” throughout the document.

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. This year’s recipient, Maureen McAndrew, DDS, MSED, clinical professor, New York University College of Dentistry, was presented with the Golden Apple Award along with funding to attend the ADA 2014 – America’s Dental Meeting.

Career Resources. The new ADA.org website features information and resources about [careers in dentistry](#) and [dental team careers](#). Brochures, posters and videos used to promote dental careers are available until the supply is depleted or they become outdated. These materials were developed under the former Career Guidance Department, which was sunset in 2012.

Dental Licensure and Clinical Licensing 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, 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. In 2013, the Council of Interstate Testing Agencies joined ADEX. The results of the ADEX examination are now accepted by 47 licensing jurisdictions for initial licensure.

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, CITA, 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

California Portfolio Examination. In response to Resolution 50H-2013, the Council monitors the Dental Board of California’s development and implementation of a portfolio-style licensure examination and reports progress via its annual report. During 2013 and 2014, the Dental Board of California posted to its [website](#) proposed rulemaking and public hearing information. A mock portfolio examination is scheduled for late summer 2014; the first official portfolio examination could be given in 2015.

Canadian Exam. The Minnesota Board of Dentistry accepts the National Dental Examining Board of Canada's two-part examination (a written test 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.

Post-Graduate Residency of One-Year (PGY-1). New York continues to be the only state mandating a PGY-1 for initial licensure. Several other states (California, 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 2013 annual report. Dental boards in 46 states plus the District of Columbia and Puerto Rico have authority to grant licensure by credentials. Delaware, Florida, Hawaii, Nevada and the Virgin Islands do not.

Joint Commission on National Dental Examinations

In 2010, the Joint Commission on National Dental Examinations (JCNDE) established a Committee on the Integrated Examination to develop and validate a new [Integrated National Board Dental Examination](#) (INBDE) that will replace NBDE Part I and Part II. The Council is monitoring this long-term project. In 2014, the JCNDE approved two key reports related to: 1) operational aspects of the INBDE and 2) examination item prototypes. The Joint Commission is now positioned to begin item development for an INBDE field test. At minimum, a four-year 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 licensure legislation. The following summarizes legislation enacted by the states during this past year:

Alabama SB 22. Amends law to set forth that licensure requirements for physicians, chiropractors, optometrists and dentists in the state shall be granted based on demonstrated skill and academic competence. Prohibits the condition of licensing of certain health care providers on their participation in any public or private health insurance plan, public health care system, public service initiative, or emergency room coverage, as well as other activities (e.g., use of electronic health records).

California 2013 AB 836. Encourages experienced, retired dentists to be voluntary providers of needed dental services by reducing continuing education requirements to maintain retired license status for the purpose of providing voluntary care.

Delaware SB 96. Designed to attract dentists to work in Federally Qualified Health Centers by providing dentists from out of state a provisional license to practice within Delaware for a single two-year period. During this time the dentist would have to comply with the requirements for obtaining full licensure if the dentist wishes to continue to practice in the state.

Florida HB 7015. Among numerous other state support services for active duty military, veterans and their families, this law provides automatic licensure eligibility for a person who serves or has served as a health care practitioner (as defined in Florida law and including dentistry) in the United States Armed Forces, United States Reserve Forces, or the National Guard or a person who serves or has served on active duty with the United States Armed Forces as a health care practitioner in the United States Public Health Service. For these individuals, the application, licensure and unlicensed activity fees are waived. The Council noted that the licensure criteria specify that: 1) applicants must receive an honorable discharge within six months before, or will receive an honorable discharge within six months after, the date of submission of the application; 2) a veteran cannot wait more than six months after discharge to apply for

licensure; 3) the applicant must submit a formal application (to be developed by the Department of Health); and 4) the applicant must have a license to practice dentistry in another state with no disciplinary action within the past five years and must have been actively practicing in the profession for the previous three years.

Idaho SB 1226. Amended existing law to revise the number of board members necessary for a quorum; to revise a provision relating to the appointment of an executive director; to revise a provision relating to the degree required for licensure as a dentist; to provide for licensure to practice dentistry and dental hygiene by credential; to provide that an examination may be conducted by an agent of the board; to revise a provision relating to the requirements for converting a license from inactive to active; and to remove a provision relating to grounds for disciplinary action.

Kansas H 2611. Amends laws related to dentists and dental facilities [deletions are ~~strike throughs~~; additions are underscored]: "It shall be unlawful, and a licensee may have a license suspended or revoked, for any licensee to conduct a dental office in the name of the licensee, or to advertise the licensee's name in connection with any dental office or offices, or to associate together for the practice of dentistry with other licensed dentists in a professional corporation or limited liability company, under a name that may or may not contain the proper name of any such person or persons or to associate together with persons licensed to practice medicine and surgery in a clinic or professional association under a name that may or may not contain the proper name of any such person or persons and may contain the word "clinic," unless such licensee is personally present in the office operating as a dentist or personally overseeing such operations as are performed in the office or each of the offices ~~during a majority~~ at least 20% of the time patients are being treated in the office or each of the offices ~~is being operated.~~"

Pennsylvania HB 1056. Allows the dental board to issue temporary volunteer dental licenses to dentists licensed in other states if they fulfill certain criteria and requirements.

Virginia S 412. Relates to a deferred compensation plan for Medicaid program independent contractors; authorizes the Board of Trustees of the Virginia Retirement System to develop policies and procedures to allow certain independent contractors performing services for the Commonwealth's Medicaid program to participate in the deferred compensation plan for employees of the Commonwealth; relates to a dentist or an oral and maxillofacial surgeon independent contractor under a Medicaid agreement or contract.

West Virginia H 4538. Amends code, all relating to the Board of Dentistry, providing authority to promulgate legislative rules concerning agreements with organizations to create alcohol or chemical dependency treatments programs and to form dentist recovery networks; authorizing the board to defer disciplinary action with regard to an impaired licensee who voluntarily enters an approved treatment program; and providing for annual renewal of anesthesia permits.

Wisconsin SB 413 & AB 552. Replaces the definition of dentistry and defines it to mean the examination, evaluation, diagnosis, prevention or treatment, including surgery, of diseases, disorders, or conditions of the human oral cavity or its adjacent or associated tissues and structures, or of the maxillofacial area, and their impact on the human body.

ADA-Recognized Dental Specialties and Specialty Certifying Boards

As part of its *Bylaws* responsibilities, the Council annually surveys the ADA-recognized dental specialty certifying boards. The [2014 Report of the ADA-Recognized Dental Specialty Certifying Boards](#) shows that all nine specialty certifying boards certified diplomates in 2013. All boards, with the exception of the American Board of Periodontics, recertified diplomates in 2013. The report includes synopses of certification and examination data; eligibility requirements; examination, application and registration procedures; re-examination and recertification/certification maintenance policies; and a list of board executive directors/secretaries.

Recognition of Interest Areas in General Dentistry

The Council has received an Application for Recognition as an Interest Area in General Dentistry from the Academy of Operative Dentistry. Using the "Criteria for Recognition of Interest Areas in General Dentistry," the Council will follow its established review process, as reported to the 2013 ADA House of Delegates, and conduct an open hearing at the 2014 ADA meeting. The Council has invited comment from the communities of interest regarding the application via various e-publications to dental leaders and the *ADA News*. The Council's Recognition of Dental Specialties and Interest Areas in General Dentistry Committee and the Council will consider the application and comments in the spring. The Council will forward its recommendation regarding the application to the 2015 House of Delegates for consideration.

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 members in performing periodic equipment and supply checks.

Managing Sedation Complications CE Course. Part 1 (4 CEUs) of this ADA CE course is available on [ADA CE Online](#). Part 2 includes hands-on training in a small group format and offers 5 CEUs. Part 2 is scheduled for August 22, 2014, at the ADA headquarters building.

Anesthesia Guidelines. The Council is considering revisions to the ADA [Guidelines for the Use of Sedation and General Anesthesia by Dentists](#) and the *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*. The proposed amendment to both documents would address the use of capnography during moderate sedation in an open airway system as well as the need for continual observation of qualitative clinical signs by monitoring for the presence of exhaled carbon dioxide (unless precluded or invalidated by the nature of the patient, procedure or equipment). The Council has directed that the proposed revisions be circulated to the communities of interest for comment. Comments will be considered by the Council in August. If the Council concludes that the amendment should be pursued at this time, a supplemental report and resolution will be transmitted to the 2014 House of Delegates.

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 at ADA.org/CERP. At the time this report was prepared, there were 441 ADA CERP nationally recognized providers. Through the CERP Extended Approval Process (EAP), 16 of these approved providers (four specialty societies and 12 state dental associations) have extended approval to an additional 112 local societies. ADA CERP-approved providers list their [CE course offerings](#) in the ADA CERP section of ADA.org.

New CERP Application Forms for CE Providers. The CERP Standard and Abbreviated Application Forms have been revised, reorganized and reformatted so that they are clearer, more logical and easier to follow. Feedback from the first cohort to complete these forms in 2013 indicates that the new forms contain fewer redundancies. The CERP Committee will continue to monitor feedback from providers and make additional modifications to the forms as needed. Over time, CERP plans to transition to an online application process.

International CE Providers. Currently, 3% of CERP approved providers are based outside the United States and Canada ("international providers"). The Council and CERP Committee support the continued participation of international providers in ADA CERP. To enhance the CERP Committee's ability to assess these providers, and to support international providers' understanding of the purpose and function of ADA CERP, the Council approved revisions to the CERP Eligibility Criteria and established a Pre-Application Process and new fee structure for CE providers based in countries other than the United States and Canada.

New Policy on Compliance With Privacy Laws. The Council approved a new ADA CERP policy on compliance with privacy laws requiring CE providers submitting materials to ADA CERP to attest that the submitted materials do not include protected health information, as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, unless they have obtained any necessary authorization, consent or release, or any other personally identifiable information that may be protected by federal, state or local laws.

CERP Governance Structure. Resolution 82H-1996, Proposed Organizational Restructure of the ADA CERP Committee (*Trans.*1996:706), charged the Council on Dental Education (now known as CDEL) with oversight responsibility for the Continuing Education Recognition Program, established the responsibilities of CERP, and defined the composition of the CERP Committee. Resolution 5H-2007, Composition of the ADA CERP Committee (*Trans.*2007:393), amended 82H-1996 to specify the names of the organizations appointing CERP Committee members and stipulate that all dentists nominated to serve must be members of the ADA.

During the past three years, the Council and CERP Committee have assessed the effectiveness of this structure and explored options to restructure CERP as an ADA agency separate from the Council to better support the program's mission, enhance its impartiality and objectivity, and minimize internal conflicts of interest. The Council is proposing the establishment of the ADA Commission for Continuing Education Provider Recognition to oversee the program. Proposed revisions to the ADA *Bylaws* and draft rules for the proposed agency (similar to those of other ADA commissions) were circulated to the communities of interest and the Board of Trustees for comment in 2013.

- In developing this proposal, the Council and CERP Committee noted that CERP's current placement under the Council can potentially create internal conflicts of interest which may be detrimental to the credibility of both the ADA and its Continuing Education Recognition Program. Under the existing structure, the ADA approves its own CE program. In the event of an adverse action by CERP against the ADA, the Council would also adjudicate the ADA's appeal.
- The Council emphasizes that the proposal represents a shift in governance from one ADA agency to another. CERP will continue to operate under ADA *Bylaws*.
- The proposed commission's rules and annual operating budget would be subject to approval by the ADA House of Delegates.
- Financial impact on the ADA is anticipated to be minimal, as the proposed commission would be supported by existing staffing and financial structures. Currently, 68% of the program's direct and indirect operating costs are covered by participating provider fees (\$262,250 budgeted revenue for 2014); the remainder is supported by the ADA.
- Initially, the new Board of Commissioners will be composed of the incumbent members of the CERP Committee and any new appointees to the CERP Committee selected by the American Association of Dental Boards, American Dental Education Association, American Society of Constituent Dental Executives and/or a sponsoring organization of any ADA recognized dental specialty. These inaugural Commission members shall serve for terms that are equal in time to their unfinished terms on the retired CERP Committee. To the extent that there exists an unfilled position on the Commission for Continuing Education Provider Recognition for an ADA appointee when the Commission is created, that position shall be treated as a vacancy and filled in accordance with the procedure set forth in CHAPTER XV. COMMISSIONS, SECTION 70 of the ADA *Bylaws*.
- The proposed commission would have the authority to approve CE providers, adopt standards and policies and manage administration of the program.
- The recognition status of CE providers approved by CERP would be maintained in accordance with CERP Recognition Standards and Procedures.

A majority of stakeholders submitting comments, including the ADA Board of Trustees, were supportive of the concept, agreeing that the proposal to create a commission to oversee CERP:

- Reflects a best practice for recognition and accreditation programs by establishing a governance structure that minimizes the possibility of direct conflicts of interest;

- Enhances an ADA program that sets standards designed to help dentists excel throughout their careers; and
- Involves representatives from all disciplines of dentistry in program oversight.

The Council believes that a strength of the program is the broad representation of stakeholder groups on the CERP Committee. In light of feedback from the communities of interest and in order to ensure that general dentists are represented on the board of the proposed new commission, the Council modified its original proposal to stipulate that at least two of the ADA's four appointments to the board must be general dentists. The Council also modified the name of the commission from the original proposal to better reflect its function. Proposed amendments to ADA *Bylaws* establishing the commission and proposed rules for the commission are attached as Appendices 1 and 2. In establishing the Commission for Continuing Education Provider Recognition, the House of Delegates is empowered to approve the Rules of that commission. Thus, the Council on Dental Education and Licensure recommends that the following resolution be adopted by the 2014 House of Delegates:

6. Resolved, that ADA *Bylaws* be amended as shown in Appendix 1 of the Council on Dental Education and Licensure's 2014 annual report, establishing the Commission for Continuing Education Provider Recognition, and be it further

Resolved, that the Rules of the ADA Commission for Continuing Education Provider Recognition as shown in Appendix 2 of the Council on Dental Education and Licensure's 2014 annual report be approved, and be it further

Resolved, that Resolution 82H-1996 and Resolution 5H-2007 be rescinded.

Continuing Education Matters

Interagency Committee on Continuing Education. The Council's Continuing Education (CE) Committee fosters interagency CE development and includes 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 the NDC. To support Members First 2020, the 2015-2019 ADA Strategic Plan, the Council and its CE Committee approved three goals to guide CE programming in the near future: 1) partner with other dental organizations to develop contemporary topics for online and in-person CE; 2) improve ADA CE branding and marketing to particular market segments; and 3) utilize currently available technology to develop customizable educational opportunities that accommodate various learning styles. The Council also established a plan to sunset the ADA Seminar Series. Beginning in 2015, the ADA will provide consultation for any group requesting advice on booking speakers using information gained via the America's Dental Meeting and other ADA educational events to offer access to an online portfolio of speakers.

ADA CE Online. ADA CE Online is in its seventh year of operation and the number of registered users continues to grow. At the end of fiscal year 2013 there were 39,229 users, an increase of 10% over 2012. Although total registrants have increased, new registrants to ADA CE Online declined from 6,572 in 2012 to 3,825 new registrants in 2013. The total number of courses taken in 2013 was 10,248, a decrease of 4,046 courses from 2012 activity. At time this report was written, there were 105 courses in the library, with 20 new courses added, including seven courses videotaped at the 2013 annual meeting and eight courses recorded at the ADA headquarters.

To further promote ADA membership benefits to specific membership markets, the Council approved actions to provide: discounted ADA CE Online courses for new members; free ADA CE Online for American Student Dental Association members; and discounted ADA CE Online for ADA members in the Federal Services. In addition, the Council reestablished an ADA CE Online loyalty program to offer a one-year subscription to CE Online courses.

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 for 2013 include:

- Average scores for first-time examinees in 2013 on all tests in the DAT battery were slightly higher than those from 2012.
- The total number of DAT administrations has decreased each year since 2009.
- The decline in total administrations appears to be due to a decrease in repeat administrations.
- DAT reliability coefficients indicate that the DAT provides consistent, stable measurement of examinee skills and abilities.
- From highest to lowest, the percentage of administrations based on examinee self-reported ethnicity in 2013 were as follows: White (52%), Asian (25%), Hispanic (8%), Black (7%), American Indian (1%), and Pacific Islander (1%). Six percent (6%) of respondents did not provide ethnicity information.

This year, the Council endorsed the development of a business plan for an admission test for advanced dental education programs. This action was taken based on the need for new measures to assess applicants' preparedness for residency programs as a result of the National Board Dental Examinations (Parts I and II) change to pass/fail scoring. Further, the Council learned that some programs are using students' DAT scores in their admission criteria for advanced education programs, even though there is currently no validity evidence available to support such usage.

Responses to House of Delegates Resolutions

33H-2013. Amendment to the Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists (Trans.2013:328)

Council response: The Council developed a process and timeline for managing this resolution which amended the Requirements for Recognition of Dental Specialties to require the sponsoring organization of a dental specialty to ensure that 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 the specialty or have sufficient experience in that specialty as deemed appropriate by the sponsoring organization and its certifying board. Information is being collected to assist the Council in determining the extent to which each sponsoring dental specialty organization meets the revised Requirement (1). As directed by the House, the Council's findings will be reported to the 2015 House of Delegates.

39H-2013. Amendment of the Policy, Eliminating Use of Human Subjects in Board Examinations (Trans.2013:351)

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

50H-2013. Response to Resolution 110H-2012, Monitoring the Dental Board of California's Development of a Portfolio Examination (Trans.2013:329)

Council response: As noted previously in the Licensure section of this report, the Council, with input from the California Dental Association, is monitoring the Dental Board of California's development and implementation of a portfolio-style licensure examination. During 2013 and 2014, the Dental Board of California posted to its [website](#) proposed rulemaking and public hearing information. A mock portfolio examination is scheduled for late summer 2014; the first official portfolio examination may be given in 2015.

*54-2013. Development of a Robust Information Portal**54S-1-2013. Substitute for Resolution 54: Development of a Robust Information Portal (Trans.2013:330)*

Council Response: Referred Resolutions 54 and 54S-1 focused on the need for appropriate agencies of the ADA, in collaboration with the communities of interest, to develop and promote a robust information portal via ADA.org to help current and prospective students be fully informed about a career in dentistry. The Council reviewed new and re-organized resources for prospective and current students on the re-designed ADA.org, and noted that with the [Education and Careers page](#) serving as the portal, information on [careers in dentistry](#), [dental student resources](#), [pre-dental student resources](#), as well as resources for members, teachers and school counselors to use with middle school and high school students are available ([resources-for-educating-prospective-dental-professionals](#)).

- With regard to information on dental careers and financial implications, the ADA has several resources available:
 - ADA [Center for Professional Success](#): provides a variety of calculators in the areas of debt load, loan payment, loan term and overhead.
 - The Education and Careers area of ADA.org: presents information on choosing a dental school, paying for dental school and dental team [careers](#).
 - [ADA Financial Planning Resources](#): the Financial Resources for Students and New Graduates area of ADA.org presents information about financial planning issues for dental students, managing student finances infopak, and free student loan contract analysis.
 - The Scholarship and Loan Repayment area of ADA.org: includes information about dental student loan repayment programs and resources, [ADA Foundation scholarships](#), federally funded scholarships and links to several other helpful sites.
 - [ADA Podcast](#): The Financial Planning for Recent Graduates area presents a podcast titled "Financial Planning for the Recent Grad."
 - [Understanding advanced dental education](#) information is available on ADA.org.
- The American Dental Education Association (ADEA) has several helpful resources for prospective and current dental students including:
 - Websites showcasing careers in dentistry, [Go Dental](#) and the health professions, [Explore Health Careers](#).
 - The ADEA [Official Guide](#) to Dental Schools has a chapter devoted to "Financing a Dental Education."
 - The ADEA Official Guide to Dental Schools publishes tuition, fees, instrument, books, supplies, estimated living expenses by academic year for all dental schools.
 - The ADEA website also has [education debt management](#) materials for dental students.
 - The Association of American Medical Colleges and the American Dental Education Association (AAMC/ADEA) developed a Dental Loan Organizer and Calculator (DLOC) that provides a secure location for dental school students and residents to both organize and track student loans. The tool also runs repayment scenarios based on an individual's career plans following dental school, including any plans for post-doctoral work. DLOC was modeled after the AAMC's Medloans[®] Organizer and Calculator (MLOC), first introduced in 2010 as a tool for medical school students and residents. The dental loan calculator is free to dental students, graduates and resident and is accessible via <http://www.aadea.org/DLOC/>.
- The American Student Dental Association has additional resources for pre-dental and dental students including:
 - [Information and advice for predental students](#),
 - A series of videos on "[A Day in the Life of a Dental Student](#),"
 - [Information on paying for dental school](#),

- The publication, “Getting into Dental School: ASDA’s Guide for Predental Students,” and
- The publication, “Getting Through Dental School: ASDA’s Guide for Dental Students.”

After careful consideration of the current resources available to prospective and current dental students and noting that the Council’s career guidance department was sunset in 2012 due to limited resources and low priority ranking by members, the Council concluded that the intent of referred Resolutions 54 and 54S-1 has been achieved—the [Education and Careers](#) section of ADA.org serves as an information portal for prospective and current dental students. Accordingly, the Council is not proposing a resolution to the House of Delegates on this topic.

56H-2013. A Comprehensive Study of the Current Dental Education Model (Trans.2013:333)

Council response: Resolution 56H-2013 directed that the ADA seek collaboration with broad communities of interest, including dental educators, students, practicing dentists, health economists, and others with appropriate expertise to define the scope and specific aims of a comprehensive study of current dental education models. It also provided that a maximum of \$80,000 be used to define the scope and specific aims of the study, to determine the estimated cost of the study, and to identify potential funding sources for the study.

The Council is convening stakeholders on June 19-20, 2014, to receive broad-based input regarding Resolution 56H-2013. The meeting will be hosted by members of the Council and includes representatives from higher education, dental education, dental practice, the dental specialties and economists. The meeting will focus on defining the scope and specific aims of a comprehensive study of current dental education models. The Council’s summary report and recommendations in response to Resolution 56H-2013 will be presented as a supplemental report to the 2014 ADA House of Delegates for consideration.

91-2013. Disclosure of Costs Incurred by Dental Students (Trans.2013:331)

Council response: Referred Resolution 91 calls for the ADA to encourage dental schools, as part of their application and interview process to “disclose the actual costs incurred by their students to complete their degrees based on exit data collected for the two most recent classes.” As required by the Accreditation Standards for Dental Education Programs, each dental school makes available information regarding tuition, fees, instrument, books, supplies, and estimated living expenses by academic year to enable prospective and current students to plan their finances. The Council believes that it is highly unlikely that dental schools would agree to collect and/or students would agree to provide “actual costs” data. Acquiring this information would require that students/graduates divulge personal information to their institutions. The Council concluded that appropriate data is published annually in the [ADEA Survey of Dental School Seniors](#), presenting student indebtedness information in the aggregate for public and private/private state related dental schools. A link to the ADEA report is provided in the Education and Careers section of ADA.org. Accordingly, the Council is not proposing a resolution to the House of Delegates on this topic.

92-2013. Presentations for Long-Term Financial Implications of Debt Incurred by Students During Dental School (Trans.2013:331)

Council response: Referred Resolution 92 requested that appropriate agencies of the ADA develop presentations for pre-dental students explaining the long-term financial implications of debt incurred during dental school, and urged that the ADA make these presentations available in the public area of the Center for Practice Success website. The Council noted that the resources posted on ADA.org at [education and careers](#), with links to the ADEA and ASDA websites, provide ample information on the financial implications of a dental education. These resources are available to pre-dental students, parents, as well as middle school, high school and college counselors to use in presentations. The Council concluded that the [ADA Center for Professional Success](#) helps members succeed as both dental practitioners and small business owners and is not an appropriate portal for the public to learn

more about the costs of dental education. Accordingly, the Council is not proposing a resolution to the House of Delegates on this topic.

Self-Assessment

In accord with Resolution 1H-2013, the Council conducted a self-assessment based on the topical outline developed by the Board of Trustees. An ad hoc committee, composed of the chairs of the Council's standing committees and two at-large Council members, requested each of the standing committees to consider the self-assessment questions and forward comments and recommendations to the ad hoc committee. In May 2014, the Council considered the ad hoc committee's draft report and approved the Council's self-assessment report for transmittal to the 2014 House of Delegates.

The Council reviewed each of the six areas of the self-assessment, which included threshold issues, structure, efficiencies, areas of responsibility, agenda review, and strategic direction and made the following conclusions. The complete assessment is presented as Appendix 3 of this report.

The Council came to the following conclusions as a result of the self-assessment:

- The current ADA/ADEA/AADB structure of the Council supports the Association and members, providing broad-based volunteer oversight, expertise and input in matters which are paramount to a learned profession. The composition of the Council and its standing committees should remain as is. The Council's unique structure of private practitioners, dental educators and dental examiners is important and necessary to address the myriad of responsibilities assigned to this agency. The Council carries out assignments and activities related to all areas of its assigned duties. Additionally, the Council receives assignments from the House of Delegates related to its assigned duties. The Council's work assignments often require input from a variety of internal and external agencies, and the Council requests the appointment of interagency committees when collaboration is required to carry out its assignments.
- The Council operates efficiently, meeting in-person twice annually and conducting business electronically and via conference calls throughout the year. When appropriate, the chair assigns business to the subject-matter standing committees for consideration and recommendation to the Council. Business conducted electronically and via teleconferencing provides more opportunity for the Council to use in-person meeting time focused on strategic discussions on dental education, licensure and recognition matters critical to the membership and the profession. Professional and administrative staff support for this agency is adequate and appropriate.
- With regard to the Council's *Bylaws* responsibilities, the Council's duties should be amended to include its responsibility for dental anesthesiology policy matters as well as governance oversight for dental admission testing (see resolution below). As noted elsewhere in this report, in December 2013 the Council concluded that conduct of the CERP Committee's business—development of standards and recognition decisions—should be overseen by an agency dedicated to these activities and separate from other Council business and Association priorities. It directed that a resolution be transmitted to the 2014 House of Delegates proposing the establishment of a separate ADA agency to oversee CERP.

Duties of the Council on Dental Education and Licensure

Based on the conclusions of the self-assessment, the Council presents the following resolution to the House of Delegates:

7. Resolved, that CHAPTER X, COUNCILS; *Section 120. DUTIES*, Subsection E. COUNCIL ON DENTAL EDUCATION AND LICENSURE of the ADA *Bylaws* be amended as follows (proposed additions are underlined):

The duties of the Council shall be to:

- a. Act as the agency of the Association in matters related to the evaluation and accreditation of all dental educational, allied dental educational and associated subjects.
- b. Study and make recommendations including the formulation and recommendation of policy 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.
 - (8) Dental licensure and allied dental personnel credentialing.
 - (9) Dental anesthesiology, sedation and related matters.
- c. Act on behalf of this Association in maintaining effective liaison with certifying boards and related agencies for dental specialties and for allied dental personnel.
- d. Monitor and disseminate information on continuing dental education and to encourage the provision of and participation in continuing dental education.
- e. Monitor and disseminate information on careers in dentistry.
- f. Act on behalf of this Association in matters related to dental admission testing.

Policy Review

In accordance with Resolution 170H-2012, Reaffirming Existing ADA Policy, the Council reviewed Association policies related to Allied Dental Education and Personnel, Laboratories and Technicians and Workforce in 2014.

Recommendations—Policies to be Maintained

The Council reviewed the following policies and determined they should be maintained:

Admissions Criteria for Dental Hygiene Programs (*Trans.*1995:639)
 Statement on Credentialing Dental Assistants (*Trans.*1995:634)
 Dentist Administered Dental Assisting and Dental Hygiene Education Programs (*Trans.*1992:616; 2010:542)
 Policy on Native American Workforce (*Trans.*2011:491)

Recommendations—Policies to be Amended

Development of Alternate Pathways for Dental Hygiene Training

The Council believes that the policy “Development of Alternate Pathways for Dental Hygiene Training” should be amended to delete the phrase, “as an educational opportunity that satisfies the criteria of 42H-1997, and that constituent dental societies be notified of this support” because this part of the statement was a directive in 1997 related to the Comprehensive Policy on Dental Auxiliary Personnel, which subsequently was revised.

8. Resolved, that the ADA policy on Development of Alternative Pathways for Dental Hygiene Training (*Trans.*1998:714) be amended by deletion of the phrase, “as an educational opportunity that satisfies the criteria of 42H-1997, and that constituent dental societies be notified of this support,” so that the amended policy reads as follows (deletions are ~~strikethroughs~~):

Development of Alternate Pathways for Dental Hygiene Training

Resolved, the American Dental Association supports the alternate pathway model of Dental Hygiene Education as used in Alabama ~~as an educational opportunity that satisfies the criteria of 42H-1997, and that constituent dental societies be notified of this support.~~

Recognition of Certification Boards for Allied Dental Personnel

The Council believes that the policies, “Recognition of Certification Board for Dental Assistants” and “National Board for Certification of Dental Laboratory Technicians’ Continued Recognition” should be amended in an effort to establish standardized declarative policy statements for approved certifying boards.

9. Resolved, that the ADA policy on Recognition of Certification Board for Dental Assistants (*Trans.*1990:551) be amended as follows (additions are underscored; deletions are ~~strikethroughs~~):

Recognition of Certification Certifying Board for in Dental Assistants Assisting

Resolved, that the American Dental Association approves the Dental Assisting National Board, Inc.’s ~~request for recognition as the certification board for dental assistants~~ as the national certifying board for dental assisting.

10. Resolved, that the ADA policy on National Board for Certification of Dental Laboratory Technicians’ Continued Recognition (*Trans.*2002:440) be amended as follows (additions are underscored; deletions are ~~strikethroughs~~):

National Board for Certification of Certifying Board in Dental Laboratory Technicians’ Continued Recognition Technology

Resolved, that the ~~American Dental Association~~ approves the National Board for Certification of ~~in Dental Laboratory Technicians’ request for continued recognition as the certification board for dental laboratory technicians be approved~~ Technology as the national certifying board for dental laboratory technology.

Criteria for Recognition of Certification Boards for Allied Dental Personnel

Further, the Council believes that the policies, “Criteria for Recognition of a Certification Board for Dental Assistants” and “Criteria for Approval of a Certification Board for Dental Laboratory Technicians” should be amended as a housekeeping measure to reflect consistent clarifying language and contemporary style.

11. Resolved, that the policy on Criteria for Recognition of a Certification Board for Dental Assistants (*Trans.*1989:520) be amended as follows (additions are underscored; deletions are ~~strikethroughs~~):

Criteria for Recognition of a Certification Board for Dental Assistants

Introduction: ~~Duties~~ A duty of the Council on Dental Education and Licensure as indicated in the *Bylaws* of the American Dental Association ~~include acting as the agency of the Association in matters related to the evaluation and accreditation of all dental and dental auxiliary education programs and to approve or disapprove~~ is to study and make recommendations on policy related to the approval or disapproval of national certifying boards for special areas of dental practice and for dental auxiliaries allied dental personnel.

~~It is the opinion of the Council on Dental Education and Licensure that a~~ A mechanism should be made available for providing evidence that a dental assistant has acquired the knowledge and ability that is expected of an individual employed as a dental assistant through a program of certification. Such a certification program should be based on the educational requirements for dental assistants approved by the Commission on Dental Accreditation.

~~The Association has already indicated its approval of certification programs for the eight recognized dental specialties and for dental laboratory technicians; the House of Delegates has approved basic requirements under which these certification programs are conducted. Such a program of certification that has been approved as meeting these basic requirements has therefore earned the approval of the dental profession even though the program itself is not conducted or operated by the American Dental Association.~~

The dental profession is committed to assuring appropriate education and training of all personnel who participate in the provision of oral health care to the public. The following basic requirements are prescribed by the Council on Dental Education and Licensure for the evaluation of an agency which seeks approval of the American Dental Association for a program to certify dental assistants on the basis of educational standards approved by the dental profession.

I. Organization

1. The Board shall have no less than five nor more than nine voting members designated on a rotation basis in accordance with a method approved by the Council on Dental Education and Licensure. The following organizations/interests shall be represented on the Board:

- a. American Dental Assistants Association
- b. American Dental Association
- c. American Dental Education Association
- d. American Association of Dental ~~Examiners~~ Boards
- e. Public
- f. The at-large population of Board Certificants

All dental assistant members shall be currently certified by the Board.

2. The Board shall submit to the Council on Dental Education and Licensure evidence of adequate financial support to conduct its program of certification.

3. The Board may select suitable consultants or agencies to assist in its operations, such as the preparation and administration of examinations and the evaluation of records and examinations of candidates. Dental assistant consultants should be certified by the board.

4. The 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 for dental assistants. This statement should include evidence that the Board has the support of the American Dental Assistants Association, the organization representative of dental assistants, as well as other groups within the ~~communities~~ of interests represented by the Board.

II. Operation of Board

1. The Board shall ~~issue certificates~~ grant certification to individuals who have provided evidence of competence in dental assisting.

2. The Board shall submit in writing to the Council on Dental Education and Licensure a plan for renewal of certificate currently held by certified persons.

3. The Board shall submit annually to the Council on Dental Education and Licensure data relative to its financial operations, applicant eligibility criteria, examination procedures and results of its certifying examination.

4. The Board shall ~~conduct at least two~~ administer the certification examinations at least twice each calendar year ~~which shall be with administrations~~ publicized at least six months prior to the examination.

5. The Board shall maintain and make available a current list of all persons certified.

6. The Board shall have authority to conduct the certification program; i.e., the Board shall be responsible for evaluating qualifications and competencies of persons certified and for maintaining adequate standards for the annual renewal of certificates. However, proposals for important changes in the examination eligibility criteria or the Board procedures and policies must be circulated reasonably well in advance of consideration to affected communities of interest for review and comment. Proposed changes must have the approval of the Council on Dental Education and Licensure.

7. The Board shall maintain close liaison with the organizations represented on the Board. The Board shall report on its program annually to the organizations represented on the Board.

III. Granting Certificates

1. In the evaluation of its candidates for certification, the Board shall use standards of education and clinical experience approved by the Commission on Dental Accreditation. The Board shall require for eligibility for certification the successful completion of a dental assisting education program accredited by the Commission on Dental Accreditation, and satisfactory performance on an examination prescribed by the Board.

2. The Board shall ~~issue certificates~~ grant certification or recertification annually to those who qualify for certification.

The Board may require an annual certificate renewal fee to enable it to carry on its program.

IV. Waivers

It is a basic view of the Council that all persons seeking certification shall qualify for certification by completing satisfactorily a minimum period of approved training and experience and by passing an examination. However, the Council realizes that there may be need for a provision to recognize candidates who do not meet the established eligibility criteria on educational training. Therefore, the Board may make formal requests to the Council on Dental Education and Licensure regarding specific types of waivers which it believes essential for certification and/or certificate renewal. Such requests shall be substantiated and justified to and supported by the organizations represented on the Board; only waivers approved by the Council on Dental Education and Licensure may be used.

12. Resolved, that the policy on Criteria for Approval of a Certification Board for Dental Laboratory Technicians (*Trans.*1998:92, 713) be amended as follows (additions are underscoring; deletions are ~~strikethroughs~~):

Criteria for ~~Approval~~ Recognition of a Certification Board for Dental Laboratory Technicians

~~One of the duties~~ A duty of the Council on Dental Education and Licensure as indicated in the Bylaws of the American Dental Association is to study and make recommendations ~~including the formulation and recommendation of~~ on policy on: ~~(4) The related to the approval or disapproval of~~

national certifying boards for allied dental personnel, ~~special areas of dental practice and for dental auxiliaries~~ (5) ~~The educational and administrative standards of the certifying boards for special areas of dental practice and for dental auxiliaries. The Council on Dental Education and Licensure believes that~~ A mechanism for the examination and certification of dental laboratory technicians is necessary to provide the dental profession with an indication of those persons who have demonstrated their ability to fulfill the dental laboratory work authorization. Such a certification program should be based on the educational requirements for dental laboratory technicians approved by the Commission on Dental Accreditation.

The following basic requirements are prescribed by the Council on Dental Education and Licensure for the evaluation of an agency which seeks approval of the American Dental Association for a program to certify dental laboratory technicians on the basis of educational standards approved by the dental profession.

I. Organization: An agency that seeks approval as a Certification Board for Dental Laboratory Technicians should be representative of or affiliated with a national organization of the dental laboratory industry and have authority to speak officially for that organization. It is required that each dental laboratory technician member of the Certification Board hold a certificate in one of the areas of the dental laboratory technology.

II. Authority and Purpose: The rules and regulations established by the Certification Board of Dental Laboratory Technicians will be considered for approval by the Council on Dental Education and Licensure on the basis of these requirements.

Changes that are planned in the rules and regulations of the Certification Board should be reported to the Council before they are put into effect. The Board shall submit data annually to the Council on Dental Education and Licensure relative to its financial operations, applicant admission and examination procedures, and results thereof.

The principal functions of the Certification Board shall be:

- a. to determine the levels of education and experience of candidates applying for certification examination within the requirements for education established by the Commission on Dental Accreditation;
- b. to prepare and administer comprehensive examinations to determine the qualifications of those persons who apply for certification; and
- c. to issue certificates to those persons who qualify for certification and to prepare and maintain a roster of ~~certifices~~ certificants.

III. Qualifications of Candidates: It will be expected that the minimum requirements established by the Certification Board for the issuance of a certificate will include the following:

- a. satisfactory legal and ethical standing in the dental laboratory industry;
- b. graduation from high school or an equivalent acceptable to the Certification Board;
- c. a period of study and training as outlined in the Accreditation Standards for Dental Laboratory Technology Education Programs, plus an additional period of at least two years of working experience as a dental laboratory technician; or, five years of education and/or experience in dental technology; and
- d. satisfactory performance on examination(s) prescribed by the Certification Board.

Titles and Descriptions of Continuing Education Courses

The Council believes that the policy "Titles and Descriptions of Dental Hygiene Continuing Education Courses" should be amended in an effort to broaden the policy to all allied personnel and to delete the resolving clauses that were directives for implementation at the time the policy was adopted.

13. Resolved, that the policy on Titles and Descriptions of Dental Hygiene Continuing Education Courses (*Trans.*1992:618) be amended as follows (additions are underscored; deletions are ~~strikethroughs~~):

Titles and Descriptions of ~~Dental Hygiene~~ Continuing Education Courses

Resolved, that the American Dental Association ~~supports the~~ opposes use of the terms “diagnosis” and “treatment planning” solely in the titles and descriptions of continuing education courses for dentists. The use of these terms in continuing education activities for allied dental personnel dental hygienists and descriptions of these courses that inappropriately imply implies that the continuing education program content or prior educational level of allied dental personnel dental hygienists is sufficient to make the dental hygienist competent for them to render diagnosis of dental disease or to develop treatment plans planning for dental patients, and be it further

Resolved, that the ADA ~~communicate its position on this issue to the American Dental Education Association and the American Association of Dental Examiners, and be it further~~

Resolved, that ~~constituent and component dental societies be asked to work with sponsors of continuing education and boards of dentistry to maintain appropriate use of terminology in continuing education program literature.~~

Summary of Resolutions

Resolution 6. Amendment of the *Bylaws* to Establish the Commission for Continuing Education Provider Recognition and Approval of the Rules of the ADA Commission for Continuing Education Provider Recognition

Resolution 7. Amendment of the *Bylaws* Duties of the Council on Dental Education and Licensure

Resolution 8. Amendment of the Policy, Development of Alternate Pathways for Dental Hygiene Training

Resolution 9. Amendment of the Policy, Recognition of Certification Board for Dental Assistants

Resolution 10. Amendment of the Policy, National Board for Certification of Dental Laboratory Technicians' Continued Recognition

Resolution 11. Amendment of the Criteria for Recognition of a Certification Board for Dental Assistants

Resolution 12. Amendment of the Criteria for Approval of a Certification Board for Dental Laboratory Technicians

Resolution 13. Amendment of the Policy, Titles and Descriptions of Dental Hygiene Continuing Education Courses

Council Minutes

For more information on recent activities, see the Council's [minutes](#) on ADA.org.

Appendix 1.

ADA BYLAWS

(additions are underscored; deletions are ~~stricken~~):

CHAPTER XV • COMMISSIONS

Section 10. NAME: The commissions of this Association shall be:

Commission on Dental Accreditation

Joint Commission on National Dental Examinations

Commission for Continuing Education Provider Recognition

Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS:

A. COMMISSION ON DENTAL ACCREDITATION. The number of members and the method of selection of the members of the Commission on Dental Accreditation shall be governed by the *Rules of the Commission on Dental Accreditation* and these *Bylaws*.

Twelve (12) of the members of the Commission on Dental Accreditation shall be selected as follows:

(1) Four (4) members shall be selected from nominations open to all trustee districts from the active, life or retired members of this Association, no one of whom shall be a faculty member working for a school of dentistry more than one day per week or a member of a state board of dental examiners or jurisdictional dental licensing agency. These members shall be nominated by the Board of Trustees and elected by the House of Delegates.

(2) Four (4) members who are active, life or retired members of this Association shall be selected by the American Association of Dental Boards from the active membership of that body, no one of whom shall be a member of a faculty of a school of dentistry.

(3) Four (4) members who are active, life or retired members of this Association shall be selected by the American Dental Education Association from its active membership. These members shall hold positions of professorial rank in dental schools accredited by the Commission on Dental Accreditation and shall not be members of any state board of dental examiners or jurisdictional dental licensing agency.

B. JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS. The Joint Commission on National Dental Examinations shall be composed of fifteen (15) members selected as follows:

a. Three (3) members shall be nominated by the Board of Trustees from the active, life or retired members of this Association and additional nominations may be made by the House of Delegates but no one of such nominees shall be a member of a faculty of a school of dentistry or a member of a state board of dental examiners or jurisdictional dental licensing agency. The House of Delegates shall elect the three (3) members from those nominated by the Board of Trustees and the House of Delegates.

b. Six (6) members who are active, life or retired members of this Association shall be selected by the American Association of Dental Boards from the active membership of that body, no one of whom shall be a member of a faculty of a dental school.

c. Three (3) members who are active, life or retired members of this Association shall be selected by the American Dental Education Association from its active membership. These members shall hold positions of professorial rank in the dental schools accredited by this Association and shall not be members of any state board of dental examiners or jurisdictional dental licensing agency.

d. One (1) member who is a dental hygienist shall be selected by the American Dental Hygienists' Association.

e. One (1) member who is a public representative shall be selected by the Joint Commission on National Dental Examinations.

f. One (1) member who is a dental student shall be selected annually by the American Student Dental Association.

C. COMMISSION FOR CONTINUING EDUCATION PROVIDER RECOGNITION. The Commission for Continuing Education Provider Recognition shall be composed of members selected as follows:

- a. Four (4) members, at least two of whom shall be general dentists, shall be selected from nominations open to all trustee districts from the active, life or retired members of this Association. These members shall be nominated by the Board of Trustees and elected by the House of Delegates.
- b. One (1) member who is an active, life or retired member of this Association (if eligible) shall be selected by the American Association of Dental Boards from the active membership of that body.
- c. One (1) member who is an active, life or retired member of this Association (if eligible) shall be selected by the American Dental Education Association from its active membership.
- d. One (1) member who is an active, life or retired member of this Association (if eligible) shall be selected by the American Society of Constituent Dental Executives from its active membership.
- e. One (1) member who is an active, life or retired member of this Association shall be selected by each sponsoring organization of the ADA recognized dental specialties.*

*The Commission for Continuing Education Provider Recognition initially shall be composed of the incumbent members of the CERP Committee of the Council on Dental Education and Licensure that was retired by the 2014 House of Delegates and any new appointees to the CERP Committee of the Council on Dental Education and Licensure selected by the American Association of Dental Boards, American Dental Education Association, American Society of Constituent Dental Executives and/or a sponsoring organization of any ADA recognized dental specialty. To the extent that there exists an unfilled position on the Commission for Continuing Education Provider Recognition for an ADA appointee when the Commission is created, that position shall be treated as a vacancy and filled in accordance with the procedure set forth in CHAPTER XV. COMMISSIONS, SECTION 70 of these ADA *Bylaws*. These inaugural Commission members shall serve for terms that are equal in time to their unfinished terms on the retired CERP Committee. This footnote shall expire at adjournment sine die of the 2018 House of Delegates.

Section 30. REMOVAL FOR CAUSE: The Board of Trustees may remove a commission member for cause in accordance with procedures established by the Board of Trustees, which procedures shall provide for notice of the charges, including allegations of the conduct purported to constitute each violation, and a decision in writing which shall specify the findings of fact which substantiate any and all of the charges, and that prior to issuance of the decision of the Board of Trustees, no commission member shall be excused from attending any meeting of a commission unless there is an opportunity to be heard or compelling reasons exist which are specified in writing by the Board of Trustees.

Section 40. ELIGIBILITY:

- A. All members of commissions who are dentists must be active, life or retired members in good standing of this Association except as otherwise provided in these *Bylaws*.
- B. A member of the Joint Commission on National Dental Examinations, who was selected by the American Association of Dental Boards and who is no longer an active member of that Association, may continue as a member of the Commission for the balance of that member's term.
- C. When a member of the Joint Commission on National Dental Examinations, who was selected by the American Dental Education Association, shall cease to be a member of the faculty of a member school of that Association, such membership on the Commission shall terminate, and the President of the American Dental Association shall declare the position vacant.
- D. Any organizations that select members to serve on the Commission for Continuing Education Provider Recognition and offer continuing dental education courses shall be continuing education providers currently approved by that Commission.
- DE. No member of a commission may serve concurrently as a member of a council or another commission.

EF. The Commissions of this Association shall elect their own chairs who shall be active, life or retired members of this Association.

Section 50. CONSULTANTS, ADVISERS AND STAFF:

A. CONSULTANTS AND ADVISERS. Each commission shall have the authority to nominate consultants and advisers in conformity with rules and regulations established by the Board of Trustees except as otherwise provided in these *Bylaws*. The Joint Commission on National Dental Examinations also shall select consultants to serve on the Commission's test construction committees. The Commission on Dental Accreditation shall have the power to appoint consultants to assist in developing requirements and guidelines for the conducting of accreditation evaluations, including site visitations, of predoctoral, advanced dental educational, and dental auxiliary educational programs. The Commission for Continuing Education Provider Recognition shall have the power to appoint consultants to assist in developing standards and procedures, conducting recognition reviews and conducting appeals.

B. STAFF. The Executive Director shall employ the staff of Commissions, in the event they are employees, and shall select the titles for commission staff positions.

Section 60. TERM OF OFFICE: The term of office of members of the commissions shall be four (4) years except that (a) the term of office of members of the Commission on Dental Accreditation selected pursuant to the *Rules of the Commission on Dental Accreditation* shall be governed by those *Rules* and (b) the term of office of the dental student selected by the American Student Dental Association for membership on the Joint Commission on National Dental Examinations shall be one (1) year. The tenure of a member of a commission shall be limited to one (1) term of four (4) years except that (a) the consecutive tenure of members of the Commission on Dental Accreditation selected pursuant to the *Rules of the Commission on Dental Accreditation* shall be governed by those *Rules* and (b) tenure in office of the dental student selected by the American Student Dental Association for membership on the Joint Commission on National Dental Examinations shall be one (1) term. A member shall not be eligible for appointment to another commission or council for a period of two (2) years after completing a previous commission appointment.

Section 70. VACANCY: In the event of a vacancy in the office of a commissioner, the following procedure shall be followed:

A. In the event the member of a commission, whose office is vacant, is or was a member of and was appointed or elected by this Association, the President of this Association shall appoint a member of this Association possessing the same qualifications as established by these *Bylaws* for the previous member, to fill such vacancy until a successor is elected by the next House of Delegates of this Association for the remainder of the unexpired term.

B. In the event the member of a commission whose office is vacant was selected by an organization other than this Association, such other organization shall appoint a successor possessing the same qualifications as those possessed by the previous member of the commission.

C. In the event such vacancy involves the chair of the commission, the President of this Association shall have the power to appoint an *ad interim* chair, except as otherwise provided in these *Bylaws*.

D. If the term of the vacated commission position has less than fifty percent (50%) of a full four-year term remaining at the time the successor member is appointed or elected, the successor member shall be eligible for election to a new, consecutive four-year term. If fifty percent (50%) or more of the vacated term remains to be served at the time of the appointment or election, the successor member shall not be eligible for another term.

Section 80. MEETINGS OF COMMISSIONS: Each commission shall hold at least one regular meeting annually, provided that funds are available in the budget for that purpose and unless otherwise directed by the Board of Trustees. Meetings may be held at the Headquarters Building, the Washington Office or

from multiple remote locations through the use of a conference telephone or other communications equipment by means of which all members can communicate with each other. Such meetings shall be conducted in accordance with rules and procedures established by the Board of Trustees.

Section 90. QUORUM: A majority of the members of any commission shall constitute a quorum.

Section 100. PRIVILEGE OF THE FLOOR: Chairs and members of the commissions who are not members of the House of Delegates shall have the right to participate in the debate on their respective reports but shall not have the right to vote.

Section 110. ANNUAL REPORT AND BUDGET:

A. ANNUAL REPORT. Each commission shall submit, through the Executive Director, an annual report to the House of Delegates and a copy thereof to the Board of Trustees.

B. PROPOSED BUDGET. Each commission shall submit to the Board of Trustees, through the Executive Director, a proposed itemized budget for the ensuing fiscal year.

Section 120. POWER TO ADOPT RULES: Any commission of this Association shall have the power to adopt rules for such commission and amendments thereto, provided such rules and amendments thereto do not conflict with or limit the *Constitution and Bylaws* of this Association. Rules and amendments thereto, adopted by any commission of this Association, shall not be effective until submitted in writing to and approved by majority vote of the House of Delegates of this Association, except the Joint Commission on National Dental Examinations shall have such bylaws and amendments thereto as the House of Delegates of this Association may adopt by majority vote for the conduct of the purposes and management of the Joint Commission on National Dental Examinations.

Section 130. DUTIES:

A. COMMISSION ON DENTAL ACCREDITATION. The duties of the Commission on Dental Accreditation shall be to:

- a. Formulate and adopt requirements and guidelines for the accreditation of dental educational and dental auxiliary educational programs.
- b. Accredite dental educational and dental auxiliary educational programs.
- c. Provide a means for appeal from an adverse decision of the accrediting body of the Commission to a separate and distinct body of the Commission whose membership shall be totally different from that of the accrediting body of the Commission.
- d. Submit an annual report to the House of Delegates of this Association and interim reports, on request, and the Commission's annual budget to the Board of Trustees of the Association.
- e. Submit the Commission's articles of incorporation and rules and amendments thereto to this Association's House of Delegates for approval by majority vote either through or in cooperation with the Council on Dental Education and Licensure.

B. JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS. The duties of the Joint Commission on National Dental Examinations shall be to:

- a. Provide and conduct written examinations, exclusive of clinical demonstrations for the purpose of assisting state boards of dental examiners in determining qualifications of dentists who seek license to practice in any state or other jurisdiction of the United States. Dental licensure is subject to the laws of the state or other jurisdiction of the United States and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.
- b. Provide and conduct written examinations, exclusive of clinical demonstrations for the purpose of assisting state boards of dental examiners in determining qualifications of dental hygienists who seek license to practice in any state or other jurisdiction of the United States. Dental hygiene licensure is subject to the laws of the state or other jurisdiction of the United States and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.

- c. Make rules and regulations for the conduct of examinations and the certification of successful candidates.
- d. Serve as a resource of the dental profession in the development of written examinations.

C. COMMISSION FOR CONTINUING EDUCATION PROVIDER RECOGNITION. The duties of the Commission for Continuing Education Provider Recognition shall be to:

- a. Formulate and adopt requirements, guidelines and procedures for the recognition of continuing dental education providers.
- b. Approve providers of continuing dental education programs and activities.
- c. Provide a means for continuing dental education providers to appeal adverse recognition decisions.
- d. Submit an annual report to the House of Delegates of this Association and interim reports, on request, and the Commission's annual budget to the Board of Trustees of the Association.
- e. Submit the Commission's rules and amendments thereto to this Association's House of Delegates for approval by majority vote either through or in cooperation with the Council on Dental Education and Licensure.

Appendix 2. Proposed Rules of the ADA Commission for Continuing Education Provider Recognition

PROPOSED

RULES OF THE ADA COMMISSION FOR CONTINUING EDUCATION PROVIDER RECOGNITION

Article I. BOARD OF COMMISSIONERS

Section 1. MANAGEMENT BODY: The management body of the Commission shall be the Board of Commissioners.

Section 2. COMPOSITION: The Board of Commissioners shall be as defined in Chapter XV, Section 20.C of the ADA *Bylaws*.

Section 3. TERM OF OFFICE: The term of office of the members of the Board of Commissioners shall be as defined in Chapter XV, Section 60 of the ADA *Bylaws*.

Section 4. POWERS:

A. The Board of Commissioners shall be vested with full power to conduct all business of the Commission subject to the laws of the State of Illinois, these *Rules* and the *Constitution and Bylaws* of the American Dental Association.

B. The Board of Commissioners shall have the power to establish rules and regulations not inconsistent with these *Rules* to govern its organization and procedures.

Section 5. DUTIES: The duties of the Board of Commissioners are as set forth in Chapter XV. Sections 50.A and 130 of the ADA *Bylaws*, and in addition the Board of Commissioners may appoint special committees of the Commission for the purpose of performing duties not otherwise assigned by these *Rules*.

Section 6. MEETINGS:

A. REGULAR MEETINGS: There shall be at least two (2) regular meetings of the Board of Commissioners each year.

B. SPECIAL MEETINGS: Special meetings of the Board of Commissioners may be called at any time by the Chairman of the Commission. The Chairman shall call such meetings on request of a majority of the voting members of the Board provided at least ten (10) days' notice is given to each member of the Board in advance of the meeting. No business shall be considered except that provided in the call unless by unanimous consent of the members of the Board present and voting.

Section 7. QUORUM: A quorum of the Board shall be defined as defined in Chapter XV, Section 90 of the ADA *Bylaws*.

Article II. OFFICERS

Section 1. OFFICERS: The officers of the Commission shall be a Chair and Vice-Chair and such other officers as the Board of Commissioners may authorize. The Chair and Vice-Chair shall be elected by the members of the Commission. The Chair and Vice-Chair shall be active, life or retired member of the American Dental Association.

Section 2. DUTIES: The duties of the officers are as follows:

A. CHAIR: The Chair shall preside at all meetings of the Board of Commissioners.

B. VICE-CHAIR: If the Chair is unable to attend any given meeting of the Board of Commissioners, the Vice-Chair shall preside at the meeting. If the Vice-chair is unable to attend the meeting, the other members of the Board of Commissioners present and voting shall elect by majority vote an acting chair for the purpose of presiding at that meeting only.

Article III. APPEAL BOARD

Section 1. APPEAL BOARD: The appellate body of the Commission shall be the Appeal Board which shall have the authority to hear and decide appeals filed by continuing education providers from decisions rendered by the Board of Commissioners of the Commission denying or revoking recognition.

Section 2. COMPOSITION: The Appeal Board consists of one representative selected by each of the organizations represented on the Board of Commissioners who has previously served on the Board of Commissioners. When an appeal is initiated, the Director selects three (3) individuals from the pool of available Appeal Board Members to hear the appeal.

Section 3. TERM OF OFFICE: The term of office of members on the Appeal Board shall be one four (4) year term.

Section 4. MEETINGS: The Appeal Board shall meet at the call of the Director of the Commission, provided at least ten (10) days' notice is given to each member of the Appeal Board in advance of the meeting. Such meetings shall be called by the Director only when an appeal to the appellate body has been duly filed by a continuing education provider.

Section 5. QUORUM: A majority of the voting members of the Appeal Board shall constitute a quorum.

Section 6. VACANCIES:

A. In the event of a vacancy in the membership of the Appeal Board, the Chair of the Commission shall appoint a member of the same organization to fill such vacancy until a successor is selected by the respective representative organization.

B. If the term of the vacated position has less than fifty percent (50%) of a full four-year term remaining at the time the successor member is appointed, the successor member shall be eligible for a new, consecutive four-year term. If fifty percent (50%) or more of the vacated term remains to be served at the time of the appointment, the successor member shall not be eligible for another term.

Article IV. CONTINUING EDUCATION RECOGNITION PROGRAM

Section I. RECOGNITION STANDARDS AND PROCEDURES: The Commission, acting through the Board of Commissioners, shall establish and publish specific Standards and Procedures for the recognition of providers of continuing dental education programs.

Section 2. PROCEDURES FOR EVALUATING INITIAL AND RENEWAL APPLICATIONS FOR RECOGNITION: Providers of continuing dental education activities shall be evaluated for compliance with the Standards and Procedures and recognition status conferred by the Board of Commissioners on the basis of the information and data provided on survey forms and reports and secured by the members

of, and consultants to, the Board of Commissioners, as set forth in the Standards and Procedures and in the Procedures for an Adverse Action Against a Continuing Education Provider.

Article V. MISCELLANEOUS

The operating procedures of the Commission shall be governed by the *Rules* except where they are in conflict with the ADA *Bylaws* and the Standing Rules of Councils and Commissions.

Appendix 3. Council on Dental Education and Licensure 2014 Self-Assessment

Strategic Plan Goal:

Goal #1: Provide support to dentists so they may succeed and excel throughout their careers.

Goal #3: Improve public health outcomes through a strong collaborative profession and through effective collaboration across the spectrum of our external stakeholders.

Summary: In accord with Resolution 1H-2013, the Council conducted a self-assessment based on the topical outline developed by the Board of Trustees. An ad hoc committee, composed of the chairs of the Council's standing committees requested each of the standing committees to consider the self-assessment questions and forward comments and recommendations to the ad hoc committee. In May 2014, the Council considered the ad hoc committee's draft report and approved the Council's Self-assessment Report for transmittal to the 2014 House of Delegates.

The Council reviewed each of the six areas of the self-assessment, which included threshold issues, structure, efficiencies, areas of responsibility, agenda review, and strategic direction and made the following conclusions. The complete assessment is presented in this report.

The Council made the following conclusions as a result of the self-assessment:

- The current ADA/ADEA/AADB structure of the Council supports the Association and members, providing broad-based volunteer oversight, expertise and input in matters which are paramount to a learned profession. The composition of the Council and its standing committees should remain as is. The Council's unique structure of private practitioners, dental educators and dental examiners is important and necessary to address the myriad of responsibilities assigned to this agency. The Council carries out assignments and activities related to all areas of its assigned duties. Additionally, the Council receives assignments from the House of Delegates related to its assigned duties. The Council's work assignments often require input from a variety of internal and external agencies, and the Council requests the appointment of interagency committees when collaboration is required to carry out its assignments.
- The Council operates efficiently, meeting in-person twice annually and conducting business electronically and via conference calls throughout the year. When appropriate, the chair assigns business to the subject-matter standing committees for consideration and recommendation to the Council. Business conducted electronically and via teleconferencing provides more opportunity for the Council to use in-person meeting time focused on strategic discussions on dental education, licensure and recognition matters critical to the membership and the profession. Professional and administrative staff support for this agency is adequate and appropriate.
- With regard to the Council's responsibilities, the Council's *Bylaws* duties should be amended to include its responsibility for dental anesthesiology policy matters as well as governance oversight for dental admission testing. Accordingly, a resolution calling for the duties to be amended is submitted to the 2014 House of Delegates. In December 2013, the Council concluded that conduct of the CERP Committee's business—development of standards and recognition decisions—should be overseen by an agency dedicated to these activities and separate from other Council business and Association priorities and directed that a resolution be transmitted to the 2014 House of Delegates proposing the establishment of a separate ADA agency to oversee CERP.

Key Issues:

- Resolution 1H-2013 adopted by the ADA House of Delegates states:

1H. Resolved, that each council and commission undertake a thorough self-assessment based on a topical outline to be developed by the Board of Trustees and submit a report to the 2014 House of

Delegates (in time for the Board to consider the report at its June 2014 meeting) on the process and its results, including any proposed resolutions to implement those results, and be it further

Resolved, that following 2014, each council and commission undertake a thorough self-assessment on a rotating basis over every five years based on a schedule and outline to be developed by the Board of Trustees, and within the Annual Report include information on the process followed and results to the next session of the House, including any proposed resolutions to implement those results, and be it further

Resolved, that the Board be urged to require the New Dentist Committee and the Committee on International Programs and Development to undertake a self-assessment, with reports to the Board, and to be included in the schedule applicable to councils and commissions, and be it further

Resolved, any council which has undertaken a thorough self-assessment in 2013 as determined by the Board and reported on that self-assessment to the 2013 House of Delegates is exempted from the requirement to conduct a self-assessment in 2014, and be it further

Resolved, that 118H-2002 (*Trans.*2002:374) be rescinded.

- A topical outline was developed by the Board of Trustees to assist the councils with their self-assessments. The outline/questions were provided to and considered by each of the Council's committees and the ad hoc committee.
- The Council's current duties, as defined in the *ADA Bylaws*, Chapter X, Councils; Section 120; Duties E. Council on Dental Education and Licensure were reviewed.
- Each of the Council's standing committees was requested to consider the self-assessment questions and forward comments to the ad hoc committee and Council for consideration. The following summarizes the findings based on the comments received:
 - Dental Education Committee: The composition of the Dental Education Committee is delineated in the *ADA Bylaws* (Chapter X – Councils; Section 20 Members, Selections, Nominations and Elections; Council on Dental Education and Licensure; c. Committees): “The Council shall establish a standing committee on Dental Education and a standing committee on Licensure, each consisting of eight (8) members selected by the Council.” The unique make-up of the Council with ADA, ADEA, and AADB representation ensures that the Dental Education Committee has broad representation from the practice, education and examiner communities. The cross-section of experience enhances the Dental Education Committee's perspective and approach to education issues. Very little Dental Education Committee time is spent on strategic direction. The fact that the Dental Education Committee does not meet in person may hinder a strategic discussion.
 - Licensure Committee: Like the Dental Education Committee, the composition of the Licensure Committee is delineated in the *ADA Bylaws*. The Council agreed with the Licensure Committee's comment that the Council should develop more strategies to engage the communities of interest to support ADA policy on licensure matters of importance to the membership. Licensure issues continue to be of concern to members, particularly future members. The Council will continue to lead in fulfilling ADA policy regarding freedom of movement in dental licensure and the elimination of patients in the clinical examination licensure process.
 - Continuing Education Recognition Program (CERP) Committee: The Council and the CERP Committee recently underwent a self-assessment activity, determining that ADA CERP should be an ADA agency, separate from the Council on Dental Education and Licensure. The CERP Committee and Council concluded that conduct of the program's business—development of standards and recognition decisions—should be overseen by an agency dedicated to these activities and separate from other Council business and Association priorities. Accordingly, the Council is pursuing steps necessary for the establishment of a separate ADA agency to oversee CERP.

In addition, the Council agreed with two comments submitted by the CERP Committee: 1) when selecting candidates for the CERP Committee, nominating organizations should be strongly urged to identify candidates who have knowledge and experience in dental education and/or continuing education, and 2) the CERP Committee reviewer workload should be monitored and options for developing an expanded pool of reviewer consultants should be identified.

- Continuing Education (CE) Committee: To address its duty related to continuing education, “Monitor and disseminate information on continuing dental education and to encourage the provision of and participation in continuing dental education,” the Council recently restructured the CE Committee to include broader representation from across the Association. This was done in parallel to a consolidation of ADA staff that provides operational support for continuing education activities. The Council believes that the CE Committee provides important volunteer input and oversight for these activities and should be retained. The CE Committee, with its revised cross-council composition, is developing effective working relationships across the Association, and these relationships are expected to mature over the next year. The Council believes that *Bylaws* oversight of continuing education by the Council is appropriate—especially given the broad, agency-wide representation on the CE Committee and the broad practitioner/educator/examiner representation on the Council.
- Dental Admission Test (DAT) Committee: The DAT Committee and the Council oversee the governance and policy setting aspects of the Dental Admission Test. Administration of the DAT is conducted by the ADA’s Department of Testing Services. The DAT provides significant member value: 1) for dental school administrators and faculty by helping identify student candidates who can be successful in the academic aspects of dental school, 2) for the profession and public by providing a standardized test that consistently demonstrates validity in predicting dental student performance; and 3) for the ADA by being a significant source of non-dues revenue. Although the Council has provided governance oversight for the DAT program for many years, this responsibility is not reflected in its *Bylaws* duties. The Council therefore proposes that an additional duty: “Act on behalf of this Association in matters related to oversight of dental admission testing” be added to the Council’s *Bylaws* duties. In regard to composition of the DAT Committee, the Council supported the DAT Committee’s recommendation to invite the Council’s American Student Dental Association liaison to attend the DAT Committee meetings.
- Recognition of Dental Specialties and Interest Areas in General Dentistry Committee: The Recognition Committee is critical to the recognition duties of the Council and should continue to exist with its current balanced composition of general dentists and specialists. The Recognition Committee composition is primarily skills-based with representation from practice, education, general dentistry and specialties, providing a broad-based perspective. The Committee’s member value is in supporting the ADA to maintain the standard of recognition for dental specialties and interest areas in general dentistry thereby protecting the highest quality of patient care and the best interests of the public ensuring that dentistry remains a learned profession. The Recognition Committee routinely meets via conference call. The Recognition Committee noted, and the Council concurred, that there may be times when a web-based meeting would enhance a conference call—particularly in the review of documents.
- Anesthesiology Committee: Since 1972, and at the request of the Board of Trustees in 1998, the Council and its Committee on Anesthesiology have served to assist the Association in policy matters related to dental anesthesiology and sedation. The Anesthesiology Committee noted, and the Council agrees, that this important duty should be reflected in the Council’s *Bylaws* duties. Accordingly, the Council proposes that the House of Delegates consider pursuing an amendment to the Council’s *Bylaw* duties, to read: “Study and make recommendations including the formulation and recommendation of policy on dental anesthesiology, sedation and related matters.”

In regard to the Anesthesiology Committee’s composition, the Committee is chaired by a Council member and includes one representative each from the following dental organizations: ADA

(general dentist), American Academy of Periodontology, American Academy of Pediatric Dentistry, American Society of Dentist Anesthesiologists, American Dental Society of Anesthesiology, American Association of Oral and Maxillofacial Surgeons and the American Society of Anesthesiologists. The composition of the Committee is skills-based and invaluable to the collaborative work of the Committee, the Council and the Association.

The Association's Guidelines for the Use of Sedation and General Anesthesia by Dentists and the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students are managed by the Anesthesiology Committee and the Council with final approval granted by the ADA House of Delegates. The Council considered whether technical guidelines such as these would be better developed and approved by experts in the subject matter rather than approval by a large oversight body such as the House of Delegates. Other Councils have "guidelines" documents that are approved by the applicable Council, but not the ADA House of Delegates, so that the documents can be updated in a timely manner, as science and practice change. Examples include guidelines developed by experts, then adopted by the Council on Scientific Affairs: 1) the "Prevention Of Orthopaedic Implant Infection in Patients Undergoing Dental Procedures: Evidence-Based Guideline and Evidence Report" jointly developed by the ADA and the American Academy of Orthopaedic Surgeons; and 2) the "Prevention of Infective Endocarditis" guidelines developed by the American Heart Association (AHA) using an interprofessional writing group appointed by the AHA for their expertise in prevention and treatment of infective endocarditis with liaison members representing the American Dental Association, the Infectious Diseases Society of America and the American Academy of Pediatrics. The Code on Dental Nomenclature and Procedures is under the purview of the Council on Dental Benefit Programs, according to the ADA *Bylaws*. Given these examples and the significance of other Association statements controlled by expert committees reporting to Councils, the Council intends to give this concept further consideration and discuss the matter with other ADA agencies.

- In summary the Council concluded that:
 - The current ADA/ADEA/AADB structure of the Council supports the Association and members, providing broad-based volunteer oversight, expertise and input in matters which are paramount to a learned profession. The composition of the Council and its standing committees should remain as is. The Council's unique structure of private practitioners, dental educators and dental examiners is important and necessary to address the myriad of responsibilities assigned to this agency. The Council carries out assignments and activities related to all areas of its assigned duties. Additionally, the Council receives assignments from the House of Delegates related to its assigned duties. The Council's work assignments often require input from a variety of internal and external agencies, and the Council requests the appointment of interagency committees when collaboration is required to carry out its assignments.
 - The Council operates efficiently, meeting in-person twice annually and conducting business electronically and via conference calls throughout the year. When appropriate, the chair assigns business to the subject-matter standing committees for consideration and recommendation to the Council. Business conducted electronically and via teleconferencing provides more opportunity for the Council to use in-person meeting time focused on strategic discussions on dental education, licensure and recognition matters critical to the membership and the profession. Professional and administrative staff support for this agency is adequate and appropriate.
 - In regard the Council's responsibilities, the Council recommends that its duties be amended to include its responsibility for dental anesthesiology policy matters and governance oversight for dental admissions tests. Further, at its December 2013 meeting, the Council concluded that conduct of the CERP Committee's business—development of standards and recognition decisions—should be overseen by an agency dedicated to these activities and separate from other Council business and Association priorities. In December 2013, the Council directed that a resolution be transmitted to the 2014 House of Delegates proposing the establishment of a separate ADA agency to oversee CERP.

Budget Impact/Financial or Operational Requirements: Conducting the self-assessment on a periodic basis will have little financial impact for the Association, other than member and staff time.

Risk/Benefit: A routine self-assessment process provides the Council and its committees, as well as the Association, an opportunity to examine overall member value, structure, efficiency, and the relevancy and appropriateness of its *Bylaws* duties.

Action: The Council directed that the following resolution be transmitted to the 2014 House of Delegates:

Resolved, that CHAPTER X, COUNCILS; *Section 120. DUTIES*, Subsection E. COUNCIL ON DENTAL EDUCATION AND LICENSURE of the ADA *Bylaws* be amended as follows (proposed additions are underlined):

The duties of the Council shall be to:

a. Act as the agency of the Association in matters related to the evaluation and accreditation of all dental educational, allied dental educational and associated subjects.

b. Study and make recommendations including the formulation and recommendation of policy 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.
- (8) Dental licensure and allied dental personnel credentialing.
- (9) Dental anesthesiology, sedation and related matters.

c. Act on behalf of this Association in maintaining effective liaison with certifying boards and related agencies for dental specialties and for allied dental personnel.

d. Monitor and disseminate information on continuing dental education and to encourage the provision of and participation in continuing dental education.

e. Monitor and disseminate information on careers in dentistry.

f. Act on behalf of this Association in matters related to dental admission testing.

Council on Dental Practice

Sessa, Kevin D., 2014, Colorado, chair
Unger, Joseph G., 2015, Illinois, vice chair
Bengtson, Gregory, 2016, Idaho
Brown, Andrew B., 2016, Florida
Cammarata, Rita, 2017, Texas
Childs, Miranda, 2015, Arkansas
Creasey, Jean L., 2016, California
Dawley, Joanne, 2014, Michigan
Dowd, Brendan P., 2014, New York
Landes, Christine, 2017, Pennsylvania
Marshall, Todd W., 2016, Minnesota
Maxwell, Charles B., 2015, South Carolina
Mazur-Kary, Michelle, 2017, Maine
O'Toole, Terry, 2017, Washington, DC
Radjabli, Edgar, 2014, Maryland, *ex officio**
Smith, J. Christopher, 2016, West Virginia
Thomas, J. Mark, 2015, Indiana
Torbush, Douglas B., 2014, Georgia

Porembski, Pamela M., director
Shapiro, Elizabeth A., senior manager
Kluck-Nygren, Cynthia, manager
Sarver, Jordan P., manager
Siwek, Alison, manager

The Council's 2013-14 liaisons include: Dr. Jeffrey D. Dow (First District trustee, Board of Trustees); Dr. Ralph L. Howell, Jr. (Council on Communications); and Mr. Martin Smallidge (American Student Dental Association).

Purpose

The purpose of the Council on Dental Practice is to recommend policies and provide resources to empower 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

Activities of the Council on Dental Practice (CDP) are consistent with and continue to support the ADA Strategic Plan 2011-14. To support Goal 1—provide support to dentists so they may succeed and excel throughout their careers—the CDP launched the Center for Professional Success (CPS) website at the 2013 ADA annual meeting. The CPS aggregates information about dental practice management, practice management educational opportunities, and work-life balance. Currently, the CPS website features 144 articles, 41 downloadable white papers, financial calculators, videos, podcasts, and slideshows behind a members-only wall. Additionally, the website links to both a dental marketplace and classified advertising section. A unique product developed through CPS, the ADA Oral Pathologist app, was released in January 2014. A total of 420 apps have been downloaded via Google Play or the Apple App Store through May 2014.

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

Table 1. CPS Goals and Updates

2013 Goal	2013 Actual	2014 Goal	2014 Actual (To Date)
CPS will launch in first quarter 2013 with a goal of achieving 10% penetration among active members within first year.	CPS had 17,994 unique visitors in 2013, indicating a potential 13.9% market penetration.	20% penetration among active members (each with one or more unique visits) by September 2014.	CPS has had 51,630 unique visitors total since site launch indicating a potential 45% market penetration.
Each active member visitor to CPS will have one or more unique page views.	Average page views per visit end of year 2013 was 3.38. Average visit duration, 6 minutes, 16 seconds.	No target set for page views 2014.	Average page views per visit by June 4, 2014, was 2.68. Average visit duration, 5 minutes, 33 seconds.
		125 dentists register for an online course through the CPS in 2014.	ADA Notre Dame certificate program development continues, with expected launch September 2014.

CDP has taken a proactive approach in educating dentists about the overprescribing of opioid medications through the development of opioid prescribing webinars, conference sessions, and supporting National Drug Take Back Days and National Recovery Week. Eight sessions on opioid prescribing issues were presented at the Conference on Dentist Health and Well-Being held on September 19-20, 2013, and were funded by a grant from the Physician Clinical Support System—Opioid (PCSS-O). Attendance ranged from 21 to 89 participants per session. Four of the eight presentations were videotaped and will be converted into online webinars for posting on the CPS web portal. Additionally, four webinars on opioid topics were presented in 2013 to a total audience of 489 individuals. A webinar, “Opioid Addiction and the Dental Patient,” was presented by Dr. Brian Fingerson, R.Ph., in February 2014 to an audience of 216 participants. These webinars were also funded by the PCSS-O grant.

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. Collaboration with the Department of Product Development and Sales (DPDS) resulted in the updating of 23 oral health products for distribution by dentists to their patients. Materials included 17 revised and three new brochures, two flip guides, and one *Chairside Instructor* book. Sales for the period from October 1, 2013, to June 1, 2014, included 561,750 individual brochures and 2,285 books and flip guides. The combined revenue for all products for the same time period was \$287,000. Overall, these items have met sales projections.

The Council supports Goal 3—improve public health outcomes through a strong collaborative profession and through effective collaboration across the spectrum of our external stakeholders—by continuing its bylaws duties to encourage and develop satisfactory relations with dental auxiliary groups and the lab industry. These efforts support Association policy that maintains that the dentist is the leader of the dental team, facilitate high-level dialogue with the national associations representing dental support staff, and ensure that the ADA is aware of the mega-issues and strategic plans of these groups. CDP’s chair presented congratulatory comments to the American Dental Hygienists’ Association (ADHA) on its centennial anniversary in June 2013. Dental Assistants Recognition Week was promoted in March in collaboration with the American Dental Assistants Association (ADAA). A CDP representative serves on the National Board for Certification in Dental Laboratory Technology (NBC) and another serves on the Dental Assisting National Board (DANB). CDP representatives attended the annual Dental Laboratory Summit in February, hosted by the National Association of Dental Laboratories (NADL). CDP representatives participated in the Dental Assisting National Board Forum on the Certified Entry Level Dental Assistant in June 2013 and reported on the CPS at the DANB August 2013 Board meeting. CDP

and the American Association of Dental Office Managers (AADOM) cosponsored a course on the foundations of dental office management at the ADA 2013 annual meeting. The CDP collaborates with the Council on ADA Sessions to present a series of dental team building seminars at the ADA annual meeting. In 2013, more than 1,900 individuals attended the six courses cosponsored by CDP, which included five Team Building Track courses and one course approved for dental office managers seeking Fellowship recognition through their AADOM association. ADHA, ADAA and NADL each met with the Council during the 2013 or 2014 Council meetings.

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 through its collaborations with DPDS and the sharing of its content expertise through the revision of oral health brochures and practice management publications. *The ADA Practical Guide to Dental Letters: Write, Blog and E-mail Your Way to Success* was revised and launched in September 2013. *The ADA Practical Guide to Valuing a Practice: A Manual for Dentists* and *The ADA Practical Guide to Associateships: Success Strategies for Dentist-Owners and Prospective Associates* books were redesigned and released in October 2013. CDP contributed to two award-winning books, the *ADA Practical Guide to Dental Office Design* and *The ADA Practical Guide to Dental Letters*, which won the Association Media & Publishing's Gold and Silver EXCEL awards in the category of technical books.

Emerging Issues and Trends

Trends in Dental Group Practice

Practice patterns are changing in the dental profession. The percentage of dentists in solo practice has declined over the last two decades, while the percentage of dentists in some form of group practice continues to increase, especially among new dentists. The CDP's interest in group practice is to gain a better understanding of group practice models in order to identify or develop resources that will assist members who elect to practice in group settings. CDP's third ADA annual meeting forum on current dental topics will focus on group practice models. "Understanding Group Practice Models" is scheduled for October 10, 2014, and will focus on the group practice classification system proposed by the Health Policy Institute (HPI).

The Department of Standards

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

This past year, the ADA SCDI continued to develop technical reports, news articles and a demonstration exhibit for ADA 2014 to carry out its mandates from the House of Delegates to develop standards for teledentistry per Resolution 107H-2012 (*Trans.*2012:455) and for the secure transmission of digital images per Resolution 83H-2009 (*Trans.*2009:420).

Teledentistry and Interoperability Activities: The Standards Department reached out to dental systems vendors to educate them about the Integrating the Healthcare Enterprise (IHE) Dental Profile: *Secure Exchange of Dental Information Content* and to promote testing of the profile in a future IHE Connect-a-thon. Multiple webinars, conference calls and email announcements were produced in cooperation with the Health Information Management Systems Society (HIMSS). As a result, a SEDI (secure exchange of dental images) profile was developed and published for future Connect-a-thons. In addition, six vendors were recruited for the demonstration of secure exchange of digital images via email for a continuing education course to be held at ADA 2014 in October, "Teledentistry: A Live Exchange of Secure Exchange of Digital Images."

DICOM Activities: The Standards Department is the Secretariat of DICOM Working Group 22-Dentistry (WG 22). The working group is developing a supplement to the DICOM standard that will describe a standard view set for organizing and viewing digital dental images and an image query/retrieve function. WG 22 also has begun development of a standard for a radiation dose report. SCDI WG 12.1 Digital Imaging is developing *Proposed ADA Technical Report No. 1082 for Practitioner's Guide to Preparing Images for Digital Exchange and E-mail Transmission*.

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. The ADA SCDI, in collaboration with NIST, is planning a demonstration of the exchange of forensic dental data as part of the SCDI 2014 interoperability demonstration. The course will include a simulation of a mass disaster and provide an opportunity for attendees to learn about dental data coding.

Health Level 7 Liaison (HL7) Activities: The SCDI presented *ANSI/ADA Standard No. 1067 for Electronic Dental Record System Standard Functional Requirements* to the Health Level 7 (HL7) Electronic Health Record (EHR) working group. The working group approved the standard for adoption into the HL7 EHR Functional Model.

Standards for Electronic Claims Attachments: The ADA SCDI has two standards that address dental attachments. The first, *ANSI/ADA Standard No. 1047 for Standard Content of an Electronic Periodontal Attachment*, specifies procedures and codes to be utilized in an electronic claim attachment for periodontal services. The second standard, *Proposed ANSI/ADA Standard No. 1079 for an Electronic Claim Attachment*, is under development and will provide a general claim attachment format for periodontal and other typical uses such as orthodontic and oral and maxillofacial surgery claim attachments. The draft standard is currently in development in SCDI Working Group 11.6, Integration of Orthodontic Standards. When complete, it will cancel and replace ADA Standard No. 1047.

Universal Device Identifier (UDI) Labeling: This is a requirement that is being mandated by the Food and Drug Administration (FDA) for all dental products. The SCDI Working Group on Track and Trace is addressing this issue in a new work item, *Proposed ADA Technical Report No. 1081 for Track and Trace for Implantable Devices and Biologics*. The working group chair attended a FDA/Dental Trade Alliance (DTA) workshop that focused on this topic, beginning a new collaboration between SCDI and DTA with the goal of recruiting new volunteers and additional information that will enable production of additional technical reports on the new requirements.

New Work Projects: Over the past year, CDP approved the following new work projects—*Proposed ADA Technical Report No. 1082 for Practitioner's Guide to Preparing Images for Digital Exchange and E-mail Transmission* and *Proposed Technical Report No. 1081 for Track and Trace for Implantable Devices*.

Responses to House of Delegates Resolutions

34H-2013. Rescission of the National Healthcare Infrastructure (NHII Task Force) (Trans.2013:313)

Resolution 34H-2013 directed that the ADA Policy on The National Healthcare Information Infrastructure (NHII) Task Force (Trans.2005:338) be rescinded. This change has been incorporated in Association policy and will be added to the current edition of *Current Policies*.

35H-2013. Amendment of the Policy, "Recommendations of Future of Dentistry Report" (Trans.2013:313)

Resolution 35H-2013 directed that the ADA Policy "Recommendations of Future of Dentistry Report" (Trans.1983:552) be amended by changing the wording in the fourth bullet point from "manpower supply" to "workforce" and by the deletion of the second and third resolving clauses. This change has been incorporated in Association policy and will be added to the current edition of *Current Policies*.

36H-2013. Amendment of the ADA Policy, "Electronic Technology Activities" (Trans.2013:313)

Resolution 36H-2013 directed that the ADA Policy on Electronic Technology Activities be amended by changing the wording in the first resolving clause to read that the field of electronic technology is a high priority for the ADA. This change has been incorporated in Association policy and will be added to the current edition of *Current Policies*.

37H-2013. Statement Supporting the Dental Team Concept (Trans.2013:313)

Resolution 37H-2013 directed that the previous policy on unsupervised practice by dental auxiliaries be updated to clarify that the dentist is the leader of the dental team. Constituent dental societies, dental educators and examiners are encouraged to work closely and cooperatively with the ADA to support the dental team concept. Also, 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. This resolution further directed that Resolution 68H-1987, Statement Opposing Unsupervised Practice by Dental Auxiliaries (*Trans.1987:514*) be rescinded. This change has been incorporated in Association policy and will be added to the current edition of *Current Policies*.

38H-2013. Use of Environmentally Conscientious Measures in the Production, Packaging and Shipping of Dental Products (Trans.2013:314)

Resolution 38H-2013 directed that the previous policy on biodegradable materials be updated to reflect the manufacturing process and end use of the products. The ADA 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. This resolution further directed that Resolution 93H-1991, Use of Biodegradable Materials in Manufacture and Packaging of Disposable Dental Products (*Trans.1991:585*), be rescinded. This change has been incorporated in Association policy and will be added to the current edition of *Current Policies*.

52H-2013. Registration of Dental Laboratories (Trans.2013:323)

Resolution 52H-2013 directed that the ADA urge all state dental boards to register U.S. dental Laboratories in order to enhance dental patient health and safety. The NADL consulted with the Council to develop a toolbox of model legislative language and case studies to assist state dental associations that may wish to pursue the registration of dental laboratories. This addition has been incorporated in Association Policy and will be added to the current edition of *Current Policies*.

Self-Assessment

In accordance with Resolution 1H-2013 (*Trans.2013:339*), the Council on Dental Practice conducted a self-assessment based on the topic outline developed by the Board of Trustees. The process was undertaken by the Subcommittee on Policy Revision with input from additional subject matter experts as warranted.

Members agreed that the CDP was unique among ADA councils because its various programs and activities touch every facet of every member's life. The structure, areas of responsibility, primary issues, agenda and key activities of the CDP were deemed appropriate and efficient, although subcommittee members did express concern that, until recently, vacant positions had caused current staff to be "stretched thin" and were gratified to learn that most vacant positions had been filled.

Discussion of the Council's *Bylaws* revealed that two bylaws specific to the dental laboratory profession could be combined and restated as a single bylaw. Members noted that the origins of the CDP go back to the 1940s and the Council was formed with the specific purpose of addressing dental laboratory issues. They noted that historical significance of the relationship with the dental laboratory, concern that

there are now only 17 dental laboratory training programs within the U.S. and the continued trend towards offshore fulfillment of dental laboratory prescriptions support the maintenance of a bylaw specific to dental laboratory issues.

As a result of the assessment, the Council presents the following resolutions to the House of Delegates:

14. Resolved, that CHAPTER X. COUNCILS, *Section 120. DUTIES*, Subsection F. COUNCIL ON DENTAL PRACTICE, Paragraphs d and e of the ADA *Bylaws*, be amended as follows (additions are underscored; deletions are ~~stricken~~):

d. Encourage and develop satisfactory relations with ~~the various organizations representing the~~ dental laboratory industry and craft by aiding in the formation and support of educational programs and appropriate collaborative efforts that help establish and maintain,
~~e. to formulate programs for establishing and maintaining the greatest efficiency, and quality and~~
of service by of the dental laboratory industry and craft in their relation to the dental profession.

and be it further

Resolved, that subsequent paragraphs f through j of CHAPTER X. COUNCILS, *Section 120. DUTIES*, Subsection F. COUNCIL ON DENTAL PRACTICE, be re-lettered e through i.

This resolution supports Goal 3—improve public health outcomes through a strong collaborative profession and through effective collaboration across the spectrum of our external stakeholders.

The complete assessment is presented as Appendix 1 of this report.

Summary of Resolutions

Resolution 14. Amendment of the ADA *Bylaws* Regarding the Duties of the Council on Dental Practice

Council Minutes

For more information on recent activities, see the Council's [minutes](#) on ADA.org.

Appendix 1. Council on Dental Practice 2014 Self-Assessment

The Council on Dental Practice (CDP) is unique among ADA councils because its programs and outreach activities touch every facet of every member's life and provide valuable tools and resources to help them succeed, at every stage of their careers. Members of the Council provide expert volunteer input to the Board of Trustees and House of Delegates, staff, membership, and external communities on a variety of dental practice issues.

1. Threshold Issues

The Council is the ADA agency responsible for:

- Recommending policies that relate to the operations and management of a dental practice; compliance with relevant regulations and legislation; and technological innovations that can affect the delivery of patient care and record-keeping.
- Monitoring and staying abreast of trends regarding how dental practices are structured, and how various practice models may be impacted by economic changes.
- Creating content that informs and educates members about relevant trends and best practices and delivering that content through multiple platforms.
- Fostering satisfactory relationships with national organizations representing members of the dental team including dental assistants, dental hygienists, dental laboratories and dental office managers.
- Serving as a resource to other agencies of the organization on informational, educational and promotional efforts directed to the public and the profession.
- Creating programs that support dentists' personal health and well-being.
- Taking a lead role in the development of dental informatics standards.

Council Activities

The Council oversees the Center for Professional Success (CPS), the ADA's online portal that provides members with information and tools to help better manage their practices and achieve a more harmonious work-life balance. CPS launched in September 2013. By May 2014, the website had 43,490 unique visitors with an average visit length of nearly six minutes. Total page views reached 99,461. Site content is classified into three primary categories—practice, learn and live. Informative articles are posted regularly. Much of the CPS-specific content includes hyperlinks to other ADA resources that provide additional information, some of which is directly available for downloading while other resources are available for purchase through the ADA's Department of Product Development and Sales. Many of the articles are targeted to new practitioners and current dental school students, a population of significant interest to the Association.

The Council also monitors and manages programs that provide assistance to dentists and dental team members struggling with addiction. In 2013, 327 dentists received assistance and more than 400,000 patients were impacted positively through the ADA's well-being programs (based on estimates of 1,500 patients per dentist in recovery). Since 2011, the ADA has awarded more than 2,000 continuing education units to individuals who participated in one of the nine webinars or eight conference sessions on opioid addiction or education. Webinar participation was available at no cost due to several grants secured by staff to underwrite the costs associated with the programs. The biennial Conference on Dentist Health and Wellness was held in 2013 and featured national experts who discussed professional impairment (addiction), opioid prescribing and abuse prevention, general health issues (cancer, obesity, diabetes) and ergonomics.

The Council advocates for members, patients and the profession by fostering and maintaining positive relationships with the national organizations representing other members of the profession: dental

assistants, dental hygienists, dental laboratory technicians and dental office managers. These efforts include developing a team building track of continuing education courses at ADA's annual meeting, promoting Dental Assistant Recognition Week and participating in the annual Dental Laboratory Summit, among others. The Council dedicates these resources to strengthen existing ADA policy and reinforce that the dentist is the leader of the dental team, to promote the concept of a dental home, and to ensure that patient diagnosis and treatment planning are properly managed. The CDP is one of three ADA councils evaluating the possibility of participating in a multi-organizational consortium that will assess whether additional efforts are necessary to boost dental office compliance with federal infection control guidelines.

Another key activity is the launch of the ADA Oral Pathologist, a mobile app that assists in formulating diagnoses and enables clinicians to search more than 200 soft tissue conditions. The app is advertised on the CPS website and is available from Apple's App Store and through Google Play for \$59.99. As of May 20, 2014, 408 units had been sold.

Efforts relating to dental informatics include oversight of proposed standards and technical reports for electronic health records, interoperability and issues relating to the safe and secure storage and exchange of digital images and patient data in dentistry and participation in Integrating the Healthcare Enterprise (IHE). The IHE is an effort to help members select digital dental information systems with proven interoperability in real-world practice settings.

Metrics

Council staff develops a post meeting survey in order to collect information on the level of satisfaction with meeting logistics, dissemination of pre-meeting materials, and on-site discussions and operations. For the November 2013 meeting, the Council was 100% satisfied with staff support before and during the meeting and 80% were satisfied with the agenda, agenda book, oral reports and presentations and time allotted for discussion.

2. Structure

CDP Membership

CDP is composed of seventeen (17) regular members with each member representing a different district. Staggering member terms ensures the continued availability of institutional knowledge and allows veteran Council members to serve as resources for those newly appointed. Newly appointed members also participate in a brief in-person orientation designed to acquaint them with the Council and its charges as well as some of the technologies used.

The Council believes that representation of each district is both appropriate and necessary to ensure the group is able to fulfill the charges of its *Bylaws*. Issues may impact areas of the country in different ways, and geographic diversity is needed. The appointment of members-at-large is also appropriate since it allows for participation by dentists representing different practice environments as well as for those at various stages of their careers. This diversity of knowledge and experience allows for the balanced and in-depth discussions required for the Council to act in accordance to its charges and to support the members.

Non-voting Council members include representatives of the American Student Dental Association (ASDA) and the New Dentist Committee as well as liaisons from the Council on Communications and the Board of Trustees.

CDP Committee Structure

The Council on Dental Practice has two standing advisory committees, three subcommittees and one ad hoc advisory committee that support the Council's efforts to address its charges from the *Bylaws*.

Consultants and Council members appointed to serve are identified and approved each year by the chair of the Council and the Board of Trustees respectively.

CDP subcommittees:

1. Subcommittee on the Dental Team
2. Subcommittee on CDP Policy Revision (which also conducted this assessment)
3. Subcommittee on Practice Models and Economics

CDP standing advisory committees:

1. Center for Professional Success (CPS) Advisory Committee
2. Dental Wellness Advisory Committee

The Ad hoc Advisory Committee on the Development of Practice Management Guidelines and other informal groups, such as the Interagency Workgroup on Dental Group Practice, are formed on an as-needed basis in order to provide expertise and input on specific issues. CDP also has representatives who participate or collaborate with the following ADA agencies or external organizations:

1. Council on Scientific Affairs (CSA) Interagency Subcommittee on Science and Research
2. Caries Classification System Stakeholder Working Group
3. ADA Clinical Evaluators Panel Members
4. Expert Panel Workshop on Topical Fluoride Caries Preventive Agents
5. Expert Panel to Update the 2008 Evidence-Based Clinical Recommendations for the Use of Pit-and-Fissure Sealants
6. Dental Quality Alliance (DQA) Steering Committee
7. Subcommittee on Quality Assessment and Improvement
8. Dental Content Committee
9. Dental Claim Form Advisory Committee
10. Standards Committee on Dental Informatics (SCDI)
11. SCDI Continuity of Care Working Group
12. Electronic Health Records Inter-agency Workgroup
13. Council on Dental Education and Licensure's (CDEL) Committee on Continuing Education (CE)
14. CDEL Stakeholders Group Related to Dental Education Models
15. Council on Access, Prevention and Interprofessional Relation's (CAPIR) Interagency Workgroup to Create Quality Educational Materials
16. National Board for Certification in Dental Laboratory Technology (NBC)
17. Dental Assisting National Board (DANB)
18. Golden Apple Judge Volunteers – Open Category/Wellness/Going Green

Table 1 at the end of this report provides details of the charge for each of the Council committees.

CDP Operations

Council operations have been significantly streamlined through the adoption of a consent calendar format. This ensures that discussions of critical issues have sufficient time for consideration and deliberation and noncontroversial matters are dispensed with expeditiously. The council chair has also implemented a protocol that requires any new business to have consent of the chair prior to being shared with members once Council materials have been distributed.

3. Efficiencies

The CDP decision making process is efficient and uses available technologies (ADA Connect, conference calls, etc.) to maximize member input while minimizing demands on their time and expertise to ensure that topics are addressed expeditiously. While volunteers dedicate a significant amount of time to Council and subcommittee activities, it would be inappropriate to redirect those discussions to staff since member input and direction is critical to ensure that the ADA remains a volunteer driven organization.

The Council is supported by a highly skilled and professional staff. Members receive sufficient background information prior to meetings and calls and have ample time to review relevant information.

Newly appointed members of the Council receive detailed orientation resources and training that allows them to be familiar with the group's structure, operations and diverse activities.

4. Areas of Responsibility

Periodic review of Council *Bylaws* responsibilities has not identified any charges that should be transferred or discontinued, nor has it revealed that new responsibilities be added. Existing subcommittees and advisory groups are sufficient to fulfill CDP's existing responsibilities. Disbanding any of these entities would be in conflict with CDP's commitment to provide resources that empower members to continue development of their practices and would have negative impacts on members, the dental team, patients and the greater dental community. It should be noted that the CDP annual report contains a recommendation that two similar *Bylaws* charges relating to dental laboratory matters be combined into a single charge and that the 2014 ADA House of Delegates may be asked to support a decision package relating to the dedication of resources to develop voluntary practice management guidelines. Table 3 at the end of this report provides an overview of the CDP activities as they relate to the *Bylaws*.

5. Agenda Review

The Council believes that its agendas are well structured, use time efficiently, and ensure that each issue is allotted sufficient time for discussion. The consent calendar has streamlined operations by dispensing with topics that are either non-controversial or that do not require extended discussion. Conference calls, especially for specific subcommittees, are scheduled between meetings to ensure that necessary business is conducted in a timely and responsive manner. Council business is also handled via ADA Connect when that platform is suitable.

The delegation of duties to staff has been done consistently on an as-appropriate basis. It should be noted that, until recently, there have been several staff vacancies and that has significantly increased the workloads of CDP personnel. It is anticipated that once the two remaining staff vacancies are filled, the current assignment of staff time and resources are appropriate based on current programs and priorities. New undertakings will need to be carefully evaluated to assess whether additional staff or other resources will be necessary to ensure the desired outcomes are delivered.

6. Are you spending time on big issues and strategic direction?

The Council believes that sufficient time is allotted for strategic discussions on all topics, including emerging issues that arise, and that its members continue to demonstrate an unparalleled commitment to helping all members succeed.

Table 2. Duties of Council on Dental Practice Committees

COUNCIL SUBCOMMITTEES	
<p>Subcommittee on the Dental Team</p> <p>Role and Function: The Subcommittee on the Dental Team ensures that the ADA maintains contact and identifies collaborative opportunities with various organizations representing the members of the dental team. It also oversees the dental team focus group which convenes periodically by conference call.</p>	<ul style="list-style-type: none"> • Supports the position of the dentist as “the leader of the dental team” by maintaining liaison relationships with national associations that represent key members of the dental team. • Fosters and maintains satisfactory relations among dental team members, including dental assistants, dental hygienists, dental laboratory technicians, dental office managers, and other allied dental personnel. • Improves the working relationship between dental team members. • Communicates oral health care information to dental team members through articles, CPS, ADA.org, seminars, conferences and other vehicles. • Ensures that a Team Building Track of continuing education is offered at the ADA annual meeting for members of the dental team. • Provides resources and training to facilitate the management of dental offices. • Enhances the recognition and professionalism of all dental team members. • Identifies significant trends affecting the dental laboratory industry and notifies the Council of those trends and possible recommendations for action. • Offers suggestions on collaborative projects between CDP and allied dental member organizations. • Facilitates communication with members of the Dental Team Focus Group, a group of eight professionals (two dental assistants, two dental hygienists, two dental laboratory technicians and two dental office managers) that provides expertise and insights on the day-to-day operations of successful dental practices.
<p>Subcommittee on CDP Policy Revision</p> <p>Role and Function: The Subcommittee on CDP Policy Revision reviews existing ADA policy and offered recommendations regarding policies that should be amended, rescinded and adopted.</p>	<ul style="list-style-type: none"> • Engages in the periodic review of ADA policy relevant to dental practices issues and offers recommendations regarding policies that should be amended, rescinded and adopted. • Performed the 2014 self-assessment as required by Resolution 1H-2013, which directed each council and commission to conduct a comprehensive self-assessment on a rotating basis over every five years based on a schedule.
<p>Subcommittee on Practice Models and Economics</p> <p>Role and Function: The Subcommittee on Practice Models and Economics studies changing trends and dental practice models and their potential impacts on the delivery of patient care.</p>	<ul style="list-style-type: none"> • Plans and executes the CDP forum at the ADA annual meeting. • Monitors practice trends, such as the growth of group practice, and recommends methods of educating members and the public about the differences among various practice models.

	<ul style="list-style-type: none"> • Coordinates the Interagency Workgroup on Group Dental Practice. • Monitors economic conditions and develops resources, as needed, to assist members in operating their practices more efficiently.
ADVISORY COMMITTEES	
Center for Professional Success (CPS) Advisory Committee Role and Function: The charge of the Advisory Committee is to monitor the ongoing progress of the CPS for the Council.	<ul style="list-style-type: none"> • Establishes the ADA as the primary, national source of dental practice management information. • Ensures a content delivery platform that offers members valuable practice management resources, including tools, education and services. • Offers dentists member-only resources that provide high tangible member value. • Enhances the value of membership by offering content and resources not available elsewhere.
Dental Wellness Advisory Committee (DWAC) Role and Function: The Advisory Committee provides expertise to the Council related to health and wellness of the dental team, issues pertaining to professional impairment, and support of constituent dentist well-being programs. It is comprised of two Council members, one of whom serves as chair and one as vice chair; remaining members are consultants to the Council.	<ul style="list-style-type: none"> • Monitors and addresses specialized issues and provides expert advice to the Council. • Advises the Council on dentist well-being and chemical dependency support issues and prescription drug abuse concerns. • Supports interagency activities related to health and wellness, well-being and ergonomics. • Oversees implementation of the three-year action plan as directed by the 2011 House of Delegates by Resolution 110H-2010, "Advocating for Victims of Addictive Disease" (<i>Trans.</i>2010:564). • Plans and executes the biennial Conference on Dentist Health and Wellness. • Develops recommendations regarding ergonomic issues facing the dental profession. • Promotes health and wellness, well-being and ergonomics in the dental workplace.
AD HOC ADVISORY COMMITTEE	
Ad Hoc Advisory Committee on the Development of Practice Management Guidelines Role and Function: The Ad Hoc Advisory Committee on the Development of Practice Management Guidelines was formed in order to convene a diverse panel to assess whether it would be beneficial for the ADA to develop a series of voluntary practice management guidelines.	<ul style="list-style-type: none"> • Convened a panel to discuss the merits and risks in leading the effort to develop voluntary practice management guidelines for dentists. • Offered a preliminary framework to the Council on Dental Practice regarding the development of a committee to lead the effort, recommendations regarding the consensus process and suggestions for specific content areas as well as an initial knowledge assessment tool that would allow members to identify areas in which additional information or training might be beneficial.

Table 3. Council on Dental Practice *Bylaws* and Relation to Activities

<i>Bylaws</i> Responsibilities: The Duties of the Council Shall be to:	Examples of Activity (Previous Three Years)
a. Formulate and recommend policies relating to dental practice.	Review of all CDP policies was completed in 2013. The 2013 House of Delegates (HOD) acted on recommendations regarding existing policies to maintain, amend or rescind these policies.
b. Study, evaluate and disseminate information concerning various forms of business organization of a dental practice, economic factors related to dental practice, practice management techniques, auxiliary utilization and dental laboratory services to the end that dentists may continue to improve services to the public.	<p>Forums on practice management practice structure offered at annual meetings.</p> <p>Provided input to the Health Policy Institute (HPI) on such efforts as the recently released brief on a proposed classification of dental group practices.</p> <p>Created and launched a member-only informational and education portal, the Center for Professional Success (CPS).</p> <p>Recommended and edited ADA practical guides on practice management related topics.</p> <p>Collaborated with the Council on Dental Education and Licensure (CDEL), the Council on Ethics, Bylaws and Judicial Affairs (CEBJA), the Council on Scientific Affairs (CSA), the Council on Governmental Affairs (CGA) and the Council on Dental Benefit Programs (CDBP), etc. to review issues and policies and make recommendations with regard to how these issues impact practicing dentists and the public.</p> <p>Developed relevant articles for inclusion on CPS and in the <i>ADA News</i>.</p> <p>Maintained a leadership position in the Dental Quality Alliance (DQA).</p> <p>Team Building Track courses offered at the ADA annual meeting.</p> <p>Annual participation in Dental Laboratory Summits.</p>
c. Develop educational and other programs to assist dentists in improved practice management, including practice management materials and continuing education seminars, and to assist constituent and component societies and other dental organizations in the development of such programs so that dentists may continue to improve the delivery of their services to the public.	<p>Forums on practice management/practice structure offered at annual meetings.</p> <p>Recommended and edited ADA practical guides on practice management related topics.</p> <p>Partnered with the Division of Legal Affairs to develop materials and articles that educate members about federal requirements and regulations impacting their practices.</p> <p>Collaborated with the Department of Product Development and Sales (DPDS) to develop and update more than 25 oral health brochures for distribution to patients.</p> <p>Developed relevant articles for inclusion on CPS and in the <i>ADA News</i>.</p> <p>Maintained a leadership position in the DQA executive committee.</p>

	<p>Collaborated with CDEL, CEBJA, CSA, CGA and CDBP, etc., to review issues and policies and make recommendations with regard to how these issues impact practicing dentists and the public.</p> <p>Team Building Track courses offered at the ADA annual meeting.</p>
d. Encourage and develop satisfactory relations with the various organizations representing the dental laboratory industry and craft.	<p>Resolution urging registration of dental labs passed by the HOD in 2013.</p> <p>Maintained representation on National Board for Certification of Dental Laboratory Technology.</p> <p>Participated in the annual Dental Laboratory Summit.</p> <p>Provided two dental laboratory technicians on the Dental Team Focus Group.</p>
e. Formulate programs for establishing and maintaining the greatest efficiency, quality and service of the dental laboratory industry and craft in their relation to the dental profession.	<p>Resolution urging registration of dental labs passed by the HOD in 2013.</p> <p>Maintained representation on the National Board for Certification of Dental Laboratory Technology.</p> <p>Participated in the annual Dental Laboratory Summit.</p> <p>Provided two dental laboratory technicians on the Dental Team Focus Group.</p>
f. Encourage and develop satisfactory relations with the various organizations representing dental auxiliaries.	<p>Attended annual meetings and/or collaborated with allied professional organizations, including 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); the American Academy of Dental Group Practice (AADGP); and the American Academy of Dental Practice Administration (AADPA).</p> <p>Leaders of allied organizations were invited to attend the spring 2014 CDP meeting and address remarks to the Council.</p> <p>Team Building Track courses offered at the ADA annual meeting.</p> <p>Representatives of hygienists, assistants, office managers and dental laboratory technicians are members of the Dental Team Focus Group.</p> <p>CDP members have been appointed to and serve on the Boards of DANB and NBC.</p>

<p>g. Gather, formulate and disseminate information related to auxiliary utilization, management and employment practices.</p>	<p>Worked with Department of Product Sales on ADA guides covering these and related topics.</p> <p>Developed relevant articles for inclusion on CPS and in the <i>ADA News</i>.</p> <p>Collaborated with CDEL, CEBJA, CSA, CGA and CDBP, etc. to review issues and policies and make recommendations with regard to how these issues impact practicing dentists and the public.</p> <p>Collaborated with ADAA to promote Dental Assistant Recognition Week.</p>
<p>h. Serve in a consultative capacity to those educational and promotional activities directed to the public and the profession and to assess their impact on dental practice.</p>	<p>Partnered with the Division of Legal Affairs to develop materials and articles that educate members about federal requirements and regulations impacting their practices.</p> <p>Collaborated with the Department of Product Development and Sales (DPDS) to develop and update more than 25 oral health brochures for distribution to patients.</p> <p>Provided input to the HPI on such efforts as the recently released brief on its proposed classification of dental group practices.</p> <p>Collaborated with CDEL, CEBJA, CSA, CGA and CDBP, etc. to review issues and policies and make recommendations with regard to how these issues impact practicing dentists and the public.</p> <p>Recommended and edited ADA practical guides on relevant topics.</p> <p>Developed and maintained relationships within the profession and with allied organizations concerned with the public's oral health.</p>
<p>i. Provide assistance, education and information on issues related to dentists' well-being.</p>	<p>Provided addiction assistance to dentists and dental team members struggling with addiction.</p> <p>Responded to an average of 10-15 calls per month from dental team members facing addiction or on behalf of an addicted colleague and provided referrals to constituent well-being programs.</p> <p>Held biennial Conference on Dentist Health and Wellness in 2011 and 2013; agendas included national experts who discussed professional impairment (addiction), opioid prescribing and abuse prevention, general health issues (cancer, obesity, diabetes) and ergonomics, which included ergonomic and posture screening by trained physical therapists.</p> <p>Assisted 327 dentists through recovery in 2013; 321 remain in the program. Impacted more than 400,000 patients through well-being programs (based on estimates of 1,500 patients per dentist in recovery).</p> <p>Secured grants to underwrite the costs of webinars to</p>

	<p>promote increased awareness of substance abuse.</p> <p>Provided nine webinars and eight Conferences on Dentist Health and Wellness opioid sessions, totaling more than 2,000 continuing education units since 2011.</p> <p>Implemented the 2012 Health Screening Program that included ergonomic screening sessions.</p> <p>Developed CPS content on women's health, addiction, opioid prescribing, and ergonomic tip sheets.</p>
j. Encourage and coordinate the development and improvement of national and international standardization programs for dental informatics.	<p>Developed 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.</p> <p>Advanced various informatics activities including teledentistry, digital technologies, forensic dental data standards and electronic dental records.</p> <p>Created a new working group on teledentistry.</p> <p>Participated in Integrating the Healthcare Enterprise (IHE), an effort to help members select digital dental information systems with proven interoperability in real-world practice settings.</p>

Council on Ethics, Bylaws and Judicial Affairs

Rosato, Richard J., 2014, New Hampshire, chair
Himmelberger, Linda K., 2015, Pennsylvania, vice chair
Auld, Douglas A., 2016, Oklahoma
Beard, Darryll L., 2015, Illinois
Curry, Barry D., 2015, Kentucky
Edwards, Adam A., 2017, New York
Halasz, Michael H., 2017, Ohio
Maupin, Heather A., Indiana, *ex officio* *
Merritt, Kennedy W., 2017, New Mexico
Muller, G. Jack, II, 2016, South Dakota
Pansick, Ethan A., 2014, Florida
Raimann, Thomas E., 2016, Wisconsin
Reynolds, Elizabeth C., 2014, Virginia
Scarborough, A. Roddy, 2016, Mississippi
Senseny, Charlotte L., 2014, California
Shekitka, Robert A., 2017, New Jersey
Walton, William M., 2016, Texas
Williams, Laura, 2015, Washington

Elliott, Thomas C. Jr., director
Elster, Nanette R., manager

The Council's 2013-14 liaisons are: Dr. Mark R. Zust (Sixth District trustee, Board of Trustees) and Ms. Halee Hyatt (American Student Dental Association).

Purpose

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

During the current term, the Council engaged in numerous activities in furtherance of the ADA's 2011-2014 Strategic Plan:

Ethical Moment Articles (Goal 1—Support Members' Success)

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* (ADA Code). During this term, subjects addressed included ethical issues relating to itinerant oral surgeons, laboratories subcontracting services without the dentist's knowledge, and providing emergency care for an abused minor who is not a patient of record, among other topics. The Council welcomes questions or topic suggestions from members. Suggestions should be sent to ethics@ada.org or can be forwarded to the Council through the Ethics Hotline at 1-800-621-8099.

* New Dentist Committee member without the power to vote.

Continuing Education Programming (Goal 1, Goal 2—Trusted Source of Oral Health Information)

In late 2013, the Council presented a continuing education course at the ADA's annual meeting in New Orleans. The program was very well attended with participants ranging from students, to dental assistants and practitioners from varied practice settings and diverse geographic areas. Overall, the program was very successful and received a great deal of positive feedback.

In April 2014, the Council was informed that the American Association of Dental Boards (AADB) was interested in the Council presenting an ethics continuing education course at its October annual meeting in San Antonio immediately prior to ADA 2014 – America's Dental Meeting. At its April 2014 meeting, the Council expressed its interest in developing a continuing education course to present at the AADB meeting and has communicated its interest to the executive director of the AADB. It is anticipated that the continuing education committee of the Council will collaborate with AADB representatives to identify any particular topics of interest to AADB and develop a continuing education course that embraces those topics. Several members of the Council will be in attendance at ADA 2014 and have indicated they are available to present the continuing education material to attendees at the AADB meeting.

In addition to the prospective continuing education presentation at the AADB meeting, the Council is reviewing the continuing education courses previously given to ensure that future continuing ethics educational offerings are best in class. During the period since the submission of its last annual report, the Council has also been working toward developing a series of web-based modules and/or webinars on a range of topics in continuing ethics education that can be made available to membership for continuing education through the ADA.

Ethics Hotline (Goal 1, Goal 2)

The ethics hotline was launched by the Council in February 2013 in collaboration with the New Dentist Committee. Initially, the hotline was promoted primarily to new dentist members. This year, the hotline has been promoted throughout the membership of the Association by articles in the *ADA News* and by information concerning the benefit being posted on the Ethics Resources site of ADA.org (<http://www.ada.org/en/about-the-ada/principles-of-ethics-code-of-professional-conduct/ada-ethics-resources/ada-ethics-hotline>). In addition, members of the Council have been requested to publicize the availability of the ethics hotline in communications to their trustee districts concerning the Council and its work. The Council staff is also investigating adding a reference to the ethics hotline to the notes that follow each "Ethical Moment" article that appears in *JADA*. Other efforts to expand the reach of the hotline and to showcase the hotline as one of the many values of ADA membership are also being investigated, including the possibility of making the ethics hotline available for a brief period of time to nonmember dentists who practice in a large group practice setting.

The hotline is staffed by a panel of Council members that rotates on approximately a quarterly basis. The ethics hotline has received over 30 inquiries. To date, the Council has been successful in responding to member inquiries within two business days of the receipt of inquiries.

Student Ethics Video Contest (Goal 1, Goal 2)

As it has since 2009, in 2013 the Council sponsored the student ethics video contest to provide an opportunity for students to consider ethical decision making as they prepare to start careers in dentistry. The goals of the contest are to create greater awareness among predoctoral dental students of ethical situations that are encountered during the everyday practice of dentistry and to provide a creative forum for students to consider how those situations should be addressed using the *ADA Code*. In 2013, eight contest entries were received. The Council awarded the contest grand prize to a team of students from the University of Texas School of Dentistry at Houston; the runner-up prize was awarded to a video submitted by students at the University of North Carolina School of Dentistry. The entry period for videos for the 2014 contest has opened and will close at the end of July 2014.

Revision of the Judicial Manual (Goal 1, Goal 4—Providing Resources to Enable Strategic and Operational Success)

During the 2013-2014 term, the Council spent a considerable amount of time reviewing and discussing the Council's Judicial Manual that was last revised in 2003. From that review, the Council considers the manual to be outdated and agrees that it is time for a fresh, more user-friendly manual. Consequently, the Council voted to retire the present manual and has begun the authoring of an updated set of guidelines and suggestions. These will be useful both to state and local dental societies empaneling committees to address allegations of ethical improprieties and to ADA members involved in the disciplinary process. It is anticipated that the replacement for the Judicial Manual will be finalized in 2015.

Emerging Issues and Trends

ADA Code 150th Anniversary

In 2016, the ADA will mark the sesquicentennial anniversary of the *ADA Code*, first adopted in 1866. The Council has begun to discuss ways in which to commemorate the *Code*'s anniversary and has identified and begun to explore the feasibility of conducting several activities to mark the 150 year event—such as a commemorative issue of the *ADA Code*, publication of *Code*-related articles in *JADA* and on ADA.org, including a commemorative banner on “Ethical Moment” articles that appear in 2016 and *ADA Code*-related events at ADA 2016 in Denver.

Large Group Practice

The Council continued to discuss the emergence of the large group practice trend and its effect on issues within the Council's *Bylaws* authority. The Council also continued to discuss the creation of membership value by promoting the *ADA Code* to the public so that the public might perceive ADA membership as an important criterion when selecting a dentist. To be successful, the Council believes that the public must be informed 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. The Council believes that recognition of the value of the *ADA Code* by the public may incentivize nonmember dentists in all practice settings to become ADA members. In 2015, the Council will seek ways to test this hypothesis. If validated, achieving public recognition of the value of the *ADA Code* is a long-term strategy; some positive benefit may be derived from the celebration of the 150 year anniversary of the *Code* in 2016.

Another tactic discussed by the Council to assist the ADA in bolstering the membership rate of dentists employed in large group practice settings is to demonstrate the benefit and value of ADA membership. A means for doing that identified by the Council is to make the ethics hotline available to nonmember dentists in large group practices and the Council is investigating implementing a pilot program for a limited period of time during 2015.

The Ethics of One-Day Charitable Events

The Council is developing a written statement that will address and provide guidance on ethical issues that may arise during temporary charitable events such as Mission of Mercy and Give Kids A Smile events. Once developed and reviewed and approved by the Council, it is anticipated that the draft statement will be circulated to other agencies of interest (e.g., the Council on Access, Prevention and Interprofessional Relations) for comment. It is anticipated that some of the ethical concerns that will be considered in the statement include privacy and confidentiality of patient records, follow-up care, the impact of these events on patients identifying a dental home and informed consent.

Emerging Ethical Issues

During the past year, the Council received a request to consider two emerging ethics-related topics—the dispensing for compassionate use (or, in a few jurisdictions, legalized sale) of cannabis and privacy issues associated with health information exchanges. With respect to the former, the Council determined

that this was an issue to be monitored by the Council but that a change or addition to the ADA *Code* was not warranted at present. The second issue was referred to the ethics committee of the Council for study and a report back to the Council.

Responses to House of Delegates Resolutions

The Council had no matters referred to it by the 2013 House of Delegates.

Self-Assessment

Pursuant to 1H-2013, the Council conducted a self-assessment during the 2013-14 term. The assessment was performed using a lengthy survey completed by the members, the results of which were tabulated and then discussed by the Council. In summary, the Council found that its *Bylaws* duties are well-defined and allow the Council to support both the existing strategic plan as well as the newly adopted strategic plan for 2015-2019 – Members First 2020. The Council also believes that the work done by the Council is necessary and that it should be performed by a council rather than staff or the Board of Trustees. The Council considered the overall Council size and manner of member selection and felt that both were satisfactory. The issue of skills-based membership was briefly considered but dismissed as impractical, as the duties of the Council embody both *Bylaws* and ethics-related activities. It was noted that a large membership from a diverse geographic area assists the Council in efficiently and successfully performing its work given the need to author monthly “Ethical Moment” articles and consider ethics and *Bylaws* issues that impact ADA members throughout the United States. Finally, the Council wishes to stress the importance of the criteria for the selection of members to serve on the Council, particularly the requirement that each Council member author one “Ethical Moment” article per year. The Council also believes that its work is facilitated by having diverse members serving on the Council and urges that diversity be a consideration when nominating members.

The Council's report of its self-assessment is provided as Appendix 1.

Policy Review

In accordance with House Resolution 170H-2012, Reaffirming Existing ADA Policy, all Association policies are to be reviewed every five years. The Council reviewed the following policies in the period following the Council's January 2014 meeting.

Recommendations—Policies to be Maintained

Guidelines for Dentist Advertising (*Trans.*1979:647)
 Criteria for Restructure of Trustee Districts (*Trans.*1986:498)
 Election of Delegates (*Trans.*1979:646)
 Patient Rights and Responsibilities (*Trans.*2009:477)

Recommendations—Policies to be Amended

Guidelines Governing the Conduct of Campaigns for All ADA Offices

The Council determined that the policy entitled “Guidelines Governing the Conduct of Campaigns for All ADA Offices” should be amended by the insertion of the word “timely” in paragraph 3 of the Guidelines to emphasize candidate invitations should be issued by district caucuses as early in the campaign year as possible for economic and conflict avoidance purposes. The Council recommends adoption of the following:

15. Resolved, that paragraph number 3 of the policy entitled Guidelines Governing the Conduct of Campaigns for All ADA Offices (*Trans.*2012:417) be amended as indicated (addition underscoring):

Resolved, that the Guidelines Governing the Conduct of Campaigns for All ADA Offices be approved and posted on ADA Connect and reprinted annually in the Manual of the House of Delegates and Supplemental Information as follows:

Guidelines Governing the Conduct of Campaigns for All ADA Offices

1. Candidates shall not formally announce their intent to run for office until the final day of the annual session immediately preceding their candidacy. Prior to this formal announcement, candidates may freely campaign within their own trustee districts. Campaign activities outside a candidate's own trustee district shall begin only after the official announcement at the annual session. The Election Commission shall meet with all candidates to negotiate cost effective agreements on campaign issues such as promotional activities and gifts (which are limited to campaign pins), campaign literature, travel, and electronic communications.

2. Candidates for the office of President-elect shall limit their campaign travel to attending state and/or district annual meetings and/or leadership conferences and annual session district caucus meetings only. Candidates for the office of Second Vice President and Speaker of the House of Delegates shall limit campaign travel to attending the district caucus meetings held during the ADA annual session.

3. District caucuses shall issue timely invitations to the President-elect candidates through the Office of the Executive Director. Caucuses are requested to provide an appropriate opportunity for the candidates to meet with their members. It is recommended that such forum be structured:

- a. to allow all candidates to make presentations;
- b. to allow caucuses freedom to assess candidates; and
- c. to allow each candidate to respond to questions.

President-elect candidates shall negotiate a mutually agreeable travel schedule and when mutually agreeable may utilize electronic communications (e.g., Skype) to accommodate conflicts with district schedules.

4. Candidates shall not use campaign-sponsored social functions or hospitality suite/meetings rooms on behalf of their candidacy at any regional, national or annual meeting. (This is not intended, however, to limit candidates from holding campaign meetings for the purpose of strategizing.) Campaign receptions are not to be held at the ADA Annual Session. Additionally, a district that annually hosts a reception during the ADA annual session and is sponsoring a candidate in a contested election should not host a reception prior to the officer elections; a reception may be held after the election.

5. News articles on and interviews of a Candidate are permissible if published by a state dental journal within the candidate's district, providing that the distribution of the journal is kept within the district, with no intentional outside distribution.

6. All candidates' campaign statements and profiles which appear in the ADA News will be posted on the Association's website, ADA.org, in an area dedicated to candidates for ADA elective offices, and on ADA Connect.

7. Candidates should not knowingly seek to have their name, photo, appearance, and writings in national trade or non-peer reviewed publications or websites during the campaign, and should avoid submitting articles in non-peer reviewed paper or electronic publications. Candidates who are participants on a speaker's bureau or earn revenue by speaking nationally or regionally must agree to avoid all unnecessary self-promotion during the campaign related to national speaking engagements.

8. The election process for the office of Treasurer may be preceded by a campaign strictly limited to visiting the district caucus meetings during the annual session. Candidates shall not be permitted to distribute any tangible election material, including but not limited to printed matters, CD-ROMs, audiovisual materials, pens, pins, stickers or other accessory items. Candidates shall not use signs, posters or any electronic means of communication including but not limited to telephones, television, radio, electronic and surface mail or the Internet. Candidates shall not attempt to raise funds to support a campaign, or to conduct any social functions, hospitality suites or other electioneering activities. The candidates' names and curriculum vitae, when applicable, will be submitted to the House in the first mailing/posting of the year of the election.

9. No material may be distributed in the House of Delegates without obtaining permission from the Secretary of the House. Materials to be distributed in the House of Delegates on behalf of any member's candidacy for office shall be limited to printed matter on paper only and nothing else. (A single distribution per candidate for each House of Delegates will be made. However, the distribution could consist of more than one piece of printed matter as long as the materials are secured together.)

10. No candidate will knowingly accept campaign contributions which create the appearance of conflict of interest as reflected in Chapter VI of the ADA *Bylaws*.

11. Candidates for all ADA elective offices should submit a summary of campaign contributions and expenses to the Election Commission at the end of the campaign.

12. Any questions regarding the Guidelines should be directed to the chair of the Election Commission for clarification.

The Dentist's Pledge

The Council determined that the policy entitled "The Dentist's Pledge" should be amended for clarity so that the *Principles of Ethics and Code of Professional Conduct* are identified as the ADA's *Principles of Ethics and Code of Professional Conduct*. The Council further believes that the pledge should be transmitted to dental schools so that it can be used by the schools as appropriate as, for example, during white coat or graduation ceremonies. Consequently, the Council recommends adoption of the following resolution:

16. Resolved, that the policy entitled The Dentist's Pledge (*Trans. 1991:598*) be amended as shown below (additions underscored, deletions ~~stricken through~~):

Resolved, that the following "Dentist's Pledge" be approved:

The Dentist's Pledge

I, (dentist's name), as a member of the dental profession, shall keep this pledge and these stipulations.

I understand and accept that my primary responsibility is to my patients, and I shall dedicate myself to render, to the best of my ability, the highest standard of oral health care and to maintain a relationship of respect and confidence. Therefore, let all come to me safe in the knowledge that their total health and wellbeing are my first considerations.

I shall accept the responsibility that, as a professional, my competence rests on continuing the attainment of knowledge and skill in the arts and sciences of dentistry.

I acknowledge my obligation to support and sustain the honor and integrity of the profession and to conduct myself in all endeavors such that I shall merit the respect of patients, colleagues and my community.

I further commit myself to the betterment of my community for the benefit of all of society.
 I shall faithfully observe the American Dental Association's Principles of Ethics and Code of Professional Conduct ~~set forth by the profession.~~

All this I pledge with pride in my commitment to the profession and the public it serves.

and be it further

Resolved, that the pledge be transmitted to U.S. dental schools for use as appropriate.

Revision of Chapters XII and XIII of the ADA Bylaws and Adoption of the ADA Procedures for Member Disciplinary Hearings and Appeals

Chapter XII of the *Bylaws* sets forth the governance basis for the ADA Code. Moreover, Chapters XII and XIII of the *Bylaws* are the source for the range of possible sanctions that exist for infractions of the ADA Code and the ADA's Member Conduct Policy. The bulk of the remainder of Chapters XII and XIII give procedural frameworks for enforcing the ADA Code and Member Conduct Policy. This year, the Council examined those portions of the *Bylaws* and determined that a number of important benefits could be achieved by removing the procedural material found in Chapters XII and XIII from the *Bylaws*. One positive result from that action is that a much more streamlined treatment of the governance aspects of the ADA Code and the Member Conduct Policy is possible; this adds clarity for leadership and members. Also, removal of the enforcement procedures relating to the ADA Code and the Member Conduct Policy allows that material to be presented in a style that is much more accessible and easier for members to understand. Finally, removal of enforcement procedures from the ADA *Bylaws* will allow revisions of those procedures to be adopted by a simple majority vote of the House of Delegates, rather than the two-thirds affirmative vote that is required to amend the *Bylaws*. This change will allow procedural revisions to be made more efficiently while still providing the House of Delegates oversight for such revisions.

To achieve these positive results, the Council is proposing that the ADA *Bylaws* be amended by moving the procedural material presently found in Chapters XII and XIII of the ADA *Bylaws* into a separate document entitled *ADA Procedures for Member Disciplinary Hearings and Appeals*.

In proposing these amendments to the House of Delegates, the Council wishes to emphasize several important points:

- There are no substantive changes proposed to the hearing and appeal procedures that have been removed from Chapters XII and XIII of the *Bylaws*. The entirety of the procedural framework present in Chapters XII and XIII remains in the separate document entitled *ADA Procedures for Member Disciplinary Hearings and Appeals*.
- Even though the procedural framework presented in the procedure manual remains unchanged, how that framework is presented has been substantially revised. The language used in the procedure manual has been revised from the "bylaws-type" presentation that currently exists to a much more readable style and type of presentation so that procedural frameworks presented will be easier for state and local dental society volunteer leaders and staff and members to understand and follow.
- To ensure that the procedures continue to be readily accessible to state and local dental societies and to ADA members, it is proposed that the *ADA Procedures for Member Disciplinary Hearings and Appeals* be appended to the ADA *Bylaws*.
- As stated above, by removing the procedural material from the ADA *Bylaws*, those procedures can be revised by an affirmative vote of a simple majority of the House of Delegates rather than by a two-thirds vote. That fact is specifically noted in the proposed *Bylaws* amendments.

The following resolution is presented to the House of Delegates for its consideration:

17. Resolved, that the procedures for disciplinary actions from Chapters XII and XIII be deleted from the *Bylaws* in the manner as follows, with revision of the remaining words for clarity as shown below (additions underscored, deletions ~~stricken through~~):

CHAPTER XII • PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT AND JUDICIAL PROCEDURE

Section 10. PROFESSIONAL CONDUCT OF MEMBERS: The professional conduct of a member of this Association shall be governed by the *Principles of Ethics and Code of Professional Conduct* of this Association and by the codes of ethics of the constituent and component societies within whose jurisdiction the member practices, or conducts or participates in other professional dental activities.

Section 20. DISCIPLINE OF MEMBERS:

A. CONDUCT SUBJECT TO DISCIPLINE. A member may be disciplined for (1) having been found guilty of a felony, (2) having been found guilty of violating the dental practice act of a state or other jurisdiction of the United States, (3) having been discharged or dismissed from practicing dentistry with one of the federal dental services under dishonorable circumstances, or (4) violating the *Bylaws*, the *Principles of Ethics and Code of Professional Conduct*, or the bylaws or code of ethics of the constituent or component society of which the accused is a member. For a member of a constituent society, disciplinary proceedings may be instituted by either the member's component or constituent society. Disciplinary proceedings against a direct member of this Association may be instituted by the Council on Ethics, Bylaws and Judicial Affairs of this Association.

B. DISCIPLINARY PENALTIES. A member may be disciplined for any of the offenses enumerated in Section 20A of this Chapter as follows:

a. CENSURE. Censure is a disciplinary sentence expressing in writing severe criticism or disapproval of a particular type of conduct or act.

b. SUSPENSION. Suspension, subject to Chapter I, Section 30 of these *Bylaws*, means all membership privileges except continued entitlement to coverages under insurance programs are lost during the suspension period. Suspension shall be unconditional and for a specified period at the termination of which full membership privileges are automatically restored. A subsequent violation shall require a new disciplinary procedure before additional discipline may be imposed.

c. EXPULSION. Expulsion is an absolute discipline and may not be imposed conditionally except as otherwise provided herein.

d. PROBATION. Probation, to be imposed for a specified period and without loss of privileges with the exception of holding or seeking an elective or appointive office, may be administratively and conditionally imposed when circumstances warrant in lieu of a suspended disciplinary penalty. Probation shall be conditioned on good behavior. Additional reasonable conditions may be set forth in the decision for the continuation of probation. In the event that the conditions for probation are found by the society which preferred charges to have been violated, after a hearing on the probation violation charges in accordance with procedures set forth in the *ADA Procedures for Member Disciplinary Hearings and Appeals* ~~Chapter XII, Section 20C~~, the original disciplinary penalty shall be automatically reinstated; except that when circumstances warrant the original disciplinary penalty may be reduced to a lesser penalty. There shall be no right of appeal from a finding that the conditions of probation have been violated.

C. PROCEDURES FOR DISCIPLINARY HEARINGS AND APPEALS. The procedures for hearings and appeals conducted pursuant to this Chapter XII shall be set forth in the *ADA Procedures for Member Disciplinary Hearings and Appeals*, a copy of which shall be appended to the ADA

Constitution and Bylaws and otherwise made freely available to members of the Association. The procedures set forth in the ADA Procedures for Member Disciplinary Hearings and Appeals shall be amendable by the House of Delegates on majority vote.

GD. DISCIPLINARY PROCEEDINGS/HEARINGS. Before a disciplinary penalty is invoked against a member, a hearing held pursuant to the procedures set forth in the ADA Procedures for Member Disciplinary Hearings and Appeals shall be held. ~~the following procedures shall be followed by the agency preferring charges:~~

a. ~~HEARING.~~ The accused member shall be entitled to a hearing at which the accused shall be given the opportunity to present a defense to all charges brought against the accused. The agency preferring charges shall permit the accused member to be represented by legal counsel.

b. ~~NOTICE.~~ The accused member shall be notified in writing of charges brought against the accused and of the time and place of the hearing, such notice to be sent by certified—return receipt requested letter addressed to the accused's last known address and mailed not less than twenty-one (21) days prior to the date set for the hearing. An accused member, upon request, shall be granted one postponement for a period not to exceed thirty (30) days.

c. ~~CHARGES.~~ The written charges shall include an officially certified copy of the alleged conviction or determination of guilt, or a specification of the bylaw or ethical provisions alleged to have been violated, as the case may be, and a description of the conduct alleged to constitute each violation.

d. ~~DECISION.~~ Every decision which shall result in censure, suspension, expulsion, or probation shall be reduced to writing and shall specify the charges made against the member. The facts which substantiate any or all of the charges, the verdict rendered, the penalty imposed or when appropriate the suspended penalty imposed and the conditions for probation, and a notice shall be mailed to the accused member informing the accused of the right to appeal. Within ten (10) days of the date on which the decision is rendered a copy thereof shall be sent by certified—return receipt requested mail to the last known address of each of the following parties: the accused member; the secretary of the component society of which the accused is a member, if applicable; the secretary of the constituent society of which the accused is a member, if applicable; the Chair of the Council on Ethics, Bylaws and Judicial Affairs of this Association; and the Executive Director of this Association.

DE. APPEALS. Before any penalty enumerated in Chapter XII, Section 20B, set forth in a decision following the hearing called for by Chapter XII, Section 20C and conducted pursuant to the ADA Procedures for Member Disciplinary Hearings and Appeals shall be final. The accused member has a right to appeal that decision, including any disciplinary sentence specified therein. Any such appeal shall be conducted within the timeframes and in accordance with the appeal procedures set forth in the ADA Procedures for Member Disciplinary Hearings and Appeals. ~~under sentence of censure, suspension or expulsion shall have the right to appeal from a decision of the accused's component society to the accused's constituent society by filing an appeal in affidavit form with the secretary of the constituent society. Such an accused member, or the component society concerned, shall have the right to appeal from a decision of the constituent society to the Council on Ethics, Bylaws and Judicial Affairs of this Association by filing an appeal in affidavit form with the Chair of the Council on Ethics, Bylaws and Judicial Affairs. Where the accused is a direct member of this Association, the accused member shall have the right of appeal from a disciplinary decision of a hearing panel of the Council on Ethics, Bylaws and Judicial Affairs to the Council by filing an appeal in affidavit form with the Chair of the Council on Ethics, Bylaws and Judicial Affairs. Members of the hearing panel shall not have the right to vote on the Council's decision on such an appeal.~~

An appeal from any decision shall not be valid unless notice of appeal is filed within thirty (30) days and the supporting brief, if one is to be presented, is filed within sixty (60) days after such decision

has been rendered. A reply brief, if one is to be presented, shall be filed within ninety (90) days after such decision is rendered. A rejoinder brief, if one is to be presented, shall be filed within one hundred five (105) days after such decision is rendered. After all briefs have been filed, a minimum of forty-five (45) days shall elapse before the hearing date. Omission of briefs will not alter the briefing schedule or hearing date unless otherwise agreed to by the parties and the chair of the appropriate appellate agency.

No decision shall become final while an appeal therefrom is pending or until the thirty (30) day period for filing notice of appeal has elapsed. In the event of a sentence of expulsion and no notice of appeal is received within the thirty (30) day period, the constituent society shall notify all parties of the failure of the accused member to file an appeal. The sentence of expulsion shall take effect on the date the parties are notified. The component and constituent societies shall each determine what portion of their current dues and their special assessments, if any, shall be returned to the expelled member. Dues and special assessments paid to this Association shall not be refundable in the event of expulsion. The following procedure shall be used in processing appeals:

a. **HEARINGS ON APPEAL.** The accused member or the society (or societies) concerned shall be entitled to a hearing on an appeal, provided that such appeal is taken in accordance with, and satisfies the requirements of, Section 20D of this Chapter. The appellate agency hearing the appeal shall permit the accused member to be represented by legal counsel. A party need not appear for the appeal to be heard by an appellate agency.

b. **NOTICE.** The appellate agency receiving an appeal shall notify the society (or societies) concerned, or where applicable the hearing panel of the Council on Ethics, Bylaws and Judicial Affairs, and the accused member of the time and place of the hearing, such notice to be sent by certified—return receipt requested letter to the last known address of the parties to the appeal and mailed not less than thirty (30) days prior to the date set for the hearing. Granting of continuances shall be at the option of the agency hearing the appeal.

c. **PREHEARING MATTERS.** Prehearing requests shall be granted at the discretion of the appellate agency. In appeals to this Association's Council on Ethics, Bylaws and Judicial Affairs, the Council chair has the authority to rule on motions from the parties for continuances and other prehearing procedural matters with advice from legal counsel of this Association. The Council chair may consult with the Council before rendering prehearing decisions.

d. **BRIEFS.** Every party to an appeal shall be entitled to submit a brief in support of the party's position. The briefs of the parties shall be submitted to the secretary of the constituent society or the Chair of the Council on Ethics, Bylaws and Judicial Affairs of this Association, as the case may be, and to the opposing party(ies) in accordance with the prescribed briefing schedule. The party initiating the appeal may choose to rely on the record and/or on an oral presentation and not file a brief.

e. **RECORD OF DISCIPLINARY PROCEEDINGS.** Upon notice of an appeal the agency which preferred charges shall furnish to the appellate agency which has received the appeal and to the accused member a transcript of, or an officially certified copy of the minutes of the hearing accorded the accused member. The transcript or minutes shall be accompanied by certified copies of any affidavits or other documents submitted as evidence to support the charges against the accused member or submitted by the accused member as part of the accused's defense. Where the agency preferring the charges does not provide for transcription of the hearing, the accused member, at the accused's own expense, shall be entitled to arrange for the services of a court reporter to transcribe the hearing.

f. **APPEALS JURISDICTION.** The agency to which a decision has been appealed shall be required to review the decision appealed from to determine whether the evidence before the society or agency which preferred charges against the accused member supports that decision or

~~warrants the penalty imposed. The appellate agency shall not be required to consider additional evidence unless there is a clear showing that either party to the appeal will be unreasonably harmed by failure to consider the additional evidence. The parties to an appeal are the accused member and the society or agency which preferred charges. In appeals to the Council on Ethics, Bylaws and Judicial Affairs of this Association, the society which heard the first appeal may, at its option, participate in the appeal.~~

~~g. DECISION ON APPEALS. Every decision on appeal shall be reduced to writing and shall state clearly the conclusion of the appellate agency and the reasons for reaching that conclusion. The appellate agency shall have the discretion to (1) *uphold* the decision of the agency which preferred charges against the accused member; (2) *reverse* the decision of the agency which preferred charges and thereby exonerate the accused member; (3) *deny* an appeal which fails to satisfy the requirements of Section 20D of this Chapter; (4) *refer* the case back to the agency which preferred charges for new proceedings, if the rights of the accused member under all applicable bylaws were not accorded the accused; (5) *remand* the case back to the agency which preferred charges for further proceedings when the appellate record is insufficient in the opinion of the appellate agency to enable it to render a decision; or (6) *uphold* the decision of the agency which preferred charges against the accused member and reduce the penalty imposed.~~

~~Within thirty (30) days of the date on which a decision on appeal is rendered, a copy thereof shall be sent by certified — return receipt requested mail to the last known address of each of the following parties: the accused member, the secretary of the component society of which the accused is a member, if applicable, the secretary of the constituent society of which the accused is a member, if applicable, the Chair of the Council on Ethics, Bylaws and Judicial Affairs of this Association and the Executive Director of this Association.~~

~~EF. SENTENCE.~~ After all appeals are exhausted or after the time for filing an appeal has expired, a sentence of censure, suspension or expulsion meted out to any member, including those instances when the disciplined member has been placed on probation, shall be enforced by such individual's component and constituent societies, if such exist, and this Association.

~~FG. NON-COMPLIANCE.~~ In the event of a failure of technical compliance with the procedural requirements of this Chapter or as set forth in the *ADA Procedures for Member Disciplinary Hearings and Appeals*, the agency hearing the appeal shall determine the effect of non-compliance.

CHAPTER XIII • PROCEDURES AND HEARINGS RELATING TO MEMBER CONDUCT POLICY

Section 10. CONDUCT SUBJECT TO REVIEW: Each member of this Association shall be subject to the provisions of the Association's Member Conduct Policy.

Section 20. DISCIPLINARY PROCEDURES AND HEARINGS:

A. MEMBER CONDUCT SUBJECT TO DISCIPLINE. Any member charged with violating the Association's Member Conduct Policy shall be afforded a fair and impartial hearing conducted in accordance with ~~Chapter XIII, Section 20C.~~ the *ADA Procedures for Member Disciplinary Hearings and Appeals*.

B. PROCEDURES FOR HEARINGS AND APPEALS HELD UNDER THE ASSOCIATION'S MEMBER CONDUCT POLICY. The procedures for hearings and appeals conducted pursuant to this Chapter XIII shall be set forth in the *ADA Procedures for Member Disciplinary Hearings and Appeals*, a copy of which shall be appended to the *ADA Constitution and Bylaws* and otherwise made freely available to members of the Association. The procedures set forth in the *ADA Procedures for Member Disciplinary Hearings and Appeals* shall be amendable by the House of Delegates on majority vote.

BC. DISCIPLINARY PENALTIES. Members may be disciplined for violating the Association's Member Conduct Policy as follows:

- a. **CENSURE.** Censure is a disciplinary sentence expressing in writing severe criticism or disapproval of a particular type of conduct or act.
- b. **SUSPENSION.** Suspension, subject to Chapter I, Section 30 of these *Bylaws*, means all membership privileges except continued entitlement to coverage under insurance programs are lost during the suspension period. Suspension shall be unconditional and for a specified period at the termination of which full membership privileges are automatically restored. A subsequent violation shall require a new disciplinary procedure before additional discipline may be imposed.
- c. **EXPULSION.** Expulsion is an absolute discipline and may not be imposed conditionally except as otherwise provided herein.
- d. **PROBATION.** Probation, to be imposed for a specified period and without loss of privileges with the exception of holding or seeking an elective or appointive office, may be administratively and conditionally imposed when circumstances warrant in lieu of a suspended disciplinary penalty. Probation shall be conditioned on good behavior. Additional reasonable conditions may be set forth in the decision for the continuation of probation. In the event that the conditions for probation are found by the Council on Ethics, Bylaws and Judicial Affairs to have been violated, after a hearing on the probation violation charges in accordance with Chapter XIII, Section 20D, the original disciplinary penalty shall be automatically reinstated, except that when circumstances warrant the original disciplinary penalty may be reduced to a lesser penalty. There shall be no right of appeal from a finding that the conditions of probation have been violated.
- e. **REMOVAL FROM OFFICE.** Removal from office as a trustee, delegate, alternate delegate or elective officer for the remaining term may be imposed in addition to, or in lieu of, any of the penalties enumerated in this Section of these *Bylaws*.

GD. DISCIPLINARY PROCEEDINGS. Before a disciplinary penalty is invoked against a member for violating the Association's Member Conduct Policy, a hearing held pursuant to the procedures set forth in the *ADA Procedures for Member Disciplinary Hearings and Appeals* shall be held. ~~the following procedures shall be followed by the Council on Ethics, Bylaws and Judicial Affairs and, as applicable, in the case of a trustee or an elective officer, reviewed by the House of Delegates:~~

- a. **CHARGES.** ~~Any member of the Association or the Association's staff shall be entitled to prefer charges alleging a violation of the Association's Member Conduct Policy. Charges shall be directed to the Chair of the Council on Ethics, Bylaws and Judicial Affairs and shall be in writing. Such written charges shall include a specification of the provision(s) of the Association's Member Conduct Policy alleged to have been violated, and a description of the conduct alleged to constitute the violation.~~
- b. **PRELIMINARY INVESTIGATION.** ~~A panel of three (3) sitting members of the Council on Ethics, Bylaws and Judicial Affairs selected by the Council's chair, which shall not include the Council member from the accused's trustee district, shall conduct a preliminary investigation into the charges and shall determine whether the allegations made in the charge sufficiently state a violation of the Member Conduct Policy.~~
- c. **NOTICE.** ~~If upon preliminary investigation the three-member investigatory panel concludes that the charge does not sufficiently state a violation of the Member Conduct Policy, the Association member or Association staff member preferring the charges shall be advised in writing of the investigatory panel's decision and the investigatory panel's decision shall be final. If the investigatory panel determines that the charge does sufficiently state a violation of the Member Conduct Policy, the accused member shall be notified in writing of the charges brought against~~

him or her and of the time and place of the hearing, such notice to be sent by certified return receipt requested letter addressed to the accused's last known address and mailed not less than twenty-one (21) days prior to the date set for the hearing. An accused member, upon request, shall be granted one postponement for a period not to exceed thirty (30) days.

d. HEARING. The accused member shall be entitled to a hearing before a panel of three (3) sitting members of the Council on Ethics, Bylaws and Judicial Affairs, which shall not include members of the investigatory panel or the Council member from the accused's trustee district, at which the accused shall be given the opportunity to present a defense to all charges brought against him or her. The Council on Ethics, Bylaws and Judicial Affairs shall permit the accused member to be represented by legal counsel.

e. DECISION. Every decision rendered by a hearing panel shall be reduced to writing and shall specify the charges made against the member, the relevant facts presented by the parties, the verdict rendered or recommended, any penalty imposed or recommended, or when appropriate any suspended penalty imposed or recommended, and the conditions for, any probation. Within ten (10) days of the date on which the decision or recommendation is rendered, a copy thereof shall be sent by certified return receipt requested mail to the last known address of each of the following parties, together with, where appropriate, a notice to the accused member informing him or her of the right to appeal: the accused member; the Association member or staff member preferring the charge; the secretary of the component society of which the accused is a member, if applicable; the secretary of the constituent society of which the accused is a member, if applicable; the chair of the Council on Ethics, Bylaws and Judicial Affairs of this Association; the Election Commission; and the Executive Director of this Association.

DE. APPEALS TO FULL COUNCIL. Before any penalty enumerated in Chapter XIII, Section 20C, set forth in a decision following the hearing called for by Chapter XIII, Section 20D and conducted pursuant to the ADA Procedures for Member Disciplinary Hearings and Appeals shall be final, the accused member has a right to appeal that decision, including any disciplinary sentence specified therein. Any such appeal shall be conducted within the timeframes and in accordance with the appeal procedures set forth in the ADA Procedures for Member Disciplinary Hearings and Appeals. The accused member under sentence or recommended sentence of censure, suspension, expulsion, probation and/or removal from office shall have the right to appeal from a hearing panel decision to the full Council on Ethics, Bylaws and Judicial Affairs by filing an appeal in affidavit form with the chair of the Council on Ethics, Bylaws and Judicial Affairs of this Association. Members of the investigatory and hearing panels, and the Council representative from the accused's trustee district, shall be recused from the appeal.

An appeal from any decision shall not be valid unless notice of appeal is filed within thirty (30) days and the supporting brief, if one is to be presented, is filed within sixty (60) days after such decision has been rendered. A reply brief, if one is to be presented, shall be filed by the Association member or Association staff member within ninety (90) days after such decision is rendered. A rejoinder brief, if one is to be presented, shall be filed within one hundred five (105) days after such decision is rendered. After all briefs have been filed, a minimum of forty-five (45) days shall elapse before the hearing date. Omission of briefs will not alter the briefing schedule or hearing date unless otherwise agreed to by the parties and the chair of the appropriate appellate agency.

No decision shall become final while an appeal therefrom is pending or until the thirty (30) day period for filing notice of appeal has elapsed. In the event of a sentence of expulsion and no notice of appeal is received within the thirty (30) day period, the Council on Ethics, Bylaws and Judicial Affairs shall notify all parties of the failure of the accused member to file an appeal. The following procedure shall be used in processing appeals to the full Council on Ethics, Bylaws and Judicial Affairs:

a. HEARINGS ON APPEAL TO FULL COUNCIL. The accused member shall be entitled to a hearing on an appeal, provided that such appeal is taken in accordance with, and satisfies the

requirements of, this Section. The Council on Ethics, Bylaws and Judicial Affairs shall permit the accused member to be represented by legal counsel. A party need not appear for the appeal to be heard by the Council on Ethics, Bylaws and Judicial Affairs.

b. ~~NOTICE.~~ The Council on Ethics, Bylaws and Judicial Affairs shall notify the accused member, the Association member or Association staff member preferring charges, the secretary of the component society of which the accused is a member, if applicable; and the secretary of the constituent society of which the accused is a member, if applicable of the time and place of the appeal hearing, such notice to be sent by certified—return receipt requested letter to the last known address of the parties to the appeal and mailed not less than thirty (30) days prior to the date set for the hearing. Granting of continuances shall be at the option of the Council on Ethics, Bylaws and Judicial Affairs.

c. ~~PREHEARING MATTERS.~~ Prehearing requests shall be granted at the discretion of the Council on Ethics, Bylaws and Judicial Affairs. The Council chair has the authority to rule on motions from the parties for continuances and other prehearing procedural matters with advice from legal counsel of this Association. The Council chair may consult with the Council before rendering prehearing decisions.

d. ~~BRIEFS.~~ Every party to an appeal shall be entitled to submit a brief in support of the party's position. The briefs of the parties shall be submitted to the Chair of the Council on Ethics, Bylaws and Judicial Affairs of this Association, and to the opposing party(ies) in accordance with the prescribed briefing schedule. The party initiating the appeal may choose to rely on the record and/or on an oral presentation and not file a brief.

e. ~~RECORD OF DISCIPLINARY PROCEEDINGS.~~ Upon notice of an appeal, the three-member hearing panel of the Council on Ethics, Bylaws and Judicial Affairs that presided over the initial hearing shall furnish to the full Council on Ethics, Bylaws and Judicial Affairs and to the accused member a transcript of, or an officially certified copy of the minutes of, the hearing accorded the accused. The transcript or minutes shall be accompanied by certified copies of any affidavits or other documents submitted as evidence to support the charges against the accused member or submitted by the accused as part of the accused's defense. Where the three-member hearing panel of the Council on Ethics, Bylaws and Judicial Affairs does not provide for transcription of the hearing, the accused member shall be entitled to arrange for the services of a court reporter to transcribe the hearing.

f. ~~APPEALS JURISDICTION.~~ The Council on Ethics, Bylaws and Judicial Affairs shall be required to review the decision appealed from to determine whether the evidence before the three-member hearing panel supports that decision or warrants the penalty(ies) imposed. The Council on Ethics, Bylaws and Judicial Affairs shall not be required to consider additional evidence unless there is a clear showing that a party to the appeal will be unreasonably harmed by failure to consider the additional evidence. The parties to an appeal are the accused member and the Association member or Association staff member that preferred charges.

g. ~~DECISION ON APPEALS NOT INVOLVING RECOMMENDED PROBATION, SUSPENSION, EXPULSION AND/OR REMOVAL OF A TRUSTEE OR ELECTIVE OFFICER.~~ In each appeal that does not involve the recommended probation, suspension, expulsion and/or removal from office of a trustee or elective officer, the decision of the Council on Ethics, Bylaws and Judicial Affairs shall be reduced to writing and shall state clearly the conclusion of the Council and the reasons for reaching that conclusion. The Council shall have the discretion to (1) *uphold* the decision of the three-member hearing panel; (2) *reverse* the decision of the three-member hearing panel and thereby exonerate the accused; (3) *deny* an appeal which fails to satisfy the requirements of Section 20D of this Chapter; (4) *refer* the case back to the three-member hearing panel for new proceedings, if the rights of the accused member under all applicable bylaws were not accorded the accused; (5) *remand* the case back to the three-member hearing panel for further proceedings when the appellate record is insufficient in the opinion of the Council on

Ethics, Bylaws and Judicial Affairs to enable it to render a decision; or (6) *uphold* the decision of the three-member hearing panel but reduce the penalty imposed. The decision of the Council on Ethics, Bylaws and Judicial Affairs under this Section 20Eg of Chapter XIII shall be final and non-appealable.

Within thirty (30) days of the date on which a final decision on appeal is rendered, a copy thereof shall be sent by certified—return receipt requested mail to the last known address of each of the following parties: the accused member, the Association member or Association staff member preferring charges, the secretary of the component society of which the accused is a member, if applicable, the secretary of the constituent society of which the accused is a member, if applicable, the Election Commission and the Executive Director of this Association.

~~h. DECISION ON APPEALS INVOLVING RECOMMENDED PROBATION, SUSPENSION, EXPULSION AND/OR REMOVAL OF A TRUSTEE OR ELECTIVE OFFICER.~~ In each appeal that involves the recommended probation, suspension, expulsion or removal of a trustee or elective officer, the decision of the Council on Ethics, Bylaws and Judicial Affairs shall be reduced to writing and shall state clearly the conclusion of the Council and the reasons for reaching that conclusion. In such appeals, the Council shall have the discretion to (1) recommend *upholding* the decision of the three-member hearing panel; (2) *reverse* the recommended decision of the three-member hearing panel and thereby exonerate the accused; (3) recommend *denying* an appeal which fails to satisfy the requirements of Section 20E of this Chapter; (4) *refer* the case back to the three-member hearing panel for new proceedings, if the rights of the accused member under all applicable bylaws were not accorded the accused; (5) *remand* the case back to the three-member hearing panel for further proceedings when the appellate record is insufficient in the opinion of the Council on Ethics, Bylaws and Judicial Affairs to enable it to render a decision; or (6) *uphold* the decision of the three-member hearing panel but reduce the penalty imposed, except in cases in which the reduced penalty is probation, suspension and/or removal from office, in which case the Council's decision shall be a recommendation. The decision of the Council on Ethics, Bylaws and Judicial Affairs under this Section 20Eh of Chapter XIII shall be final and non-appealable in such cases only if the Council's decision does not result in a recommendation of probation, suspension, expulsion and/or removal from office.

In cases not involving recommended probation, suspension, expulsion and/or removal from office, within thirty (30) days of the date on which a final decision on appeal is rendered, a copy thereof shall be sent by certified return receipt requested mail to the last known address of each of the following parties: the accused trustee or elective officer; the Association member or Association staff member preferring charges; the secretary of the component society of which the trustee is a member, if applicable; the secretary of the constituent society of which the trustee or elective officer is a member, if applicable; the Election Commission and the Executive Director of this Association.

In cases involving the recommended probation, suspension, expulsion and/or removal from office of a trustee or elective officer, within thirty (30) days of the date on which a recommended decision on appeal is rendered, a copy thereof shall be sent by certified return receipt requested mail to the last known address of each of the following parties: the accused trustee or elective officer; the Association member or Association staff member preferring charges; the Election Commission, the secretary of the component society of which the trustee or elective officer is a member, if applicable; the secretary of the constituent society of which the trustee or elective officer is a member, if applicable; and the Executive Director of this Association. Trustees or elective officers recommended to be sentenced to probation, expulsion, suspension and/or removal from office shall have the right to respond in writing to the recommendation, which response shall be delivered to the chair of the Council on Ethics, Bylaws and Judicial Affairs within thirty (30) days from the date of the recommended decision. The chair of the Council on Ethics, Bylaws and Judicial Affairs shall forward its recommendation, along with any response, to the Speaker of the House of Delegates, the Election Commission and the Association's Executive Director.

~~EF.~~ CONSIDERATION OF RECOMMENDED PROBATION, SUSPENSION, EXPULSION AND/OR REMOVAL FROM OFFICE OF TRUSTEES OR ELECTIVE OFFICERS BY HOUSE OF DELEGATES. The House of Delegates shall decide whether to accept or reject any the recommendation of a sentence of probation, suspension, expulsion and/or removal from office made pursuant to this Chapter XIII against Trustees or Elected Officers of this Association. Delegates and alternate delegates who participated in any portion of the procedures that resulted in such recommendation shall be of the Council on Ethics, Bylaws and Judicial Affairs. Members, and as applicable, former members, of the Council on Ethics, Bylaws and Judicial Affairs who were sitting on the Council at any time during which charges were pending against an accused shall be recused from deliberations under this Section 20F. A two-thirds (2/3) affirmative vote of the delegates present and voting is required to impose a disciplinary sentence of expulsion from membership ~~or~~ removal from office, suspension or probation.

~~FG.~~ SENTENCE. After all appeals are exhausted or after the time for filing an appeal has expired, a sentence of censure, suspension, expulsion and/or removal from office meted out to any member, including those instances when the disciplined member has been placed on probation, shall be enforced by such individual's component and constituent societies, if such exist, and this Association.

~~GH.~~ NON-COMPLIANCE. In the event of a failure of technical compliance with the procedural requirements of this Chapter or of the Procedures set forth in the *ADA Procedures for Member Disciplinary Hearings and Appeals*, the Council on Ethics, Bylaws and Judicial Affairs shall determine the effect of non-compliance.

and be it further

Resolved, that the deleted procedures be revised for clarity and placed in a separate, newly established document as shown:

ADA Procedures for Member Disciplinary Hearings and Appeals

I. INITIAL DISCIPLINARY HEARINGS HELD PURSUANT TO ADA BYLAWS CHAPTER XII

The following procedures are to be followed by a society bringing ethics violation charges:

A. NOTICE. A society bringing charges against a member alleging a violation of Chapter XII, Section 20A of the *ADA Bylaws* shall issue a notice of charges that will meet the following specifications:

1. Charges Brought. The notice of charges will contain a detailed statement of all disciplinary charges brought against the accused member, including (a) an official certified copy of any alleged conviction or determination of guilt that is the basis for the disciplinary action, (b) description of the section(s) of the *Bylaws* or the ethical provisions alleged to have been violated, and/or (c) a description of the conduct alleged to constitute each violation.
2. Time of Hearing. The notice of charges shall contain notification of the date, time and place that a hearing on the charges will be held.
3. Delivery. The notice of charges shall be sent to the accused member by certified mail, return receipt requested. The notice of charges shall be addressed to the accused member's last known address and mailed not less than twenty-one (21) days prior to the date set for the hearing.

B. HEARING. Any member accused of a violation of Chapter XII, Section 20A of the *ADA Bylaws* is entitled to a hearing before a hearing body of the society bringing the charges.

1. Purpose. The purpose of a disciplinary hearing is to provide the accused member with the opportunity to present a defense to the charges brought against him or her.

2. Representation by Counsel. The society bringing the charges must allow the accused member to be represented by legal counsel at any hearing convened under these procedures.

3. Continuances. An accused member is entitled to one (1) hearing postponement. The postponement cannot exceed thirty (30) days. Additional requests for postponement may be granted or denied by the hearing body in its reasonable discretion.

C. DECISION.

1. Requirement of Written Decision. Every decision of a hearing body that imposes a penalty of censure, suspension, expulsion, or probation will be in writing. The written decision will:

- (a) Contain a statement of the charge(s) made against the member;
- (b) State the facts that support the charge(s) and the verdict arrived at by the hearing body;
- (c) State the penalty imposed and, if the penalty is to be suspended during a period of probation, the length of the probationary period and any other conditions included in the probation; and
- (d) Be sent to the accused member by certified mail, return receipt requested, and addressed to the accused member's last known address.
- (e) Be sent to by certified mail, return receipt requested, to the last known address of each of the following:
 - (i) The secretary of the accused member's component society, if any;
 - (ii) The secretary of the accused member's constituent society, if applicable;
 - (iii) The Chair of the American Dental Association Council on Ethics, Bylaws and Judicial Affairs; and
 - (iv) The Executive Director of the American Dental Association.

D. NOTICE OF RIGHT TO APPEAL. Every written decision issued by a hearing body that imposes a penalty of censure, suspension, expulsion, or probation will be accompanied by a separate notice stating that the accused member has a right to appeal the decision. The notice of right to appeal will direct the member to Article II of these Procedures for Member Disciplinary Hearings and Appeals.

E. FINALITY OF DECISION. A decision will not become final while an appeal of it is pending or until the thirty (30) day period for filing a notice of appeal has expired.

1. Non-Appeal of Decision Containing Sentence of Expulsion. If a decision includes a sentence of expulsion and a notice of appeal is not received within the thirty (30) day period within which to appeal, the constituent society will notify all parties of the failure of the accused member to file an appeal. The sentence of expulsion will take effect on the date the parties receive such notice. The component and constituent societies shall each determine what portion of their current dues and special assessments, if any, shall be returned to the expelled member. Dues and special assessments paid to this Association will not be refunded to an expelled member.

II. APPEALS FROM DISCIPLINARY DECISIONS ISSUED PURSUANT TO ADA BYLAWS CHAPTER XII

The following procedures shall be followed in any appeal from a decision issued as a result of a disciplinary hearing pursuant to Chapter XII, Section 20D of the ADA *Bylaws*:

A. RIGHT TO APPEAL.

1. Disciplinary Decision of a Component Society. Any member shall have the right to appeal a disciplinary decision issued by the member's component society that imposes a penalty of

censure, suspension, expulsion, or probation. That appeal shall be made to member's constituent society by filing a notice of appeal in affidavit form with the secretary of the constituent society.

2. Disciplinary Decision of a Constituent Society. Any member or component society shall have a right to appeal a disciplinary decision that is adverse to it that is issued by a constituent society. That appeal shall be made to the Council on Ethics, Bylaws and Judicial Affairs of this Association by filing a notice of appeal in affidavit form with the Chair of the Council on Ethics, Bylaws and Judicial Affairs.

3. Disciplinary Decision Adverse to a Direct Member. A direct member of this Association* shall have the right to appeal a disciplinary decision of a hearing panel of the Council on Ethics, Bylaws and Judicial Affairs that imposes a penalty of censure, suspension, expulsion, or probation. That appeal shall be made to the Council on Ethics, Bylaws and Judicial Affairs of this Association by filing a notice of appeal in affidavit form with the Chair of the Council on Ethics, Bylaws and Judicial Affairs. Members of the hearing panel that issued the decision being appealed shall have no right to vote on the Council's decision in such an appeal.

B. **TIME TO APPEAL**. An appeal from any decision shall not be valid unless the appeal is filed within thirty (30) days of the date the decision appealed from was issued.

C. **TIME FOR THE FILING OF BRIEFS ON APPEAL**. Briefs in appeals brought under this Article II must be filed in accordance with the following schedule:

1. Appellant's Initial Brief. If being filed, an initial brief supporting an appeal must be filed within sixty (60) days of the issue date of the decision being appealed.

2. Reply Brief. If being filed, a reply brief must be filed within ninety (90) days of the issue date of the decision being appealed.

3. Rejoinder Brief. If being filed, a rejoinder brief must be filed within one hundred five (105) days of the issue date of the decision being appealed.

D. **TIME FOR APPEAL HEARING**. No hearing shall be held within one hundred fifty (150) days of the issue date of the decision being appealed or forty-five (45) days after the last brief in the appeal was filed, whichever is later. Omission of briefs will not alter the date for the hearing of an appeal unless otherwise agreed to by the parties and the chair of the body hearing the appeal.

E. **CONDUCT OF THE APPEAL HEARING**. The following procedure shall be used in processing appeals:

1. Appeal Hearings. If the requirements of Sections A and B of this Article II are met, the party bringing the appeal shall be entitled to a hearing.

2. Parties to an Appeal. The parties to an appeal are the accused member and the society or body that brought the charges against the accused member. In appeals to the Council on Ethics, Bylaws and Judicial Affairs of this Association, the society which heard the first appeal, if any, may, at its option, participate in the appeal.

3. Right to be Represented by Counsel. The parties to an appeal shall be entitled to be represented by counsel in the appeal.

4. Appearance at Hearing not Required. A party to an appeal is not required to attend a hearing in an appeal brought pursuant to this Article.

* As defined in the second explanatory note to Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, sub-section A. ACTIVE MEMBERS, paragraph a QUALIFICATIONS of the ADA BYLAWS.

5. Option to Conduct Telephonic Hearings. Upon the request by a party and the concurrence of all other parties, the body hearing the appeal may permit one or more of the parties to an appeal to participate in the hearing remotely via telephone or other suitable means. The decision whether to allow remote participation in an appeal hearing is discretionary with the body hearing the appeal and granting such a request can be subject to meeting reasonable terms and conditions set by the hearing body.

6. Hearing Notice. A body that receives a notice of appeal shall notify the society (or societies) concerned or, where applicable, the hearing panel of the Council on Ethics, Bylaws and Judicial Affairs, and the accused member of the time and place of the appeal hearing. Such notice shall be sent by certified mail, return receipt requested, to the last known address of each party to the appeal. The hearing notice should be mailed not less than thirty (30) days prior to the hearing date.

7. Hearing Continuances. Granting of hearing continuances shall be at the discretion of the hearing body.

8. Prehearing Matters. Prehearing requests shall be granted at the discretion of the hearing body. In appeals to this Association's Council on Ethics, Bylaws and Judicial Affairs, the Council chair has the authority to rule on requests from the parties for continuances and other prehearing procedural matters with advice from legal counsel of this Association. The Council chair may consult with the Council before rendering prehearing decisions.

9. Briefs. Each party to an appeal shall be entitled to submit a brief in support of the party's position. The briefs of the parties shall be submitted to the secretary of the constituent society or the Chair of the Council on Ethics, Bylaws and Judicial Affairs of this Association, as appropriate, in accordance with the prescribed briefing schedule. A copy of any brief filed in the appeal must be delivered to every other party in the appeal at the same time as the filing of the brief. The party initiating the appeal may choose to rely on the record and/or on an oral presentation and not file a brief.

10. Record of Disciplinary Proceedings. Upon notice of an appeal, the society or body that issued the decision being appealed shall provide to the body hearing the appeal and to the accused member a transcript, or an officially certified copy of the minutes, of the hearing accorded the accused member. Certified copies of any affidavits or other documents submitted as evidence to support or refute the charges against the accused member in the disciplinary hearing and any other material considered by the body issuing the decision being appealed will accompany the transcript or minutes. Where the body conducting the hearing resulting in the decision being appealed does not transcribe the hearing, the accused member, at the accused's own expense, is entitled to arrange for transcription of the hearing by a court reporter.

11. Appeals Jurisdiction. The body to which a decision has been appealed shall be required to review the decision appealed from to determine whether the evidence before the society or body which brought the charges against the accused member supports that decision or warrants the penalty imposed. The body hearing the appeal shall not be required to consider additional evidence unless there is a clear showing that a party to the appeal will be unreasonably harmed by failure to consider the additional evidence.

12. Decisions on Appeals. Every decision on appeal shall be in writing and must clearly state the conclusion of the hearing body and the reasons for that conclusion. The body hearing the appeal shall have the discretion to:

- (a) *Uphold* the decision of the society or body that brought charges against the accused member;
- (b) *Reverse* the decision of the society or body that brought the charges and thereby exonerate the accused member;

- (c) *Deny* an appeal where it fails to satisfy the requirements of Chapter XII, Section 20D of the *ADA Bylaws*;
- (d) *Refer* the case back to the body that brought the charges for new proceedings, if the rights of the accused member under all applicable bylaws were violated or if adopted disciplinary procedures were not followed to the detriment of the accused;
- (e) *Remand* the case back to the agency that issued the charges for further proceedings when the record in the appeal is insufficient to enable the body hearing the appeal to form a conclusion concerning the correctness of the decision being appealed; or
- (f) *Modify* the decision of the agency that issued the charges against the accused member by reducing the penalty imposed.

13. Delivery of the Appeal Decision to the Parties. Within thirty (30) days of the date on which a written decision on appeal is approved by the agency conducting the appeal, a copy of the written decision shall be sent by certified mail, return receipt requested, to the last known address of each of the following: the accused member; the secretary of the component society of which the accused is a member, if applicable; the secretary of the constituent society of which the accused is a member, if applicable; the Chair of the Council on Ethics, Bylaws and Judicial Affairs of this Association; and the Executive Director of this Association.

III. MEMBER CONDUCT HEARINGS

The following procedures will be followed by the Council on Ethics, Bylaws and Judicial Affairs in cases involving allegations of violations of the Member Conduct Policy of the Association:

A. **CHARGES**. Any member of the Association or the Association's staff will have the right to bring charges alleging a violation or violations of the Association's Member Conduct Policy. Charges must:

1. Be in writing.
2. Sent to the Chair of the Council on Ethics, Bylaws and Judicial Affairs.
3. Include an identification of the provision(s) of the Association's Member Conduct Policy alleged to have been violated and a detailed description of the conduct alleged to constitute the violation.

B. PRELIMINARY INVESTIGATION.

1. Selection. Upon receipt of charges alleging violation of the Member Conduct Policy, the Chair of the Council on Ethics, Bylaws and Judicial Affairs will select an investigatory panel of three (3) members of the Council.
2. Ineligible Council Member. The Council member from the Trustee District of the member accused of violating the Member Conduct Policy is ineligible to serve on the investigatory panel. The investigatory panel will conduct a preliminary investigation of the charges alleged and determine whether the allegations made in the charges sufficiently state a violation of the Member Conduct Policy.

C. NOTICE OF DETERMINATION OF INVESTIGATORY PANEL.

1. No Violation. If, upon preliminary investigation, the investigatory panel determines that the charges do not sufficiently state a violation of the Member Conduct Policy, the Association member or Association staff member bringing the charges will be advised in writing of the investigatory panel's determination. The investigatory panel's decision will be final and without right of appeal.

2. Determination of Possible Violation. If the investigatory panel determines that the charge does sufficiently state a violation of the Member Conduct Policy, the accused member shall be notified in writing.

3. Notice of Possible Violation. The notice of possible violation shall:

- (a) Provide a specification of the charges brought against him or her;
- (b) Specify the time and place of hearing on the charges brought against the accused member;
- (c) Be sent via certified mail, return receipt requested, to the accused's last known address; and
- (d) Be mailed not less than twenty-one (21) days prior to the date set for the hearing.

D. **HEARING.** The accused member shall be entitled to a hearing before a panel of three (3) members of the Council on Ethics, Bylaws and Judicial Affairs.

1. Hearing Panel Make Up. Members of the investigatory panel that investigated the allegations against the accused member and the Council member from the accused's trustee district are ineligible to sit on the hearing panel.

2. Purpose. The purpose of the hearing is to provide the accused member with an opportunity to present a defense to the charges brought against him or her.

3. Representation by Counsel. The accused member is entitled to be represented by legal counsel at the member conduct hearing.

4. Continuances. An accused member is entitled to one (1) hearing postponement. The postponement cannot exceed thirty (30) days. Additional requests for postponement may be granted or denied at the discretion of the chair of the Council on Ethics, Bylaws and Judicial Affairs, who may but need not consult with the Council or the hearing panel on the request.

E. **DECISION.**

1. Requirement of Written Decision. Every decision of a member conduct hearing panel will be in writing. The written decision will:

- (a) Contain a statement of the charges made against the member;
- (b) State the relevant facts;
- (c) State the verdict arrived at by the hearing body; and
- (d) State the penalty imposed or recommended and, if the penalty is to be suspended during a period of probation, the length of the probationary period and any other conditions included in the probation.

2. Mailing of Decision. Every hearing panel decision must be sent, by certified mail, return receipt requested, within ten (10) days of the written decision being approved by the hearing panel, to the last known address of each of the following:

- (a) The accused member;
- (b) The Association member or staff member who brought the charges;
- (c) The secretary of the accused member's component society, if any;
- (d) The secretary of the accused member's constituent society, if applicable;
- (e) The Chair of the American Dental Association Council on Ethics, Bylaws and Judicial Affairs;
- (f) The Executive Director of the American Dental Association; and, if applicable
- (g) The Election Commission of the Association.

F. **NOTICE OF RIGHT TO APPEAL.** A written notice to the accused member informing the member of his or her right to appeal the decision of the hearing panel must accompany the copies of the decision sent pursuant to Section E2 of Article III of these procedures.

G. **FINALITY OF DECISION.** A decision will not become final while an appeal of the decision is pending or until the thirty (30) day period for filing notice of appeal has expired.

1. Non-Appeal of Decision Containing Sentence of Expulsion. If a decision includes a sentence of expulsion and no notice of appeal is received within the thirty (30) day period within which to appeal, the Council on Ethics, Bylaws and Judicial Affairs shall notify all parties of the failure of the accused member to file an appeal. The sentence of expulsion will take effect on the date the parties receive such notice. The disciplined member's component and constituent societies shall each determine what portion of their current dues and special assessments, if any, shall be returned to the expelled member. Dues and special assessments paid to this Association will not be refunded to an expelled member.

IV. MEMBER CONDUCT APPEALS

The following procedures shall be followed in any appeal from a decision issued as a result of a member conduct hearing pursuant to Chapter XIII, Section 20D of the ADA *Bylaws*:

A. **RIGHT TO APPEAL.** Any member shall have the right to appeal a disciplinary decision issued by a member conduct hearing panel that imposes a penalty of censure, suspension, expulsion or probation on him or her to the full Council on Ethics, Bylaws and Judicial Affairs by filing an appeal in affidavit form with the chair of the Council on Ethics, Bylaws and Judicial Affairs of this Association.

B. **TIME TO APPEAL.** An appeal from any decision under this Article IV will not be valid unless the appeal is filed within thirty (30) days of the date the decision appealed from was issued.

C. **TIME FOR FILING BRIEFS ON APPEAL.** Brief in appeals brought under this Article IV will be filed according to the following schedule:

1. Appellant's Initial Brief. If being filed, an initial brief supporting an appeal must be filed within sixty (60) days after the date the decision being appealed was issued.

2. Reply Brief. If being filed, a reply brief supporting the decision appealed from must be filed by the Association member or staff member who lodged the member conduct complaint within ninety (90) days after the decision being appealed was issued.

3. Rejoinder Brief. If being filed, a rejoinder brief supporting an appeal must be filed within one hundred five (105) days after the date the decision being appealed was issued.

D. **TIME FOR APPEAL HEARING.** No hearing on an appeal will be held within one hundred fifty (150) days of the date the decision appealed from was issued or forty-five (45) days after the last brief in the appeal was filed, whichever is later. Omission of briefs will not alter the hearing date unless otherwise agreed to by the parties and the chair of the body hearing the appeal.

E. **CONDUCT OF THE APPEAL HEARING.** The accused member shall be entitled to a hearing on an appeal, provided that such appeal meets the requirements of this Article.

1. Council Members Hearing the Appeal. Members of the investigatory and hearing panels involved in the action being appealed and the Council representative from the accused member's Trustee District shall be recused from and will not take part in the appeal.

2. Parties to the Appeal. In any appeal of a decision under the Member Conduct Policy, the parties to such an appeal shall be the accused member and the Association member or the Association staff member who brought the charges.

3. Representation by Counsel. In any appeal, the accused member is entitled to be represented by legal counsel.

4. Attendance at Hearing. A party need not appear for the appeal to be heard by the Council on Ethics, Bylaws and Judicial Affairs.

5. Option to Conduct Telephonic Hearings. Upon the request by a party and the concurrence of all other parties, the Council on Ethics, Bylaws and Judicial Affairs may permit one or more of the parties to an appeal to participate in the hearing remotely via telephone or other suitable means. The decision whether to allow remote participation in an appeal hearing is discretionary with the Council and granting such a request can be subject to meeting reasonable terms and conditions set by the Council.

6. Hearing Notice. The Council on Ethics, Bylaws and Judicial Affairs shall notify the accused member; the Association member or Association staff member bringing the charges; the secretary of the accused member's component society, if applicable; and the secretary of the accused member's constituent society, if applicable of the time and place of the appeal hearing. The hearing notice will be sent by certified—return receipt requested letter to the last known addresses of the parties to the appeal and the other entities receiving notice. The notice of hearing is to be mailed not less than thirty (30) days prior to the hearing date.

7. Hearing Continuances. The granting of continuances shall be at the discretion of the Council on Ethics, Bylaws and Judicial Affairs.

8. Prehearing Matters. Prehearing requests shall be granted at the discretion of the Council on Ethics, Bylaws and Judicial Affairs. The Council chair has the authority to rule on requests from the parties for continuances and other prehearing procedural matters with advice from legal counsel of this Association. The Council chair may consult with the Council before rendering prehearing decisions.

9. Briefs. Each party to an appeal shall be entitled to submit a brief in support of the party's position. The briefs of the parties shall be submitted to the Chair of the Council on Ethics, Bylaws and Judicial Affairs of this Association in accordance with the prescribed briefing schedule. A copy of each brief filed in an appeal must be delivered to the opposing party in the appeal at the same time as the filing of the brief. The party initiating the appeal may choose to rely on the record and/or an oral presentation and not file a brief.

10. Record of Hearing. Upon receiving a notice of an appeal, the hearing panel of the Council on Ethics, Bylaws and Judicial Affairs that presided over the initial hearing shall furnish a transcript or an officially certified copy of the minutes of the hearing being appealed to the Council on Ethics, Bylaws and Judicial Affairs and the parties to the appeal. The transcript or minutes shall be accompanied by certified copies of any affidavits or other documents submitted as evidence to support the charges against the accused member or submitted by the accused as part of the accused's defense. If the hearing panel did not provide for transcription of the hearing, any party shall be entitled to arrange for the services of a court reporter to transcribe the hearing.

11. Appeals Jurisdiction. The Council on Ethics, Bylaws and Judicial Affairs is required to review the decision appealed from to determine whether the evidence before the hearing panel supports that decision or warrants the penalty(ies) imposed. The Council on Ethics, Bylaws and Judicial Affairs shall not be required to consider additional evidence unless there is a clear showing that a party to the appeal will be unreasonably harmed by failure to consider the additional evidence.

F. DECISION ON APPEALS

1. Appeals not Involving Recommended Probation, Suspension, Expulsion and/or Removal of a Trustee or Elective Officer.

- (a) Written Decision. In any appeal that does not involve the recommended probation, suspension, expulsion and/or removal from office of a trustee or elective officer, the decision of the Council on Ethics, Bylaws and Judicial Affairs shall be reduced to writing. The decision must clearly state the conclusion of the Council and the reasons for reaching that conclusion.
- (b) Permissible Penalties. The Council shall have the discretion to:

- (i) *Uphold* the decision of the hearing panel;
- (ii) *Reverse* the decision of the hearing panel and thereby exonerate the accused member;
- (iii) *Deny* an appeal that fails to satisfy the requirements of Chapter XIII, Section 20D of the *ADA Bylaws*;
- (iv) *Refer* the case back to the hearing panel for new proceedings, if the rights enumerated under all applicable bylaws and procedures were not accorded the accused;
- (v) *Remand* the case back to the member conduct hearing panel for further proceedings when the appellate record is insufficient in the opinion of the Council on Ethics, Bylaws and Judicial Affairs to enable it to render a decision; or
- (vi) *Modify* the decision of the hearing panel by reducing the penalty imposed.

- (c) Final Decision. The decision of the Council on Ethics, Bylaws and Judicial Affairs in an appeal not involving a recommended probation, suspension, expulsion and/or removal of a trustee or elective officer shall be final and non-appealable.

- (d) Delivery of the Appeal Decision to the Parties. Within thirty (30) days of the date on which a final decision on appeal is approved by the Council on Ethics, Bylaws and Judicial Affairs, a copy of the written decision shall be sent by certified mail, return receipt requested, to the last known address of each of the following parties: the accused member; the Association member or Association staff member bringing charges; the secretary of the component society of which the accused is a member, if applicable; the secretary of the constituent society of which the accused is a member, if applicable; the Election Commission of the Association and the Executive Director of this Association.

2. Appeals Involving Recommended Probation, Suspension, Expulsion and/or Removal of a Trustee or Elective Officer.

- (a) Written Decision. In any appeal that involves the recommended probation, suspension, expulsion or removal of a trustee or elective officer, the decision of the Council on Ethics, Bylaws and Judicial Affairs shall be reduced to writing. The decision must clearly state the conclusion of the Council and the reasons for reaching that conclusion.

- (b) Permissible Penalties. The Council shall have the discretion to:

- (i) Recommend *upholding* the decision of the hearing panel;
- (ii) *Reverse* the recommended decision of the hearing panel and thereby exonerate the accused member;
- (iii) Recommend *denial* of an appeal that fails to satisfy the requirements of Chapter XIII, Section 20D of the *ADA Bylaws*;
- (iv) *Refer* the case back to the hearing panel for new proceedings, if the rights enumerated under all applicable bylaws and procedures were not accorded the accused;
- (v) *Remand* the case back to the hearing panel for further proceedings when the appellate record is insufficient in the opinion of the Council on Ethics, Bylaws and Judicial Affairs to enable it to render a decision; or
- (vi) *Modify* the decision of the hearing panel by reducing the penalty imposed, except in cases in which the reduced penalty is probation, suspension and/or removal from office, the Council's decision shall be a recommendation.

(c) Final Decision. The decision of the Council on Ethics, Bylaws and Judicial Affairs shall be final and non-appealable only in cases where the Council's decision does not result in the recommendation of a sentence of probation, suspension, expulsion and/or removal from office.

(d) Delivery of the Appeal Decision in Cases not Involving Recommended Probation, Suspension, Expulsion and/or Removal from Office. Within thirty (30) days of the date on which a final decision that does not recommend probation, suspension, expulsion and/or removal from office is approved by the Council on Ethics, Bylaws and Judicial Affairs, a copy of the decision shall be sent by certified-return receipt requested mail to the last known address of each of the following parties: the accused trustee or elective officer; the Association member or Association staff member preferring charges; the secretary of the component society of which the trustee is a member, if applicable; the secretary of the constituent society of which the trustee or elective officer is a member, if applicable; the Election Commission and the Executive Director of this Association.

(e) Delivery of the Appeal Decision in Cases Involving Recommended Probation, Suspension, Expulsion and/or Removal from Office. Within thirty (30) days of the date on which a decision that recommends probation, suspension, expulsion and/or removal from office of a trustee or elective officer is approved by the Council on Ethics, Bylaws and Judicial Affairs, on appeal is rendered, a copy thereof shall be sent by certified mail, return receipt requested, to the last known address of each of the following parties: the accused trustee or elective officer; the Association member or Association staff member preferring charges; the Election Commission, the secretary of the component society of which the trustee or elective officer is a member, if applicable; the secretary of the constituent society of which the trustee or elective officer is a member, if applicable; and the Executive Director of this Association.

(f) Right to Respond. When a decision recommends that a trustee or elective official be sentenced to probation, expulsion, suspension and/or removal from office, that trustee or elected official has the right to respond in writing to the decision and recommendation. The response of the trustee or elective official must be delivered to the chair of the Council on Ethics, Bylaws and Judicial Affairs within thirty (30) days from the date the decision and recommendation was issued. The chair of the Council on Ethics, Bylaws and Judicial Affairs will forward the decision and recommendation, along with any response received from the trustee or elected official, to the Speaker of the House of Delegates, the Election Commission and the Association's Executive Director.

(g) Consideration of Decision by House of Delegates. Any decision that recommends probation, suspension, expulsion and/or removal from office of a trustee or elective officer shall be considered by the House of Delegates in accordance with Chapter XIII, Section 20F of the ADA *Bylaws*.

A copy of Chapters XII and XIII of the ADA *Bylaws* amended as proposed is attached to this report as Appendix 2.

Summary of Resolutions

Resolution 15. Amendment of the Guidelines Governing the Conduct of Campaigns for All ADA Offices
 Resolution 16. Amendment of the Policy, The Dentist's Pledge
 Resolution 17. Amendment of Chapters XII and XIII of the ADA *Bylaws*

Council Minutes

For more information on recent activities, see the Council's [minutes](#) on ADA.org.

Appendix 1. Council on Ethics, Bylaws and Judicial Affairs 2014 Self-Assessment

Pursuant to the directive of 1H-2013, the Council on Ethics, Bylaws and Judicial Affairs conducted a self-assessment during the 2013-2014 term. The Council review began with the completion of a detailed survey followed by the Council analyzing and discussing the 44 page compiled survey results. This report will summarize the conclusions reached by the Council taken from the survey responses and the Council's discussion, and will address the subjects outlined in the memo from Mr. Jerome Bowman, the ADA's Chief of Governance and Strategy Management to council, commission and committee directors dated January 10, 2014.

The report is informational in nature. The Council's self-assessment resulted in no recommendations for action, although some comments elicited during the self-assessment process suggest that refinements of certain Council activities and processes may be in order to enhance the operation of the Council. Such suggestions will be noted at appropriate places within the council report.

I. Threshold Issues

The survey responses tendered by the members of the Council are almost unanimous in indicating that members view the primary value of the Council as defined by the ethics-related duties of the Council found in Chapter X, Section 120G of the ADA *Bylaws*. One comment epitomizes the many responses on this issue that were tendered (emphasis in the original):

The primary benefit that CEBJA provides to *members* is to act as the conscience of the profession and provide guidance on long-standing, as well as emerging ethical concerns for the practice and profession of dentistry.

Many members of the Council also recognized that fulfilling the Council's responsibilities concerning the ADA *Bylaws* is a valuable service that the Council provides. The Council recognizes that its *Bylaws* oversight assists in maintaining the organizational integrity of the ADA which is vital to the functioning and effectiveness of the organization. These duties led the Council to unanimously conclude that it should continue to exist, as there is no other ADA agency performing oversight functions relating to ethics and the ADA *Bylaws*. Again, a comment made in a survey response succinctly states the Council's sentiment:

CEBJA is directly involved in achieving the core value of Integrity. Maintaining the professional ethics and code of conduct makes the ADA a professional organization. Without a group specifically tasked to maintain the relevance of bylaws, the code of ethics and professional decorum we have no accountability.

Generally, the members of the Council feel that duties are being carried out efficiently and effectively. Some members noted, however, that there may be room for improvement and that the ADA's governance structure makes adoption of major changes problematic.

The top three annual goals identified by members revolve around the Council's duties identified in the *Bylaws*. As one member commented:

1. Work to stress the importance of ethics in our profession; 2. Work to improve the efficiency of the Association through a workable set of Bylaws to guide the Association; [and] 3. Help to resolve issues through our function as mediators in judicial affairs.

Generally, the Council views itself as successful in achieving the overall goals identified as important. There was some sentiment expressed respecting consistently carrying out the programs adopted by the Council to accomplish those goals. For example, there were comments made concerning the difficulty the Council has experienced in consistently having sufficient "Ethical Moment" articles ready for publication in *The Journal of the American Dental Association*. Also mentioned was the difficulty in planning and completing successful continuing education programs. The Council has begun to take steps to address

these issues by stressing during the new member orientation session the need for each member of the Council to author one “Ethical Moment” article per year and by requesting additional funding to allow for greater collaboration in ethics continuing education development.

II. Structure

The Council's self-assessment also reviewed the Council's structure and governance. A majority of Council members indicated their belief that members should continue to be appointed as currently done—one member per trustee district, nominated by the district's trustee. It is felt that the geographic diversity that is a byproduct of the present appointment process allows for the Council to have the benefit of a variety of experiences and outlooks when considering ethical issues. One member stated views on the selection of members as follows:

I believe that appointing council members from each of the trustee districts is vitally important in order to have a broad outlook on the ethical landscape.

It was mentioned, however, that council appointments should be made being mindful of the need for diversity on the Council. The Council believes that gender, ethnic and professional diversity adds to the balanced and thoughtful way the Council approaches consideration of ethical issues and judicial determinations.

Members also commented that it is important for trustees to be cognizant of the criteria for service as a member on the Council and of the *Bylaws* duties of the Council so that appropriate individuals are selected for service on the Council. This is extremely important as it relates to the authoring of “Ethical Moment” articles, among other things. Appointing members who are at least willing to author one “Ethical Moment” article per year can only enhance the Council's ability to consistently meet *JADA* publication deadlines.

The nature and extent of the programming that the Council undertakes led the members to virtually uniformly indicate that the current size of the Council should be maintained. The current size of the Council helps to ensure that a sufficient number of “Ethical Moment” articles are written annually and adequate coverage of the Ethics Hotline is maintained throughout the year.

In 2013, the Council reduced its committees by half, eliminating a number of ad hoc committees that were charged with working on single issues in favor of broader based standing committees generally organized to coincide with the Council's enumerated *Bylaws* duties. This change has increased the efficiency of the Council. As one member put it:

I think the committees we have now address each of the objectives outlines by the Bylaws without redundancy, overlap, or undue pressure placed on any one committee. It would seem to me that we have the correct number of committees to achieve our goals efficiently.

III. Efficiencies

Members of the Council are in strong agreement that the Council performs its assigned duties efficiently and effectively. It was noted that the work done by the committees tends to focus the Council's deliberations and has cut down on the number of lengthy discussions that, at times, seemed to be repetitive. It was also observed that, given the responsibilities of the Council, focusing too much on efficiency by shortening or eliminating in-person meetings carries the risk that justice and fairness might be sacrificed.

It was also noted that the committee structure allows the Council to engage in more frequent strategic discussions than was possible under the ad hoc committee structure that was previously employed.

The majority of the members responding to the Council's self-assessment survey indicated that two meetings a year were sufficient to accomplish the Council's work. Citing the need to conduct disciplinary

hearings, several members commented that they did not believe the Council could successfully meet its responsibilities with a single in-person meeting annually. All members responding expressed that in-person meetings were extremely valuable and worthwhile. One comment summarizes the feelings of the Council:

Extremely valuable. The discussions, particularly around ethical issues, are invaluable. Secondly, since we are tasked with being the “appeal court” for judicial affairs, we must meet together. Finally, there is trust-building that must be accomplished if Council members are to work well together. I believe that this is accomplished most readily by in-person meetings.

Council members uniformly were in agreement that the Council’s use of conference calls facilitated the work of the Council and were valuable for the work of smaller committees; it was noted that committee conference call work acted to make the in-person meeting of the Council very efficient. A number expressed dissatisfaction with the use of conference calls to convene meetings of the entire Council because the calls suffer from the seeming lack of involvement by some members on the call.

The Council views its handling of issues before it to be efficient and effective, with the opportunity given for everyone to express their views. A number of members commented on the respectful treatment given members as being conducive to members’ willingness to express opinions freely. All but one member indicated that sufficient information was provided to the Council to facilitate the Council’s work. One member recited:

I was not overwhelmed with the information. The agenda was presented in plenty of time and I received the necessary information to be adequately prepared for the meeting.

Another member stated that “the amount of information we receive is well-researched and well organized, making it very easy to decide issues.”

On the question of staff, the Council expressed satisfaction with and sincere appreciation of the consistency and quality of support staff members provide the Council; Council members were also satisfied with the sufficiency of the support received. Council members were generally unaware of the quantity of time spent by staff on Council matters. The response “I am not fully aware of the staff time commitment to our Council, but they certainly do a wonderful job” is typical of responses to an inquiry concerning time spent by staff on supporting the Council’s work.

Those members responding to inquiries concerning the appropriateness of tasks performed by staff versus the work done by volunteers expressed general satisfaction with the division of responsibilities in completing the Council’s work. The following comments illustrate the responses to that question:

So far, delegation of duties and responsibilities between “volunteers” and “staff” seem appropriate and well balanced.

I believe the staff at CEBJA is very careful to allow the volunteer dentists to guide the policy journey of our work.

I think the staff does an excellent job with their work. This is a volunteer driven Council and staff is there for support.

I think the staff does an excellent job of handling all clerical and organizational work. The real work of the Council members is in strategizing and brainstorming. When it is necessary to hold a hearing the staff facilitates the process. I have not been asked to do a task that I felt could have been handled by a staff member.

IV. Areas of Responsibility

When questioned about the Council’s responsibilities enumerated in the *Bylaws*, no areas were identified that the Council members thought were better able to be addressed by other agencies. Several members

acknowledged that there can be some overlap between the areas of interest of the Council and other Councils of the ADA. For example:

...there are issues that CEBJA handles that might be best addressed in collaboration with other Councils, e.g., the issue of ethics and licensure which was done in concert with CDEL.

The Council was also strongly of the belief that the duties assigned by the *Bylaws* are addressed by the Council in its work. For example, in responding to the questions “Is CEBJA effective in carrying out each of its Bylaws duties? Why or why not?” one member stated:

Yes I think so. We are very aware of our responsibilities and take them very seriously. Additionally we have an excellent staff that is meticulous about keeping up the council work.

Another member answered this way:

Absolutely. I think we have a clear vision for not only the objectives of our Council spelled out by the *Bylaws* but also for our individual goals as a council. We discuss goals and reiterate our objectives, our members know what these are, and each objective seems to be checked against [*Bylaws* Chapter X] Section G. Ethical issues brought up by Council members and the general membership are consistently brought to the council via email and at our meetings to discuss in order to determine whether advisory opinions or *Code* revisions are necessary – or if other action is warranted [on *Bylaws* Chapter X, Section G, subsections] a and b. We keep our pulse on the ethical issues in the entire profession in order to accomplish our *Bylaws* duties. We also reviewed the *Bylaws* last fall and consistently evaluate the need for revision [of *Bylaws* Chapter X, Section G, subsections] g, h, j, and k. We hold judicial hearings as necessary [for *Bylaws* Chapter X, Section G, subsections] d and e. One area we could improve on is [*Bylaws* Chapter X, Section G, sub]section I – to disseminate more information for use by component societies.

One member noted a single *Bylaws* duty that has not been addressed by the Council during the member’s tenure is hearing disputes between constituent societies or between state and local societies. However, for the past several years, no state society or state and local society disputes have come before the Council for resolution.

V. Support of the Strategic Plans of the Association

The self-assessment questionnaire used by the Council also asked how the Council could better support the 2011-14 strategic plan and if Council members believed that the Council would support the 2015-19 plan if the Council continues its work as presently performed. Regarding support of the current plan, members consistently identified taking a more prominent role in educating the public concerning the *Code of Ethics* and “showcasing how ADA members are different from non-members” in agreeing to abide by the *Code* when joining the Association.

Regarding the newly adopted Members First 2020 strategic plan, the Council was unanimous in expressing the sentiment that the Council should be an integral part of the ADA meeting the plan’s goals. Two comments by members aptly illustrate this belief:

I believe that CEBJA will continue to support the 2015-2019 strategic plan in the same manner as it supports the current plan. The *Code* is the foundation and framework which allows dentistry to build itself as a profession and the *Bylaws* are the foundation and framework on which the profession builds itself as an organization.

[Members First 2020 strategic plan] *Objective 1: The public will recognize the ADA and its members as leaders and advocates in oral health.... 1.2 Position ADA membership as a positive differentiating factor for patients.* What better way to differentiate the ADA member than the existence of the *Code*!? With the sesquicentennial right around the corner, now is the time to celebrate the ADA members’ commitment to ethical practice.

When queried concerning their suggestions for how the Council could better support and drive the Members First 2020 plan, a theme similar to the comments about the current strategic plan was evident—promoting the *Code of Ethics* to members and the public and educating them on the central role that the *Code* plays in the maintenance of the practice of dentistry as a profession and dentists as trusted professionals. One member commented that the upcoming 150 year anniversary of the *Code*, occurring in 2016, is a significant milestone that should be widely recognized:

CEBJA will continue to support the plan as a positive differentiating factor through CE, Ethical Moment, Ethics Hotline, Student Video Competition, Golden Apple Award. In addition the celebration of 150 years of the Code will be a source of great pride for the membership. I believe that it is important that all ADA communications and public relation entities be brought into the planning for the recognition of this significant milestone. I believe that it is also very important for the Code to be easily found on our website, whether by a “button” on the home page or easier navigation through the web pages.

Conclusion

Members of the Council, both individually and as a group, spent considerable time and effort critically examining the issues addressed in this report. Although no major changes to the governance, operation or duties of the Council were identified, each of those areas received careful consideration. At the end of the day, the Council believes that its current governance, procedures and staff allow it to perform its *Bylaws* duties efficiently and effectively. The Council also understands that carrying out those duties is critical not only to successfully completing the current and recently adopted strategic plans, but also to the continued vitality and success of the ADA as an organization that is perceived nationally as the trusted voice of the profession of dentistry.

Council Chair: Dr. Richard J. Rosato
Council Director: Thomas C. Elliott, Jr.

Appendix 2. ADA Bylaws Chapters XII and XIII as Amended per Resolution 17

CHAPTER XII • PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT AND JUDICIAL PROCEDURE

Section 10. PROFESSIONAL CONDUCT OF MEMBERS: The professional conduct of a member of this Association shall be governed by the *Principles of Ethics and Code of Professional Conduct* of this Association and by the codes of ethics of the constituent and component societies within whose jurisdiction the member practices, or conducts or participates in other professional dental activities.

Section 20. DISCIPLINE OF MEMBERS:

A. CONDUCT SUBJECT TO DISCIPLINE. A member may be disciplined for (1) having been found guilty of a felony, (2) having been found guilty of violating the dental practice act of a state or other jurisdiction of the United States, (3) having been discharged or dismissed from practicing dentistry with one of the federal dental services under dishonorable circumstances, or (4) violating the *Bylaws*, the *Principles of Ethics and Code of Professional Conduct*, or the bylaws or code of ethics of the constituent or component society of which the accused is a member. For a member of a constituent society, disciplinary proceedings may be instituted by either the member's component or constituent society. Disciplinary proceedings against a direct member of this Association may be instituted by the Council on Ethics, Bylaws and Judicial Affairs of this Association.

B. DISCIPLINARY PENALTIES. A member may be disciplined for any of the offenses enumerated in Section 20A of this Chapter as follows:

a. CENSURE. Censure is a disciplinary sentence expressing in writing severe criticism or disapproval of a particular type of conduct or act.

b. SUSPENSION. Suspension, subject to Chapter I, Section 30 of these *Bylaws*, means all membership privileges except continued entitlement to coverages under insurance programs are lost during the suspension period. Suspension shall be unconditional and for a specified period at the termination of which full membership privileges are automatically restored. A subsequent violation shall require a new disciplinary procedure before additional discipline may be imposed.

c. EXPULSION. Expulsion is an absolute discipline and may not be imposed conditionally except as otherwise provided herein.

d. PROBATION. Probation, to be imposed for a specified period and without loss of privileges with the exception of holding or seeking an elective or appointive office, may be administratively and conditionally imposed when circumstances warrant in lieu of a suspended disciplinary penalty. Probation shall be conditioned on good behavior. Additional reasonable conditions may be set forth in the decision for the continuation of probation. In the event that the conditions for probation are found by the society which preferred charges to have been violated, after a hearing on the probation violation charges in accordance with procedures set forth in the *ADA Procedures for Member Disciplinary Hearings and Appeals*, the original disciplinary penalty shall be automatically reinstated; except that when circumstances warrant the original disciplinary penalty may be reduced to a lesser penalty. There shall be no right of appeal from a finding that the conditions of probation have been violated.

C. PROCEDURES FOR DISCIPLINARY HEARINGS AND APPEALS. The procedures for hearings and appeals conducted pursuant to this Chapter XII shall be set forth in the *ADA Procedures for Member Disciplinary Hearings and Appeals*, a copy of which shall be appended to the *ADA Constitution and Bylaws* and otherwise made freely available to members of the Association. The procedures set forth in

the *ADA Procedures for Member Disciplinary Hearings and Appeals* shall be amendable by the House of Delegates on majority vote.

D. DISCIPLINARY HEARINGS. Before a disciplinary penalty is invoked against a member, a hearing held pursuant to the procedures set forth in the *ADA Procedures for Member Disciplinary Hearings and Appeals* shall be held.

E. APPEALS. Before any penalty enumerated in Chapter XII, Section 20B, set forth in a decision following the hearing called for by Chapter XII, Section 20C and conducted pursuant to the *ADA Procedures for Member Disciplinary Hearings and Appeals* shall be final, the accused member has a right to appeal that decision, including any disciplinary sentence specified therein. Any such appeal shall be conducted within the timeframes and in accordance with the appeal procedures set forth in the *ADA Procedures for Member Disciplinary Hearings and Appeals*

F. SENTENCE. After all appeals are exhausted or after the time for filing an appeal has expired, a sentence of censure, suspension or expulsion meted out to any member, including those instances when the disciplined member has been placed on probation, shall be enforced by such individual's component and constituent societies, if such exist, and this Association.

G. NON-COMPLIANCE. In the event of a failure of technical compliance with the procedural requirements of this Chapter or as set forth in the *ADA Procedures for Member Disciplinary Hearings and Appeals*, the agency hearing the appeal shall determine the effect of non-compliance.

CHAPTER XIII • PROCEDURES AND HEARINGS RELATING TO MEMBER CONDUCT POLICY

Section 10. CONDUCT SUBJECT TO REVIEW: Each member of this Association shall be subject to the provisions of the Association's Member Conduct Policy.

Section 20. DISCIPLINARY PROCEDURES AND HEARINGS:

A. MEMBER CONDUCT SUBJECT TO DISCIPLINE. Any member charged with violating the Association's Member Conduct Policy shall be afforded a fair and impartial hearing conducted in accordance with the *ADA Procedures for Member Disciplinary Hearings and Appeals*.

B. PROCEDURES FOR HEARINGS AND APPEALS HELD UNDER THE ASSOCIATION'S MEMBER CONDUCT POLICY. The procedures for hearings and appeals conducted pursuant to this Chapter XIII shall be set forth in the *ADA Procedures for Member Disciplinary Hearings and Appeals*, a copy of which shall be appended to the *ADA Constitution and Bylaws* and otherwise made freely available to members of the Association. The procedures set forth in the *ADA Procedures for Member Disciplinary Hearings and Appeals* shall be amendable by the House of Delegates on majority vote.

C. DISCIPLINARY PENALTIES. Members may be disciplined for violating the Association's Member Conduct Policy as follows:

a. CENSURE. Censure is a disciplinary sentence expressing in writing severe criticism or disapproval of a particular type of conduct or act.

b. SUSPENSION. Suspension, subject to Chapter I, Section 30 of these *Bylaws*, means all membership privileges except continued entitlement to coverage under insurance programs are lost during the suspension period. Suspension shall be unconditional and for a specified period at the termination of which full membership privileges are automatically restored. A subsequent violation shall require a new disciplinary procedure before additional discipline may be imposed.

c. EXPULSION. Expulsion is an absolute discipline and may not be imposed conditionally except as otherwise provided herein.

d. **PROBATION.** Probation, to be imposed for a specified period and without loss of privileges with the exception of holding or seeking an elective or appointive office, may be administratively and conditionally imposed when circumstances warrant in lieu of a suspended disciplinary penalty. Probation shall be conditioned on good behavior. Additional reasonable conditions may be set forth in the decision for the continuation of probation. In the event that the conditions for probation are found by the Council on Ethics, Bylaws and Judicial Affairs to have been violated, after a hearing on the probation violation charges in accordance with Chapter XIII, Section 20D, the original disciplinary penalty shall be automatically reinstated, except that when circumstances warrant the original disciplinary penalty may be reduced to a lesser penalty. There shall be no right of appeal from a finding that the conditions of probation have been violated.

e. **REMOVAL FROM OFFICE.** Removal from office as a trustee, delegate, alternate delegate or elective officer for the remaining term may be imposed in addition to, or in lieu of, any of the penalties enumerated in this Section of these *Bylaws*.

D. **DISCIPLINARY PROCEEDINGS.** Before a disciplinary penalty is invoked against a member for violating the Association's Member Conduct Policy, a hearing held pursuant to the procedures set forth in the *ADA Procedures for Member Disciplinary Hearings and Appeals* shall be held.

E. **APPEALS TO FULL COUNCIL.** Before any penalty enumerated in Chapter XIII, Section 20C, set forth in a decision following the hearing called for by Chapter XIII, Section 20D and conducted pursuant to the *ADA Procedures for Member Disciplinary Hearings and Appeals* shall be final, the accused member has a right to appeal that decision, including any disciplinary sentence specified therein. Any such appeal shall be conducted within the timeframes and in accordance with the appeal procedures set forth in the *ADA Procedures for Member Disciplinary Hearings and Appeals*.

F. **CONSIDERATION OF RECOMMENDED PROBATION, SUSPENSION, EXPULSION AND/OR REMOVAL FROM OFFICE OF TRUSTEES OR ELECTIVE OFFICERS BY HOUSE OF DELEGATES.** The House of Delegates shall decide whether to accept or reject any recommendation of a sentence of probation, suspension, expulsion and/or removal from office made pursuant to this Chapter XIII against Trustees or Elected Officers of this Association. Delegates and alternate delegates who participated in any portion of the procedures that resulted in such recommendation shall be recused from deliberations under this Section 20F. A two-thirds (2/3) affirmative vote of the delegates present and voting is required to impose a disciplinary sentence of expulsion from membership, removal from office, suspension or probation.

G. **SENTENCE.** After all appeals are exhausted or after the time for filing an appeal has expired, a sentence of censure, suspension, expulsion and/or removal from office meted out to any member, including those instances when the disciplined member has been placed on probation, shall be enforced by such individual's component and constituent societies, if such exist, and this Association.

H. **NON-COMPLIANCE.** In the event of a failure of technical compliance with the procedural requirements of this Chapter or of the Procedures set forth in the *ADA Procedures for Member Disciplinary Hearings and Appeals*, the Council on Ethics, Bylaws and Judicial Affairs shall determine the effect of non-compliance.

Council on Government Affairs

LoMonaco, Carmine J., 2014, New Jersey, chair
Black, Richard C., 2015, Texas, vice chair
Breault, Michael R., 2015, New York
Bronson, Mark E., 2017, Ohio
Cobb, Regina E., 2017, Arizona
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
Incalcaterra, Charles J., 2017, Pennsylvania
Jaeger, Frederick J., 2016, Wisconsin
Jennings, Mary S., 2014, Washington
Lebovics, Irving S., 2015, California
Martin, Raymond K., 2016, Massachusetts
Marron-Tarrazzi, Irene, 2014, Florida*
McDougall, Kenneth, 2014, North Dakota, *ex officio* **
Morrison, Scott L., 2017, Nebraska
Vlahos, Gus C., 2015, Virginia

Spangler, Thomas J., director

The Council on Government Affairs 2013–14 liaisons include: Dr. Roger Kiesling (Eleventh District trustee, Board of Trustees), Dr. Robert J. Manzanares (Council on Communications), Dr. W. Roy Thompson (Council on Access, Prevention and Interprofessional Relations), Ms. Teresa Theurer (Alliance of the American Dental Association), and Ms. Alena Reich (American Student Dental Association).

Purpose

The Council on Government Affairs' 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

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

The Council on Government Affairs' (CGA) top goals vary from year to year, depending on ADA legislative priorities and actions taken by Congress and the federal agencies. In 2014, they include helping to address excessive student loan debt, ensuring dentistry is well represented with regard to the Patient Protection and Affordable Care Act (ACA) implementation, pursuing favorable tax treatment of

* New Dentist Committee member without the power to vote.

** ADPAC chair without the power to vote.

small businesses (such as extension of the Section 179 expensing provision), and ensuring that Medicaid audits are fairly conducted. The Council will also continue to work on some long-standing issues, such as ERISA reform and McCarran-Ferguson legislation, among many other issues.

The ADA lobbied at the Washington Leadership Conference (WLC) for support of the Federal Student Loan Refinancing Act, S. 1066, which authorizes anyone currently repaying Direct Loans (or a Federal Direct Consolidation Loan) to consolidate (or refinance) their loan(s) at a fixed rate of 4.0%. It would retroactively apply to all such loans taken out between July 1, 2006, and the date of the bill's passage. The ADA also lobbied at the WLC for support of the Student Loan Interest Deduction Act of 2013, H.R. 1527, which would increase the allowable student loan interest deduction from \$2,500/year to \$5,000/year and eliminate the income limit (or cap). Regarding Section 179 expensing and the medical device tax, the Senate Finance Committee passed a two-year tax extenders bill that indexes the Section 179 small business expensing limits to inflation. There was also a long discussion of delay/repeal of the medical device tax but that was not included in the legislation. The House Ways and Means Committee is also considering extenders legislation that will very likely include Section 179 expensing. The Recovery Audit Contractor (RAC) program, established pursuant to the ACA, is affecting both Medicaid and Medicare programs. Concerning Medicaid Audits, on April 3, the ADA sent a letter to the Centers for Medicare and Medicaid Services (CMS) requesting that CMS send guidance to the states that would establish best practices to help all states implement a fair, transparent Medicaid RAC audit program. The ADA sought Congressional support for a "Dear Colleague" letter offered by Rep. Paul Gosar (AZ, 4th) on this matter at the WLC. Regarding Medicare Part D, in response to objections raised by the ADA and many others, the Obama Administration pulled a proposed rule that would require dentists to sign up with Medicare or opt-out in order to have Medicare-covered prescriptions filled for their patients.

Numerous Q&A style articles on ACA implementation and how it affects the profession can be found on ADA.org. Most recently, an *ADA News* piece on the 90-day grace period explains that patients who receive an advance premium tax credit but do not pay the premiums will enter a "grace period." The insurer will pay claims for the first month. However, the patient is responsible for paying the entire bill for services rendered during the second and third months unless the premiums are paid in full during the 90-day period. Plans will be filing 2015 plan rates and products in the spring and the enrollment numbers may impact future product designs. The open enrollment period was extended beyond March 31 for exchanges run by the federal government and a number of states running their own exchanges have also extended the enrollment deadline into April. The ADA is continuing to work with federal officials to address newly proposed rules, such as lowering the out-of-pocket maximums for stand-alone dental plans (SADPs) to \$300 for one child and \$400 for two or more children, down from the current \$700 and \$1,400 levels currently recommended.

State Activity

As of May 2014, five states have filed bills to restrict dental plans' ability to impose fee caps on non-covered services. So far, 33 states have enacted a non-covered services bill since 2009. At least four states have a bill requiring dental plans to allow for assignment of benefits, and a bill in Michigan would excuse plans from having to pay interest on late payments if the error was out of the plan's control. A Silent PPO bill in Missouri would require notification if a plan intends to grant access to the dental care services of a participating provider, and the bill would allow the dentist to refuse to continue providing services to third-party entities, which have been granted access. A bill moving through the legislative process in California would require health care service plans covering dental services to spend at least 85% of the premiums in the large group market on actual care or 80% in the small group or individual market.

A new law in Colorado requiring the state to design and implement an adult dental Medicaid benefit is moving forward. Partial implementation took effect in April and full implementation takes place in July. At this writing, the Missouri legislature is moving ahead with a plan to improve adult dental in Medicaid. Illinois also has a legislative plan to add dental benefits in Medicaid to improve its 'emergency only' status. Idaho is proposing to improve Medicaid dental benefits as well. A bill in Connecticut would help to

create a fairer Medicaid audit environment in that state. The bill would set limitations in the process and bolster training for providers to reduce the incidents of errors.

The efforts to enact alternative dental workforce plans continued unabated across the nation in 2014. Seven states saw at least one alternative model introduced as legislation (often multiple bills and models) and another three states have experienced concerted efforts to consider the idea. As of this writing, only one bill had advanced to a governor's desk. In April, Gov. Paul LePage of Maine signed legislation to create a license for mid-level dental hygiene therapists and vetoed bills to establish a separate dental hygiene board and restructure the dental board. The new law creates a dental hygiene therapist who may practice only with on-site supervision of a dentist licensed to practice in Maine. The legislation directs the Board of Dental Examiners to adopt rules by January 1, 2015, setting requirements for dental hygiene therapy education programs consistent with the following criteria:

- All education programs for dental hygiene therapy must be accredited by CODA (there are no CODA approved hygiene therapy programs); however, if CODA has no accredited programs, the dental board MAY approve a program in the interim.
- Education programs must be a minimum of four semesters and be consistent with the AAPHD curriculum model.
- Hygiene therapy programs must meet the requirements established by the dental board.
- All applicants must hold a BS in dental hygiene as a prerequisite. Those with an associate degree in dental hygiene may complete the bachelors program either before beginning the hygiene therapy program or concurrently.
- Graduates must pass an independent, comprehensive, competency-based clinical exam for licensure. A graduate failing twice must complete additional education as determined by the dental board prior to sitting for the exam again.
- Instead of 500 clinical hours of on-site supervised practice, 2,000 hours is now required.
- When the 2,000 hours is completed, the hygiene therapist must still work with the on-site supervision of a dentist licensed in Maine when working in therapy scope.
- Patients must first be seen by the supervising dentist before work may be delegated to the hygiene therapist. The scope remains the same, but all work must be delegated by the supervising dentist who is on-site.
- Sites where a hygiene therapist may provide services are limited to: hospitals, public schools, nursing facilities, residential care facilities, health centers reimbursed as FQHCs, FQHCs, public health settings serving underserved populations, or private practices where at least 50% of the patients served by the hygiene therapist are covered by MaineCare (Medicaid) or are underserved adults.

In 2014, the ADA's State Public Affairs (SPA) program worked with 21 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 2014 budget was approximately \$2.8 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. Additionally, SPA funded a demonstration project for Community Dental Health Coordinators in Florida in 2014 and anticipates doing the same with the Navajo Nation during the summer. Feedback from the states participating in SPA has been very positive as reflected in their mid-year reviews about the program. 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

Federal Issues

Implementation of the Affordable Care Act (ACA) is accelerating changes in the health care marketplace, resulting in an increased emphasis on value-purchasing, a growth in the number of price sensitive individuals (not employers) making dental benefit purchasing decisions in marketplaces, and more people with dental coverage, including Medicaid dental coverage for adults. About 98% of the pre-ACA dental

benefits market was dental products offered separate from a medical plan, according to the National Association of Dental Plans. That is changing as many more people will be purchasing their dental benefits embedded in their medical plans, especially in products offered in the ACA marketplaces (exchanges) and in private marketplaces. In 2014, ACA marketplaces are offering the dental benefit either through an embedded product or through a SADP. No exchange is offering a bundled benefit product. Some experts are predicting an explosion in the number of people purchasing their health care coverage on private marketplaces (up to 40 million by 2016). The ACA marketplaces are projected to grow to about 25 million people by 2024, according to the Congressional Budget Office.

As reported in an April 2014 survey released by Leavitt Partners, LLC, the ACA is accelerating the trend toward narrow networks and the impact will be greatest on solo practitioners by adversely affecting their negotiating leverage. The use of tools such as Accountable Care Organizations (ACOs) may affect dentistry long term, although presently the focus is on medicine. ACOs are groups of physicians, hospitals and other health care providers, who come together to provide coordinated care to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. ACOs tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. Preliminary research conducted by the ADA's Health Policy Resources Center (HPRC) published in March 2014¹ concluded that there is limited plan information available to consumers on many key attributes of dental plans offered within the ACA marketplaces, making it a challenge to make meaningful comparisons. The study also showed that SADPs and embedded dental products differed in out-of-network coverage, deductible arrangements, and premium costs. More specifically, the study found that: there is much more information available to SADP consumers compared with consumers of embedded products; that while covered services and coinsurance levels are similar, deductibles are significantly lower for SADPs (due to the fact that many medical plans use a single deductible for medical and dental services, although most plans do not apply the deductible to preventive services); out-of-network coverage is much more limited for embedded products; and the premiums are significantly lower in embedded products.

State 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 increased 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.

¹ *Health Insurance Marketplaces Offer a Variety of Dental Benefit Options, but Information Availability is an Issue*, March 2014, American Dental Association, Health Policy Resources Center.

Responses to House of Delegates Resolutions

93H-2013. Contingency Based Medicaid Audits (Trans.2013:362)

This resolution calls for the study of Medicaid audits including exploring options for improving the system. In coordination with other stakeholders, the ADA is asked to develop a politically prudent, fiscally responsible federal legislative/regulatory effort to revise the audits. The ADA should advocate for auditing procedures that include appropriate professional review by dentists or dental specialists in the case of specialty care who are licensed in the state. ADA's division of government and public affairs, AAPD and APIR's Medicaid Provider Advisory Committee (MPAC) continue to investigate the extent to which program integrity and Recovery Audit Contractor (RAC) audits affect dental practitioners, both individually and within the context of the whole healthcare team. To that end, with the Medicaid-CHIP State Dental Association (MSDA), the ADA partially sponsored a "Program Integrity Summit" to gain additional information about the various audits being conducted. As an outcome of that summit, MSDA is advocating for a national program integrity task force with a multi-prong approach of educating providers, creating state-level action coalitions and enlightening legislators. This is a potential long-term strategy beginning in June 2014. Though ADA, AAPD, MPAC and third-party payer representatives support such collaboration, this group believes that there are also short-term strategies that can be employed in a timely manner. On April 3, the ADA sent a letter to the Centers for Medicare and Medicaid Services (CMS) requesting that CMS send guidance to the states that would establish best practices to help all states implement a fair, transparent Medicaid RAC audit program. The RAC program, established pursuant to the Patient Protection and Affordable Care Act (ACA), is affecting both Medicaid and Medicare programs. Attendees at the WLC sought Congressional support for a "Dear Colleague" letter offered by Rep. Paul Gosar (AZ, 4th) on this matter.

95H-2013. Assignment of Benefits (Trans.2013:363)

This resolution directs the ADA to develop model Assignment of Benefits legislation, seek endorsement of applicable stakeholder organizations, and transmit the model to the constituent dental societies. Suggested model to be inserted in appropriate state insurance statute as determined by bill drafters:

Any contract providing benefits for dental care, whether such contract is pursuant to a medical insurance policy or certificate, a stand-alone dental plan, a health maintenance provider contract, a managed health care plan, a self-insured plan, or otherwise, shall permit and agree to honor a subscriber's direction that the payment of dental care benefits under the contract be made in the name of the nonparticipant dentist providing such covered dental care services. An assignment of benefits under this section does not limit or otherwise affect the payment of benefits payable under the contract, or affect the nature, scope, or extent of coverage provided under the contract.

The ADA will transmit the above proposed language to constituent dental societies and is reaching out to a variety of stakeholder organizations, including the National Conference of State Legislatures and the Conference of State Governments.

Self-Assessment

Pursuant to House Resolution 1H-2013, the Council conducted a self-assessment at its January meeting. In summary, the Council believes it is effective as it provides quick, thoughtful feedback to staff and leadership on a wide variety of legislative and regulatory issues on virtually a weekly basis through use of a listserv. However, the Council believes it needs to do a better job of integrating strategic discussions into the Council agenda to help the Council be a little more forward looking. For the most part, the decision-making process between meetings is very efficient. The process of using the Council listserv works well for obtaining Council input and approving advocacy pieces sent to Congress (such as testimony) and to federal agencies (such as comments on proposed rules). However, staff could do a better job of explaining the changes made to the final documents as a result of Council recommendations; and it would be helpful if the Council received feedback on the response from the legislators and regulators in cases where a response was forthcoming. The time spent by volunteers cannot be reduced because of the volume and complexity of the issues this Council deals with as well as the fluid nature of

the issues. The current balance between work done by staff and volunteers is about right. (See Appendix 1 for full self-assessment.)

The Council reviewed its bylaws and is recommending that portions of the bylaws that would micromanage the ADA's relationship with the federal dental services be amended to more accurately reflect what actually takes place. To this end, the Council is recommending that the subsections identified below that concern internal decision making in the federal dental services be deleted, which leaves in place the more general bylaws provisions providing for the Council to serve as a liaison and to formulate and recommend policies designed to advance the professional status of federally employed dentists.

Amendment of the ADA Bylaws Regarding Duties of the Council on Government Affairs

18. Resolved, that CHAPTER X. COUNCILS, *Section 120. DUTIES*, Subsection H. COUNCIL ON GOVERNMENT AFFAIRS, of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

H. COUNCIL ON GOVERNMENT AFFAIRS. The duties of the Council shall be to:

- a. Encourage the improvement of the health of the public and to promote the art and science of dentistry in matters of legislation and regulations by appropriate activities.
- b. Formulate and recommend policies related to legislative and regulatory issues and to governmental agency programs.
- c. Formulate proposed legislation, approved by the Board of Trustees, that may be submitted to Congress and which will promote the art and science of dentistry in accordance with Association policies.
- d. Disseminate information which will assist the constituent and component societies involving legislation and regulation affecting the dental health of the public.
- e. Serve and assist the American Dental Association as a liaison with agencies of the federal government.
- f. Advise other Association agencies charged with developing, recommending and/or implementing legislative policies adopted by the House of Delegates.
- g. Serve as liaison for the American Dental Association with those agencies of the federal government which employ dental personnel and have dental care programs~~in direct dental care delivery programs and the dentists in those services.~~
- ~~h. Recommend programs and policies which will ensure that eligible beneficiaries of federal dental service programs have access to quality dental care.~~
- ~~i. Recommend programs and policies which promote an efficient and effective dental care delivery system within the federal dental services.~~
- ~~j. Assist in the development of dental workforce requirements and appropriate mobilization programs in times of emergency.~~
- ~~k.~~ h. Formulate and recommend policies which are designed to advance the professional status of federally employed dentists.
- ~~l. Monitor dental training programs conducted by the federal dental services.~~

So that, as amended, Subsection H reads as follows:

H. COUNCIL ON GOVERNMENT AFFAIRS. The duties of the Council shall be to:

- a. Encourage the improvement of the health of the public and to promote the art and science of dentistry in matters of legislation and regulations by appropriate activities.
- b. Formulate and recommend policies related to legislative and regulatory issues and to governmental agency programs.
- c. Formulate proposed legislation, approved by the Board of Trustees, that may be submitted to Congress and which will promote the art and science of dentistry in accordance with Association policies.
- d. Disseminate information which will assist the constituent and component societies involving legislation and regulation affecting the dental health of the public.

- e. Serve and assist the American Dental Association as a liaison with agencies of the federal government.
- f. Advise other Association agencies charged with developing, recommending and/or implementing legislative policies adopted by the House of Delegates.
- g. Serve as liaison for the American Dental Association with those agencies of the federal government which employ dental personnel and have dental care programs.
- h. Formulate and recommend policies which are designed to advance the professional status of federally employed dentists.

Policy Review

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

18. Amendment of the ADA *Bylaws* Regarding the Duties of the Council on Government Affairs

Council Minutes

For more information on recent activities, see the Council's [minutes](#) on ADA.org.

Appendix 1. Council on Government Affairs 2014 Self-Assessment

Threshold Issues

State the primary value of your council or commission to a member.

CGA provides the “members’ perspective” on legislative and regulatory advocacy positions taken by the ADA. Staff relies on that feedback and adjusts draft documents to address council members’ concerns before sending to ADA leadership for final approval. This is accomplished through systematic, regular (weekly) review of draft Congressional testimony, regulatory comments, or other communications with the legislative and executive branches of our federal government. The CGA also provides guidance to the Association’s state government affairs department, including member participation on the SPA Oversight Workgroup. Support through the SPA program is highly valued by the constituent dental societies.

Should your council or commission continue to exist? If not, why?

Yes. Member surveys have consistently rated advocacy as one of the top membership values. Advocacy by the ADA as a collective ensures not only that our positions on legislative issues are heard in Washington, D.C., but that we have a strong voice in shaping the discussion and protecting dentistry’s best interest for our members and the public we serve.

Is your council or commission effective in carrying out its bylaws authority? If not, why?

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.

The Council believes it is effective as the CGA provides quick, thoughtful feedback to staff and leadership on a wide variety of legislative and regulatory issues on virtually a weekly basis through use of the CGA’s listserv. The meeting agendas for the CGA’s two annual meetings are always full and designed to encourage volunteer guidance and direction.

What are the top three goals to be accomplished by your council or commission annually? How are these related to member value? How successful has your council or committee been with respect to these goals?

The CGA’s top goals vary from year to year, depending on our legislative priorities and actions taken by Congress and the federal agencies. In 2014, they are likely to be helping to address the excessive student loan debt, Affordable Care Act implementation, and ensuring that Medicaid audits are fairly conducted. We will also continue to work on some long-standing issues, such as ERISA reform and McCarran-Ferguson legislation, among many other issues. Due to the nature of advocacy in today’s political climate, success in the legislative and regulatory arenas is unfortunately measured by taking the incremental steps necessary to ensure organized dentistry’s voice is heard. The Council believes we have been successful in helping to ensure policymakers understand the ADA’s position on the important issues of the day affecting the profession and our patients.

How do you define/measure success for the council or commission annually?

The CGA responds to requests for recommendations and reviews of advocacy documents in a timely fashion via electronic communications or by conference calls between meetings and engages in thoughtful discussions on similar matters at council meetings. As a result, ADA is able to effectively

convey our positions to policymakers in Congress and the federal agencies. In addition, the CGA volunteers, through proper dissemination of information about ADA activities, facilitates where appropriate similar efforts among the constituent dental societies. For example, to fully address ERISA reform requires legislation at both the federal and state levels.

Structure

Should your council or commission be skills based, or elected at large? Is the manner of member selection ideal (e.g. geographic vs. skills based)?

Presently, a CGA member is selected by his/her representative on the Board of Trustees. The Council sees no need to change that process, although it is very useful to have had legislative advocacy experience (e.g., served on the state's government affairs committee/council) at the state level before joining the CGA.

Do you have an agenda that enables strategic discussion to the extent you would like?

We could do better. The chair and vice chair approve the meeting agenda developed by staff. The agendas are extensive, covering a wide variety of legislative and regulatory issues; however, the Council would like to see more strategic discussions integrated into the discussions. As some evidence that more could be done to encourage strategic discussions, there were a limited number of recorded votes in 2013 and limited discussion of the possible need for new ADA policy to address current or possibly new legislative issues.

Do you have the optimal number of members to conduct business well and efficiently?

Yes. The CGA believes we should continue to have a representative from each of the 17 districts to properly represent the variety of political perspectives. It is also helpful to have liaisons from the Board of Trustees, ADPAC, AADA, NDC, CC, CAPIR and ASDA as part of the team.

Do you have the right number of committees and members on committees? Should you use standing committees or ad hoc task forces?

The CGA does have three workgroups, but the agenda items are addressed by the full council and a great many issues sent to the council for feedback via our listserv are sent to the full council. Ad hoc task forces could be utilized on an as-needed basis.

Would a task force structure as opposed to a council structure be better? Worse?

Task forces should be used to address ad hoc items that require significant cross-divisional participation. In these cases, a task force could be used to avoid the time-consuming process of the issue being addressed by many individual councils in a sequential fashion.

Efficiencies

Is the decision making process efficient? If not, why?

Yes, for the most part, the decision making process between meetings is very efficient. The process of using the CGA listserv works well for obtaining CGA input and approving advocacy pieces sent to Congress (such as testimony) and to federal agencies (such as comments on proposed rules). However, staff could do a better job of explaining the changes made to the final documents as a result of Council recommendations and it would be helpful if the Council received feedback on the response from the legislators and regulators in cases where a response was forthcoming. In terms of our Council meetings, we are efficient in our decision making process. The CGA seems to have had in the past and currently a dedicated group of volunteers that all want to work collegially and come to a decision when meeting in person.

How can you reduce the time spent by volunteers on your work, while still doing what needs to be done?

The CGA does not think it needs to be reduced—the volunteers are not over worked. We cannot reduce the time spent by volunteers because of the volume and complexity of the issues this Council deals with as well as the fluid nature of the issues that can change literally day to day. CGA volunteers would welcome spending more time in strategic discussions. The workload is consistent with the level of decisions the Council is challenged to make.

Do you meet in person enough? Too much? Too little?

Given the frequent use of emails, the Council believes two meetings a year are adequate, although there could be more use of conference calls.

What work done by volunteers could be handled by staff?

The current balance is about right. The ADA hires staff to help devise and carry out advocacy activities with the input and approval of elected and appointed volunteers. ADA government affairs staff is excellent at their jobs. Volunteer dentists do not lobby directly. Staff handles a great deal of information and drafts a good many advocacy documents that are best done by them. The volunteer's role is to review the drafts and approve or disapprove the final product.

Are issues brought to your council in an efficient or appropriate manner?

Yes, especially with the very frequent use of email and listservs. Letters to agencies or legislators are sent to the Council for review almost weekly. On the other hand, the Council could utilize more conference calls throughout the year to discuss issues that are time sensitive and that require a more detailed group interaction to decide.

Are you provided with sufficient information to address and decide issues?

Yes but the Council recently has not been called upon often enough to make decisions. Perhaps the introduction of more strategic discussions will remedy this.

Is the discussion of issues efficient and effective?

In terms of the weekly letters sent for review, discussion is direct, immediate, and concise. Feedback to the Council once the letters are sent is seldom so effective and is hard to judge. Some issues, such as McCarran-Ferguson reform, have been advocacy priorities for years. At some point, if the goal clearly becomes unattainable due to Congressional inaction, the ADA should consider removing it as a priority.

Are there matters left to the council or commission that should be handled by a smaller group?

No, there are various workgroups within the Council that are doing just that. The Council's function is effective as a collective.

Do you effectively use conference calls and web-based meeting time? Can you do so more or better?

Advocacy issues are sent for consideration via email and responded to in a timely manner. Certain work groups within the CGA effectively use conference calls. CGA would not function as a whole (17 members plus many liaisons) frequently using conference calls or web-based meetings. Conference calls have been used in the past when needed. They were concise and to the point. The issue was moved forward. As stated previously, while the Council effectively uses conference calls as a tool to communicate, perhaps it is overlooking opportunities to effectively use more conference calls in the future.

Are you aware of the staff time devoted to your activities? Can that staff time be directed to other activities?

No knowledge of staff time spent on Council specific activities. The Council is not aware of staff time devoted on an hour by hour basis, but believes that most of their time is devoted to the Council's business. It is obvious they do a huge amount of the work, especially behind the scenes.

Is your staff support sufficient?

Staff support is sufficient. Questions of staff have always been answered quickly and in detail.

Areas of Responsibility

Based on a review of the bylaws, should some responsibilities be placed elsewhere or discontinued?

No, the CGA's responsibilities should not be placed elsewhere. However, the Council reviewed its bylaws and is recommending that portions of the bylaws that would micromanage the ADA's relationship with the federal dental services be amended to more accurately reflect what actually takes place. To this end, the CGA is recommending that the subsections identified below that concern internal decision making in the federal dental services be deleted. This leaves in place the more general bylaws provisions providing for the CGA to address legislative and regulatory issues, serve as a liaison and to formulate and recommend policies designed to advance the professional status of federally employed dentists.

18. Resolved, that CHAPTER X. COUNCILS, *Section 120. DUTIES*, Subsection H. COUNCIL ON GOVERNMENT AFFAIRS, of the ADA *Bylaws* be amended as follows (Additions underscored, deletions ~~stricken through~~):

H. COUNCIL ON GOVERNMENT AFFAIRS. The duties of the Council shall be to:

- a. Encourage the improvement of the health of the public and to promote the art and science of dentistry in matters of legislation and regulations by appropriate activities.
- b. Formulate and recommend policies related to legislative and regulatory issues and to governmental agency programs.
- c. Formulate proposed legislation, approved by the Board of Trustees, that may be submitted to Congress and which will promote the art and science of dentistry in accordance with Association policies.
- d. Disseminate information which will assist the constituent and component societies involving legislation and regulation affecting the dental health of the public.
- e. Serve and assist the American Dental Association as a liaison with agencies of the federal government.
- f. Advise other Association agencies charged with developing, recommending and/or implementing legislative policies adopted by the House of Delegates.
- g. Serve as liaison for the American Dental Association with those agencies of the federal government which employ dental personnel and have dental care programs ~~in direct dental care delivery programs and the dentists in those services.~~
- ~~h. Recommend programs and policies which will ensure that eligible beneficiaries of federal dental service programs have access to quality dental care.~~
- ~~i. Recommend programs and policies which promote an efficient and effective dental care delivery system within the federal dental services.~~
- ~~j. Assist in the development of dental workforce requirements and appropriate mobilization programs in times of emergency.~~
- ~~k-h.~~ h. Formulate and recommend policies which are designed to advance the professional status of federally employed dentists.
- ~~l. Monitor dental training programs conducted by the federal dental services.~~

So that, as amended, Subsection H reads as follows:

H. COUNCIL ON GOVERNMENT AFFAIRS. The duties of the Council shall be to:

- a. Encourage the improvement of the health of the public and to promote the art and science of dentistry in matters of legislation and regulations by appropriate activities.
- b. Formulate and recommend policies related to legislative and regulatory issues and to governmental agency programs.
- c. Formulate proposed legislation, approved by the Board of Trustees, that may be submitted to Congress and which will promote the art and science of dentistry in accordance with Association policies.
- d. Disseminate information which will assist the constituent and component societies involving legislation and regulation affecting the dental health of the public.

- e. Serve and assist the American Dental Association as a liaison with agencies of the federal government.
- f. Advise other Association agencies charged with developing, recommending and/or implementing legislative policies adopted by the House of Delegates.
- g. Serve as liaison for the American Dental Association with those agencies of the federal government which employ dental personnel and have dental care programs.
- h. Formulate and recommend policies which are designed to advance the professional status of federally employed dentists.

Are you addressing each area of responsibility? If not, should you, or should you change the bylaws?

Yes, we are addressing each area of responsibility.

Can your responsibilities be consolidated with those of another entity or be done better by another entity?

No, the CGA does not recommend consolidation. With input from numerous liaisons attached to the Council, the CGA is in the best position to offer advice and counsel to staff and leadership on the variety of legislative and regulatory matters that come before it for consideration.

Agenda Review

As you consider a self-assessment, use your agenda as a tool in the assessment:

- **Is each item an efficient use of your time?**
Most items are an efficient use of Council time.
- **Which items can be handled in other ways—conference calls, consent, etc.?**
Most things have been handled via email between Council meetings. Should something of importance come up that warranted a full Council discussion, the Council believes a conference call would be arranged.
- **What are you doing which is “down in the weeds,” operational as opposed to directional?**
Much of the work of the CGA is driven by the action of Congress and the federal agencies. Therefore, the Council believes it correctly deals with a fair amount of detail concerning a majority of the work produced, but it's not operational in nature.
- **What can you ask staff to take over?**
Nothing more than what they are already doing. CGA staff is doing an excellent job with their current duties. It's the Council that needs to do more with regard to strategic thinking.

Are you spending time on big issues and strategic direction?

Not enough, the Council could spend more time on big issues and strategic direction as it relates to our *Bylaws* charges.

Council on Members Insurance and Retirement Programs

Coleman, Robert A., 2014, Michigan, chair
Barnashuk, Frank C., 2016, New York, vice chair
Chaney, Mark S., 2015, Louisiana
Coleman, J. Preston, 2017, Texas
Ellison, Naomi L., 2015, California
Ferguson, Larry J., 2017, South Carolina
Gillcrist, James A., 2015, Tennessee
Grogan, Patrick M., 2016, Washington, D.C.
Hettinger, Richard F., 2014, Iowa
Houten, David E., 2016, Washington
Hymes, Rachel Dasher, 2014, *ex officio**
Kincheloe, Bradley B., 2017, Wyoming
McLean, David E., 2017, Vermont
Miller, Paul R., 2016, Florida
Paumier, Thomas M., 2014, Ohio
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 2013-14 liaisons are: Dr. Carol Gomez Summerhays (Thirteenth District trustee, Board of Trustees) and Ms. Alex Martella (American Student Dental Association).

Purpose

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

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-sponsored Members Insurance Plans and the ADA-endorsed Members Retirement Programs overseen by the Council provide a source of non-dues revenue in the form of royalty revenue from the insurance plans and service income from the retirement plans 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.

The Milliman financial audit of the ADA Members Insurance Plans validated that there is opportunity to provide exceptional high value to current certificate holders and enhance member value for all ADA members through non-dues revenue from the ADA Members Insurance Plans. The ADA is entitled to a royalty for use of its member list, name, logo, goodwill, and other intangibles in marketing the ADA Members Insurance Plans. At its August 2013 meeting, the Council adopted guidelines for determining the amount of royalty revenue that the plans can support.

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

The 2013 House adopted Resolution 84H-2013 to study a potential approach to on-going royalty revenue for the ADA Members Insurance Plans. The Board of Trustees established a workgroup (including two members of CMIRP) to explore the benefits and drawbacks of maintaining all or some portion of the royalties received from the ADA Members Insurance Plans in a designated reserve account for purposes of dues stabilization and long-term financial stability. The Board of Trustees will be reporting to the 2014 House of Delegates on its findings.

The ADA Members Insurance Plans consist of Term Life, Term Plus (universal life), Disability Income Protection, Office Overhead Expense and MedCASH. In addition, the ADA-sponsored Student Term Life and Disability Plans are provided to ADA student members at no cost. At end-of-year 2013, approximately 66,229 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 21,000 spouses or domestic partners, along with 8,068 children.

Table 1. Insured ADA Plan Participation for Policy Years 2011–2013

Insurance Plan	2011	2012	2013
Member Term Life ¹	53,989	53,899	59,172
Spouse Term Life	19,005	18,830	18,649
Child Term Life ²	7,597	7,493	7,391
Term Plus Plan	1,520	1,466	1,418
Disability Income Protection	18,695	19,314	19,956
Member MedCASH	4,408	4,248	4,084
Spouse MedCASH	2,410	2,320	2,260
Child MedCASH	984	959	928
Office Overhead Expense	9,820	10,726	11,594
Student Term Life ³	13,681	13,388	10,908 ⁴
Student Disability	11,036	12,524	10,834
TOTAL: All Plans	143,145	145,167	147,194

With the baby boomer population aging its way out of the insurance plans, there is a renewed focus on developing new marketing strategies to address the needs of new dentists, as well as product enhancements designed to retain existing member participants. In 2013, the Council approved providing auto-enrollment of student members into the no-cost ADA-sponsored Student Term Life and Disability Insurance Plans to help promote the value of ADA membership and increase potential conversion rates to the ADA Members Insurance Plans by graduating student members. In 2013, a “new ADA member” insurance offer which provides \$100,000 of term life coverage at no cost for six months was extended to

¹ Member participants plus 2013 graduates reclassified as members on 12/31/13.

² Number of members who are insuring their children.

³ Student participants less 2013 graduates reclassified as members on 12/31/13.

⁴ 2013/2014 Student life and disability auto-enroll information not complete at the time of this report. Figures shown will increase as enrollees are added monthly.

graduated student members who converted from student to active ADA membership. The ADA new member no-cost term life insurance offer was introduced in support of the ADA's 2013 strategic initiative to build member value and create additional incentive for dentists to become ADA members. The 2013 membership recruitment campaigns promoting the no-cost insurance offer were successful in attracting 5,648 new members.

The Council also oversees the ADA-endorsed Members Retirement Program administered by AXA 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. Dentist employer 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 down economy. Nonetheless, the ADA Members Retirement Program remains strong financially with total program assets of approximately \$1.68 billion as of December 31, 2013.

In 2013, the Council contracted with Milliman Inc. to conduct a program review and benchmarking study of the ADA-endorsed Members Retirement Program to find ways to reverse the downward trend in participation. The study recommended that AXA and the ADA hold a strategic planning session to address program goals and to develop objectives to strengthen the long-term viability of the program, capture additional market share and increase non-dues revenue opportunities for the ADA. The objective was to develop a short and long-range strategic plan to ensure the ADA program is well positioned to address the future needs of a diverse membership through best-in-class product offerings, educational resources and services that maximize ADA member value. The Council continues to oversee and monitor the 2014 ADA-AXA Strategic Plan targeted goals and timeline for implementing marketing initiatives to enhance the marketability of the programs.

Table 2. ADA Members Retirement Program Participation

	2011	2012	2013
Number of Dentist Employers	4,930	4,660	4,369
Total Number of Dentists and Employee Participants	18,098	17,190	16,442

The Individual Retirement Account (IRA) can be adopted as a traditional IRA, Roth IRA, Rollover IRA or Self-Employed IRA (SEP-IRA). Table 3 lists the number of dentists and employees participating in the IRA (300+ Series) Program.

Table 3. Individual Retirement Accounts Participation

	2011	2012	2013
Number of Participants	1,679	1,647	1,612

Table 4 details the service income ADA has received annually since 2011 for its endorsement of the ADA Members Retirement Programs.

Table 4. ADA Members Retirement Program: Service Income

Year	Amount Paid to ADA
2011	516,289
2012	516,436
2013	543,491
Total	\$1,576,216

One of the most notable accomplishments this year was the introduction of the ADA Health Insurance Resource page on ADA.org that includes a link to the new ADA-endorsed American Health Insurance Exchange (AHIX) web portal, powered by JLBG Health, which launched February 15, 2014. In support of the Power of 3, the Health Insurance Resource page provided a unique opportunity to collaborate with the state dental societies to heighten awareness of the state endorsed plan options for members as well as provide a valuable resource for ADA members that do not have a state endorsed plan option.

There were approximately 3,000 unique visitors to the ADA Health Insurance Resource page on ADA.org during the limited open enrollment period which demonstrates the timely and responsive action taken by the Council and Board of Trustees to meet the needs of ADA members.

Raising awareness of member value through the ADA Members Insurance Plans, ADA Members Retirement Programs and the Health Insurance Resource page on ADA.org, which includes the ADA-endorsed American Health Insurance Exchange, as well as educating the membership on the principles of effective risk management, are key priorities for the Council. These topics have gained greater visibility through enhanced multi-channel marketing, articles in *ADA News* and e-publications, conferences and event sponsorships such as the ADA Annual Conference on Recruitment & Retention. The Council also sponsors three educational risk management seminars at the ADA America's Dental Meeting, which are presented at no cost to the Association or seminar attendees.

Additionally, the Council collaborates with the Council on Dental Practice and other ADA agencies in developing content for the Center for Professional Success to promote the value of insurance and financial risk management educational resources for dentists.

Emerging Issues and Trends

Pursuant to its *Bylaws* responsibilities, the Council will continue to monitor, evaluate, and if appropriate, recommend action be taken 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, low cost member products as well as educational member resources will help dental professionals succeed.
- The trend in dental practice away from solo practice to large group and corporate practice is likely to impact the market for insurance and retirement plans, and will require monitoring to assess opportunities to enhance member value through ADA member products, services and risk management resources.
- Leverage marketing opportunities resulting from the Affordable Care Act to develop a new approach to promote the value of the ADA MedCASH Plan benefits to members to better meet their health insurance needs.
- Emerging issues and trends related to dental malpractice and proper risk management techniques; cyber liability exposures and the impact of new digital media and technology enhancements.

Responses to House of Delegates Resolutions

There were no assignments from the 2013 ADA House of Delegates.

Self-Assessment

In accord with Resolution 1H-2013, the Council on Members Insurance and Retirement Programs conducted a self-assessment at its March 2013 meeting, based on the topical outline developed by the Board of Trustees. The Council discussed its structure, composition and areas of responsibility referring to the *Potential Areas of Inquiry in a Council Self-Study* reference document as a guide in its evaluation of six areas which included: 1) participant criteria, 2) size of the Council, 3) term limits and number of terms, 4) meeting frequency, 5) type of meeting, and 6) type/reporting structure. There was general consensus on the participant criteria, frequency of meetings and type of meeting. Consensus on the future size of the Council and terms of service centered on two options for each; 17 or 9 members for the former and two three-year terms or one four-year term for the latter. After further discussion, the Council agreed a Governance workgroup should be formed to evaluate the options and recommendations presented and report back to the Council at its August meeting.

The Council governance workgroup met twice to continue the March council meeting self-assessment discussions and reach consensus on recommendations regarding the structure and composition of the Council. The results of both the Council's self-assessment survey and the Governance Task Force survey of current and past council members, as well as Council staff and additional historical background information on the structure and composition of CMIRP, meeting costs, resource material regarding optimal size of groups for decision making and how other professional associations structure similar committees were provided to facilitate their discussion. With the exception of the criteria for determining the size of the council and terms of service, the Council workgroup's recommendations aligned with the Council's initial recommendations to maintain the Council in its current structure and composition. Ultimately, the Council did not take action and came to agreement to maintain the Council structure as is.

The complete assessment is presented as Appendix 1 of this report.

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.

Appendix 1. Council on Members Insurance and Retirement Programs 2013 Self-Assessment

Council on Members Insurance and Retirement Programs
June 2013

Item 14
Governance Workgroup Report

Report of the Council Governance Workgroup

Background: This report provides an update on the discussions and recommendations of the Council Governance Workgroup regarding criteria for Council members, size of the Council, term limits and number of terms, meeting frequency, type of meeting and reporting structure. The workgroup met twice in June by conference call in follow-up to the Council discussion in March. Ultimately, the workgroup elected to recommend that the Council on Members Insurance and Retirement Programs be maintained as it currently exists.

The Council should review and discuss the workgroup recommendations and may wish to take action; no action is required to maintain the Council as is.

Overview: At its March 22-23, 2013 meeting, the Council held a strategic discussion on its structure, composition and areas of responsibility. To facilitate its self-assessment discussions, the Council broke into two groups. The Council referred to the *Potential Areas of Inquiry in a Council Self-Study* reference document as a guide in its evaluation of six areas which included 1) participant criteria, 2) size of the Council, 3) term limits and number of terms, 4) meeting frequency, 5) type of meeting, and 6) type/reporting structure. Each group's recommendations on the areas were then shared with the full Council. In summary, there was general consensus on the participant criteria, frequency of meetings and type of meeting. Consensus on the future size of the Council and terms of service centered on two options for each; 17 or 9 members for the former and two three-year terms or one four-year term for the latter. After further discussion, the Council agreed a Governance workgroup should be formed to evaluate the options and recommendations presented and report back to the Council at its August meeting.

Council Governance Workgroup: The Council Governance workgroup was formed in May with Drs. Coleman, Hettinger, Miller, Paumier, Rashall and Schwartz volunteering to participate. Dr. Gregory Rashall was appointed to serve as workgroup chair. The workgroup held two conference call meetings on June 4 and June 19. The initial conference provided the framework for both meeting agendas and outlined the purpose and goal of the workgroup to continue the March Council meeting self-assessment discussions to reach consensus on recommendations regarding the future structure and composition of CMIRP.

Prior to the March meeting, the Board of Trustees Governance Task Force conducted a survey of current and past council members as well as council staff as part of its charge (Resolution 94H-2012) to study ADA councils within the governance structure. The results of this survey were not available prior to the Council's self-assessment discussion at its March meeting but were later provided to the workgroup along with additional historical background information on the structure and composition of CMIRP, meeting costs, resource material regarding optimal size of groups for decision making and how other professional associations structure similar committees.

In addition to the Governance Task Force survey, CMIRP members participated in an *online* self-assessment survey conducted as a follow-up to the Council's March meeting discussions. The survey questionnaire was created using the questions outlined in the *Potential Areas of Inquiry in a Council Self-Study* reference document and captured information related to: the role of the council in the ADA governance process; the council's primary value in serving the needs of the ADA membership; its effectiveness in terms of *Bylaws* authority; council priorities and strategic discussions; goals and success

measures; council criteria in terms of size, election process and overall efficiency. It also included questions on possible alternative ways to structure council activities. A summary of the Council survey results was provided to the Governance workgroup in preparation for its conference meetings.

Evaluation: The workgroup undertook a review of the six areas, weighing the merits of the Council recommendations and giving consideration to the future needs of the ADA membership, before developing its recommendations. The results of both the Council and Governance Task Force surveys and additional information provided background for the discussions.

There was some inconsistency in the pattern of responses between the March Council meeting governance discussions, the two surveys, and the workgroup recommendations. More specifically, with the exception of the criteria for determining the size of the council and terms of service, the workgroup's recommendations aligned with the Council's initial recommendations.

Workgroup Discussion and Recommendations: The following summarizes the Governance workgroup recommendations on each of the six evaluation areas on the proposed structure and composition of the Council:

- A. **Participant Criteria:** The Board of Trustees nominates Council members on a rotational basis and, per the *Bylaws*, CMIRP shall be composed of seventeen members, one from each trustee district. At its March meeting, the Council agreed on, and the workgroup also discussed, the following criteria for nominating Council members. a) interest, background and experience in insurance, finance and budgeting, and 2) diversity of group in terms of stage of practice and experience in organized dentistry. The workgroup agreed that the skills-based criteria was appropriate and important given the technical nature of the members insurance and retirement programs and the financial value of the total plan assets under management. Additionally, the workgroup felt that diversity and practice experience among volunteers fosters a broader perspective and valuable insights into addressing the needs of member dentists at all stages of practice, particularly as respects to development of risk management educational programs and services.

Recommendation: Modify participant criteria to include a) interest, background and experience in insurance, finance and budgeting, and 2) diversity of group in terms of stage of practice and experience in organized dentistry.

- B. **Size of the Council:** The Council discussed two options regarding council size for the workgroup's discussion a) remain with the current number of 17 members, or b) reduce the size of the council to 9 members. At its March meeting, the majority of the Council voted in favor of reducing the size of the Council noting that a smaller group would provide the same effectiveness as a larger group if selected on the basis of qualifications and experience. Additionally, the results of the Governance Task Force survey supported a reduction in the size of the council by the majority of respondents. The workgroup discussion however, resulted in a different outcome.

More specifically, following discussion on the pros and cons of reducing the size of the Council, the workgroup approved by a majority but not unanimous, vote that the Council should remain at 17, with member representation from each district. The rationale for reducing the size of the council was supported by the thinking that a strategic core group fosters greater engagement and increased efficiency, at lower cost. The significant past year accomplishments of the Council insurance and retirement workgroups were cited as examples of the effectiveness of a smaller decision making group. In advocating for the current structure of 17, the workgroup discussed functionality and future workload, the need for greater diversity, and the political sensitivities of limiting district representation and eliminating uniformity in the ADA governance structure as respects to the council selection process. Members of the workgroup also noted that three subcommittees of council members are being established this year. Based on resource materials pertaining to optimal decision group size and the anticipated workload for each subcommittee, it

was suggested that each subcommittee should be composed of five or six members with individual Council members serving on only one subcommittee.

Recommendation: Maintain Council size at 17.

- C. **Term of Service Limits/Number of Terms:** The Council provided two options regarding term of service limits and number of terms 1) two, 3-year terms or 2) one, 4-year term. The workgroup discussed option one, two, 3-year terms of service but agreed that in keeping with their recommendation to not reduce the size of the Council, the term of service should be consistent with the current one-term, four year rotation process.

Recommendation: Maintain current terms of service.

- D. **Frequency of Meetings and Type of Meeting:** (in-person, phone conference) The Council agreed there should be two “in person” meetings per year, with the option of conducting virtual meetings through conference calls as needed. The workgroup supported the recommendation of the Council and noted that increased technology capabilities, including video conferencing and web-based applications, should provide greater flexibility in future, and possible additional, meeting arrangements.

Recommendation: Maintain current in-person meeting schedule.

- E. **Structure:** Following discussion of alternatives, including becoming a committee of the Board, the Council unanimously agreed that CMIRP should remain within the current governance structure reporting to the House of Delegates.

Recommendation: Maintain current Council status.

Recommendation: The Council should discuss the workgroup’s recommendations and come to agreement regarding what will be reported to the Board of Trustees in the Council’s October 2013 report to the Board and to the House of Delegates in the 2014 Annual Report on the outcome of the Council’s Self-Assessment.

Council on Membership

Kelly, Thomas S., 2014, Ohio, chair
Durbin, Michael G., 2017, Illinois, vice chair
Aguirre, Alejandro M., 2016, Minnesota
Cassidy, Kevin M., 2014, Kansas
Del Valle-Sepulveda, Edwin, 2015, Puerto Rico
Ingram, William L., 2016, Alabama
Johnson, Nicole S., 2016, Pennsylvania
Jones, Gary O., 2017, Arizona
LeBlanc, Michael A., 2014, Kansas, *ex officio**
Lee, Natasha A., 2015, California
Maranga, Maria C., 2017, New York
Ogata, Randall H., 2014, Washington
Olson, Shelley B., 2015, North Carolina
Pohl, Gregory J., 2016, Kentucky
Shoemaker, Eugene B., 2015, Wisconsin
Smith, Carmen P., 2017, Texas
Wilson, Kevin Drew, 2016, New Hampshire
Zuknick, Stephen J., 2014, Florida

Rauchenecker, Steven M., director
Bronson, Elizabeth M., manager

The Council's 2013-14 liaisons include: Dr. Julian Hal Fair, III (Sixteenth District trustee, Board of Trustees); Dr. Minerva Patel (Council on Communications); and Mr. Daryn Lu (American Student Dental Association).

Purpose

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 state and local dental societies, as well as those at the national organization to support, monitor and encourage membership activities and to enhance cooperation and communication on recruitment and retention efforts across all three levels. 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

The Council on Membership supports the ADA Strategic Plan through: the creation of strategies and resources that highlight member value; working with the state and local societies 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:

* 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.

Objective 1: Increase the reserves of the Association so that a reserve level of 50% of the Association's annual budgeted operating expense is achieved, as urged by HOD Resolution 59-2007H-2008.

The Council on Membership has been involved with key initiatives intended to reverse the declining membership market share trend. This past year, the Council collaborated on the Power of Three Initiative and developed the Membership Growth Plan.

Addressing Active Licensed Dentist Membership Trends (2008–2013)

After a period of membership growth and increasing membership market share in the early 2000s, the number of ADA members has remained flat even as the size of the market has increased, resulting in a steady decline in membership market share (Figure 1). During this time, the percentage point gains for number of members in most of the market segments have increased (Table 1). Women, ethnically diverse, recent graduate dentists, as well as full-time faculty member segments have shown sizeable gains in the numbers of members. The current member cohort is aging and there is a need to focus both on recruitment and retention of dentists in their first five to 10 years out of dental school. The number of recent graduate dentist members increased by 4%, almost 1,200 members, since 2008, but market share has declined by over 3%.

Figure 1. Active Licensed Dentist Trends 2008–2013

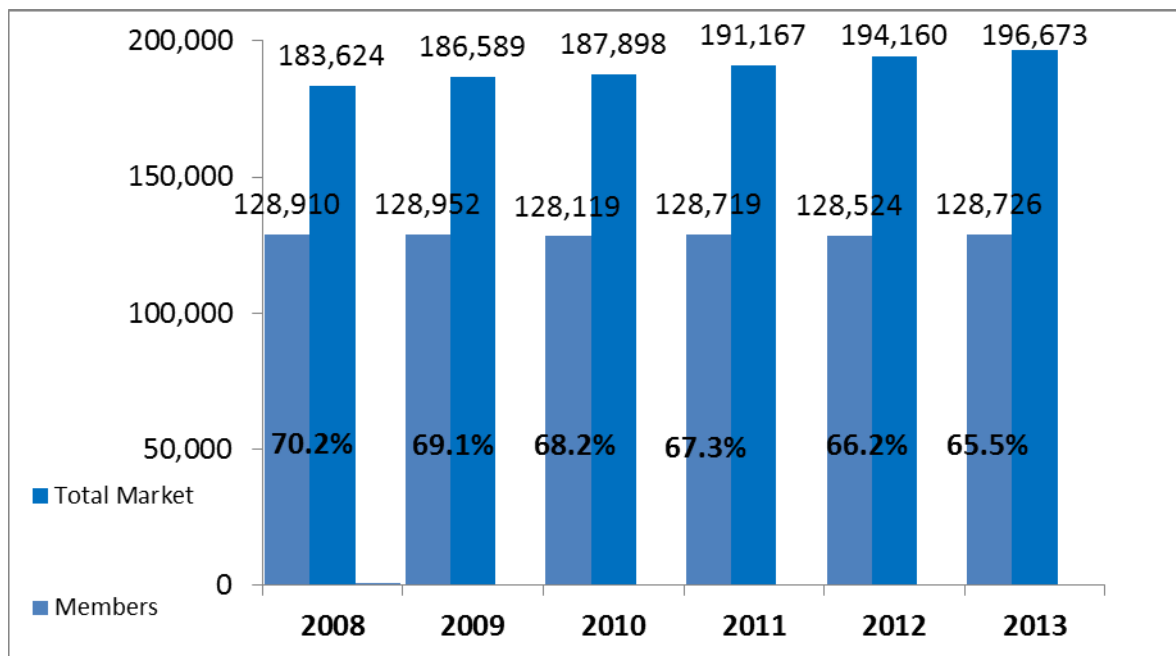


Table 1. Market Segment Trend Results 2008–2013

TARGET GROUP	2008		2013		2008/2013		
	Mbrs	Mkt Share %	Mbrs	Mkt Share %	Mbr Diff.	Mkt Share Diff.	Overall Change Mbrs %
All Dentists	128,910	70.2%	128,726	65.5%	-184	-4.7%	-0.1%
Women	26,199	63.3%	31,869	60.0%	5,670	-3.3%	21.6%
All Faculty	5,367	73.2%	5,965	69.1%	598	-4.1%	11.1%
Full Time Faculty	1,999	64.8%	3,065	65.2%	1,066	0.4%	53.3%
General Practitioners	99,352	67.4%	98,386	62.8%	-966	-4.6%	-1.0%
Specialists	29,558	81.8%	30,340	75.6%	782	-6.2%	2.7%
Federal Dental Service	2,803	61.2%	2,816	54.4%	13	-6.8%	0.5%
Graduate Students	2,264	69.5%	2,285	63.8%	21	-5.7%	0.9%
Foreign Trained	5,135	50.8%	5,210	45.8%	75	-5.0%	1.5%
All Minorities	16,543	54.4%	20,005	53.0%	3,462	-1.4%	20.9%
New Dentists	29,437	69.0%	30,613	65.8%	1,176	-3.2%	4.0%

The Power of Three

The Power of Three: Building Member Value debuted in 2013 as a membership-building program designed around the national, state, and local dental societies of the ADA working together to grow membership. Through this effort, member value will be increased throughout all levels of the ADA, providing every dentist a reason to join and every member a reason to maintain their membership. The goals of the Power of Three are to reverse the national market share decline, create more value for members and position the ADA for ongoing growth.

The Power of Three includes work from across the ADA, including Action for Dental Health and the Aptify rollout to the states. Within Membership, it includes a number of powerful tools that are already in place, including:

- The Membership Success Factors tool helps dental societies conduct a self-assessment on key functions that support member value creation and service delivery. Twenty-three of the 53 state dental societies have completed the assessment as of June 1, 2014. Client services continues to work through the Council on Membership and directly to obtain completed assessments from all state societies.
- The Member Value and Loyalty Strategic Plan template helps societies prioritize their actions to enhance member value.
- The Membership Tool Kit shares resources and information to promote best practices in membership recruitment, retention and service.
- The National Collaborative Campaigns allow societies to customize images and messages for nonmember recruitment campaigns.
- The Membership Program for Growth (MPG) gives grants to dental societies for promising outreach efforts. The 2013 cycle of the program has attributed 1,116 new members and 4,912 members retained as direct results of MPG related efforts.
- Quarterly membership reports assess progress.

Membership Growth Plan

The Council on Membership has developed the Membership Growth Plan with strategies and initiatives to improve membership growth and market share for the Association. The plan defines a clear approach to

build unique, compelling and relevant ADA member value by collaboration across the ADA at the national, state and local levels. The goal is to reverse the membership market share decline by achieving a net gain of 8,700 active licensed members by end-of-year 2016, and position the ADA for ongoing growth.

The plan drives success across national, state and local agencies by:

- Acknowledging the sense of urgency and securing each dental societies responsibility for member growth, creating a culture that embraces change.
- Creating and communicating a compelling, unique rationale for membership, tailored to key market segments and to recruit, retain, and convert aggressively at the national, state and local levels.
- Establishing “Power of Three” partnerships that will focus on a renewed commitment to the member at all levels in order to collaboratively and continuously increase member value and loyalty. This aligned partnership will be committed to: a) consistent creation of member value; b) consistent concierge level member service/experience; and c) driving member loyalty beginning with admission to dental school and continuing throughout a dentist’s career.
- Creating consistent high quality service to drive member engagement and improve member satisfaction.

The plan was approved by the ADA Board of Trustees at its March 2014 meeting and is currently in the implementation process. To date, the following accomplishments have seen significant progress or have been achieved:

- As a result of efforts thus far, 100% of key stakeholders agree:
 - They are aware of the membership trends impacting the decline in membership (key stakeholders include the ADA Board of Trustees, the Council on Membership, constituent and component officers and executive directors, and membership staff);
 - That reversing the membership trend is one of the top three priorities for the tripartite; and
 - That collaborative action is needed to address the market share decline.

These goals were achieved prior to the January 31, 2014, timeline set out in the plan.

- Nearly 400 ADA leaders signed on to an “Open Letter From Leaders Throughout the ADA Organization: Supporting Member Success Through the Power of Three.”
- To date, 43% of state dental societies have completed the Membership Success Factor self-assessment. This compares to the plan’s end-of-year goal of 75%.
- A pilot study of dental societies using Aptify will begin in the fall of 2014 to establish baseline metrics and document improvement in key alignment areas, including: the enrollment process overall, ease of joining and tripartite goals, roles and mutual support. This is ahead of schedule.
- The first session of Member Service University has sold out, prompting early provision of the next class to accommodate additional interest. Also, ahead of schedule.
- Dental school participation in 2014 signing days was up 25% over previous years, with 50 schools participating. This bodes well for increasing the dental student conversion rate.

Dental School Strategy

A key initiative of the Membership Growth Plan is the Dental School Strategy. The goal of this strategy is to increase retention of ADA student direct membership through full ADA membership. Strategies to drive student and new dentist membership growth include:

- Engaging dental students at every year in dental school
- Engaging full-time faculty, part-time faculty and dental school deans
- Simplifying the dental student conversion process

- Identifying and communicating benefits package for dental students through third-year after graduation
- Development of state and local client portfolios to drive growth

Sustaining Long-Term Membership Growth Through Conversion of Dental Students to Active, Licensed Membership

- At end-of-year 2013, the conversion rate for the class of 2012 was 67%, an increase over the class of 2011 conversion rate of 66.1%.
- As a result of the work done by the Dental School Strategy Advisory Team, dental student conversion is now positioned as a contributing strategy to the overall membership plan for growth and the Power of Three. The advisory team has also identified two key strategies for increasing conversion at the target schools, which include:

The Dental Student Experience: Develop and articulate a meaningful value proposition for students that emphasizes both benefits and participation, and to collaborate with state and local societies on dental school engagement activities throughout their years in dental school; and

Faculty Engagement: The dental school faculty are a significant influencer of new dentist participation in organized dentistry. Therefore, it is imperative that the Association understand the unique needs of faculty and position itself as a resource that supports faculty in research, teaching, student mentorship and personal professional development. Tactics include a clinical research distance learning course being piloted by the ADA Center for Evidence-Based Dentistry; an evidence-based dentistry faculty award, a *CDT Code* and claim submission workshop under development by the ADA Practice Institute; and personal outreach to deans at the target schools by the ADA executive director.

Goals to Reverse the Membership Decline

The Council is using the initiatives outlined in the Power of Three, the Membership Growth Plan, and the Dental School Strategy to assist in achieving these objectives:

1. **Membership Recruitment:** Increase active membership to 131,000 or more by end of year 2014 for a market share of 66.6%.
2. **Membership Retention:** Achieve a 95.8% renewal rate among active licensed members at end-of-year 2014.
3. **Membership Conversion:** Achieve dental student membership in ASDA and ADA of 85% by end of year 2014. Convert 67.1% of the class of 2013 into ADA membership by end of year 2014 and convert 50% of the class of 2014 into ADA membership by end of year 2014.
4. **Membership Outreach:** Focus on reversing the declining market share trend in each of the top five states (California, Florida, Pennsylvania, New York and Texas) with the largest nonmember growth opportunity, while influencing overall market share gains in all other state dental societies over end of year 2013 figures by end of 2014. Focus specifically on improving dental student conversion and new dentist recruitment/retention in these states, with the intent of also influencing market share increases in both the women and ethnic/diverse market segments.

Emerging Issues and Trends

The Council on Membership continues to monitor and identify trends and factors that influence membership market share including:

Proliferation of the Group Practice Business Model

The dental care delivery model is changing. Solo practice remains the dominant form of delivery in the private practice of dentistry; however, the field appears to be consolidating, i.e. the number of dentists in solo or cooperative practices is decreasing while the number of dentists in some form of group practice, including large group practices, is increasing.

- The ADA is going through a process of understanding this complex and evolving portion of organized dentistry in order to position itself to better serve its dentists and business owners. Understanding the evolution of group practices has been difficult because past discussions and research have suffered from a lack of specificity.
- Current policies and processes related to membership affect the Association's ability to recruit and retain member dentists in this dental practice segment. The Council on Membership is closely studying this issue and the impact it has on overall membership trends.
- An Interagency Workgroup on Dental Group Practice (IWDGP), led by the Council on Dental Practice, continues to meet to strengthen channels of communication and cooperation between ADA councils and commissions on initiatives related to this market segment.
- A project team is currently working on an implementation plan to define and deliver value to existing and prospective member dentists working in a group practice setting. Metrics supporting the plan's achievement are also under development.

Responses to House of Delegates Resolutions

Resolution 86-2013. Lifetime Membership Rule of 95 (Trans.2013:369)

At the 2013 House of Delegates, Resolution 86-2013 was referred to the Council on Membership. Resolution 86-2013 proposes that individuals would achieve Retired Life membership when: 1) the member's chronological age as of January 1 of the membership year, and 2) the number of years the member has been an active and/or retired member in good standing of this Association equals or exceeds ninety-five (95). For example, the proposed change in the calculation for life membership eligibility would allow a retired member to be elected to life membership if they retired at 63 and had 32 years of consecutive membership (63+32=95). Dues would remain the same for life members who are still practicing dentistry as found in Chapter I, Section 20 of the ADA *Bylaws*.

The Council studied the pros and cons of the *Bylaws* change and various related membership scenarios and determined, based on the effectiveness of the current approach to Retired Life membership and concluded that the current requirements should be maintained. Therefore, the Council is not presenting a resolution to the House of Delegates.

Resolution 92H-2009. Impact on Dues Revenues (Trans.2009:415)

Resolution 92H-2009 calls for the appropriate ADA agency to report yearly to the House of Delegates the five-year anticipated (projected) dues revenues impact from members' transition to life membership. This information is reported through the Council on Membership and is included as Appendix 1 to this report.

Self-Assessment

The Council on Membership conducted a self-assessment based on the outline developed by the Board of Trustees. The self-assessment was completed by 14 members of the Council, Board of Trustees liaison and the liaison from the Council on Communications. Some key findings identified by the Council were:

- The Council's agenda needs to be more strategic;
- Using geographic representation as a basis for establishing the composition of the Council ranked higher than having only a composition based upon skill set;
- Using both skills and geographic representation ranked nearly as important as geographic alone;
- Time spent volunteering should be reduced;
- Effective access to Council materials and information via ADA Connect and the use of the consent calendar has allowed the Council to spend more time on strategic discussions;
- The Council would benefit from trusting the subcommittees' work (i.e. minimizing rework of committee actions at the Council's full meetings) and continuing to use the consent calendar to foster expeditious Council work;

- The Council was split on assessing the use of subcommittees and workgroups and mentioned using smaller groups for specific items and the Council for larger items; and
- The Council felt that its *Bylaws* responsibilities were appropriate.

The complete self-assessment can be found as Appendix 2 to this report.

Policy Review

In accordance with Resolution 170H-2012, Reaffirming Existing ADA Policy, the Council on Membership reviewed several ADA policies and presents a series of resolutions with recommendations to maintain, rescind or amend those policies.

Recommendations—Policies to be Maintained

The Council reviewed the following policies and determined that they should be maintained as written:

Dental Organization Membership Contingent on ADA Membership (*Trans.*1985:610; 1996:667)
Association Support for Members Participating in Various Reimbursement Systems (*Trans.*1996:674)
Other Organizations' Support for ADA Recruitment and Retention Activities (*Trans.*1989:540; 1997:659)
Compliance With Civil Rights Laws (*Trans.*1997:666)
ADA Notification of New Tripartite Members by Constituent Societies (*Trans.*2000:446)
Streamlining Membership Category Transfers (*Trans.*2001:426)

Recommendation—Policy to be Amended

The Council recommends that the policy Tripartite Membership Application Procedures (*Trans.*1998:685) be amended for clarity and offers the following resolution:

19. Resolved, that the ADA Policy on Tripartite Membership Application Procedures (*Trans.*1998:685) be amended so that the policy reads as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the ADA urges constituent state dental societies to review their own membership application procedures to ensure ~~there are no barriers to membership~~ that they support a consistent application process that minimizes membership barriers and presents a positive member experience, and be it further

Resolved, that the ADA urges the use of ~~its the Tripartite Membership Application~~ Tripartite System and its related software.

Summary of Resolutions

Resolution 19. Amendment of the Policy, Tripartite Membership Application Procedures

Council Minutes

For more information on recent activities, see the Council's [minutes](#) on ADA.org.

**Appendix 1. Response to Resolution 92H-2009:
Five-Year Projected Dues Revenue Impact From Members Transitioning to Life Membership**

Executive Summary

The Council on Membership is providing this informational report to the House of Delegates in response to Resolution 92H-2009:

Resolved, that the appropriate ADA agency report yearly to the House of Delegates the five-year anticipated (projected) dues revenues impact from members transitioning to life membership.

Impact

The Health Policy Resources Center, in conjunction with the Division of Membership, Tripartite Relations and Marketing, developed projections of the dues revenue impact from members' transitioning to life membership. The projections were developed through statistical modeling and extensive review of retirement trends among dentists. It should be noted that retirement rates among dentists have dropped slightly both as a result of the economic downturn and also as part of a longer-term trend. The most significant component of the drop in retirement rates took place in 2009. Accordingly, the projections are more likely to overstate than understate the financial impact. Based on historical patterns and the current age and member longevity, it is estimated that the dues revenue impact from members transitioning to life membership will be as follows (Table 2):

Table 2. Dues Revenue Impact From Members Transitioning to Life Membership

Year	Estimated Reduction in Dues Revenue From Prior Year for Members Transitioning to Life Membership
2014	(\$352,825)
2015	(\$395,255)
2016	(\$361,938)
2017	(\$377,294)
2018	(\$433,257)

At the end of 2013, there were 14,429 active life members and 24,190 retired life members. While the ADA is mindful of the anticipated transition of baby boom dentists into different membership categories and into retirement, it should also consider that current workforce projections (Table 3) indicate that the dental workforce will continue to grow through 2030. This projection does not incorporate potential graduates from dental schools that have not yet opened.

Table 3. Census Counts and Projections, 1993–2030

Year	Professionally Active Dentists	Active Private Practitioners	Applicants to Dental School	Applicant Rate	First-Year Enrollment	Graduates	Applicants per Admission
1993	155,087	142,603	6,761	0.352	4,100	3,778	1.649
1994	157,228	144,581	7,713	0.402	4,121	3,875	1.872
1995	158,641	146,089	7,996	0.421	4,237	3,908	1.887
1996	160,388	147,247	8,598	0.461	4,255	3,810	2.021
1997	160,781	147,778	9,829	0.537	4,347	3,930	2.261
1998	163,291	151,309	9,447	0.528	4,268	4,041	2.213
1999	164,664	152,151	9,010	0.503	4,314	4,095	2.089
2000	166,383	152,798	7,770	0.428	4,327	4,171	1.796
2001	168,556	155,716	7,412	0.399	4,407	4,367	1.682
2002	169,894	156,921	7,538	0.394	4,448	4,349	1.695
2003	173,574	160,184	8,176	0.413	4,618	4,443	1.770
2004	175,709	162,184	9,433	0.464	4,612	4,350	2.045
2005	176,634	162,180	10,731	0.519	4,688	4,478	2.289
2006	179,594	164,864	12,463	0.595	4,733	4,515	2.633
2007	181,725	166,837	13,742	0.652	4,770	4,714	2.881
2008	181,774	167,769	12,178	0.575	4,918	4,796	2.476
2009	186,415 ¹	171,110 ¹	12,202	0.575	5,089	4,873	2.398
2015	193,456	179,836	12,477	0.554	5,737	5,110	2.175
2020	197,654	183,960	12,200	0.559	6,032	5,585	2.022
2025	201,115	187,262	12,755	0.565	6,211	5,819	2.054
2030	202,913	189,343	13,560	0.566	6,464	6,005	2.098

Source: American Dental Association, Health Policy Resources Center, 2012 ADA Dental Workforce Model: 2009-2030.

Table 4 shows the number of members who begin paying in the life membership dues rates over the next five years. And that the number of members is expected to increase from 2,687 in 2014 to 3,308 in 2018. This projection assumes that there will be no dues increase during the next five years and that all members will retain membership. It is also assumed that the retirement rate will remain the same during this same time period.

As expected, due to the reduction in the active life member discount, the ADA experienced an increase in the nonrenew rate among active life members in 2013. The nonrenewal rate increased from 2.7% in 2012 to 4.8% in 2013. This was consistent with previous estimates of a 5% nonrenewal rate for active life members in 2014. The percentage is still below the 5.7% nonrenewal rate for active members at year-end. It is anticipated that the nonrenewal percentage for active life members in 2014 will be less than in 2013. It should be noted that the further out in the projection, the less accurate the forecast.

¹ The 2009 numbers for professionally active dentists and active private practitioners were revised after the *Distribution of Dentists in the United States by Region and State, 2009* was published. The numbers in this table are the correct numbers for 2009.

Table 4. Forecast for Members Paying Life Dues for First Time 2014-2018

Year Paying Life Dues for First Time	2014	2015	2016	2017	2018
Expected Active Life	2,245	2,546	2,476	2,602	3,036
Expected Retired Life	442	470	285	278	272
Total Projected to Become Life Members	2,687	3,016	2,761	2,880	3,308

Table 4 Note: Total forecasted to be elected to life membership for 2014-2018 as of 3/5/2014.

Table 5. Five-Year Projected Dues Revenue Impact From Members Moving to Life Membership

	2014	2015	2016	2017	2018
Total estimated reduction in dues revenue from prior year	(\$352,825)	(\$395,255)	(\$361,938)	(\$377,294)	(\$433,257)

Table 5 Note: Full dues in 2014 are \$522. Assumes retired patterns will remain the same in future years and assumes no deaths. Assumes no dues increase and no assessment in years 2014-2018. Only dues payers were figured in the reduction from prior year calculations based on payments in 2013.

Appendix 2. Council on Membership 2014 Self-Assessment

1. State the primary value of your council to a member.
 - Identify trends in data - 4
 - Identify obstacles to membership - 1
 - Recruitment/Retention, i.e., adds value to existing memberships, adds value to legislative initiatives, gives security to ADA's future - 10
 - Add member value 3
 - Govern issues on membership - 1
2. Should your council continue to exist?
 - Yes, i.e., because of membership crisis, as a liaison for tripartite, because of its value to the association - 16
3. Is your council effective in carrying out its *Bylaws* authority?
 - Yes - 15
 - Somewhat limited in this aspect/Process is too slow - 1
4. What are the top three goals to be accomplished?
 - Recruitment/Retention/Market Share - 16
 - Promote/Discover Membership Value - 12
 - Determine Barriers to Membership - 1
 - Increase membership among desirable segments, i.e. diversity, students - 3
 - Assist tripartite with membership initiatives/MPG - 3
 - Advise Board on membership issues - 1
5. How do you define/measure success for your council annually?
 - Number/Percentage of Recruited - 13
 - ROI/Conversion Rates/ROO - 2
 - Membership satisfaction surveys - 2
 - Brand awareness - 2
6. Should your council be skills based, or elected at large?
 - Skills based - 3
 - Elected at large - 4
 - Both - 8
 - No response - 1
7. Do you have an agenda that enables strategic discussion to the extent you would like?
 - Yes - 7
 - No - 5
 - Subcommittees help/Process is improving - 2
 - No response - 2
8. Do you have the optimal number of members to conduct business well and efficiently?
 - Yes, i.e., must remain district-related - 15
 - No - 1
9. Is the manner of member selection ideal (e.g. geographic vs. skills based)?
 - Prefer geographic - 9

- Prefer skills based - 0
- Both - 6

10. Do you have the right number of committees and members on committees? Should you use standing committees or ad hoc task forces?

Do you have the right number of committees and members on committees?

- Yes - 6
- Not sure - 1
- No response - 9

Should you be using committees or ad hoc task forces?

- Standing - 5
- Ad Hoc - 5
- Both - 4
- No response - 2

11. Would a task force structure as opposed to a council structure be better? Worse?

- Worse - 14
- Same - 1
- No response - 1

12. Is the decision making process efficient?

- Yes - 8
- Yes - evolving to become more efficient - 1
- Sometimes - 2
- No—too staff driven - 1
- No—agenda moves too slowly - 3
- Not sure - 1

13. How can you reduce the time spent by volunteers on your work, while still doing what needs to be done?

- Time spent is appropriate - 5
- Time spent by volunteers should be increased - 2
- Time spent by volunteers should be reduced, i.e., by delegating, by summarizing reports/ releasing reports earlier, by video conferencing/use of ADA Connect - 6
- Not sure - 1
- No response - 2

14. Do you meet in person enough? Too much? Too little?

- Yes - 11
- Too much- could be reduced by video conferencing - 3
- Too little- too much time on ADA Connect - 1
- Too little- could be improved with video conferencing - 1

15. What work done by volunteers could be handled by staff?

- Staff/council contribution is a good mix- balanced and appropriate - 9
- Not sure - 2
- Staff should do more work - i.e., outreach/travel, summaries after meetings, running programs - 4
- Volunteers should handle more work - 1

16. Are issues brought to your council in an efficient or appropriate manner?

- Yes - 11
- Not sure - 1
- Both/Sometimes - senior staff/legal review slows process, more video conferencing/use of technology could speed things up - 4

17. Are you provided with sufficient information to address and decide issues?

- Yes - 13
- Sometimes, i.e., process is slow/timeliness is an issue - 3

18. Is the discussion of issues efficient and effective?

- Yes - 11
- Sometimes - 2
- Improving over time - 3

19. Are there matters left to the council that should be handled by a smaller group?

- Yes, already in place - 5
- No - 6
- Not sure - 3
- Sometimes/depends on issue - 2

20. Do you effectively use conference calls and web-based meeting time? Can you do so more or better?

Do you effectively use conference calls and web-based meeting time?

- Yes - 14
- No - 1
- No response - 1

Can you do so more or better?

- Can do more - 8
- No response - 8

21. Are you aware of the staff time devoted to your activities? Can that staff time be directed to other activities?

Are you aware of the staff time devoted to your activities?

- Yes - 10
- No - 5
- No response - 1

Can that staff time be directed to other activities?

- Yes - 1
- No - 2
- No response - 9
- Not sure - 4

22. Is your staff support sufficient?

- Yes - 14
- Somewhat - 1
- Not sure - 1

23. Based on a review of the *Bylaws*, should some responsibilities be placed elsewhere?

- Yes, blurs with Council on Communications - 1
- Maybe - 1

- No - 12
- Not sure - 1
- No response - 1

24. Are you addressing each area of responsibility? If not, should you, or should you change the *Bylaws*?

- Responsibilities are met, and *Bylaws* are appropriate - 9
- Not sure - 3
- No - 2
- Changing *Bylaws* is not an effective use of time - 1
- No response - 1

25. Is each item an efficient use of your time?

- Yes - 11
- No/Not always, i.e. DecisionLens - 1
- Some are/Some are not - 3
- Improving - 1

26. Which items can be handled in other ways – conference calls, consent, etc.?

- Not sure - 4
- None - 6
- No response - 3
- Future meeting dates - 1
- Video conferencing - 1
- Provide executive summaries and action item questions - 1
- More discussion topics - 1

27. What are you doing which is “down in the weeds,” operational as opposed to directional?

- Improving - 3
- Nothing/Rarely happens - 4
- Necessary at times - 1
- Don't know - 2
- Rereading reports - 1
- Pricing study - 1
- Process vs. Strategic - 2
- No response - 2

28. What can you ask staff to take over?

- Nothing (good balance) - 8
- Guidance in making decisions - 1
- Not sure - 3
- Target Tier 1 in Outreach - 1
- Reminders we are “in the weeds” - 1
- No response - 2

29. Are you spending time on big issues and strategic direction?

- Yes/Mostly - 10
- Not enough or very little - 4
- Improving - 1
- Too tactical/need more time - 1

30. Are there any additional comments you would like to offer?

No

Associations, ADA Membership and Dentists are all part of an ever evolving dynamic. Like the cork on the water we will have highs and lows during this time. Our goal is to figure out how to ride the Crest (highs) of the swells and not get caught in the Bottom (lows).

No

Change council meeting time of year to be late fall and early spring to best coincide with HOD resolution actions and strategic and budgetary planning for the next year (fall), and to hear complete year end reports and create agenda, action items, resolutions and strategies for current year (spring); would like to consider reduction to one in person meeting and quarterly call, video conferences; would like to better utilize professional team to spend time doing the work vs. planning for the next in person meeting and all being at the meeting and away from the day-to-day membership needs; use ADA Connect more efficiently and regularly. Concerned when it appears that Council recommendations are not followed if conflicting with ADA staff agenda.

Reports should be consistent with council direction and actions and not offer counterpoints or make generalizations which may not correctly represent council members position; council elected by the HOD to represent the HOD and our members in fulfilling the duties as prescribed in the Bylaws.

I think the Council serves a very important role in keeping the membership strong and engaged at the ADA.

I am looking forward to the council developing and implementing an action plan.

Council right now has a good balance between staff/volunteer duties/functions. Would like to see a bit more in terms of qualifications for new members; increased use of technology to disseminate information, for meetings.

I think that this committee is essential to the ADA. Right now, we have strong leadership that is very effective and efficient at their positions. The entire committee takes their work very seriously. I would like to see more specific direction for districts who have "room for improvement" with directions on how to achieve better statistics. It is a very complex action to have laid out previous but one that needs to happen.

No

None

31. Please enter your name (optional):

- Hilton Israelson
- Steve Zuknick
- Randy Ogata
- Krista Jones
- Tom Kelly
- Mike Durbin
- Kevin Cassidy
- Mark Bauman
- Nicole Johnson
- Steven Bradley
- Bill Ingram
- No response - 5

Joint Commission on National Dental Examinations

Drisko, Connie L., 2015, Georgia, chair, American Dental Education Association
Podruch, LeeAnn G., 2014, Wisconsin, vice chair, American Association of Dental Boards
Fujimoto, Luis J., 2017, New York, American Association of Dental Boards
Gerosky, Mary Lou, 2014, Ohio, American Dental Hygienists' Association
Hersh, Robert A., 2015, New Jersey, American Dental Association
Lee, Jiwon, 2014, New York, American Student Dental Association
Levitan, Marc E., 2016, South Carolina, American Dental Education Association
Licari, Frank W., 2017, Utah, American Dental Education Association
McVea, Conrad P., III, 2016, Louisiana, American Association of Dental Boards
Murray, Rhett L., 2017, Colorado, American Dental Association
Parker, Patricia A., 2017, Oregon, American Association of Dental Boards
Perkins, David W., 2017, Connecticut, American Association of Dental Boards
Peterson, Lorin D., 2014, Washington, American Dental Association
Shannon, Kelley, 2014, Washington, DC, Public Member
VanderVeen, M. Reggie, 2015, Michigan, American Association of Dental Boards

Waldschmidt, David M., secretary
Hinshaw, Kathleen J., senior manager
Ryske, Ellen, manager
Yang, Chien-Lin, manager

The Joint Commission's 2013-2014 liaisons and observers include: Dr. Brian E. Scott (first vice president, Board of Trustees) and Kristopher Mendoza (American Student Dental Association, student observer).

Purpose

The Joint Commission on National Dental Examinations (JCND E) 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

At its April 2014 meeting, the Joint Commission accomplished the following:

Budget Proposal and Fees. Approved the Joint Commission's budget proposal, including 2015 application fees and score report request fees. The total examination fees charged in 2015 to candidates will be \$420 for the National Board Dental Examination (NBDE) Part I, \$465 for the NBDE Part II, and \$410 for the National Board Dental Hygiene Examination (NBDHE). Candidates from non-accredited institutions will be assessed an additional \$100 processing fee at the time of application. Score report request fees in 2015 will be \$34.

National Board Dental and Dental Hygiene Examinations. Reaffirmed the Joint Commission's commitment to the quality and validity of its current examination programs (NBDE Parts I and II, NBDHE). This includes the following:

- *Practice Analysis for the NBDHE.* Approved an updated practice analysis approach for the NBDHE. Practice analyses are used to help determine the content that appears on an examination.

- *Standard Setting for NBDE Parts I and II.* Approved updating the Joint Commission's approach to standard setting activities for the NBDE Parts I and II. Standard setting activities are used to help determine the passing score for an examination.
- *Cognitive Levels.* Affirmed the Joint Commission's existing practices with respect to the use of cognitive levels within test construction committee meetings. Cognitive levels are used by the Joint Commission to encourage quality item development.
- *Fairness and Sensitivity Considerations.* In accordance with the Joint Commission's policy of building examination content that treats individuals fairly and with sensitivity, approved enhanced training to Test Construction Committee members concerning fairness and sensitivity considerations in examination development.
- *Integrated National Board Dental Examination (INBDE) Enhancements.* Approved incorporating various enhancements identified for the INBDE, directly into the Joint Commission's current examinations, where appropriate.
- *Case Materials.* Approved investigation into the quality of case materials—particularly, radiographic images—to identify activities to improve the quality of those materials.
- *Test Constructor Appointments.* 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 2015.
- *Technical Reports.* Approved the 2013 editions of the NBDE and NBDHE Technical Reports.
- *Research Projects.* Approved a list of additional 2014 and 2015 research and development projects and expenditures.

*Integrated National Board Dental Examination (INBDE).*¹ Approved two key reports pertaining to the INBDE, a written examination that will supplant NBDE Parts I and II in the future. The first report provided operational recommendations in the following areas:

- The Concepts of Integration, Clinical Relevance, and Examination Purpose
- Item Presentation Considerations Involving Content
- Language Conventions
- Administration Conditions
- Item Writing Standards
- Item Content Standards
- Item Writing/Review Process
- Item Classification/Tagging Approach
- Field Testing Approach

The second report presented INBDE model examination items, which are intended to serve as prototypes of items that could appear on the INBDE. The Joint Commission is now positioned to begin item development for an INBDE field test. The Joint Commission will provide stakeholders and communities of interest with at least four years' advance notice prior to formal implementation of the INBDE.

Joint Commission Standing Rules and Examination Regulations. Adopted proposed revisions to the Joint Commission's Standing Rules and Examination Regulations. This includes editorial modifications to clarify language within each document and align language more closely with prior Joint Commission decisions. The following clarifications/changes are noteworthy:

- *Role of Validity in Appeals and Accommodations.* The Joint Commission affirmed that the predominant consideration with respect to appeal and testing accommodations decisions concerns the validity of examination results.

¹ As a reminder, the purpose of the NBDE Parts I and II is to assist state boards of dentistry in determining the qualifications of individuals who seek licensure to practice dentistry. The JCNDE is developing the 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 written examination.

- *Eligibility Revocation.* A candidate's eligibility to take an examination may be revoked if the Joint Commission has reason to believe that the candidate is taking an examination for purposes other than National Board certification.
- *Privacy Policy.* The Joint Commission has updated its privacy policy to permit the Joint Commission to release examination results—with personally identifying information removed—to legitimately interested parties for research and policy making purposes.
- *Test Constructor Qualifications.* To provide more timely review and revision of the qualifications for Test Construction Committee members, Test Constructor Qualifications will be removed from the Standing Rules and placed in a new document titled: Qualification Requirements for National Board Dental and Dental Hygiene Test Constructors.
- *Penalties Concerning Unreleased Examination Content.* Candidates who receive information concerning unreleased examination content should destroy the information immediately without reviewing it. Candidates who have been found to be in possession of such information—or to have participated in the distribution of this information—may have their examination results voided. Penalties may be imposed subsequent to discovery and investigation of the original incident, which may occur years after the incident itself.

Revisions to Examination Regulations are effective immediately; revisions to Joint Commission Standing Rules are contingent upon approval by the ADA House of Delegates. The Joint Commission recommends that the following resolution be adopted by the 2014 House of Delegates:

20. Resolved, that the *Standing Rules* of the Joint Commission on National Dental Examinations be approved as revised in Appendix 1 of the Joint Commission's 2014 annual report.

Approved the following in support of communities of interest:

- *ASDA Licensing Renewal.* Approved a three-year renewal of the Joint Commission's licensing agreement with the American Student Dental Association (ASDA) concerning sales of NBDE released item content.
- *12-Month Retest Requirement.* Approved a resolution requesting that the Committee on Administration—in consultation with the American Dental Education Association (ADEA) and other appropriate stakeholders—investigate modifications to or the elimination of the 12-month retest requirement and report back to the Joint Commission with its recommendation.
- *Use of Released Materials by Educational Programs.* Approved procedures for granting permission for use of the Joint Commission's released examination materials by dental and dental hygiene educational programs.
- *Use of Content 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.
- *Sales of Dental Hygiene Released 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 actions consistent with the Joint Commission's mission to serve as a leader and resource on assessment for the oral health care profession:

- *Dental Therapy Accreditation Standards.* Directed staff to monitor the activities of the Commission on Dental Accreditation (CODA) as it develops accreditation standards for dental therapy education programs.
- *Joint Commission Self-Assessment.* Approved the Joint Commission's self-assessment for transmittal to the ADA House of Delegates per Resolution 1H-2013.
- *Innovative Dental Assessment (IDEA) Grant Program.* Sunset the Joint Commission's IDEA Grant Program, effective April 9, 2014. This program was no longer meeting its intended goals.
- *Joint Commission Elections.* Elected Dr. Robert A. Hersh as chair and Dr. M.H. Reggie VanderVeen as vice chair of the Joint Commission. Their terms will begin in October 2014.

- *Meeting Dates.* The previously approved meeting date for 2015 is April 29. At its April 2014 meeting, the Joint Commission approved April 13, 2016, as the scheduled meeting date for 2016.

The following initiatives were pursued to enhance and improve the services provided:

- *New Item Bank Vendor (Zoomorphix).* This was a multi-year project that provided a more powerful and user friendly item bank for the department and test construction committees.
- *New Software Infrastructure Platform (Aptify).* The Joint Commission's previous platform (SAS) was DOS based and highly fragmented, involving 15 separate software programs. The Joint Commission's transition to Aptify not only included these 15 programs, but also migration of over 30 years of historical data. The transition to Aptify has required considerable and painstaking effort, but has created a level of standardization and uniformity that was not previously available. These improvements have not only enhanced daily operational procedures, but also the user experience as well.
- *Website Updates and Phase Two Aptify (E-Business).* Initial planning and design for enhancements to the Joint Commission's website and phase two of the Aptify launch (e-business) began in late 2013. The website has been revised to create a more user-friendly experience and to align with the ADA.org website redesign, which improves online access for smartphone and tablet users. E-business further involves the redesign of the user experience components of the website (applications, score report requests, documents, etc.). The enhancements are scheduled to be completed by the fourth quarter of 2014.

Emerging Issues and Trends

The following presents trends in performance on the National Board Dental and Dental Hygiene Examinations over a 10-year period beginning in 2004. 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. Generally speaking, Table 1 shows smooth and steady growth in the number of first-time candidates from accredited programs taking NBDE Part I across the 10-year period indicated. The year 2007 represents the exception to this trend, with a 10-year low of just 4,179 candidates. The total number of first time candidates from non-accredited programs also increased during this 10-year timeframe, with 2013 representing the peak at 1,919 candidates. The total number of administrations (i.e., first-time candidates and repeating candidates from accredited and non-accredited programs) increased from 7,722 in 2004 to 8,939 in 2013. This represents an overall increase of 1,217 candidates (i.e., 15.8%). 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.

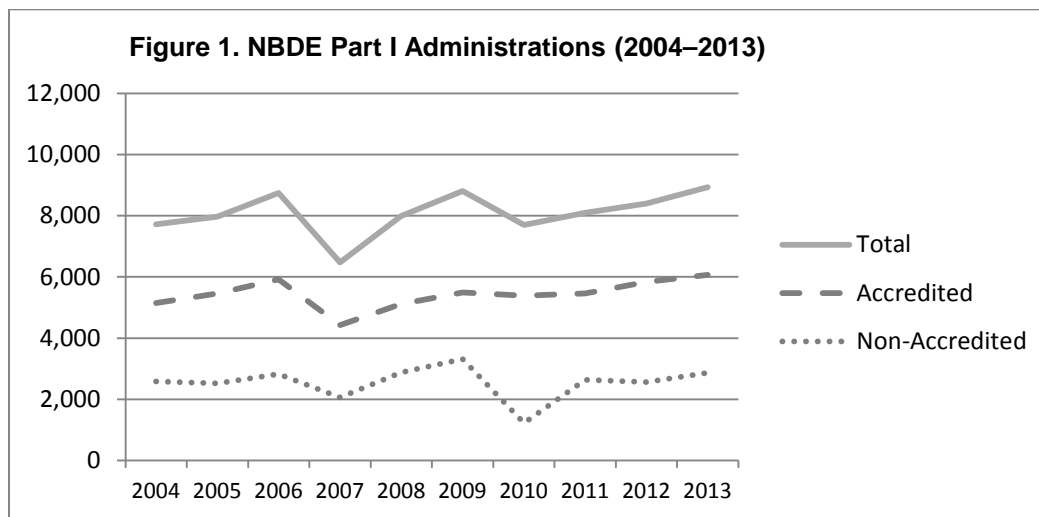
In interpreting this table, note that effective 2007, NBDE Part I became a comprehensive examination that was no longer administered in four sections based on subject matter. Prior to 2007, candidates had to pass all four sections in order to pass the examination. Additionally, effective 2010, candidates who have passed NBDE Part I may not retake the examination unless required by a state board or relevant regulatory agency.

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
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
2013	5,571	6.3	502	30.3	1,919	36.1	947	63.1	8,939	20.1

*From 2004 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 around 4,000), jumped precipitously in 2007, and then showed continued growth through 2011. Volume decreased from 2011 to 2012, and then increased in 2013 to a 10-year high (5,328). There has been quite a bit of variability since 2006, ranging from a low of 3,775 candidates in 2006 to a high of 5,328 in 2013 (i.e., a 41% increase). The total number of first-time and repeating candidates from non-accredited programs increased from 1,285 in 2004 to 1,720 in 2013. Comparing the number of total administrations occurring in 2004 (6,078) with 2013 (7,511) shows a 24% increase in overall administration volume, with gains occurring in both accredited and non-accredited candidates.

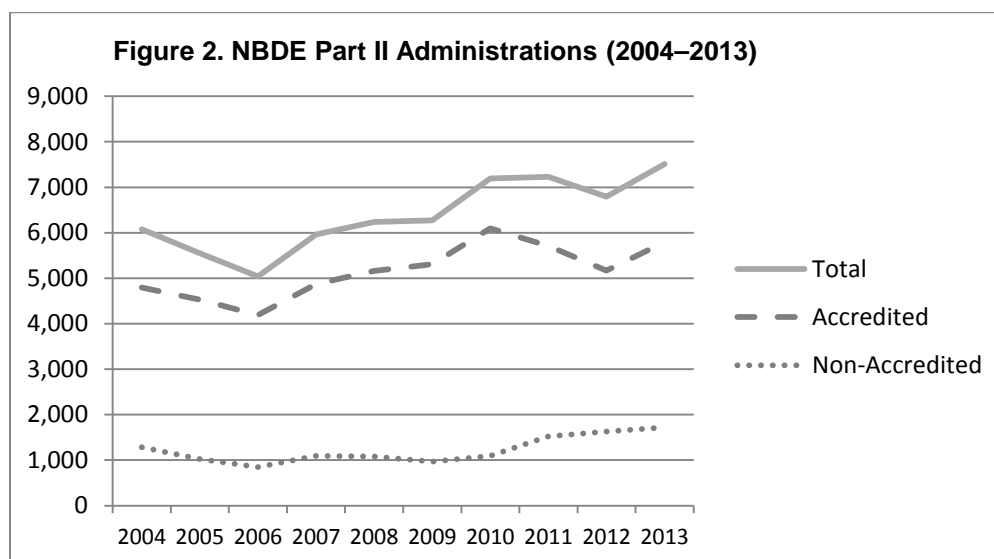
Concerning NBDE Part II failure rates, the Joint Commission recognized an increase in the failure rate from 2008 to 2009. The Joint Commission reviewed procedures and protocols associated with the

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, effective in 2010 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 first-time candidates from accredited programs was 6.3% in 2013; this represents a decrease relative to 2009 (13.7%), but an increase relative to 2012 (5.6%).

TABLE 2
Numbers and Failure Rates for First-time and Repeating Candidates
NBDE Part II

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
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
2013	5,328	6.3	463	22.0	1,204	36.4	516	53.3	7,511	15.3

* A new standard was introduced this year, based on updated standard setting activities.



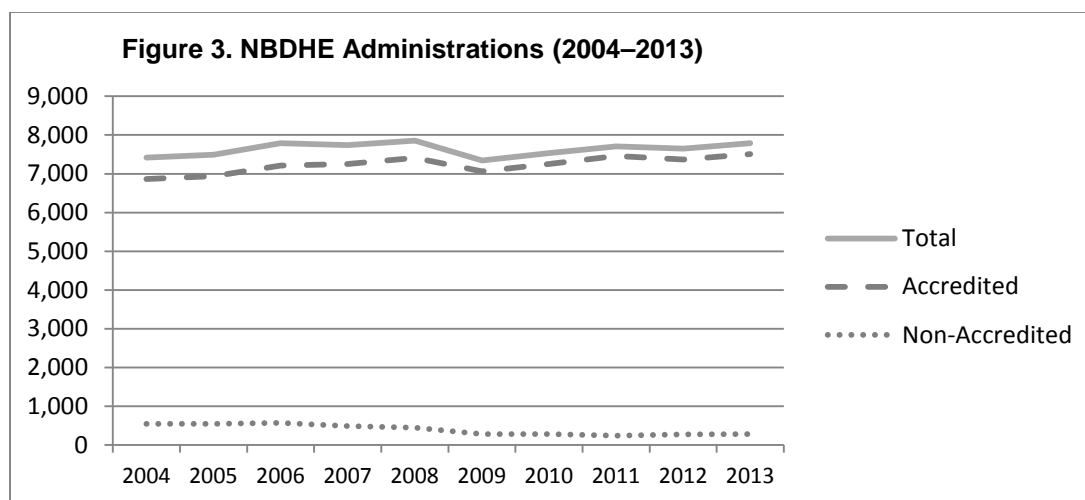
NBDHE: Table 3 presents failure rate trends for the National Board Dental Hygiene Examination (NBDHE) over the past 10 years, while Figure 3 provides a graphic depiction of administration volume. As shown in Table 3, the number of first-time candidates from accredited programs increased from 6,065 in 2004 to 7,016 in 2013 (i.e., a 16% 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 7% of administrations occurring in 2004 and approximately 4% of administrations occurring in 2013. Comparing the number of total administrations occurring in 2004 with 2013 shows an overall increase of 373 first-time and repeating candidates from accredited and non-accredited programs (i.e., a 5% increase). Generally speaking, NBDHE total administration volume has been quite stable over the 10-year period indicated.

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 much higher, ranging from 17.3% in 2013 to 66.2% in 2004. The general trend shows a substantial decrease in failure rates for first-time candidates from non-accredited programs, over the 10-year period.

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
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
2013	7,016	4.8	489	45.8	231	17.3	52	53.9	7,788	8.1

* A new standard was introduced this year, based on updated standard setting activities.



Responses to House of Delegates Resolutions

58H-2013. Joint Commission on National Dental Examinations Standing Rules Revisions (Trans.2013:330)

Joint Commission Response: Appropriate documents have been corrected to reflect the amended *Standing Rules*.

Self-Assessment

The Joint Commission has conducted a self-assessment (Appendix 2) as requested per Resolution 1H-2013 (*Trans.2013:339*). The Joint Commission concluded that it continues to play a critical and unique public service role in helping state dental boards to assess the qualifications of licensure candidates for dentistry and dental hygiene. The structure and responsibilities defined within the *ADA Bylaws* remain appropriate and are being carried out effectively. The Joint Commission includes appropriate representation from stakeholders and communities of interest, and the Joint Commission's examinations continue to be accepted by all U.S. state boards. Over 24,000 examinations were administered by the Joint Commission in 2013. It is vital that the Joint Commission continue to maintain its independence in decision making and its semi-autonomous status. From an operational perspective, the Joint Commission believes that its decision-making process is efficient and that volunteer time has been optimized. Detailed discussion and projects are referred to the Joint Commission's four standing committees, and test construction activities are delegated to Test Construction Committees. Ad hoc committees are appointed as needed. Day-to-day operations are appropriately delegated to staff. The Joint Commission monitors its need for resources and takes actions accordingly. The Joint Commission recognizes that quality and innovation are essential to the validity and clinical relevance of the Joint Commission's examination programs, which have tremendous impact on public health.

Summary of Resolutions

Resolution 20. Revisions to the Standing Rules of the Joint Commission on National Dental Examinations

Commission Actions

For more information on recent activities, see the Joint Commission's Unofficial Report of Major Actions on ADA.org: <http://www.ada.org/en/jcnde/news-resources/unofficial-reports>.

Appendix 1. Revisions to Standing Rules of the Joint Commission on National Dental Examinations

STANDING RULES

PROPOSED CHANGES TO DOCUMENT

Underline indicates text that has been inserted.

~~Strikeout~~ indicates text that has been deleted.

April 20132014

A publication of the Joint Commission on National Dental Examinations
American Dental Association Building
211 East Chicago Avenue, Suite 600
Chicago, Illinois 60611-2637

The Joint Commission on National Dental Examinations operates within the limits imposed by three documents, listed here in order of precedence:

1. Bylaws of the American Dental Association
2. Bylaws of the Joint Commission on National Dental Examinations
3. Standing Rules for Councils and Commissions

Subject to constraints defined in these documents, the Joint Commission is free to establish its own policies and procedures for the conduct of its business. Such policies and procedures as have been adopted are compiled here.

TABLE OF CONTENTS

Election of a Public Member	43
Qualifications	43
Term	43
Identification of Nominees	43
Roles of Committees	43
Assignments	54
Committee on Administration	54
Committee on Dental Hygiene	54
Committee on Examination Development	54
Committee on Research and Development	5
Committee Actions	65
Reporting	65
Criteria for Dental Test Constructors	6
Part I Test Construction Committees	7
Anatomic Sciences	7
Biochemistry Physiology	7
Microbiology Pathology	7
Dental Anatomy and Occlusion	8
Testlet Development	8
Consultant Review	8
Part II Test Construction Committees	8
Operative Dentistry	8
Pharmacology	8
Prosthodontics	8
Oral and Maxillofacial Surgery Pain Control	9
Orthodontics Pediatric Dentistry	9
Endodontics	9
Periodontics	9
Oral Diagnosis	9
Patient Management	9
Full-Time Practitioners	9
Component B	10
Case Selection	10
Consultant Review	10
Criteria for Dental Hygiene Test Constructors	10
Basic Sciences	10
Radiology	10
Periodontics	11
Oral Medicine/Oral Diagnosis	11
Special Needs Professional	11
Dental Hygiene Curriculum	11
Clinical Dental Hygiene	11
Community Dental Health	11
Dental Hygiene Test Construction Committees	11
Case Selection	12
Consultant Review	12

<u>Test Constructor Selection Criteria</u>	<u>6</u>
Detection of Irregularities Based on Forensic Analyses	136
Definitions	13
Criteria for Withholding Scores.....	13
Limited Right of Appeal for Examination Candidates	136
Conflict of Interest Policy	147
Assistance to Other Agencies	157
Availability	157

ELECTION OF A PUBLIC MEMBER

The Joint Commission is charged with electing a public member to serve as a commissioner. Policies relating to election are as follows:-

Qualifications

The public member shall not be a(n):

- a. Dentist
- b. Dental hygienist
- c. Dental student
- d. Dental hygiene student
- e. Faculty member of an ~~accredited~~ dental school or dental hygiene program
- f. Employee of the Joint Commission
- g. Member of another health profession
- h. Professional who has represented the Joint Commission, dental profession, or dental hygiene profession for a fee in the last five years
- i. Spouse of any of the above

Not more than five percent of the public member's income shall be derived from the Joint Commission, dentistry, or dental hygiene.

It is suggested that the public member not be employed by a firm with a substantial interest in dentistry or dental hygiene, and that the public member be experienced in health issues, testing, credentialing, ~~or advocating the interest of the public~~ and/or advocating for the interests of the public. Individuals wishing to serve as the public member must disclose in their application materials any financial benefits they may be receiving from the Joint Commission's examination programs.

Term

The public member will serve a single four-year term.

Identification of Nominees

When a new public member is needed, nominations will be requested from appropriate agencies, such as state boards of dentistry and public service organizations. Each nominee will be requested to supply a summary of his or her qualifications. At least two qualified nominees will be identified prior to conducting ~~of~~ an election.

ROLES OF COMMITTEES

~~Four~~ The following four Joint Commission standing committees meet in conjunction with the annual meeting of the Joint Commission. ~~They are:~~

- a. Committee on Administration
- b. Committee on Dental Hygiene
- c. Committee on Examination Development
- d. Committee on Research and Development

Each committee is assigned a portion of the materials to be considered by the Joint Commission, and is responsible for formulating specific recommendations for Joint Commission action.

Assignments

Assignment of topics to specific committees is the responsibility of the Joint Commission Chair, but this responsibility may be delegated in part or in total to the Secretary. Listed and discussed below are examples of topics that are typically assigned to each committee.

A topic may be assigned to more than one committee. In addition, provided that it completes its assigned items, a committee may consider a topic assigned to a different committee.

Committee on Administration

This committee's responsibility relates to both National Board Dental Examinations and the National Board Dental Hygiene Examination. The committee deals with operations. Specific topics to be considered include:

- a. Examination security, including procedures for examination administration
- b. Examination regulations
- c. Joint Commission Bylaws and Standing Rules
- d. Finances, including an annual comparison of income and expenses

Committee on Dental Hygiene

This committee's responsibility relates primarily to the National Board Dental Hygiene Examination. Specific topics to be considered include:

- a. Examination content and specifications
- b. Test construction procedures, including nomination of test constructors and establishment of qualification requirements
- c. Information circulated to publicize or explain the testing program
- d. Portions of Examination Regulations that affect dental hygiene candidates
- e. Matters pertaining to finances, ADA and Joint Commission Bylaws, and Joint Commission Standing Rules that affect the National Board Dental Hygiene Examination

Committee on Examination Development

This committee's responsibility relates primarily to the National Board Dental Examinations. Specific topics to be considered include:

- a. Examination content and specifications
- b. Test construction procedures, including nomination of test constructors and establishment of qualification requirements
- c. Information circulated to publicize or explain the testing program
- d. Portions of Examination Regulations that affect dental candidates
- e. Matters pertaining to finances, ADA and Joint Commission Bylaws, and Joint Commission Standing Rules that affect the National Board Dental Examinations

Committee on Research and Development

This committee's responsibility relates to both the National Board Dental Examinations and

the National Board Dental Hygiene Examination. Topics considered by this Committee include any research ~~or~~and developmental activities related to the ~~E~~examinations.

Committee Actions

A committee is expected to consider and report on all assigned topics. For most topics, committee actions are to be presented in the form of recommendations for Joint Commission action. ~~The F~~Following are three exceptions:

- a. A decision about the manner in which a committee approaches its assignment ~~for~~For example, a change in the personal data form for potential test constructors— need not be reported.
- b. Identification of background materials requested ~~for~~to inform future deliberations may be reported as informational without an accompanying recommendation. If compilation of needed background materials requires substantial resources, however, a specific recommendation for action is appropriate.
- c. A decision not to act may be reported as an informational item. If the topic has generated substantial outside interest, however, a recommendation not to act is appropriate so as to allow the Joint Commission to affirm the committee's decision.

Reporting

Background information prepared for Committee deliberations is circulated to all Commissioners and all Committee members. Exceptions are: as follows: 1) information about a nominee to a test construction committee is provided only to the committee charged with screening nominees and 2) technical reports provided as background for the Committee on Research and Development.

Committee reports are provided to the Joint Commission in written or electronic form. Topics are discussed in the order they are listed on the Joint Commission's agenda, and background information related to each topic is identified. For each recommendation, ~~a~~the report should include a brief summary or rationale. An exception is made in that no rationale is expected for appointment of a test constructor. Instead, an alternate is named for each newly proposed test constructor.

Preparation and presentation of a committee's report is the responsibility of each committee's Chair. Preparation may be delegated to a staff ~~secretary~~member assigned to the committee. If the committee Chair is not a commissioner or if, for some other reason, the committee Chair is not present at the Joint Commission's annual meeting, responsibility for presenting the report may be delegated to a commissioner who has served on that committee.

Committee reports are presented orally, stopping for action as needed. At each stop for action, the presenter represents the committee's views through his or her answers to questions. Only after ensuring that the committee's views have been represented adequately may the presenter impart any personal views.

TEST CONSTRUCTOR SELECTION CRITERIA FOR DENTAL TEST CONSTRUCTORS

The Joint Commission selects consultants to serve on its Dental and Dental Hygiene Test Construction Committees. A test constructor is appointed for a one-year term and may be reappointed to four consecutive terms. To be considered for appointment, ~~a person~~candidates must possess appropriate qualifications and must submit a completed personal data form.

~~Someone~~ Test constructor qualifications are published in the Joint Commission's *Qualification Requirements for National Board Dental and Dental Hygiene Test Constructors*. Test Constructors who ~~have~~ completed five years of service on a committee will not be considered for reappointment to the same committee.

~~The following are the criteria for test constructors on Anatomic Sciences, Biochemistry/Physiology, Microbiology/Pathology, Dental Materials, Pharmacology, Patient Management, and Testlet Development Committees:~~

- ~~a. Dentist with a master's degree in that biomedical science OR a professional with a doctoral degree in that biomedical science.~~
- ~~b. Three years of experience within the last five years teaching or in research in that biomedical science.~~

~~The following are the criteria for test constructors on Dental Anatomy and Occlusion, Operative Dentistry, Prosthodontics, Oral and Maxillofacial Surgery/Pain Control, Orthodontics/Pediatric Dentistry, Endodontics, Periodontics, and Oral Diagnosis Committees:~~

- ~~a. Dentist~~
- ~~b. In the case of special areas of dentistry, graduation from an accredited advanced education program in that specialty.~~

Part I (Component A) Test Construction Committees

Anatomic Sciences

~~This five member committee includes the following. At least one of the four subject-matter experts must be a dentist.~~

- ~~a. Gross anatomists (2)~~
- ~~b. Histologists (2); including one whose expertise is embryology and one whose expertise is neuroanatomy~~
- ~~c. Full-time practitioner (1)~~

Biochemistry/Physiology

~~This five member committee includes the following. At least one of the four subject-matter experts must be a dentist.~~

- ~~a. Biochemists (2)~~
- ~~b. Physiologists (1)~~
- ~~c. Full-time practitioner (1)~~

Microbiology/Pathology

~~This five member committee includes the following. At least one of the four subject-matter experts must be a dentist.~~

- ~~a. Microbiologists (2); including one whose expertise is immunology~~
- ~~b. Pathologists (2)~~
- ~~c. Full-time practitioner (1)~~

Dental Anatomy and Occlusion

~~This four member committee consists of 4 dentists who are:~~

- ~~a. Dental anatomists (3)~~
- ~~b. Full-time practitioner (1)~~

Part I (Component B) Test Construction Committees

Testlet Development

~~This nine member committee consists of:~~

- ~~_____ a. Dental educators representing the various discipline areas, and all of who should already have served on a Part I discipline-based committee. (5)~~
- ~~_____ b. Dental practitioners representing each of the discipline-based Part I committees. (4)~~

Consultant Review

~~This committee is responsible for reviewing the discipline-based (Component A) and testlet-based (Component B) components of the Comprehensive Part I examinations to ensure the examinations adhere to test specifications and item guidelines outlined by the Joint Commission. The composition of this two member committee varies between the dental-discipline experts and practitioners. Members of this committee should already have served on a Component A committee.~~

Part II (Component A) Test Construction Committees

Operative Dentistry

~~This five member committee consists of:~~

- ~~a. Restorative/operative dentists (3)~~
- ~~b. Expert in dental materials (1)~~
- ~~c. Full-time practitioner (1)~~

Pharmacology

~~This four member committee consists of:~~

- ~~a. Pharmacologists (3), one who is a dentist~~
- ~~b. Full-time practitioner (1)~~

Prosthodontics

~~This six member committee consists of:~~

- ~~a. Prosthodontists (4), two with expertise in fixed prosthodontics and two with expertise in removable partial/complete prosthodontics~~
- ~~b. Expert in dental materials (1)~~
- ~~c. Full-time practitioner (1)~~

Oral and Maxillofacial Surgery/Pain Control

~~This four member committee consists of:~~

- ~~a. Oral and maxillofacial surgeons (3), at least one with expertise in pain control~~
- ~~b. Full-time practitioner (1)~~

~~Orthodontics/Pediatric Dentistry~~

~~This six member committee consists of:~~

- ~~a. Orthodontists (3)~~
- ~~b. Pediatric dentists (2)~~
- ~~c. Full-time practitioner (1)~~

~~Endodontics~~

~~This four member committee consists of:~~

- ~~a. Endodontists (3)~~
- ~~b. Full-time practitioner (1)~~

~~Periodontics~~

~~This four member committee consists of:~~

- ~~a. Periodontists (3)~~
- ~~b. Full-time practitioner (1)~~

~~Oral Diagnosis~~

~~This six member committee consists of:~~

- ~~a. Oral pathologists (2)~~
- ~~b. Oral and maxillofacial radiologists (2)~~
- ~~c. Dentist with advanced education in oral diagnosis (1)~~
- ~~d. Full-time practitioner (1)~~

~~Patient Management~~

~~This eight member committee consists of:~~

- ~~a. Dental public health specialists (2)~~
- ~~b. Dentist with advanced education in special needs (1)~~
- ~~c. Behavioral scientists (3), at least one who must be a dentist~~
- ~~d. Full-time practitioners (2)~~

~~Full-time Practitioners~~

~~A full-time practitioner is a currently licensed dentist (not necessarily a specialist) in the United States, practicing dentistry full-time (30 to 40 hours per week) for at least 10 years.~~

~~Part II (Component B) Test Construction Committee~~

~~Component B~~

This committee develops the case-based items for the Comprehensive Part II examination. This thirteen member committee consists of:

- a. Members representing the dental disciplines, all of who have served on a Part II Component A committee (10)
- b. General practitioners with experience in preparing educational or licensure examinations (2)
- c. Behavioral scientist (1)

Case Selection

As an adjunct to the Component B committee, this committee does the preliminary work of screening new patient cases, and identifying suitable cases. This committee drafts and reviews the patient histories, dental charts, and treatment plans associated with the cases. The composition of this 4 member committee varies between dental discipline experts and practitioners.

Consultant Review

This committee is responsible for reviewing the discipline-based (Component A) and case-based (Component B) components of the Comprehensive Part II examinations to ensure the examinations adhere to test specifications and item guidelines outlined by the Joint Commission. The composition of this two member committee varies between the dental discipline experts and practitioners. Members of this committee should already have served on a Component A committee.

CRITERIA FOR DENTAL HYGIENE TEST CONSTRUCTORS

The National Board Dental Hygiene Examination is constructed by committees of consultants with subject matter expertise in the following eight areas:

Basic Sciences

The basic sciences include anatomy, histology, biochemistry and nutrition, physiology, microbiology and immunology, pathology, pharmacology, and oral biology.

- a. Doctoral degree in a biomedical science, or a dentist or dental hygienist with an advanced degree in a biomedical or dental science.
- b. At least three years' experience within the last five years teaching a biomedical or dental science to dental hygiene students.

Radiology

- a. Dentist or dental hygienist with a baccalaureate degree from an accredited program.
- b. An oral and maxillofacial radiologist or a dental hygienist with formal education in dental radiology beyond what was provided in dental hygiene program.
- c. At least three years' experience within the last five years teaching radiology.

Periodontics

- a. Graduate of an accredited dental or dental hygiene program with advanced formal education or training in periodontics.

- b. ~~At least three years' experience within the last five years teaching or practicing periodontics.~~

Oral Medicine/Oral Diagnosis

- a. ~~Dentist with advanced clinical training.~~
- b. ~~At least three years of experience within the last five years teaching oral medicine/oral diagnosis.~~

Special Needs Professional

- a. ~~Dentist or dental hygienist with advanced clinical training.~~
- b. ~~At least three years of experience within the last five years teaching a clinical science.~~

Dental Hygiene Curriculum

- a. ~~Dental hygienist who has graduated from an accredited program.~~
- b. ~~Advanced degree, preferably in dental hygiene.~~
- c. ~~Experience in curriculum design as a dental hygiene program director, member of a dental hygiene curriculum committee, or accreditation consultant for dental hygiene.~~
- d. ~~At least three years' experience within the last five years teaching to dental hygiene students.~~

Clinical Dental Hygiene

- a. ~~Dental hygienist who has graduated from an accredited program.~~
- b. ~~Baccalaureate degree in dental hygiene, education, or a biomedical science.~~
- c. ~~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.~~

Community Dental Health

- a. ~~Dentist or dental hygienist who has graduated from an accredited program.~~
- b. ~~Advanced degree in public health or related field.~~
- c. ~~At least three years' experience within the last five years in a public health position or teaching community and public health courses to dental or dental hygiene students.~~

Dental Hygiene Test Construction Committees

Three dental hygiene Component A committees (total of 15 members) and a dental hygiene Component B committee (8 members) construct the National Board Dental Hygiene Examination.

Component A Committees

_____ Dental Hygiene I

- a. ~~Basic science experts (3)~~
- b. ~~Dental hygiene curriculum expert (1)~~

Dental Hygiene II _____

- a. ~~Periodontists (3), at least one who must be a dentist~~

- b. ~~Dental hygiene curriculum expert (1)~~
- c. ~~Clinical dental hygiene experts (2)~~
- d. ~~Oral and Maxillofacial Radiologist or dental hygienist with formal education in radiology (1)~~

~~Dental Hygiene III~~

- a. ~~Dental Hygiene Curriculum expert (1)~~
- b. ~~Clinical Dental Hygiene expert (1)~~
- c. ~~Community Dental Health experts (2)~~

Component B Committees

~~Component B~~

- a. ~~Basic science expert (1)~~
- b. ~~Dental hygiene curriculum expert (1)~~
- c. ~~Clinical dental hygiene expert (1)~~
- d. ~~Community dental health expert (1)~~
- e. ~~Oral medicine/oral diagnosis expert (1)~~
- f. ~~Periodontist (1)~~
- g. ~~Oral and Maxillofacial radiologist or dental hygienist with formal education in radiology (1)~~
- h. ~~Special needs expert (1)~~

Case Selection

~~Members from various dental hygiene disciplines (4)~~

Consultant Review

~~Members from the various dental hygiene disciplines, one of which must be a dentist (4)~~

~~Members on these Component B committees should have already served on a Dental Hygiene Component A committee.~~

DETECTION OF IRREGULARITIES BASED ON FORENSIC ANALYSES

Definitions

The Joint Commission is responsible for protecting the integrity of National Board Examination scores~~results~~. One method used is to ~~withhold scores that reflect unrealistic response patterns.~~ Procedures for withholding scores are listed in the Examination Regulations for National Board Examinations.

~~Statistical criteria for withholding scores are based on the response patterns~~involves forensic analyses of candidates ~~or the performance of candidates on the overall examination.~~ Potential to detect irregularities and aberrant response patterns. may include, but are not limited to, the following:

Aberrant results: ~~Inconsistent response patterns as measured by response aberrance index (e.g., answering difficult questions correctly and missing easy questions).~~

~~**Latency aberrance:** Candidates with inconsistent or inappropriate use of time in responding to items.~~

~~**Perfect tests:** Two or more candidates with identical test results or perfect tests.~~

~~**Unrealistic similarity:** Two or more candidates who have more identical wrong answers than different wrong answers.~~

~~**Unusual gain in scores:** Candidates with unusual or artificial gains in scores in comparison to previous testing attempts.~~

Criteria for Withholding Scores

Candidate's ~~scores~~results may be withheld or, as circumstances may warrant, reported when 1) aberrant response patterns or aberrant examination performance is detected through forensic analyses or 2) ~~other information~~evidence comes to light that supports the possibility that the candidate has given or received confidential information concerning examination content during or prior to the examination. Similarly, ~~scores~~results may be withheld or reported if compelling information is available that suggests that the candidate was not testing for the intended purpose.

LIMITED RIGHT OF APPEALS FOR EXAMINATION CANDIDATES

The Joint Commission on National Dental Examinations (JCND E) recognizes that strict application of the Examination Regulations for National Board Examinations may, because of unusual circumstances, impose an unusual burden on one or more candidates. In these situations, the ~~Joint Commission~~JCND E may consider an appeal ~~for special consideration~~.

Requests for an appeal pertaining to test results must be initiated within 30 days of receiving test results or, in the case of withheld ~~scores~~results, within 30 days of receiving written notice that ~~scores~~results are being withheld. In the event that the ~~Joint Commission~~JCND E has given notice that previously released ~~scores~~results are to be invalidated or voided, the request for appeal must be submitted within 30 days of that notice. In this case, a request for appeal will stay the action to invalidate or void the ~~scores~~results until such time as the appeal is decided or the time for submitting a request for appeal has expired. A request for an appeal must be submitted in writing and must include adequate supporting documentation. The request for an appeal must indicate the specific relief requested.

A request for an appeal will first be screened by the Chair in consultation with the secretary. The Chair, ~~in~~at his/her sole discretion, may 1) ~~allow~~grant the appeal ~~(if,~~2) deny the appeal, or 3) forward the appeal to the full Joint Commission for its consideration. If during the Joint Commission's deliberations credible information becomes available indicating an error was made in the decision to withhold scores, the Chair believes that there is a reasonable basis for the ~~review~~ in consultation with the secretary may end the deliberations and grant the appeal. At his or her discretion, the Chair may delegate the screening of the facts ~~appeals to another member of the case and the procedures applied thereto), 2) deny an appeal, or 3) recommend, in consultation with the secretary, to release scores~~Joint Commission.

When considering an appeal, the Joint Commission will strive to ensure that the candidates have an opportunity to gain National Board certification equal to, but not greater than, the opportunity provided other candidates.

In rendering a decision with respect to appeals—and particularly in situations where results have been withheld—the touchstone and foremost consideration is the validity of examination results, in alignment with the purpose of the examination. The Joint Commission strives to be fair and objective in its decision making process, as it remains true to its mission. When considering appeals, the JCNDE avoids favoritism and strives to ensure that all candidates are treated equally and fairly.

If the issue presented in an appeal is likely to recur, the ~~Joint Commission~~ JCNDE may consider a change in ~~regulations. Granting its Examination Regulations.~~ The granting of an appeal will be considered a precedent only if a change in regulations is also adopted. The candidate will be notified of the ~~Joint Commission~~ JCNDE action within 60 days after receipt of the written request for the an appeal.

~~The Chair of the JCNDE, in consultation with the secretary of the JCNDE, may grant an appeal when additional, convincing information becomes available early in the appeal process that indicates an error was made in the decision to withhold scores.~~

CONFLICT OF INTEREST POLICY

Policies and procedures used in National Board testing programs should provide for fairness and impartiality in the conduct of examinations and treatment of all candidates. Central to the fairness of the JCNDE's operations and the impartiality of its decision-making process is an organizational and personal duty to avoid real or perceived conflicts of interest. The potential for a conflict of interest arises when one's duty to make decisions in the public's interest is compromised by competing interests of a personal or private nature, including but not limited to pecuniary interests. Conflicts of interest can result in a partiality or bias which might interfere with objectivity in decision-making with respect to policy, or the evaluation of candidate appeals.

~~Conflict of interest is considered to be:~~

- ~~1) Any relationship with a candidate for National Board certification, or~~
- ~~2) A partiality or bias which might interfere with objectivity in the decision-making with respect to policy or the evaluation of individual appeals to the Joint Commission.~~

The Joint Commission strives to avoid conflicts of interest ~~or~~ and the appearance of a ~~conflicts~~ in decisions regarding examination policy or individual candidate appeals. Potential conflicts of interest ~~off~~ or Commissioners include, but are not limited to:

- A professional or personal relationship or an affiliation with the individual or an organization that may create a conflict or the appearance of a conflict.
- Being an officer or administrator in a dental education program, testing agency, or board of dentistry with related decision-making influence regarding a candidate for National Board certification.

To safeguard the objectivity of the Joint Commission, it is the responsibility of any Commissioner to disclose any potential conflicts. Any member with a direct conflict of interest must recuse himself/herself from the decision-making process regarding candidate appeals, or from discussions involving policies that impact the fairness and impartiality of the JCNDE's examination programs.

ASSISTANCE TO OTHER AGENCIES

One of the duties of the Joint Commission is to serve as a resource for the dental profession in the area of developing written examinations for licensure. ~~The~~This charge is fulfilled by providing assistance to state boards of dentistry and to national and international dental organizations. This policy statement describes limitations on availability.

Availability

Operation of ~~the~~ the National Board ~~e~~Examinations is the Joint Commission's primary charge. Assistance is provided to ~~a~~ a state boards s of dentistry or national dental organizations s only upon request and only if the Joint Commission possesses the resources to fulfill the request.

If the Joint Commission is forced to select agencies to receive assistance, highest priority will be given to state boards of dentistry that accept National Board scores. For dental organizations in the U.S. and its territories, assistance is limited to consultation and sharing general information about Joint Commission policies and procedures. Requests for testing services will be referred to the ADA Department of Testing Services or other organizations or individuals that provide such services.

Appendix 2. The Joint Commission on National Dental Examinations 2014 Self-Assessment

Introduction

The Joint Commission on National Dental Examinations (JCNDE or “Joint Commission”) is pleased to participate in the self-assessment process authorized by the House of Delegates of the American Dental Association (ADA). The Joint Commission recognizes the usefulness of implementing a periodic checkpoint to ensure goals remain relevant and are being achieved, and that activities are optimized to make the best use of available resources.

Self-Assessment Process

The process for conducting this self-assessment was as follows:

- The initial self-assessment was performed by the vice chair and standing committee chairs of the Joint Commission¹, with assistance from staff. The format and questions provided by the ADA Board of Trustees was used, and a draft report developed.
- Each of the standing committees in turn considered these questions and the draft report. Committee members provided input, which was incorporated into an addendum report.
- The draft report and addendum report were subsequently reviewed and discussed by the full Joint Commission at its annual meeting on April 9, 2014.
- The Joint Commission issued a resolution adopting the content of the reports, directing staff to consolidate the material into a final report, and authorizing the final report's submission—subsequent to final review by the vice chair—to the ADA Board of Trustees and the ADA House of Delegates, per Resolution 1H-2013.

Joint Commission Bylaws Duties

The *Bylaws* of the American Dental Association indicate that the duties of the Joint Commission on National Dental Examinations shall be to:

- Provide and conduct written examinations, exclusive of clinical demonstrations for the purpose of assisting state boards of dental examiners in determining qualifications of dentists who seek license to practice in any state or other jurisdiction of the United States. Dental licensure is subject to the laws of the state or other jurisdiction of the United States and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.
- Provide and conduct written examinations, exclusive of clinical demonstrations for the purpose of assisting state boards of dental examiners in determining qualifications of dental hygienists who seek license to practice in any state or other jurisdiction of the United States. Dental hygiene licensure is subject to the laws of the state or other jurisdiction of the United States and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.
- Make rules and regulations for the conduct of examinations and the certification of successful candidates.
- Serve as a resource of the dental profession in the development of written examinations.

Joint Commission Mission and Examination Programs

In keeping with these outlined bylaws duties, the mission statement adopted by the Joint Commission (2009) is as follows:

The JCNDE develops and conducts highly reliable, state of the art cognitive examinations that assist regulatory agencies in making valid decisions regarding licensure of oral health care professionals, develops and implements policy for the orderly, secure, and fair

¹ The Joint Commission chair was unable to participate in this self-assessment due to health reasons, and delegated this task to the vice chair.

administration of its examinations, and is a leader and resource in assessment for the oral health care profession.

Joint Commission Examination Programs

In fulfillment of its duties the Joint Commission oversees three examination programs, collectively referred to as the National Board Examinations:

- National Board Dental Examination (NBDE) Part I
- National Board Dental Examination (NBDE) Part II
- National Board Dental Hygiene Examination (NBDHE)

The content of each National Board Examination is developed and reviewed by Test Construction Committees (TCCs). The members of these committees are volunteers who serve as subject matter experts (e.g., general dentists, faculty of dental schools or dental hygiene programs). These committees are facilitated by assessment specialists (Joint Commission staff).

National Board Examinations are administered year-round at professional-level testing facilities located throughout the United States. Administration occurs through vendors under contract with the Joint Commission. These vendors administer other national high-stakes examinations and are able to provide the level of examination security required to safeguard the Joint Commission's examination programs, and the necessary geographic locations to ensure convenient access by candidates. Joint Commission staff provide support for the examination programs, including the online application and eligibility process, examination scoring and reporting, publishing Joint Commission rules and regulations, and arranging for reasonable accommodations for candidates with documented disabilities.

U.S. state boards of dentistry require successful completion of NBDE Parts I and II in order to become licensed to practice dentistry in the U.S. Similarly, state boards require successful completion of the NBDHE in order to become licensed to practice dental hygiene in the U.S.

Joint Commission Governance Structure

The governance structure of the Joint Commission is described in Attachment 1. Joint Commission duties as indicated in the ADA *Bylaws* are provided in Attachment 2. The Joint Commission's Bylaws and Standing Rules are provided as Attachments 3 and 4.

Self-Assessment Questions and Responses

The following provides the Joint Commission's responses to the questions posed by the ADA Board of Trustees.

1. Threshold Issues

a. State the primary value of your council or commission to a member.

The Joint Commission provides a critical service to the public, protecting the public health by providing information to state boards as to whether licensure candidates have the written skills and abilities necessary to safely practice dentistry or dental hygiene. While the decision to license an individual is based on multiple criteria and is ultimately the responsibility of state boards, the Joint Commission's National Board Examinations provide an impartial and independent evaluation of candidate qualifications to inform state boards' decision-making processes. The primary value of the Joint Commission to an ADA member involves helping to enhance public confidence and maintain the professional reputation of dentistry.

b. Should your council or commission continue to exist? If not, why?

The Joint Commission plays a critical role in the licensure decision making process, and should continue to oversee the development and administration of the National Board Dental and Dental Hygiene Examinations. The Joint Commission was established in 1980 through a joint agreement between the American Association of Dental Examiners (precursor to AADB), the American Association of Dental Schools (precursor to ADEA), and the American Dental Association. These groups agreed that it was in the best interests of the public health and the dental profession for a single examination to be utilized for licensure decision making, as opposed to having different examinations of varying quality competing for this privileged position. In short, the public would be best served through the adoption of a single set of consistent, high quality national examinations that reflected expert decisions. The structure of the Joint Commission, outlined later in this document, emerged through negotiation and includes appointments by key stakeholders and communities of interest.

The Joint Commission examinations are accepted by all U.S. state boards as evidence indicating whether candidates possess the level of competence necessary to be licensed, with regard to candidate written knowledge and cognitive skills. It required nearly 60 years to achieve this level of acceptance by state boards. The first national board examinations were conducted in 1934, and from 1934 through 1938 an average of only 70 candidates per year received certificates. In 1938, only 11 states accepted national board results. By 1960, this number had risen to 33 states. By 1976, results were accepted by 48 states. Finally, in 1990 all U.S. licensing jurisdictions accepted National Board examinations as evidence that candidates had successfully fulfilled state boards' written examination requirement.

c. Is your council or commission effective in carrying out its bylaws authority? If not, why?

As noted previously, the *Bylaws* of the American Dental Association charge the Joint Commission with four duties:

- Provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of assisting state boards of dental examiners in determining qualifications of dentists who seek license to practice in any state or other jurisdiction of the United States. Dental licensure is subject to the laws of the state or other jurisdiction of the United States and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.
- Provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of assisting state boards of dental examiners in determining qualifications of dental hygienists who seek license to practice in any state or other jurisdiction of the United States. Dental hygiene licensure is subject to the laws of the state or other jurisdiction of the United States and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.

- Make rules and regulations for the conduct of examinations and the certification of successful candidates.
- Serve as a resource of the dental profession in the development of written examinations.

The Joint Commission believes it is effective in carrying out these duties. With regard to the first and second duties listed, in 2013 the Joint Commission administered 24,507 written examinations for dentists and dental hygienists. As evidenced in the table below, the volume of administrations has been fairly consistent over the past four years.

Number of Examinations Administered				
	2010	2011	2012	2013
NBDE Part I	7,696	8,548	8,692	9,051
NBDE Part II	7,185	7,432	6,920	7,610
NBDHE	7,519	7,753	7,726	7,846
TOTAL	22,400	23,733	23,338	24,507

In 2013, Department of Testing Services (DTS) staff provided the following assistance to examinees. Unless otherwise indicated, these numbers include the Joint Commission's three examinations, as well as two additional examinations developed, administered, and supported by the DTS.

- Responses to requests:
 - 68,000+ phone calls
 - 18,000+ emails, faxes, and letters
 - 10,000+ involving the need to resolve DENTPIN issues
- Processed applications:
 - 8,743 NBDE Part I
 - 7,751 NBDE Part II
 - 7,234 NBDHE
- Processed additional score report requests
 - 35,764 NBDE Part I and NBDE Part II
 - 3,265 NBDHE
- 581 accommodations were granted in compliance with the Americans with Disabilities Act (note: examinees receiving accommodations often receive more than one accommodation within a given administration). Typical accommodations include extended testing time, additional breaks, or longer breaks.
- 478 problems resolved concerning the testing experience (e.g., sudden illness, weather closures, etc.).
- 175 audits conducted at the request of examinees.

During 2013, DTS pursued the following initiatives to enhance and improve the services provided:

- **New item bank vendor (Zoomorphix).** This was a multi-year project that provided a more powerful and user friendly item bank for the department and test construction committees.
- **New software infrastructure platform (Aptify).** The Joint Commission's previous platform (SAS) was DOS based and highly fragmented, involving 15 separate software programs. The Joint Commission's transition to Aptify not only included these 15 programs, but also migration of over 30 years of historical data. The transition to Aptify has required considerable and painstaking effort, but has created a level of standardization and uniformity that was not previously available. These improvements have not only enhanced daily operational procedures, but also the user experience as well.

- **Website updates and Phase Two Aptify (e-business).** Initial planning and design for enhancements to the Joint Commission's website and phase two of the Aptify launch (e-business) began in 2013. The website will be revised to create a more user friendly experience and to align with the ADA.org website redesign, which improves online access for smartphone and tablet users. E-business further involves the redesign of the user experience components of the website (applications, score report requests, documents, etc.). The Joint Commission's payment vendor will also transition from Cybersource to PayPal, and transactions will align with similar retail sites (e.g., Amazon). The enhancements are scheduled to be completed by the fourth quarter of 2014.

With regard to the third duty listed, *establishing rules and regulations for the conduct and certification of successful candidates*, the Joint Commission publishes separate Examination Guides for NBDE Part I and Part II and for the National Board Dental Hygiene Examination (see Attachment 5). These documents provide the format and content of the examination, eligibility requirements, retesting policies, the appeal process, scoring, and examples of item formats. These documents are updated annually. The Guides are available on the Joint Commission's website: <http://www.ada.org/5553.aspx>.

Regarding certification, successful examinees are provided with a report that serves as evidence of satisfactory achievement with respect to the examination. The Joint Commission adheres to established industry best practices and standards to score the examinations and verify the measurement of examinees' knowledge, skills and abilities. These practices have progressed over time, and have improved both the validity and reliability of the examinations, resulting in significantly higher levels of quality.

The Joint Commission utilizes a professional staff that includes individuals with advanced degrees in psychological measurement, industrial/organizational psychology, and related fields. Sophisticated statistical techniques and algorithms are used to enhance validity, and efforts are regularly undertaken to further improve and evolve the examinations so they continue to reflect best practices.

The Joint Commission also implements policy changes to ensure its examinations are being used appropriately, in alignment with their intended purpose. For example, the Joint Commission moved to a pass/fail reporting approach in January of 2012. Previously examination scores were being used by dental specialty programs for admission purposes. This resulted in increased examination content exposure, which reduces examination security. The Joint Commission's examinations were not designed for admission purposes.

To properly assess examinees for licensure purposes, examination content must address appropriate subject areas. It is impossible to cover every aspect of general dentistry or dental hygiene in an examination of reasonable length. Thus, examination content must constitute a representative sample of important material. Topics are determined based on findings from a comprehensive practice analysis involving a sample of new, general dental practitioners. This yields test specifications, which indicate how many items should be allocated to specific topic areas. Test specifications can evolve over time based on feedback received from subject matter experts.

The Joint Commission encourages continuous quality improvement for all examinations (see 2012 Test Item Development Guide in Attachment 5). New test items are frequently developed through Joint Commission Test Construction Committees (TCCs), which are composed of subject matter experts whose qualifications correspond to examination content areas. Test items are subject to review by TCC members before they appear on examinations. Psychometric analyses are conducted to evaluate item performance.

Additional information about the validity and reliability of Joint Commission examinations is provided in Joint Commission technical reports (see Attachment 5), which are updated annually.

With respect to the fourth duty listed, *serve as a resource of the dental profession in the development of written examinations*, the Joint Commission provides information concerning examination development regularly at meetings of the American Dental Education Association (ADEA) and the American Association of Dental Boards (AADB) and publishes information on the Joint Commission website. As it

develops the Integrated National Board Dental Examination, the Joint Commission has kept stakeholders and communities of interest informed regarding test development efforts and the validity evidence that has been acquired to date.

d. What are the top three goals to be accomplished by your council or commission annually? How are these related to member value? How successful has your council or committee been with respect to these goals?

The three annual goals of the Joint Commission are as follows:

1. Administration of the NBDE Parts I and II and the NBDHE.

Member Value: Results of the NBDE and NBDHE assist state boards in assessing the qualifications of individuals seeking licensure to practice dentistry or dental hygiene.

Success Measures: Successful completion of the NBDE is a requirement for licensing of dentists by all US State Boards of Dentistry. Successful completion of the NBDHE is a requirement for licensing of dental hygienists by all US State Boards of Dentistry.

The Joint Commission maintains its own bylaws (Joint Commission Bylaws) that provide additional clarity concerning success measures. This includes the following:

#3 – Develop, publish and periodically review rules and regulations for the fair and orderly administration of National Board Dental and Dental Hygiene Examinations.

#4 – Cause National Board Dental and Dental Hygiene Examinations to be administered at least annually at locations throughout the United States.

#5 – Cause scores from National Board Dental and Dental Hygiene Examinations to be reported in a timely fashion to candidates and/or their schools and to state boards of dentistry identified by candidates.

#6 – Cause a permanent record of national Board Dental and Dental Hygiene scores to be maintained so that such scores may be reported to individuals or institutions identified by candidates.

#7 – Protect the security of National Board Dental and Dental Hygiene Examinations and the integrity of National Board Dental and Dental Hygiene scores.

2. Ongoing development of the NBDE Parts I and II and the NBDHE Programs

Member Value: Refresh the content of national board examinations regularly, so these examinations continue to assess the current science and practice of dentistry and dental hygiene.

Success Measures: Test Construction Committees meet at least annually to develop and review new examination items.

Targeted investigations are conducted periodically to provide evidence supporting the use and interpretation of examination results with respect to the intended purpose. For example, efforts are underway concerning the following:

- Standard setting: Set new pass/fail cut scores for the NBDE Parts I and II in 2014, and for the NBDHE in 2015.

A critical step in the development of any pass/fail examination is the setting of the cut score that separates passing and failing candidates. For the Joint Commission's examinations, cut scores represent a collective judgment by subject matter experts that those who fall below a particular skill level have an unacceptably high likelihood of making serious errors in the practice of

dentistry and dental hygiene. The Joint Commission periodically conducts standard-setting activities to ensure the appropriateness of the minimum passing score for the National Board Dental and Dental Hygiene Examinations.

- Practice Analysis: Review the domain of dental hygiene practice.

Practice analyses represent the foundation upon which Joint Commission examinations are built. With respect to the NBDHE, practice analysis is used to ensure that the knowledge, skills, and abilities assessed by the NBDHE are relevant to the safe, entry-level practice of dental hygiene.

Joint Commission Bylaws provide further clarity concerning success measures:

#1 – Develop, publish and periodically review specifications for National Board Dental and Dental Hygiene Examinations.

#2 – Appoint consultants with appropriate qualifications to assist in the construction of National Board Dental and Dental Hygiene Examinations.

3. Research and develop innovations necessary to the future of the national board examinations.

Member Value: Ensure the national board examinations keep pace with industry standards and do not become outdated.

With respect to innovation within the Joint Commission's examination programs, the Joint Commission is currently in the process of building a new examination to replace NBDE Parts I and II. The Integrated National Board Dental Examination (INBDE) is focused on the concept of clinical relevance in alignment with the purpose of the Joint Commission's examination program. Development of the INBDE is a monumental undertaking that began in earnest in 2010, and will continue to require many years of careful planning. The Joint Commission identified the need for the INBDE through results from investigations conducted by a Joint Commission strategic planning committee.

Success Measures: Every year, the Joint Commission identifies activities and investigations to conduct so that its examination programs can continue to keep pace with industry standards for high-stake examinations. The Joint Commission closely monitors progress as it works to meet its objectives.

Joint Commission Bylaws provide further clarity concerning success measures:

#1 – Develop, publish and periodically review specifications for National Board Dental and Dental Hygiene Examinations.

e. How do you define/measure success for the council or commission annually?

The Joint Commission defines success in terms of the validity evidence that supports its examination programs. For the National Board Dental and Dental Hygiene Examinations, validity refers to the degree to which logic and evidence support the use and interpretation of examination results for making pass/fail decisions with regard to candidates for licensure to practice dentistry or dental hygiene, respectively. Validity is a key measure of success for the Joint Commission's examinations, and in fact, any examination.

As mentioned earlier, each year the Joint Commission publishes Technical Reports for the National Board Dental Examinations and the National Board Dental Hygiene Examination. These reports represent an important source of information concerning the background, purpose, content, development process, scoring, and administration of the examinations. The Technical Reports are structured based on professional standards pertaining to the validity of credentialing/licensure

examinations (American Educational Research Association, American Psychological Association, and the National Council on Measurement in Education, 1999). The Technical Reports document the available validity evidence, and provide metrics permitting evaluation of the quality of the Joint Commission's examination programs. State licensing boards and other users of these examinations rely on the Technical Reports to describe the technical performance of Joint Commission examinations, as well as the general performance of candidates who complete Joint Commission examinations.

A key indicator of the success of the Joint Commission's NBDE programs is the fact that successful completion of the NBDE continues to be a requirement for the licensure of dentists by all US State Dental Boards. Similarly, successful completion of the NBDHE is a requirement for the licensure of dental hygienists.

In working to develop, administer, and support high quality, high stakes examination programs, the Joint Commission also endeavors to provide positive experiences to stakeholders and communities of interest as they interact with the Joint Commission and use the information provided to make decisions. This type of information is available through surveys conducted by the Joint Commission (e.g., optional candidate surveys administered at the end of all examinations), and through feedback received directly from these groups. Feedback received is typically quite positive.

2. Structure

- a. **Should your council or commission be skills based, or elected at large?**
- b. **Do you have an agenda that enables strategic discussion to the extent you would like?**
- c. **Do you have the optimal number of members to conduct business well and efficiently?**
- d. **Is the manner of member selection ideal (e.g., geographic vs. skills based)?**
- e. **Do you have the right number of committees and members on committees?**
Should you use standing committees or ad hoc task forces?
- f. **Would a task force structure as opposed to a council structure be better? Worse?**

These questions concerning the structure of the Joint Commission will be answered as a set.

The Joint Commission recognizes that its examinations serve key stakeholders (state boards of dentistry, who serve the public health) and have implications for important communities of interest (e.g., dental educators, dental practitioners). By taking these varying perspectives into account the Joint Commission is better able to achieve its mission. These perspectives have been incorporated into the membership of the Joint Commission as follows:

Appointing Organization	Perspective	Membership Restrictions	# of Members (15 Total)	%
American Association of Dental Boards (AADB)	State boards of dentistry that uses Joint Commission examination information to help make licensure decisions that protect the public	Cannot be members of dental school faculties. Must be active, life or retired members of the American Dental Association.	6	40%
American Dental Education Association (ADEA)	Dental schools and dental educators	Must hold positions of professorial rank in dental schools accredited by CODA. Cannot be member of state board of dental examiners or jurisdictional dental licensing agency. Must be active, life or retired members of the American Dental Association.	3	20%

American Dental Association (ADA)	Current dental practitioners	Cannot be a member of a faculty of a school of dentistry or a member of a state board of dental examiners or jurisdictional dental licensing agency. Must be active, life or retired members of the American Dental Association.	3	20%
The Public	The general public (dental patients)	Must NOT be a dentist, a dental hygienist, a dental student, a dental hygiene student, or a faculty member of an accredited dental school or dental hygiene program. Must NOT have a professional or personal financial interest in dentistry or dental hygiene.	1	6.7%
American Student Dental Association (ASDA)	Current dental students	Must be a dental student.	1	6.7%
American Dental Hygienists' Association (ADHA)	Dental Hygiene practitioners, educators, and students	Must be a dental hygienist.	1	6.7%

State boards of dentistry serve as the primary stakeholders for the examinations, due to the fact that these agencies ultimately use information provided by the examinations to make licensure decisions that protect the public health. For this reason, state boards provide the largest percentage of members of the Joint Commission. Although commissioners are appointed by various associations, once appointed they are to fully adopt the mission of the Joint Commission (as opposed to serving as representatives of their appointing association).

Commissioners appointed by the AADB, ADEA, and ADA must be active, life, or retired members of the ADA. The term of office for members is four years, except for the ASDA member who serves a one-year term. A second individual from ASDA serves as a non-voting observer to Joint Commission activities for one year. This individual becomes a full member of the Joint Commission as the ASDA appointee, subsequent to their year as an observer.

Commissioners are appointed or elected by their respective associations, which operate at the national level. A national perspective is appropriate since the examinations are intended to be used by all US states and jurisdictions. With respect to member appointment decisions, the Joint Commission imposes no geographic requirements on appointing organizations, nor does it impose specific skills requirements beyond those indicated in the preceding table.

The Joint Commission elects its own chair and vice chair each year. Traditionally the role of chair has rotated between the three appointing associations that hold the highest percentage of commissioners (AADB, ADEA, and ADA).

The Joint Commission's agenda is established to facilitate discussion on important topics such as the monitoring of examination quality and the policies governing examination eligibility and administration. The Joint Commission accomplishes its work through the operation of four standing committees which—with the exception of the Committee on Dental Hygiene—are composed entirely of members of the Joint Commission. It is the duty of the Joint Commission chair to assign topics to one or more committees. The committees and examples of topics typically assigned to each are as follows:

Committee on Administration

This committee's responsibility relates to both the National Board Dental Examinations and the National Board Dental Hygiene Examination. This committee deals with operations. Specific topics considered by the committee include:

- Examination security, including procedures for examination administration
- Examination regulations
- Joint Commission Bylaws and Standing Rules
- Finances, including an annual review of income and expenses

Committee on Dental Hygiene

This committee's responsibility relates primarily to the National Board Dental Hygiene Examination. Specific topics considered by the committee include:

- NBDHE content and specifications
- NBDHE test construction procedures, including nomination of test constructors
- Information circulated to publicize or explain the testing program
- Portions of Examination Regulations that affect dental hygiene candidates
- Matters pertaining to finances, ADA and Joint Commission Bylaws, and Joint Commission Standing Rules that affect the National Board Dental Hygiene Examination

Committee on Examination Development

This committee's responsibility relates primarily to the National Board Dental Examinations. Specific topics to be considered include:

- NBDE content and specifications
- NBDE test construction procedures, including nomination of test constructors
- Information circulated to publicize or explain the testing program

Committee on Research and Development

This committee's responsibility relates to both the National Board Dental Examinations and the National Board Dental Hygiene Examination. Topics considered by this committee include any research or developmental activities related to the examinations (e.g., psychometric investigations, practice analyses, and standard setting activities).

Most Joint Commission members serve on a single committee, although some serve on up to two committees. The size of the Joint Commission is large enough so that the different perspectives discussed previously can be brought to bear on important issues, yet the Joint Commission is small enough to operate efficiently and successfully.

For the majority of activities, a task force structure would not be appropriate for the Joint Commission since a task force typically has a limited focus and always has a completion date. The development, administration, and improvement of the national board examinations is ongoing. The responsibilities of the Joint Commission are quite broad.

Certain activities of the Joint Commission have been addressed, when appropriate, using a task force approach and ad hoc committees. For example:

- 2007: Standard-Setting Task Forces. Used to determine the standard (i.e., cut score) for passing the examination. This cut score is set based on expert judgment concerning minimum competency levels required to safely practice (as opposed to being set normatively).
- 2008: Ad Hoc committee on Strategic Planning. Used to set the strategic direction of the Joint Commission. Most notably, discussed replacing NBDE Parts I and II with one, integrated examination, and also studied the feasibility of restructuring Test Construction Committees.
- 2009: Ad Hoc Committee for an Integrated Examination (CIE). Charged with developing and validating a new examination instrument for dentistry that integrates basic, behavioral and clinical sciences to assess entry level competency in dental practice. The new examination is called the INBDE, the Integrated National Board Dental Examination.

The CIE continues to operate as an ad hoc committee and has provided the Joint Commission with content specifications and operating principles for its consideration. Work on the examination is

ongoing. The CIE includes four current members of the Joint Commission: the chair of the Joint Commission and the three NBDE standing committee chairs, all of whom serve as ex officio members. The CIE also includes core members who previously served on the Joint Commission, but whose terms within the Joint Commission have since ended. This structure helps facilitate communication and alignment with the Joint Commission, while also benefiting from the continuity provided by a core membership. As appropriate, work is transitioned from the CIE to the full Joint Commission; the CIE will at one point be disbanded and the work assigned to Joint Commission NBDE standing committees. More information about the CIE and INBDE is available at <http://www.ada.org/5553.aspx>.

3. Efficiencies

a. Is the decision making process efficient? If not why?

The Joint Commission believes that its decision-making process is efficient. Policy decisions and modifications to existing rules and regulations are addressed annually via revisions and updates to the Joint Commission's Standing Rules and Examination Regulations. Between meetings, operational duties (e.g., the handling of examination irregularities) are accomplished using electronic tools and communication.

In the future, INBDE development may benefit from a more flexible decision-making approach. The transitioning of efforts from the CIE to the full Joint Commission may assist in this regard, since ownership of the examination and ultimate decision making power rests with the Joint Commission. The inclusion of the four ex officio members of the Joint Commission within the CIE is also helpful in this regard. Decisions that have budgetary implications are particularly challenging. The INBDE is an innovative effort; it can be quite difficult to predict resource needs far in advance (as required by the current budgetary process). Progress can be delayed if funds are unavailable for use.

b. How can you reduce the time spent by volunteers on your work, while still doing what needs to be done?

Members of the Joint Commission establish the policies for examination administration, and review and approve the approach to specifying and establishing test content.

Examinees can appeal Joint Commission decisions (e.g., involving penalties associated with irregularities), and they can request that particular rules be waived (e.g., concerning retesting timeframes). The handling of appeals and rule waivers represents an operational duty that can only be performed by the Commissioners themselves. A special process and technology have been established to optimize Commissioners' time so this function can be performed remotely.

The development of examination content is delegated to other volunteers who are selected by the Joint Commission to serve on Test Construction Committees. Day-to-day operations are delegated to Joint Commission staff under the direction of the Director of Testing Services, who also serves as the Secretary of the Joint Commission. This approach focuses on optimizing the time of volunteers.

c. Do you meet in person enough? Too much? Too little?

The Joint Commission meets in person annually for one day at the ADA Headquarters building in Chicago, IL. In addition, each standing committee meets annually for one day. Travel time has been minimized since three of the four standing committees meet the day before the full Joint Commission meeting. The AADB mid-year meeting, also held at the ADA Headquarters building and attended by some of the Commissioners, precedes the committee meetings. The Joint Commission sponsors the National Dental Examiners' Advisory Forum, which occurs at the end of the AADB mid-year meeting.

The CIE typically meets 2 or 3 times per year to complete INBDE development tasks. Typically these meetings have been in person, but conference calls have also been utilized to expedite the work of the committee. As the project progresses, depending on the tasks required the frequency and format of meetings may change and may be accomplished using electronic collaboration capabilities.

In 2013 the Joint Commission issued a resolution to establish a one-day, in-person orientation session for new Commissioners. Previously this orientation occurred via conference call. The in- person meeting was well-received by the new Commissioners and will be repeated in the future.

To build examination content, the Joint Commission's Test Construction Committees generally meet in-person at the ADA Headquarters building. Over 30 meetings are conducted, with each committee typically meeting once per year (with a few exceptions). The creation of item content requires the knowledge of dentists, dental hygienists, and other subject matter experts, and cannot be done by staff. Joint Commission staff organize and facilitate these meetings, maintain the examination content, and electronically package the examination forms for implementation by test administration vendors when these forms are ready to be delivered to examinees. With respect to TCCs, experience has shown that in-person meetings are more effective than individual and offsite work in developing examination content. A modified structure with the potential for more electronic and remote participation is being investigated for the new exam. In conducting this investigation test security considerations will also be of paramount importance.

To date, the above meetings have been sufficient to carry out the work of the Joint Commission.

d. What work done by volunteers could be handled by staff?

The Joint Commission has not identified any work currently done by volunteers that could be handled by staff.

The delineation of duties involving volunteers and staff members is clearly defined and appropriate. Members of the Joint Commission establish rules and regulations concerning the conduct of National Board Examinations, approve policy exceptions, establish criteria for selecting volunteers who serve on National Board Test Construction Committees (TCCs), and select TCC members. These duties cannot be delegated to staff.

Volunteers who serve on National Board TCCs provide subject matter expertise in dentistry and dental hygiene. These volunteers develop and review test items that adhere to Joint Commission content and quality standards. Similarly, these duties cannot be delegated to staff.

e. Are issues brought to your council in an efficient or appropriate manner?

The Joint Commission chair is in constant communication with staff and is kept apprised of issues as they occur via email or phone calls. Issues are then brought to the full Joint Commission as necessary.

The Joint Commission is currently working to develop formal procedures for managing emergency situations involving the National Board Examinations. These procedures will be specific and detailed in nature, providing instructions on how to proceed with regard to communication efforts in a timely and efficient manner, minimizing risk. These procedures will be based on industry best practices and will be sensitive to the fact that members of the Joint Commission may or may not be available at a time when action is required. In those rare situations, pre-established principles and procedures will guide actions and activities in accordance with the mission and duties of the Joint Commission.

f. Are you provided with sufficient information to address and decide issues?

Staff are very diligent in preparing information and providing resources for the Joint Commission's Annual Meeting and other initiatives throughout the year. While the information provided is time consuming to review, the information is pertinent to the ability to make reasoned decisions. Reports should be provided early enough for Commissioners to prepare in advance.

g. Is the discussion of issues efficient and effective?

Due to the excellent preparatory work performed by staff, timely receipt of information from the staff to the Commissioners, and committed Commissioners, the discussions are robust and meaningful and provide sound direction for staff.

h. Are there matters left to the council or commission that should be handled by a smaller group?

The standing and ad hoc committees of the Joint Commission each handle the business areas assigned to them. The standing committees then make recommendations to the Joint Commission for consideration. This structure allows smaller groups to discuss the issues in more detail before they are brought to the full Commission.

i. Do you effectively use conference calls and web-based meeting time? Can you do so more or better?

The Joint Commission is committed to utilizing electronic means of communication for meetings and between meetings whenever feasible and appropriate. The Joint Commission uses these tools routinely for voting on examinee appeals using special, secure technology provided by the IT department. Additional balloting using ADA Connect will be assessed shortly.

Having noted this, it should also be recognized that some business is best conducted face-to-face. Conference calls and web-based meeting times have been used if a quorum can be assembled; however, it has proven difficult to schedule these sessions on-the-fly. It is more desirable to have the entire Joint Commission or Committee available for input and discussion.

j. Are you aware of the staff time devoted to your activities? Can that staff time be directed to other activities?

Some commissioners may have a general idea, but most are likely not fully aware of the amount of time staff devote to various activities. Commissioners rely upon the Director of Testing Services to advise when additional staffing is required, or when staff time for an activity is not in balance with the importance of the activity. The Joint Commission is sensitive to the wise use of staff time and is always willing to consider how staff time is disseminated around the various responsibilities of the Joint Commission.

k. Is your staff support sufficient?

The original staff structure was established when the Joint Commission's examinations were paper-based and administered two to three times per year. The examinations are now presented via computer, and administrations are conducted every business day of the year. Some of the newer, technology based innovations and operations (e.g., DENTPIN) have required staff to acquire specialized knowledge and expertise.

In the past four years, the new INBDE has required the attention of all areas of the program, including staff from test development, test administration, and scoring/psychometrics, as well as staff specifically assigned to support the ad hoc CIE.

Staff resources in the past three years have been stretched thin by initiatives beyond operations and the new examination. This includes development of a unique identification system for candidates (DENTPIN), a new examination software infrastructure platform (Aptify), a new item bank (Zoomorphix Exam Studio), and in 2014, a new website structure, and e-business platform.

Development of an integrated examination is a tremendous undertaking that requires significant staff support. As anticipated and planned, resource additions have been requested through the Joint Commission's R&D fund to support INBDE development. The R&D fund is independent of the ADA's operating budget, and is supported by assessment fees levied on candidates. The Joint Commission

recognized the need for funding and raised examinee assessment fees starting in 2014, to bolster the R&D fund. Development of this new examination and corresponding funding/staffing needs will be closely monitored by the Joint Commission.

The Department of Testing Services is also reviewing its staffing needs against the staffing levels required to ensure quality and fully support Joint Commission initiatives. **Quality and innovation are essential to the Joint Commission's examination programs, which have tremendous impact on public health.** Quality and innovation requires appropriate staffing to achieve and maintain high-level outcomes for all operations. The Joint Commission supports this review.

4. Areas of Responsibility

a. Based on a review of the bylaws, should some responsibilities be placed elsewhere or discontinued?

The responsibilities of the Joint Commission as defined in the ADA Bylaws are appropriate. The Joint Commission, composed of members appointed from six groups, is uniquely structured to fulfill these responsibilities.

It is efficient to develop and conduct national board examinations for both dentists and dental hygienists. The oversight, functions, processes, and psychometric expertise needed are the same; only the examination content differs. For the NBDHE, dental hygiene expertise is provided by volunteers serving on NBDHE Test Construction Committees and the Joint Commission's Committee on Dental Hygiene.

b. Are you addressing each area of responsibility? If not, should you, or should you change the bylaws?

As indicated previously, the Joint Commission is addressing each area of responsibility within its bylaws. The Joint Commission feels that it is conducting its activities appropriately and with high quality.

c. Can your responsibilities be consolidated with those of another entity or be done better by another entity?

While the Joint Commission is established through the ADA's *Bylaws*, the Joint Commission itself is a semi-autonomous agency that operates at arm's length from the ADA. As noted previously, members of the Joint Commission are appointed by various groups (AADB, ADEA, ADA, ADHA, ASDA, the public), due to the contribution provided by each group's perspective. Members are asked to serve and commit themselves to the purpose and mission of the Joint Commission.

This approach is necessary from a legal perspective, due to the critical role played by the Joint Commission's examinations in a high stakes licensure process, the results of which impact the public health. It is vital that the Joint Commission maintain its independence in decision making and its semi-autonomous status. It would not be appropriate for Joint Commission responsibilities to be consolidated with another entity, or for individual duties to be reassigned elsewhere.

5. Agenda Review: As you consider a self-assessment, use your agenda as a tool in the assessment:

- a. Is each item an efficient use of your time?
- b. Which items can be handled in other ways—conference calls, consent, etc.?
- c. What are you doing which is “down in the weeds,” operational as opposed to directional?
- d. What can you ask staff to take over?

These questions concerning the structure of the Joint Commission will be answered as a set.

The meeting agenda corresponds directly to the areas of responsibility for the Joint Commission. The agenda consists of topics pertinent to the administration, development, and scoring of the examinations (e.g., updates to policies, rules and regulations, examination fees, qualifications and selection of

volunteers on Test Construction Committees). The meeting agenda includes reports from standing committees who bring forward recommendations and supporting materials. These topics are all appropriate for the meeting agenda. A consent agenda is also utilized to expedite the business of the Joint Commission.

Meeting materials include information about examination operations. It is appropriate for the Joint Commission to review operations since this is part of the Joint Commission's responsibility. Usually this information is on the consent agenda and is only discussed by the full Joint Commission when there are additional issues or questions.

As noted previously, the division of duties between members of the Joint Commission, volunteers serving on Test Construction Committees, and staff are well-defined and appropriate. The staff does an excellent job. Members of the Joint Commission feel that there is nothing more that staff could take over.

6. Are you spending time on big issues and strategic direction?

The Joint Commission's efforts in constructing an integrated examination to replace NBDE Parts I and II have brought strategic issues to the forefront. The concept of integration led to the development of a new content model which describes dentistry more holistically in terms of clinical competencies and foundation knowledge areas. The Joint Commission's "Domain of Dentistry" model serves as the integrated content domain for the INBDE. Under NBDE Part I and Part II, the basic sciences (Part I) and dental disciplines (Part II) have been covered largely in isolation, within exam content silos. The notion of pursuing an integrated examination represents a major change in strategic direction that was put forward by the Joint Commission.

Development of the INBDE is an important and highly innovative endeavor with significant implications in numerous areas (public health, the dental profession, dental education, etc.). From an operational perspective, this has substantial implications for how the Joint Commission approaches its work (e.g., Test Construction Committee structure is anticipated to be more representative of general dentists at the integrated entry-level practice of dentistry.) At least four years' advance notice will be provided to the parties of interest prior to implementation of the INBDE. This project is both strategic and long-term.

The Joint Commission is also taking a strategic perspective with respect to test security. Security concerns are not unique to the Joint Commission; it is a regular topic of discussion among all providers of high-stakes examinations. Security breaches represent major threats to examination programs, because they call into question the validity of examination results. They additionally can wreak havoc from a budgetary perspective, since examination items are quite costly to develop and validate (estimates from the research literature place the cost of each item as high as \$4,000+). The Joint Commission has taken steps to address security through reduced test exposure—for example, by modifying retesting policy and by moving to pass/fail results reporting. Vendors who administer the Joint Commission's examinations require complete identification, and examinees are monitored on video feeds throughout the examination period.

The Joint Commission may also consider newer strategic approaches to stave off the security threat (e.g., computer adaptive testing, additional forensic analyses), different scoring approaches that improve the accuracy of candidate skills assessment (e.g., testlet scoring, 3 parameter (3-PL) Item Response Theory) and approaches that enhance item and form development (automatic item generation, automated form assembly). These approaches represent investments that can require a long lead time to develop and implement, but can lead to greater accuracy and efficiency over time.

Joint Commission Self-Assessment Conclusions

The Joint Commission appreciates this opportunity to critically consider its mission and how its activities are aligned with that mission. In conducting this self-assessment and providing its response, the Joint Commission also identified specific resolutions that will help improve the efficiency of its operations.

For example, in considering the functioning of Test Construction Committees, it was realized that TCC member qualifications represent an operational matter that should likely be removed from the Joint Commission's Standing Rules and placed in a separate document that would be subject to approval by the Joint Commission. The Joint Commission's Standing Rules require approval by the House of Delegates, which has introduced delays that slow progress. An example of the inefficiency brought about by this structure is that it required approximately 1½ years to move between the idea and implementation phases when the Joint Commission identified the need to add the word 'preferably' to the qualifications listed for TCC members serving on the Clinical Dental Hygiene TCC.

As the Joint Commission works to construct an integrated examination, greater flexibility is needed so the Joint Commission can work quickly to make adjustment to TCC membership and structure, in alignment with the Joint Commission's mission.

The self-assessment effort also led to insights concerning the need for the Joint Commission to become more involved in the broader testing community (e.g., within the Association of Test Publishers), so the Joint Commission can expand its knowledge of best practices in high stakes testing through increased lines of communication with other high stakes testing organizations.

The following presents specific resolutions adopted by the Joint Commission at its April 2014 meeting, that either emerged through self-assessment discussions, or were influenced by these discussions:

Resolved, that the Joint Commission form an ad hoc committee to investigate crisis management policies and procedures, and present a report to the Joint Commission at its April 2015 meeting or before.

Resolved, that the Joint Commission become a member of the Association of Test Publishers.

Resolved, that the JCNDE accept the proposed changes to the *Joint Commission's Standing Rules* and the *Examination Regulations*.

Note: The specific change to the Joint Commission's Standing Rules that was influenced by the self-assessment can be summarized as follows:

In an attempt to provide a more timely review and revision of the qualifications for Test Construction Committee members, content concerning these qualifications will be removed from the Standing Rules and placed in a new JCNDE document entitled: *Qualification Requirements for National Board Dental and Dental Hygiene Test Constructors*. Creating this document and removing the content from the JCNDE Standing Rules will permit the JCNDE the flexibility to review and revise the qualifications in a more expedient manner.

List of Attachments

1. Governance: Joint Commission on National Dental Examinations
2. ADA Bylaws Concerning the Joint Commission on National Dental Examinations
3. Joint Commission (JCNDE) Bylaws
4. Joint Commission (JCNDE) Standing Rules 2013
5. Links to Joint Commission Online Resources

Attachment 1. Governance: Joint Commission on National Dental Examinations

The Joint Commission on National Dental Examinations operates within the limits imposed by these documents, listed here in order of precedence:

1. Bylaws of the American Dental Association
2. Bylaws of the Joint Commission on National Dental Examinations (JCNDE Bylaws)
3. Standing Rules for Councils and Commissions (ADA)

Subject to constraints defined in these documents, the Joint Commission is free to establish its own policies and procedures for the conduct of its business. Such policies and procedures as have been adopted are compiled in this document:

4. Standing Rules, a publication of the Joint Commission on National Dental Examination

Adopted regulations pertaining to the conduct of the National Board Dental and Dental Hygiene Examinations are compiled in the Joint Commission's Examination Regulations and are published in annual Examination Guides corresponding to each examination program.

Attachment 2. ADA Bylaws Concerning the Joint Commission on National Dental Examinations

This document provides a subset of the Constitution and Bylaws of the American Dental Association (2013), for reference by the Joint Commission during its 2014 Self-Assessment. For readability purposes, line numbers were removed, additional spacing was added, and Section Names were bolded. The intent was to fully preserve the relevant substantive content of the Bylaws, while increasing its accessibility to members of the Joint Commission. The Bylaws in their original format are regarded as authoritative.

CHAPTER XV • COMMISSIONS

Section 10. NAME:

The commissions of this Association shall be:

Commission on Dental Accreditation

Joint Commission on National Dental Examinations

Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS:

A. COMMISSION ON DENTAL ACCREDITATION. *(details omitted from this subset)*

B. JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS.

The Joint Commission on National Dental Examinations shall be composed of fifteen (15) members selected as follows:

- a. Three (3) members shall be nominated by the Board of Trustees from the active, life or retired members of this Association and additional nominations may be made by the House of Delegates but no one of such nominees shall be a member of a faculty of a school of dentistry or a member of a state board of dental examiners or jurisdictional dental licensing agency. The House of Delegates shall elect the three (3) members from those nominated by the Board of Trustees and the House of Delegates.
- b. Six (6) members who are active, life or retired members of this association shall be selected by the American Association of Dental Boards from the active membership of that body, no one of whom shall be a member of a faculty of a dental school.
- c. Three (3) members who are active, life or retired members of this Association shall be selected by the American Dental Education Association from its active membership. These members shall hold positions of professorial rank in the dental schools accredited by this Association and shall not be members of any state board of dental examiners or jurisdictional dental licensing agency.
- d. One (1) member who is a dental hygienist shall be selected by the American Dental Hygienists' Association.
- e. One (1) member who is a public representative shall be selected by the Joint Commission on National Dental Examinations.
- f. One (1) member who is a dental student shall be selected annually by the American Student Dental Association.

Section 30. REMOVAL FOR CAUSE:

The Board of Trustees may remove a commission member for cause in accordance with procedures established by the Board of Trustees, which procedures shall provide for notice of the charges, including allegations of the conduct purported to constitute each violation, and a decision in writing which shall specify the findings of fact which substantiate any and all of the charges, and that prior to issuance of the decision of the Board of Trustees, no commission member shall be excused from attending any meeting of a commission unless there is an opportunity to be heard or compelling reasons exist which are specified in writing by the Board of Trustees.

Section 40. ELIGIBILITY:

- A. All members of commissions who are dentists must be active, life or retired members in good standing of this Association except as otherwise provided in these Bylaws.
- B. A member of the Joint Commission on National Dental Examinations, who was selected by the American Association of Dental Boards and who is no longer an active member of that Association, may continue as a member of the Commission for the balance of that member's term.
- C. When a member of the Joint Commission on National Dental Examinations, who was selected by the American Dental Education Association, shall cease to be a member of the faculty of a member school of that Association, such membership on the Commission shall terminate, and the President of the American Dental Association shall declare the position vacant.
- D. No member of a commission may serve concurrently as a member of a council or another commission.
- E. The Commissions of this Association shall elect their own chairs who shall be active, life or retired members of this Association.

Section 50. CONSULTANTS, ADVISERS AND STAFF:**A. CONSULTANTS AND ADVISERS.**

Each commission shall have the authority to nominate consultants and advisers in conformity with rules and regulations established by the Board of Trustees except as otherwise provided in these Bylaws.

The Joint Commission on National Dental Examinations also shall select consultants to serve on the Commission's test construction committees.

The Commission on Dental Accreditation shall have the power to appoint consultants to assist in developing requirements and guidelines for the conducting of accreditation evaluations, including site visitations, of predoctoral, advanced dental educational, and dental auxiliary educational programs.

B. STAFF.

The Executive Director shall employ the staff of Commissions, in the event they are employees, and shall select the titles for commission staff positions.

Section 60. TERM OF OFFICE:

The term of office of members of the commissions shall be four (4) years except that (a) the term of office of members of the Commission on Dental Accreditation selected pursuant to the Rules of the Commission on Dental Accreditation shall be governed by those Rules and (b) the term of office of the dental student selected by the American Student Dental Association for membership on the Joint Commission on National Dental Examinations shall be one (1) year.

The tenure of a member of a commission shall be limited to one (1) term of four (4) years except that

- (a) the consecutive tenure of members of the Commission on Dental Accreditation selected pursuant to the Rules of the Commission on Dental Accreditation shall be governed by those Rules and
- (b) tenure in office of the dental student selected by the American Student Dental Association for membership on the Joint Commission on National Dental Examinations shall be one (1) term.

A member shall not be eligible for appointment to another commission or council for a period of two (2) years after completing a previous commission appointment.

Section 70. VACANCY:

In the event of a vacancy in the office of a commissioner, the following procedure shall be followed:

- A. In the event the member of a commission, whose office is vacant, is or was a member of and was appointed or elected by this Association, the President of this Association shall appoint a member of this Association possessing the same qualifications as established by these Bylaws for the previous member, to fill such vacancy until a successor is elected by the next House of Delegates of this Association for the remainder of the unexpired term.
- B. In the event the member of a commission whose office is vacant was selected by an organization other than this Association, such other organization shall appoint a successor possessing the same qualifications as those possessed by the previous member of the commission.
- C. In the event such vacancy involves the chair of the commission, the President of this Association shall have the power to appoint an ad interim chair, except as otherwise provided in these Bylaws.
- D. If the term of the vacated commission position has less than fifty percent (50%) of a full four-year term remaining at the time the successor member is appointed or elected, the successor member shall be eligible for election to a new, consecutive four-year term. If fifty percent (50%) or more of the vacated term remains to be served at the time of the appointment or election, the successor member shall not be eligible for another term.

Section 80. MEETINGS OF COMMISSIONS:

Each commission shall hold at least one regular meeting annually, provided that funds are available in the budget for that purpose and unless otherwise directed by the Board of Trustees. Meetings may be held at the Headquarters Building, the Washington Office or from multiple remote locations through the use of a conference telephone or other communications equipment by means of which all members can communicate with each other. Such meetings shall be conducted in accordance with rules and procedures established by the Board of Trustees.

Section 90. QUORUM:

A majority of the members of any commission shall constitute a quorum.

Section 100. PRIVILEGE OF THE FLOOR:

Chairs and members of the commissions who are not members of the House of Delegates shall have the right to participate in the debate on their respective reports but shall not have the right to vote.

Section 110. ANNUAL REPORT AND BUDGET:

- A. ANNUAL REPORT. Each commission shall submit, through the Executive Director, an annual report to the House of Delegates and a copy thereof to the Board of Trustees.
- B. PROPOSED BUDGET. Each commission shall submit to the Board of Trustees, through the Executive Director, a proposed itemized budget for the ensuing fiscal year.

Section 120. POWER TO ADOPT RULES:

Any commission of this Association shall have the power to adopt rules for such commission and amendments thereto, provided such rules and amendments thereto do not conflict with or limit the Constitution and Bylaws of this Association. Rules and amendments thereto, adopted by any commission of this Association, shall not be effective until submitted in writing to and approved by majority vote of the House of Delegates of this Association, except the Joint Commission on National Dental Examinations shall have such bylaws and amendments thereto as the House of Delegates of this Association may adopt by majority vote for the conduct of the purposes and management of the Joint Commission on National Dental Examinations.

Section 130. DUTIES:

- A. COMMISSION ON DENTAL ACCREDITATION. *(details omitted from this subset)*
- B. JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS.

The duties of the Joint Commission on National Dental Examinations shall be to:

- a. Provide and conduct written examinations, exclusive of clinical demonstrations for the purpose of assisting state boards of dental examiners in determining qualifications of dentists who seek license to practice in any state or other jurisdiction of the United States. Dental licensure is subject to the laws of the state or other jurisdiction of the United States and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.
- b. Provide and conduct written examinations, exclusive of clinical demonstrations for the purpose of assisting state boards of dental examiners in determining qualifications of dental hygienists who seek license to practice in any state or other jurisdiction of the United States. Dental hygiene licensure is subject to the laws of the state or other jurisdiction of the United States and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.
- c. Make rules and regulations for the conduct of examinations and the certification of successful candidates.
- d. Serve as a resource of the dental profession in the development of written examinations.

Attachment 3

JOINT COMMISSION BYLAWS

September 2002

A publication of the Joint Commission on National Dental Examinations
American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611

The Joint Commission on National Dental Examinations is governed by three documents. In order of precedence, they are:

Bylaws of the American Dental Association
Bylaws of the Joint Commission on National Dental Examinations
Standing Rules for Councils and Commissions

Joint Commission *Bylaws*, which follow, are consistent with but more comprehensive than ADA *Bylaws*. Joint Commission *Bylaws* were adopted in 1980 and amended since. Additional modifications may be made by the ADA House of Delegates without prior notification.

ARTICLE I. PURPOSE

The purposes of the Joint Commission on National Dental Examinations are:

- A. To provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of assisting state boards in determining qualifications of dentists who seek licensure to practice in any state, district or dependency of the United States, which recognizes the National Board Examinations, here and after referred to as National Board Dental Examinations.
- B. To provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of assisting state boards in determining qualifications of dental hygienists who seek licensure to practice in any state, district or dependency of the United States, which recognizes the National Board Examinations, here and after referred to as the National Board Dental Hygiene Examinations.
- C. To make rules and regulations for the conduct of National Board Dental and Dental Hygiene Examinations and for the issuance of National Board Dental and Dental Hygiene Certificates.
- D. To serve as a resource for the dental profession in the development of written examinations.

ARTICLE II. BOARD OF COMMISSIONERS

SECTION 1. LEGISLATIVE AND MANAGEMENT BODY

The legislative and management body of the Joint Commission on National Dental Examinations shall be the Board of Commissioners.

SECTION 2. COMPOSITION

The Board of Commissioners shall consist of fifteen (15) Commissioners to be selected as follows:

- A. Six (6) Commissioners who are active, life or retired members of the American Dental Association shall be selected by the American Association of Dental Examiners from its active membership,¹ no one of whom is a member of a faculty of an accredited dental school.
- B. Three (3) Commissioners who are active, life or retired members of the American Dental Association and who hold professorial rank at accredited dental schools shall be selected by the American Dental Education Association from its active membership, no one of whom is a member of a state board of dentistry.
- C. Three (3) Commissioners shall be selected by the American Dental Association from its active, life and retired members, no one of whom is a faculty member of an accredited dental school or a member of a state board of dentistry.

¹ For the purpose of these *Bylaws*, the active membership of the American Association of Dental Examiners is defined as all active members (members who currently serve on state boards), all individual active members (members who formerly served on state boards) and all life members of that Association.

- D. One (1) Commissioner shall be selected by the American Dental Hygienists' Association from its active membership.
- E. One (1) Commissioner shall be selected by the American Student Dental Association from its active membership.
- F. One (1) Commissioner shall be elected as a public representative by the Board of Commissioners, but such public representative shall not be a dentist, a dental hygienist, a dental student, a dental hygiene student or a faculty member of an accredited dental school or dental hygiene program.

SECTION 3. TERM OF OFFICE

The term of office of a Commissioner shall be four (4) years except that the Commissioner selected by the American Student Dental Association shall serve a term of one (1) year.

The tenure of a Commissioner shall be limited to one (1) term.² Terms of Commissioners shall begin and end with adjournment of the closing session of the annual meeting of the House of Delegates of the American Dental Association in the appropriate year.

SECTION 4. POWERS

- A. The Board of Commissioners shall be vested with full power to conduct all business of the Joint Commission on National Dental Examinations subject to laws of the state of Illinois, the *Bylaws of the American Dental Association* and these *Bylaws*.
- B. The Board of Commissioners shall have the power to establish rules and regulations to govern its organization and procedure provided that such rules and regulations are consistent with the *Bylaws of the American Dental Association* and with these *Bylaws*.

SECTION 5. DUTIES

- A. **EXAMINATION DEVELOPMENT AND ADMINISTRATION:** The Board of Commissioners shall:
 1. Develop, publish and periodically review specifications for National Board Dental and Dental Hygiene Examinations.
 2. Appoint consultants with appropriate qualifications to assist in the construction of National Board Dental and Dental Hygiene Examinations.
 3. Develop, publish and periodically review rules and regulations for the fair and orderly administration of National Board Dental and Dental Hygiene Examinations.
 4. Cause National Board Dental and Dental Hygiene Examinations to be administered at least annually at locations throughout the United States.
 5. Cause scores from National Board Dental and Dental Hygiene Examinations to be reported in a timely fashion to candidates and/or their schools and to state boards of dentistry identified by candidates.

² The Commissioner selected by the American Student Dental Association may be selected one (1) year in advance and may attend meetings of the Board of Commissioners as an observer before his or her term begins.

6. Cause a permanent record of National Board dental and dental hygiene scores to be maintained so that such scores may be reported to individuals or institutions identified by candidates.
7. Protect the security of National Board Dental and Dental Hygiene Examinations and the integrity of National Board dental and dental hygiene scores.

B. LIAISON: The Board of Commissioners shall:

1. Submit an annual report of the activities and future plans of the Joint Commission on National Dental Examinations to appropriate officials of the American Association of Dental Examiners, the American Dental Education Association, the American Dental Association, the American Dental Hygienists' Association and the American Student Dental Association.
2. Conduct an annual forum for representatives of state boards of dentistry for the purposes of providing information about and receiving recommendations for National Board Dental and Dental Hygiene Examinations.

C. FINANCIAL MANAGEMENT: The Board of Commissioners shall:

1. Submit annually to the Board of Trustees of the American Dental Association an appropriation request for the next year.
2. Control allocated funds in a manner consistent with the budgetary policy of the American Dental Association.
3. Monitor the relationship between expenses for National Board Examinations and income from examination fees and recommend to the Board of Trustees of the American Dental Association such changes in fees as needed to avoid either profit or loss.

D. MISCELLANEOUS: The Board of Commissioners shall monitor these *Bylaws* for consistency with the *Bylaws of the American Dental Association*. When or if a conflict exists, the Board of Commissioners shall describe such conflict in its annual report to sponsoring associations and recommend changes to achieve conformity.

SECTION 6. MEETINGS

A. REGULAR MEETINGS: There shall be one (1) regular meeting of the Board of Commissioners each year.

B. SPECIAL MEETINGS: A special meeting of the Board of Commissioners may be called at any time by the Chair of the Joint Commission on National Dental Examinations. The Chair shall call a special meeting at the request of nine (9) of the fifteen (15) members of the Board of Commissioners. Members of the Board of Commissioners shall be notified at least ten (10) days in advance of the convening of a special meeting.

SECTION 7. QUORUM

A majority of voting members of the Board of Commissioners shall constitute a quorum.

ARTICLE III. COMMITTEES

SECTION 1. COMMITTEE ON DENTAL HYGIENE

The Joint Commission on National Dental Examinations shall have a standing Committee on Dental Hygiene.

A. COMPOSITION: The Committee on Dental Hygiene shall be composed of eight (8) members to be selected as follows:

1. One (1) Commissioner appointed by the Chair who is a representative of the American Association of Dental Examiners.
2. One (1) Commissioner appointed by the Chair who is a representative of the American Dental Education Association.
3. One (1) Commissioner appointed by the Chair who is a representative of the American Dental Association.
4. The Commissioner who is a representative of the American Dental Hygienists' Association plus three (3) additional dental hygienists who are selected by the American Dental Hygienists' Association. Of the four (4) dental hygienist members, two (2) members shall be faculty members of accredited dental hygiene programs and two (2) members shall represent practicing dental hygienists.
5. One (1) dental hygiene student who is selected by the American Dental Hygienists' Association.

B. MEETINGS: The Committee on Dental Hygiene shall have one (1) regular meeting each year.

This meeting shall precede the regular, annual meeting of the Board of Commissioners. Special meetings of the Committee on Dental Hygiene shall be convened at the request of the Board of Commissioners or at the request of a majority of Committee members subject to approval by the Board of Commissioners.

C. DUTIES: The Committee on Dental Hygiene shall consider matters related to the National Board Dental Hygiene Examination.

SECTION 2. TEST CONSTRUCTION COMMITTEES

The Joint Commission on National Dental Examinations shall establish and convene regular meetings of such committees as are necessary to construct National Board Dental and Dental Hygiene Examinations.

SECTION 3. OTHER COMMITTEES

The Chair, with the advice and consent of the Board of Commissioners, may appoint such other committees as are necessary to ensure the orderly functioning of the business of the Joint Commission on National Dental Examinations. Excluding test construction committees, each committee will include at least one (1) Commissioner who is a representative of the American Association of Dental Examiners, one (1) Commissioner who is a representative of American Dental Education Association and one (1) Commissioner who is a representative of the American Dental Association.

SECTION 4. AUTHORITY

Decisions of committees shall be subject to approval by the Board of Commissioners.

ARTICLE IV. OFFICERS

- A. ELIGIBILITY:** The Chair of the Joint Commission on National Dental Examinations shall be a dentist who is a member of the Board of Commissioners.
- B. ELECTION:** The Chair of the Joint Commission on National Dental Examinations shall be elected by the Board of Commissioners during its regular, annual meeting. The term of the Chair shall be one (1) year beginning and ending with adjournment of the closing session of the annual meeting of the House of Delegates of the American Dental Association.
- C. DUTIES:** The Chair of the Joint Commission on National Dental Examinations shall:
 - 1. Appoint members and chairmen of such committees as are necessary for the orderly conduct of business except as otherwise provided in these Bylaws.
 - 2. Circulate or cause to be circulated an announcement and an agenda for each regular or special meeting of the Board of Commissioners.
 - 3. Preside during meetings of the Board of Commissioners.
 - 4. Prepare or supervise the preparation of an annual report of the Joint Commission on National Dental Examinations.
 - 5. Prepare or supervise the preparation of an annual appropriation request for the Joint Commission on National Dental Examinations.
 - 6. Represent the Joint Commission on National Dental Examinations during sessions of the House of Delegates of the American Dental Association.

SECTION 2. VICE CHAIR

- A. ELIGIBILITY:** The Vice Chair of the Joint Commission on National Dental Examinations shall be a dentist who is a member of the Board of Commissioners.
- B. ELECTION:** The Vice Chair of the Joint Commission on National Dental Examinations shall be elected by the Board of Commissioners during its regular, annual meeting. The term of the Vice Chair shall be one (1) year beginning and ending with adjournment of the closing session of the annual meeting of the House of Delegates of the American Dental Association.
- C. DUTIES:** The Vice Chair of the Joint Commission on National Dental Examinations shall assist the Chair in the performance of his or her duties.

SECTION 3. SECRETARY:

- A. APPOINTMENT:** The Secretary of the Joint Commission on National Dental Examinations shall be an employee of the American Dental Association selected by the Executive Director of that Association.
- B. EVALUATION:** The performance of the Secretary may be evaluated by the Board of Commissioners. If the Board of Commissioners exercises this option, written

evaluation including recommendations signed by the Chair shall be forwarded to the Executive Director of the American Dental Association.

C. **DUTIES:** The Secretary of the Joint Commission on National Dental Examinations shall:

1. Keep minutes of meetings of the Board of Commissioners.
2. Be the custodian of records of the Joint Commission on National Dental Examinations.
3. Manage the office and staff of the Joint Commission on National Dental Examinations.

ARTICLE V. MISCELLANEOUS

SECTION 1. FINANCIAL RECORDS

Financial records of the Joint Commission on National Dental Examinations shall be maintained by the American Dental Association in a manner consistent with accepted principles of accounting. Such financial records shall be available on reasonable notice for inspection by a representative or agent of the American Association of Dental Examiners, the American Dental Education Association, the American Dental Hygienists' Association or the American Student Dental Association.

SECTION 2. ADDITIONAL RULES

The rules contained in the current edition of *Sturgis Standard Code of Parliamentary Procedures* shall govern the deliberations for the Board of Commissioners in all instances where they are applicable and not in conflict with the *Bylaws of the American Dental Association*, these *Bylaws* or previously established rules and regulations of the Board of Commissioners.

SECTION 3. VACANCY

In the event of a vacancy in the office of a Commissioner, the following procedures shall be employed:

- A. In the event that the Commissioner was selected by an association, such association shall select a successor who possesses the qualifications established by these Bylaws to complete the unexpired term.
- B. In the event that the Commissioner was the public representative, the Board of Commissioners shall elect a successor who possesses the qualifications established by these *Bylaws* to complete the unexpired term.
- C. In the event the vacancy involves the Chair, the Vice Chair shall immediately assume all duties of the Chair.

ARTICLE VI. AMENDMENT

These *Bylaws* may be amended only by majority vote of the House of Delegates of the American Dental Association.

Attachment 4

STANDING RULES

April 2013

A publication of the Joint Commission on National Dental Examinations
American Dental Association Building
211 East Chicago Avenue, Suite 600
Chicago, Illinois 60611-2637

The Joint Commission on National Dental Examinations operates within the limits imposed by three documents, listed here in order of precedence:

1. Bylaws of the American Dental Association
2. Bylaws of the Joint Commission on National Dental Examinations
3. Standing Rules for Councils and Commissions

Subject to constraints defined in these documents, the Joint Commission is free to establish its own policies and procedures for the conduct of its business. Such policies and procedures as have been adopted are compiled here.

TABLE OF CONTENTS

Election of a Public Member	4
Qualifications.....	4
Term	4
Identification of Nominees	4
Roles of Committees	4
Assignments.....	5
Committee on Administration	5
Committee on Dental Hygiene.....	5
Committee on Examination Development	5
Committee on Research and Development.....	5
Committee Actions	6
Reporting.....	6
Criteria for Dental Test Constructors.....	6
Part I Test Construction Committees	7
Anatomic Sciences	7
Biochemistry-Physiology	7
Microbiology-Pathology	7
Dental Anatomy and Occlusion	8
Testlet Development	8
Consultant Review	8
Part II Test Construction Committees	8
Operative Dentistry.....	8
Pharmacology	8
Prosthodontics.....	8
Oral and Maxillofacial Surgery-Pain Control.....	9
Orthodontics-Pediatric Dentistry.....	9
Endodontics.....	9
Periodontics.....	9
Oral Diagnosis.....	9
Patient Management	9
Full-Time Practitioners	9
Component B	10
Case Selection	10
Consultant Review	10
Criteria for Dental Hygiene Test Constructors.....	10
Basic Sciences.....	10
Radiology	10
Periodontics	11
Oral Medicine/Oral Diagnosis	11
Special Needs Professional	11
Dental Hygiene Curriculum	11
Clinical Dental Hygiene	11
Community Dental Health	11
Dental Hygiene Test Construction Committees	11
Case Selection	12

Consultant Review	12
Detection of Irregularities Based on Forensic Analyses	13
Definitions	13
Criteria for Withholding Scores	13
Limited Right of Appeal for Examination Candidates	13
Conflict of Interest Policy	14
Assistance to Other Agencies	15
Availability	15

ELECTION OF A PUBLIC MEMBER

The Joint Commission is charged with electing a public member to serve as a commissioner. Policies relating to election are as follows.

Qualifications

The public member shall not be a(n):

- a. Dentist
- b. Dental hygienist
- c. Dental student
- d. Dental hygiene student
- e. Faculty member of an accredited dental school or dental hygiene program
- f. Employee of the Joint Commission
- g. Member of another health profession
- h. Professional who has represented the Joint Commission, dental profession, or dental hygiene profession for a fee in the last five years
- i. Spouse of any of the above

Not more than five percent of the public member's income shall be derived from the Joint Commission, dentistry, or dental hygiene.

It is suggested that the public member not be employed by a firm with a substantial interest in dentistry or dental hygiene, and that the public member be experienced in health issues, testing, credentialing, or advocating the interest of the public.

Term

The public member will serve a single four-year term.

Identification of Nominees

When a new public member is needed, nominations will be requested from appropriate agencies, such as state boards of dentistry and public service organizations. Each nominee will be requested to supply a summary of his or her qualifications. At least two qualified nominees will be identified prior to conduct of an election.

ROLES OF COMMITTEES

Four standing committees meet in conjunction with the annual meeting of the Joint Commission. They are:

- a. Committee on Administration
- b. Committee on Dental Hygiene
- c. Committee on Examination Development
- d. Committee on Research and Development

Each committee is assigned a portion of the materials to be considered by the Joint Commission and is responsible for formulating specific recommendations for Joint Commission action.

Assignments

Assignment of topics to specific committees is the responsibility of the Joint Commission Chair, but this responsibility may be delegated in part or in total to the Secretary. Listed and discussed below are examples of topics that are typically assigned to each committee.

A topic may be assigned to more than one committee. In addition, provided that it completes its assigned items, a committee may consider a topic assigned to a different committee.

Committee on Administration

This committee's responsibility relates to both National Board Dental Examinations and the National Board Dental Hygiene Examination. The committee deals with operations. Specific topics to be considered include:

- a. Examination security, including procedures for examination administration
- b. Examination regulations
- c. Joint Commission Bylaws and Standing Rules
- d. Finances, including an annual comparison of income and expenses

Committee on Dental Hygiene

This committee's responsibility relates primarily to the National Board Dental Hygiene Examination. Specific topics to be considered include:

- a. Examination content and specifications
- b. Test construction procedures, including nomination of test constructors
- c. Information circulated to publicize or explain the testing program
- d. Portions of Examination Regulations that affect dental hygiene candidates
- e. Matters pertaining to finances, ADA and Joint Commission Bylaws, and Joint Commission Standing Rules that affect the National Board Dental Hygiene Examination

Committee on Examination Development

This committee's responsibility relates primarily to National Board Dental Examinations. Specific topics to be considered include:

- a. Examination content and specifications
- b. Test construction procedures, including nomination of test constructors
- c. Information circulated to publicize or explain the testing program

Committee on Research and Development

This committee's responsibility relates to both the National Board Dental Examinations and the National Board Dental Hygiene Examination. Topics considered by this Committee include any research or developmental activities related to the Examinations.

Committee Actions

A committee is expected to consider and report on all assigned topics. For most topics, committee actions are to be presented in the form of recommendations for Joint Commission action. Following are three exceptions:

- a. A decision about the manner in which a committee approaches its assignment - for example, a change in the personal data form for potential test constructors - need not be reported.
- b. Identification of background requested for future deliberations may be reported as information without an accompanying recommendation. If compilation of needed background requires substantial resources, however, a specific recommendation for action is appropriate.
- c. A decision not to act may be reported as an informational item. If the topic has generated substantial outside interest, however, a recommendation not to act is appropriate so as to allow the Joint Commission to affirm the committee's decision.

Reporting

Background information prepared for Committee deliberations is circulated to all Commissioners and all Committee members. Exceptions are: information about a nominee to a test construction committee provided only to the committee charged with screening nominees and technical reports provided as background for the Committee on Research and Development.

Committee reports are provided to the Joint Commission in written or electronic form. Topics are discussed in the order they are listed on the Joint Commission's agenda, and background information related to each topic is identified. For each recommendation, a report should include a brief summary or rationale. An exception is made in that no rationale is expected for appointment of a test constructor. Instead, an alternate is named for each newly proposed test constructor.

Preparation and presentation of a committee's report is the responsibility of each committee's Chair. Preparation may be delegated to a staff secretary assigned to the committee. If the committee Chair is not a commissioner or if, for some other reason, the committee Chair is not present at the Joint Commission's annual meeting, responsibility for presenting the report may be delegated to a commissioner who has served on that committee.

Committee reports are presented orally, stopping for action as needed. At each stop for action, the presenter represents the committee's views through his or her answers to questions. Only after ensuring that the committee's views have been represented adequately may the presenter impart any personal views.

CRITERIA FOR DENTAL TEST CONSTRUCTORS

The Joint Commission selects consultants to serve on its Dental and Dental Hygiene Test Construction Committees. A test constructor is appointed for a one-year term and may be reappointed to four consecutive terms. To be considered for appointment, a person must possess appropriate qualifications and must submit a completed personal data form. Someone

who has completed five years of service on a committee will not be considered for reappointment to the same committee.

The following are the criteria for test constructors on Anatomic Sciences, Biochemistry-Physiology, Microbiology-Pathology, Dental Materials, Pharmacology, Patient Management, and Testlet Development Committees:

- a. Dentist with a master's degree in that biomedical science OR a professional with a doctoral degree in that biomedical science.
- b. Three years of experience within the last five years teaching or in research in that biomedical science.

The following are the criteria for test constructors on Dental Anatomy and Occlusion, Operative Dentistry, Prosthodontics, Oral and Maxillofacial Surgery-Pain Control, Orthodontics-Pediatric Dentistry, Endodontics, Periodontics, and Oral Diagnosis Committees:

- a. Dentist
- b. In the case of special areas of dentistry, graduation from an accredited advanced education program in that specialty.

Part I (Component A) Test Construction Committees

Anatomic Sciences

This five member committee includes the following. At least one of the four subject-matter experts must be a dentist.

- a. Gross anatomists (2)
- b. Histologists (2); including one whose expertise is embryology and one whose expertise is neuroanatomy
- c. Full-time practitioner (1)

Biochemistry/Physiology

This five member committee includes the following. At least one of the four subject-matter experts must be a dentist.

- a. Biochemists (2)
- b. Physiologists (1)
- c. Full-time practitioner (1)

Microbiology/Pathology

This five member committee includes the following. At least one of the four subject-matter experts must be a dentist.

- a. Microbiologists (2); including one whose expertise is immunology
- b. Pathologists (2)
- c. Full-time practitioner (1)

Dental Anatomy and Occlusion

This four member committee consists of 4 dentists who are:

- a. Dental anatomists (3)
- b. Full-time practitioner (1)

Part I (Component B) Test Construction Committees

Testlet Development

This nine member committee consists of:

- a. Dental educators representing the various discipline areas, and all of who should already have served on a Part I discipline-based committee. (5)
- b. Dental practitioners representing each of the discipline-based Part I committees. (4)

Consultant Review

This committee is responsible for reviewing the discipline-based (Component A) and testlet-based (Component B) components of the Comprehensive Part I examinations to ensure the examinations adhere to test specifications and item guidelines outlined by the Joint Commission. The composition of this two member committee varies between the dental discipline experts and practitioners. Members of this committee should already have served on a Component A committee.

Part II (Component A) Test Construction Committees

Operative Dentistry

This five member committee consists of:

- a. Restorative/operative dentists (3)
- b. Expert in dental materials (1)
- c. Full-time practitioner (1)

Pharmacology

This four member committee consists of:

- a. Pharmacologists (3), one who is a dentist
- b. Full-time practitioner (1)

Prosthodontics

This six member committee consists of:

- a. Prosthodontists (4), two with expertise in fixed prosthodontics and two with expertise in removable partial/complete prosthodontics
- b. Expert in dental materials (1)
- c. Full-time practitioner (1)

Oral and Maxillofacial Surgery/Pain Control

This four member committee consists of:

- a. Oral and maxillofacial surgeons (3), at least one with expertise in pain control
- b. Full-time practitioner (1)

Orthodontics/Pediatric Dentistry

This six member committee consists of:

- a. Orthodontists (3)
- b. Pediatric dentists (2)
- c. Full-time practitioner (1)

Endodontics

This four member committee consists of:

- a. Endodontists (3)
- b. Full-time practitioner (1)

Periodontics

This four member committee consists of:

- a. Periodontists (3)
- b. Full-time practitioner (1)

Oral Diagnosis

This six member committee consists of:

- a. Oral pathologists (2)
- b. Oral and maxillofacial radiologists (2)
- c. Dentist with advanced education in oral diagnosis (1)
- d. Full-time practitioner (1)

Patient Management

This eight member committee consists of:

- a. Dental public health specialists (2)
- b. Dentist with advanced education in special needs (1)
- c. Behavioral scientists (3), at least one who must be a dentist
- d. Full-time practitioners (2)

Full-time Practitioners

A full-time practitioner is a currently licensed dentist (not necessarily a specialist) in the United States, practicing dentistry full-time (30 to 40 hours per week) for at least 10 years.

Part II (Component B) Test Construction Committee

Component B

This committee develops the case-based items for the Comprehensive Part II examination. This thirteen member committee consists of:

- a. Members representing the dental disciplines, all of who have served on a Part II Component A committee (10)
- b. General practitioners with experience in preparing educational or licensure examinations (2)
- c. Behavioral scientist (1)

Case Selection

As an adjunct to the Component B committee, this committee does the preliminary work of screening new patient cases, and identifying suitable cases. This committee drafts and reviews the patient histories, dental charts, and treatment plans associated with the cases. The composition of this 4-member committee varies between dental discipline experts and practitioners.

Consultant Review

This committee is responsible for reviewing the discipline-based (Component A) and case-based (Component B) components of the Comprehensive Part II examinations to ensure the examinations adhere to test specifications and item guidelines outlined by the Joint Commission. The composition of this two member committee varies between the dental discipline experts and practitioners. Members of this committee should already have served on a Component A committee.

CRITERIA FOR DENTAL HYGIENE TEST CONSTRUCTORS

The National Board Dental Hygiene Examination is constructed by committees of consultants with subject matter expertise in the following eight areas.

Basic Sciences

The basic sciences include anatomy, histology, biochemistry and nutrition, physiology, microbiology and immunology, pathology, pharmacology, and oral biology.

- a. Doctoral degree in a biomedical science, or a dentist or dental hygienist with an advanced degree in a biomedical or dental science.
- b. At least three years' experience within the last five years teaching a biomedical or dental science to dental hygiene students.

Radiology

- a. Dentist or dental hygienist with a baccalaureate degree from an accredited program.
- b. An oral and maxillofacial radiologist or a dental hygienist with formal education in dental radiology beyond what was provided in dental hygiene program.
- c. At least three years' experience within the last five years teaching radiology.

Periodontics

- a. Graduate of an accredited dental or dental hygiene program with advanced formal education or training in periodontics.
- b. At least three years' experience within the last five years teaching or practicing periodontics.

Oral Medicine/Oral Diagnosis

- a. Dentist with advanced clinical training.
- b. At least three years of experience within the last five years teaching oral medicine/oral diagnosis.

Special Needs Professional

- a. Dentist or dental hygienist with advanced clinical training.
- b. At least three years of experience within the last five years teaching a clinical science.

Dental Hygiene Curriculum

- a. Dental hygienist who has graduated from an accredited program.
- b. Advanced degree, preferably in dental hygiene.
- c. Experience in curriculum design as a dental hygiene program director, member of a dental hygiene curriculum committee, or accreditation consultant for dental hygiene.
- d. At least three years' experience within the last five years teaching to dental hygiene students.

Clinical Dental Hygiene

- a. Dental hygienist who has graduated from an accredited program.
- b. Baccalaureate degree in dental hygiene, education, or a biomedical science.
- c. 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.

Community Dental Health

- a. Dentist or dental hygienist who has graduated from an accredited program.
- b. Advanced degree in public health or related field.
- c. At least three years' experience within the last five years in a public health position or teaching community and public health courses to dental or dental hygiene students.

Dental Hygiene Test Construction Committees

Three dental hygiene Component A committees (total of 15 members) and a dental hygiene Component B committee (8 members) construct the National Board Dental Hygiene Examination.

Component A Committees

Dental Hygiene I

- a. Basic science experts (3)
- b. Dental hygiene curriculum expert (1)

Dental Hygiene II

- a. Periodontists (3), at least one who must be a dentist
- b. Dental hygiene curriculum expert (1)
- c. Clinical dental hygiene experts (2)
- d. Oral and Maxillofacial Radiologist or dental hygienist with formal education in radiology (1)

Dental Hygiene III

- a. Dental Hygiene Curriculum expert (1)
- b. Clinical Dental Hygiene expert (1)
- c. Community Dental Health experts (2)

Component B Committees

Component B

- a. Basic science expert (1)
- b. Dental hygiene curriculum expert (1)
- c. Clinical dental hygiene expert (1)
- d. Community dental health expert (1)
- e. Oral medicine/oral diagnosis expert (1)
- f. Periodontist (1)
- g. Oral and Maxillofacial radiologist or dental hygienist with formal education in radiology (1)
- h. Special needs expert (1)

Case Selection

Members from various dental hygiene disciplines (4)

Consultant Review

Members from the various dental hygiene disciplines, one of which must be a dentist (4)

Members on these Component B committees should have already served on a Dental Hygiene Component A committee.

DETECTION OF IRREGULARITIES BASED ON FORENSIC ANALYSES

Definitions

The Joint Commission is responsible for protecting the integrity of National Board Examination scores. One method used is to withhold scores that reflect unrealistic response patterns. Procedures for withholding scores are listed in the Examination Regulations for National Board Examinations.

Statistical criteria for withholding scores are based on the response patterns of candidates or the performance of candidates on the overall examination. Potential irregularities may include, but are not limited to, the following:

Aberrant results: Inconsistent response patterns as measured by response aberrance index (e.g., answering difficult questions correctly and missing easy questions).

Latency aberrance: Candidates with inconsistent or inappropriate use of time in responding to items.

Perfect tests: Two or more candidates with identical test results or perfect tests.

Unrealistic similarity: Two or more candidates who have more identical wrong answers than different wrong answers.

Unusual gain in scores: Candidates with unusual or artificial gains in scores in comparison to previous testing attempts.

Criteria for Withholding Scores

Candidate's scores may be withheld or, as circumstances may warrant, reported when aberrant response patterns or aberrant examination performance is detected through forensic analyses or other information that supports the possibility that the candidate has given or received confidential information concerning examination content during or prior to the examination. Similarly, scores may be withheld or reported if compelling information is available that suggests that the candidate was not testing for the intended purpose.

LIMITED RIGHT OF APPEALS FOR EXAMINATION CANDIDATES

The Joint Commission recognizes that strict application of the Examination Regulations for National Board Examinations may, because of unusual circumstances, impose an unusual burden on one or more candidates. In these situations, the Joint Commission may consider an appeal for special consideration.

Requests for an appeal pertaining to test results must be initiated within 30 days of receiving test results or, in the case of withheld scores, within 30 days of receiving written notice that scores are being withheld. In the event that the Joint Commission has given notice that previously released scores are to be invalidated or voided, the request for appeal must be submitted within 30 days. In this case, a request for appeal will stay the action to invalidate or void the score until such time as the appeal is decided or the time for submitting a request for appeal has expired. A request for an appeal must be submitted in writing and must include adequate documentation. The request for an appeal must indicate the specific relief requested.

A request for an appeal will first be screened by the Chair. The Chair, in his/her sole discretion, may 1) allow an appeal (if the Chair believes that there is a reasonable basis for the review of the facts of the case and the procedures applied thereto), 2) deny an appeal, or 3) recommend, in consultation with the secretary, to release scores.

When considering an appeal, the Joint Commission will strive to ensure that the candidates have an opportunity to gain National Board certification equal to, but not greater than, the opportunity provided other candidates.

If the issue presented in an appeal is likely to recur, the Joint Commission may consider a change in regulations. Granting of an appeal will be considered a precedent only if a change in regulations is also adopted. The candidate will be notified of the Joint Commission action within 60 days after receipt of the written request for the appeal.

The Chair of the JCNDE, in consultation with the secretary of the JCNDE, may grant an appeal when additional, convincing information becomes available early in the appeal process that indicates an error was made in the decision to withhold scores.

CONFLICT OF INTEREST POLICY

Policies and procedures used in National Board testing programs should provide for fairness and impartiality in the conduct of examinations and treatment of all candidates. Central to the fairness of the JCNDE's operations and the impartiality of its decision-making process is an organizational and personal duty to avoid real or perceived conflicts of interest. The potential for a conflict of interest arises when one's duty to make decisions in the public's interest is compromised by competing interest of a personal or private nature, including but not limited to pecuniary interests.

Conflict of interest is considered to be:

- 1) Any relationship with a candidate for National Board certification, or
- 2) A partiality or bias which might interfere with objectivity in the decision-making with respect to policy or the evaluation of individual appeals to the Joint Commission.

The Joint Commission strives to avoid conflict of interest or the appearance of a conflict in decisions regarding examination policy or individual candidate appeals. Potential conflicts of interest of Commissioners include, but are not limited to:

- A professional or personal relationship or affiliation with the individual or organization that may create a conflict or the appearance of a conflict.
- Being an officer or administrator in a dental education program, testing agency or board of dentistry with related decision-making influence regarding a candidate for National Board certification.

To safeguard the objectivity of the Joint Commission, it is the responsibility of any Commissioner to disclose any potential conflicts. Any member with a direct conflict of interest must recuse himself/herself from the decision-making process regarding candidate appeals or policies that impact the fairness and impartiality of the JCNDE's examination programs.

ASSISTANCE TO OTHER AGENCIES

One of the duties of the Joint Commission is to serve as a resource for the dental profession in the area of developing written examinations for licensure. The charge is fulfilled by providing assistance to state boards of dentistry and to national and international dental organizations. This policy statement describes limitations on availability.

Availability

Operation of National Board examinations is the Joint Commission's primary charge. Assistance is provided to a state board of dentistry or national dental organization only upon request and only if the Joint Commission possesses the resources to fulfill the request.

If the Joint Commission is forced to select agencies to receive assistance, highest priority will be given to state boards of dentistry that accept National Board scores. For dental organizations in the U.S. and its territories, assistance is limited to consultation and sharing general information about Joint Commission policies and procedures. Requests for testing services will be referred to the ADA Department of Testing Services or other organizations or individuals that provide such services.

Attachment 5. Links to Joint Commission Online Resources

NBDE Part I Guide

http://www.ada.org/~media/ADA/Education%20and%20Careers/Files/nbde01_examinee_guide.ashx

NBDE Part II Guide

http://www.ada.org/~media/ADA/Education%20and%20Careers/Files/nbde02_examinee_guide.ashx

NBDHE Guide

http://www.ada.org/~media/ADA/Education%20and%20Careers/Files/nbdhe_examinee_guide.ashx

2012 Test Item Development Guide

http://www.ada.org/~media/ADA/Education%20and%20Careers/Files/test_item_dev_guide.ashx

2012 NBDE Technical Report

http://www.ada.org/~media/JCNDE/pdfs/nbde_technical_report.ashx

2012 NBDHE Technical Report

http://www.ada.org/~media/JCNDE/pdfs/nbdhe_technical_report.ashx

Council on Scientific Affairs

Truelove, Edmond L., 2014, Washington, chair
Hart, Thomas C., 2015, Illinois, vice chair
Abt, Elliot G., 2016, Illinois
Dmytryk, John J., 2017, Oklahoma
Hale, Robert G., 2016, Texas (Federal Dental Services)
Janik, Andrea, 2014, Texas, *ex officio**
Ludlow, John B., 2016, North Carolina
Michalowicz, Bryan S., 2014, Minnesota
Milgrom, Peter M., 2015, Washington
Noraian, Kirk W., 2014, Illinois
Novy, Brian B., 2014, Massachusetts
Platt, Jeffrey A., 2017, Indiana
Slayton, Rebecca L., 2017, Washington
Sollecito, Thomas P., 2015, Pennsylvania
Weyant, Robert J., 2017, Pennsylvania
Williams, Ray C., 2015, New York
Wilson, Thomas G., Jr., 2015, Texas, *ad interim*
Young, Douglas A., 2016, California

Beltrán, Eugenio D., senior director

The Council's 2013–14 liaisons include: Dr. Andrew J. Kwasny (Third District trustee, Board of Trustees), Dr. Alice G. Boghosian (Council on Communications) and Ms. Sameet Gill (American Student Dental Association). The ADA president, in consultation with the Board of Trustees, appointed Dr. Thomas Wilson to complete the term of Dr. Geoffrey Thompson, who resigned from CSA in early 2014.

Purpose

The ADA Council on Scientific Affairs (CSA) serves the public, the dental profession and other health professions by advising the ADA on relevant and emerging scientific information for the promotion of oral health and the prevention and treatment of oral disease.

Supporting the Strategic Plan: Activities, Results and Accomplishments

The CSA manages the following primary programs that provide direct support to member dentists: development and review of evidence-based clinical recommendations; administration of the ADA Seal of Acceptance Program; conducting laboratory testing and clinical product reviews in conjunction with the *ADA Professional Product Review* program; and development of peer-reviewed journal reports, scientific policies, dental standards, CSA statements and online resources for ADA.org.

Helping Members Succeed and Excel

Evidence-Based Dentistry. In 2007, the ADA Board of Trustees established the ADA Center for Evidence-Based Dentistry (EBD Center), under CSA's oversight, to lead in the promotion of oral health by disseminating the best available scientific information and helping practitioners implement EBD in clinical practice. The Council and the EBD Center work collaboratively to develop evidence-based clinical practice guidelines as first-line resources to help dentists integrate science with their professional judgment and patients' needs and preferences. The Association's [EBD website](#) was updated in 2014 to provide improved access to the ADA's clinically relevant resources supporting evidence-based care, including clinical practice guidelines, systematic reviews of the literature, critical summaries of systematic

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

reviews, and chairside guides that provide concise information for reference at the point of care. These resources, plus the Center's educational programs—EBD Champions Conference, Advanced EBD Workshop and customized workshops—support professional excellence in evidence-based practice.

The EBD Center achieved the following measures of success in 2013-2014:

- The EBD website had 56,769 unique visitors in 2013, exceeding the EBD Center's target level by 13%.
- The EBD Center exceeded its attendance goal by 65%, and had overwhelmingly positive evaluations, with most parameters rated as very good or excellent.
- The Advanced EBD workshop had 40 registered participants to reach its maximum capacity as it has done since its inception.

Seal of Acceptance Program. The Seal of Acceptance Program provides the profession and the public with reliable information on safe and effective OTC oral health products. The success of the Seal Program can be measured by the number of products in the Seal Program, the number of visits to Seal web pages on ADA.org and MouthHealthy.org, and by consumers' and dental professionals' perception of the ADA Seal's importance.

Over the past year, the number of brand-name products in the Seal Program increased by 1.5%, and combined visits to the ADA Seal web pages on ADA.org and MouthHealthy.org increased by 76%. Consumer opinion about the ADA Seal has also remained relatively strong. A 2012-2013 consumer survey of individuals who were exposed to an ADA Seal marketing program found the following:

- 66% were more inclined to purchase products with the ADA Seal after their dental visit.
- Nearly three out of four consumer respondents agreed that the ADA Seal simplifies the selection of products, and three out of four also said they were likely to select products with the ADA Seal.

For clinicians who participated in this survey and the ADA Seal marketing program, 90% said they were more likely to recommend Seal products to patients. Overall, the 2012-2013 survey suggests that when consumers have more information about the ADA Seal Program, they indicate that they will likely choose Seal products. To inform more consumers about the Seal, the ADA Marketing department is expanding Seal promotion via conventional and social media platforms, and adding consumer-oriented information on MouthHealthy.org.

The CSA is continuing its efforts to improve the Seal Program and encourage manufacturers to submit more products for the ADA Seal. The Council invited several manufacturers of over-the-counter (OTC) oral care products to the April 2014 CSA meeting to provide perspectives on where they feel the Seal Program functions well, and where it could be modified or improved. The Council will consider these and other comments as it appraises methods to increase manufacturer participation and member value in the Seal Program.

Trusted Resource for Oral Health Information

The Council aims to identify and meet the oral health information needs of ADA members and the patients they serve, and to build the profession's knowledge in EBD and dental science. This section addresses recent projects of CSA and the EBD Center to develop evidence-based reports and resources.

Evidence-Based Clinical Practice Guidelines. In 2013-2014, the EBD Center led the development of four evidence-based clinical practice guidelines projects:

- *Topical Fluoride for Caries Prevention:* The CSA approved an updated clinical practice guideline and a [comprehensive systematic review](#) on topical fluoride for caries prevention, which was published as an [executive summary](#) in the November 2013 JADA. A [chairside guide for clinicians](#), podcast, press release, articles in *ADA News* and *New Dentist News*, as well as postings on

social media, blogs, and e-communications, were concurrently released to promote the new guideline.

- *Nonsurgical Treatment of Chronic Periodontitis*: A preliminary draft of this full clinical practice guideline and comprehensive systematic review are under development.
- *Pit-and-Fissure Sealants for Caries Arrest and Prevention*: The CSA appointed an expert panel to update the evidence-based clinical practice guidelines on pit-and-fissure sealants. The American Academy of Pediatric Dentistry (AAPD) is co-sponsoring this project.
- *Update on Dental Treatment for Patients With Prosthetic Joints*: To provide clarity to ADA members and health professionals with respect to the American Academy of Orthopaedic Surgeons (AAOS)/ADA prophylactic antibiotics for prevention of prosthetic joint infection recommendations, a CSA-convened panel is developing guidelines based on the AAOS systematic review

EBD Website. In 2013, the EBD website drew 56,769 online visitors, and the site has demonstrated a consistent increase since its launch in 2009. In spring 2014, the EBD website was re-launched as part of the ADA.org redesign to provide enhanced functionality and a better user experience, and to promote the ADA's clinical practice guidelines, critical summaries, tutorials and other EBD educational resources.

Collaboration With American Association for Dental Research (AADR) at ADA 2014—America's Dental Meeting. In 2014, the EBD Center will collaborate with AADR to offer their Fall Focused Symposium just prior to ADA 2014—America's Dental Meeting on October 7-8. The theme for the symposium will be translation of science into practice.

Dissemination and Implementation Research. Formerly known as “translational research,” dissemination and implementation (D&I) research aims to understand barriers to using current science in practice, and develop strategies to effectively overcome those barriers. The EBD Center is collaborating with the National Dental Practice-Based Research Network (NDPBRN) to conduct D&I research on the clinical practice guidelines program and to evaluate the NDPBRN. The EBD Center also collaborated with the University of Alabama and the Dentaquest Institute on an NIH R21 grant application to understand dentists' current use of the ADA's radiography guidelines.

To promote EBD education and implementation, EBD Center staff collaborated on a [January 2014 JADA article](#) that evaluated the concordance between clinical practice and published evidence of dentists who participate in the NDPBRN. EBD Center staff also authored a [peer-reviewed article on translating evidence from bench-top to chairside](#), which summarizes the EBD Center's processes for developing evidence-based guidelines and other resources to help clinicians.

EBD Champions 2.0 Conference. In May 2014, the EBD Center hosted a two-day EBD Champions 2.0 Conference, which focused on implementing science in clinical practice and served as a reunion conference for past EBD Champions attendees. Partially supported by a contribution from Procter & Gamble, the Champions 2.0 Conference aimed to create leaders in promoting oral health by sharing resources and building skills for dental professionals to integrate clinically relevant scientific evidence at the point of care.

Advanced EBD Workshop. Formerly held at the Forsyth Institute in Boston, the Advanced EBD Workshop was held in October 2013 at ADA headquarters. Taught by faculty from the ADA, the Forsyth Institute, and the Oxford Centre for Evidence-Based Dentistry, the course drew a capacity attendance of 40 participants who were educated on critical appraisal of systematic reviews and clinical studies, online citation management and more. The next Advanced EBD Workshop will be offered in February 2015.

Dental School Faculty and Student Outreach. In support of the ADA's focus on dental school faculty and student outreach for membership recruitment and retention, the EBD Center has several new and existing programs that target these populations:

- *Customized EBD Workshop*: The EBD Center conducted one custom EBD workshop in early 2014 at Columbia University. Other dental schools (e.g., Indiana University, University of

Pennsylvania and Kuwait University) have expressed interest in similar custom workshops in 2014-2015.

- *Distance Learning Certificate in Clinical Research:* For over 20 years, the University of Washington School of Dentistry has offered a research training institute, known as the Summer Institute in Clinical Dental Research Methods, for dental school faculty and students. The EBD Center and the University of Washington are now investigating the feasibility to transition this program into a pilot, one-year distance-learning course in clinical research methods. The course will offer a clinical research certificate from the university and the ADA, and over 100 hours of continuing education credit.
- *EBD Semester Course for Dental Students:* The EBD Center is investigating the feasibility of developing a one-semester, two-credit-hour online course in EBD, which is aimed to help dental schools take steps to meet CODA's accreditation standards for EBD.

Science Podcast. This year, the EBD Center will conduct a one-year, pilot podcast program called "ADA Science." The podcasts will be approximately 20 minutes, available on iTunes, and posted bi-weekly. Topics will center around EBD initially, but will be broadened to include other Science-wide programs.

Developing a Definition for the Term "Oral Health." In 2013-2014, the Council followed a stepwise process to develop a clear, concise definition for the term "oral health" that encapsulates the essential components of this central concept for the practice of dentistry and dental patient care. In summer 2013, the Council prepared an initial draft definition and circulated the draft to ADA councils for comment. The Council then circulated a revised draft definition to a number of outside dental specialty and governmental organizations for comment.

After reviewing various comments (mostly positive) from outside reviewers at its April 2014 meeting, the Council adopted the following as its definition for the term "oral health":

Oral health is a functional, structural, aesthetic, physiologic and psychosocial state of well-being and is essential to an individual's general health and quality of life.

This definition will serve as a focal point for CSA as it works to fulfill the ADA's mission of service in advancing the oral health of the public. The Council recognizes that oral health is a multidimensional yet relative concept that varies from person to person, but that it also encompasses some specific components on a universal level, including structure, function and aesthetics. Oral health is also a capacity and capability to maintain adequate function and structure, which in turn enhances one's psychosocial well-being. The Council hopes that the oral health definition will bring clarity and consensus to understanding that oral health is a basic human right, and to align future research efforts and oral health care, which contribute to the general health and well-being of patients. Additional information will be provided in the Council's supplemental report to the House of Delegates.

Caries Management and the ADA Caries Classification System. The Council has been examining current trends in caries prevalence and the microbiological processes involved in caries etiology. Dental caries is still the most prevalent disease in the United States, but the dental profession has primarily focused on restoring lesions rather than treating underlying causes of the disease. The Council recognizes the need for clinical management at all stages of the disease process, including assessment of caries risk factors, evidence-based interventions for caries prevention, and treatment or reversal of early, pre-cavitated lesions.

Accordingly, the Council has been working on developing a statement on caries management that will address strategies for minimizing risk factors, improving diagnostics, and reducing the incidence and severity of the disease. As one component of this project, the Council believes that it is first necessary to be able to accurately diagnose caries at its early stages, before frank lesions develop. One important goal of such a system is that it is easily understandable and usable by dentists in their everyday practices.

To this end, and after considerable review by caries experts, the CSA refined its ADA Caries Classification System and adopted it in spring 2014. The Council is also preparing a report for publication

that explains the ADA Caries Classification System and how practitioners can use it in clinical practice. Pending further CSA review and approval, this report will be submitted for publication later this year.

Improve Pediatric Oral Health by Finalizing Consensus Recommendations of Fluoride Toothpaste Use in Young Children Under Six Years of Age. For many years, the ADA has recommended that children from two to six years of age should brush with a pea-sized amount of fluoride toothpaste twice a day, and that children under two years should do so only with the recommendation of a dentist or physician. In recent years, other dental organizations started to promote different recommendations, which created confusion among oral health professionals and consumers.

The Council decided to assess the current state of the science. To do this, the Council conducted a systematic review of the available clinical study evidence on both the anticaries effectiveness and risk of fluorosis in children under six who use fluoride toothpaste. This evidence-based review, titled "[Fluoride Toothpaste Efficacy and Safety in Children Younger Than 6 Years: A Systematic Review](#)," was published in the February 2014 edition of *JADA*.

Based on the results of this study, and after review by various dental organizations, the Council also published a CSA report titled "[Fluoride Toothpaste Use for Young Children](#)" in the February 2014 issue of *JADA*, with new recommendations for use of fluoride toothpaste by children under six years of age. As of mid-May 2014, this CSA report was the third most-read *JADA* article over the previous 12-month period. Considering the available evidence and the continued high caries rate in children, the Council now recommends the following for children under age six when brushing twice daily with fluoride toothpaste (in tandem with supervision by a parent or guardian):

- For children younger than three years, caregivers should begin brushing children's teeth as soon as they begin to erupt by using fluoride toothpaste in an amount no more than a smear or the size of a grain of rice.
- For children three to six years of age, caregivers should dispense no more than a pea-sized amount of fluoride toothpaste.
- It is especially critical that dentists provide counseling to caregivers that involves the use of oral description, visual aids and actual demonstration to help ensure that the appropriate amount of toothpaste is used.

Clinical Management of Xerostomia and Salivary Gland Hypofunction. In 2014, the Council completed a new report to the profession on clinical management of xerostomia and salivary gland hypofunction, which presents an evidence-guided approach to dry mouth patient evaluation, diagnostic testing and interventions to reduce oral complications. An executive summary of this CSA report has been accepted by *JADA* for publication, which is anticipated in summer or fall 2014.

ADA 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. *PPR* primarily uses the ADA Laboratory's resources to provide scientifically sound product evaluations and critical analysis of product-related issues facing today's practitioners.

The October 2013 *PPR*, the most widely read issue to date (with over 55,000 visits), featured a laboratory evaluation of bulk-fill versus traditional multi-increment-fill resin-based composites. The January and April 2014 *PPR* newsletters have drawn over 39,500 visits, and included evaluations of surface disinfectants, electronic health records systems, and evaluations of dental unit waterline treatment systems, disposable air-turbine handpieces, and electric handpiece temperature and the associated risk of burns. This year also marked the debut of a new *PPR* feature, Mailbox, which highlights the myriad questions posed by ADA members to the Division of Science.

Building on previous *PPR* coverage of the origin of bisphenol A (BPA) in dental materials, an upcoming 2014 issue of *PPR* will feature a thorough evaluation of the amount of BPA measured in several resin-based dental composites. Based on ADA member input, additional content for 2014 provides laboratory evaluations of root canal irrigants, LED curing lights, and self-etch, self-adhesive resin cements, along

with articles that examine dental office ergonomics, occupational injury prevention and chairside screenings.

ADA Research and Laboratories. As primary content providers for the *PPR* newsletter, ADA Research and Laboratories staff provide leadership in the development and implementation of dental standards and guidelines for product evaluation. ADA scientists are currently involved in the standardization of test methods for antibacterial biofilm treatments for dental unit water delivery systems, powered toothbrush head retention, and cyclic fatigue of endodontic rotary instruments.

Research and Laboratories staff also investigate emerging issues that could impact environmental concerns and occupational health and safety. In late 2013, ADA scientists compiled one of the largest databases of information on potential risks associated with the practice of dentistry by examining more than 30 years of Health Screening Program data. The comprehensive database is being employed for occupational epidemiology research, and ongoing studies are investigating the prevalence of neurological disease, cumulative mercury exposure and peripheral nerve function among U.S. dentists.

Standards Development—2014 ADA SCDP/U.S. TAG Meeting. The Council promotes dental excellence by developing standards and technical reports for the current and emerging technologies used in clinical practice. In March 2014, 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 Charlotte, NC, where nine subcommittees and 24 working groups convened. Key discussion items included: work on profilometry-based techniques for abrasion testing in dentifrices; test methods to assess the separation force of the tuft plate for power brushes; and test methods for the evaluation of erosion. A joint Working Group with the Standards Committee on Dental Informatics (SCDI) was formed to address regulatory topics of relevance to the dental industry and profession, including issues surrounding the upcoming implementation of the FDA regulation on unique device identifiers for medical devices and “track and trace” for dental products.

2013 ISO/TC 106 Dentistry Meeting (Incheon, South Korea). In fall 2013, the ADA Department of Standards Administration facilitated participation by a U.S. delegation of over 50 dental professionals at the 2013 annual meeting of ISO/TC 106 Dentistry in South Korea. This delegation represented the U.S. among approximately 20 countries attending this annual meeting of international standards development.

Significant actions under U.S. leadership included presentation of a horizontal fluoride measurement standard for measuring bioavailable fluoride; approval of a new U.S.-led CAD/CAM working group on interoperability; presentation of the ADA Laboratory’s test equipment and work on a standard method for testing of brush head retention of powered toothbrushes; presentation of the ADA dental forensic data set standard and subsequent ISO agreement to form a task group for the creation of a standardized set of data needed for the oral identification of disaster victims; adoption of the ADA definition of nickel-free as “contains a maximum of 0.1% (m/m) nickel” into draft standard; agreement by ISO to consider creating a new work item to evaluate the use of dental sachets; and as a result of concern about metal ion release from dental implants, an ADA staff scientist, as convener of the corrosion working group, prepared a report on test methods for characterizing implant corrosion.

ANSI/ADA Standards Development. The ADA’s voluntary ANSI-accredited standards program develops consensus standards that provide direct value to ADA members. This year, the SCDP completed work on one new standard (Test Methods for the Evaluation of Treatment Methods Intended to Improve or Maintain the Microbiological Quality of Dental Unit Procedural Water), two joint standards with the Association for the Advancement of Medical Instrumentation (Table-Top Dry Heat [Heated Air] Sterilization and Sterility Assurance in Health Care Facilities; Table-top Steam Sterilizers), four revised ANSI/ADA standards (Root Canal Enlargers; Dental Obturating Cones; Dentifrices—Requirements, Test Methods and Marking; Barbed Broaches and Rasps) and two reaffirmations (Dental Absorbent Points; Dental Operating Lights).

The SCDP worked with the SCDI to complete a revised joint technical report entitled “Infection Control for Dental Information Systems.” SCDP also approved the development of a new standard to address the screening method for erosion potential of oral rinses on dental hard tissues and the development of a

technical report to address performance characteristics specific to dental gloves not otherwise covered in non-sterile gloves standards. These new items are being developed to assist member dentists and the profession to make informed purchasing decisions and provide improved materials to their patients.

The SCDI develops standards and technical reports that help provide interoperability for digital patient data, imaging systems and electronic health records (EHR) with health IT networks. The SCDI initiated two new projects: a technical report on Track and Trace for Implantable Devices, which will provide guidelines on technologies for tracking implants and saving product data to the patient's EHR; and a standard for recording patient radiation dose from digital imaging systems and uploading data to the patient's EHR.

Emerging Issues and Trends

The Council continually monitors emerging issues across the dental community and scientific landscape. The Minamata Convention, an international treaty designed to limit the use of mercury and mercury products, was ratified in October 2013 after four years of negotiation, and signed by delegates of about 140 nations. Consistent with the positions advocated by ADA representatives, the treaty calls for a phasedown instead of a ban of dental amalgam in 2020. The treaty also includes provisions that promote research to develop safe, cost-effective, mercury-free materials as an alternative to dental amalgam.

Another emerging issue for CSA has been the growing number of over-the-counter and direct-to-consumer genetic tests for assessing risk factors associated with the development of various diseases, including oral and periodontal diseases. The Council has become concerned about the availability of genetic test products that provide consumers with results that may lack clinical validity or clinical utility. The Council discussed one professional product that has been promoted as a genetic risk test for identifying patients at risk for periodontal disease, and raised questions about the supporting research for this and other genetic test products. As more information becomes available, the Council will provide guidance on the clinical relevance of genetic testing in oral health care.

Other emerging issues for CSA in 2014 have included: addressing pseudoscientific claims about the effectiveness of "oil pulling" (i.e., swishing natural oil in the oral cavity) to improve oral or general health, plus unsubstantiated online information on a potential association between endodontic treatment and an increased risk of developing systemic health conditions. To address these issues, the Council recommended that these and other potential non-scientific claims relative to oral health and patient safety be considered as a recurring agenda item at future CSA meetings. In addition, the Council chair provided perspectives on the practice of "oil pulling," which were integrated into a May 2014 [article](#) for "Science in the News" on ADA.org.

Responses to House of Delegates Resolutions

The Council's only assignment from the 2013 ADA House of Delegates was to undertake a thorough self-assessment in accordance with Resolution 1H-2013. This CSA self-assessment is presented below.

Self-Assessment

In accordance with Resolution 1H-2013, the Council reviewed comments and feedback that were provided by CSA members in response to a set of self-assessment questions that were shared with CSA before its April 2014 meeting. The Council also considered its primary programs, duties and effectiveness as an ADA council, its need to remain as an existing ADA council, the effectiveness of CSA's meeting agendas and usage of in-person meeting time at ADA headquarters. The Council's primary conclusions from its 2014 self-assessment are presented below:

- The Council's primary value to ADA members is: to provide the scientific basis for the profession of dentistry; to provide scientific, evidence-based approaches to patient care; and to address issues of direct importance to dentists and consumers from the perspective of science.

- The top three goals for the Council are: to support the profession by providing science and evidence-based information through scientific articles, evidence-based clinical practice guidelines, and review of professional products through the *ADA Professional Product Review*; to maintain the public trust by addressing critical issues related to detection, management and prevention of oral disease, and conducting the ADA Seal of Acceptance Program for OTC oral care products; and to protect the profession through the development of testing standards for dental products.
- CSA membership must remain skills-based, and not based upon an equitable distribution of CSA members by geographic location or other criteria, which could weaken CSA's research expertise in some areas (e.g., orofacial pain, genetics).
- The CSA continues to be regarded as a useful, necessary ADA agency because the basis of the profession lies in science. Council members unanimously agreed that CSA should continue to exist in its current form, and to provide leadership in addressing key concerns and emerging issues related to dental science, oral health care and disease prevention.
- One concern cited in CSA's self-assessment was that one or more of CSA's *Bylaws* duties could be better defined or more clearly phrased based on CSA's current programs and areas of focus, and with more of a contemporary context. Specific rephrasings of CSA's *Bylaws* duties were not considered as part of CSA's self-assessment, but CSA will consider this further in 2014.
- There was general agreement on the following:
 - CSA's current size (17 members) is appropriate because it provides the wide range of expertise necessary to address key scientific and health-related issues for the profession.
 - Holding three CSA meetings each year (at the standard meeting length of three days) is appropriate for all the issues that CSA addresses.
 - CSA has used a subcommittee structure to address issues between meetings and to improve the efficiency of in-person meetings; CSA noted that this structure is working well.
 - While CSA's decision-making processes are generally effective, CSA's meeting time could be improved or streamlined for greater efficiency.
- On occasion, resolutions from the House of Delegates require CSA to redirect resources into different areas to fulfill specific House-mandated directives, as occurred when CSA was asked to conduct a systematic review on alternative dental workforce models. CSA suggested that the ADA could consider "cross-training" staff from various ADA divisions outside the Division of Science, who could assist if large-scale collaborative projects arise. Future projects will require more clarity and proactive action regarding staffing needs and adequate staff coverage.
- The Council leadership noted that CSA staff does a tremendous amount of work. One reason that CSA performs more of its work through member subcommittees is because of staff's existing heavy workload. To do the things CSA determines are important for ADA members, CSA member involvement in helping to produce content in various areas is crucial. CSA members said they were relatively unaware of the staff-time allocations for CSA-supported projects, and knowing that information might influence their decision-making when considering projects to be pursued.
- The Council observed that it previously held a stronger relationship with the ADA Foundation (ADAF) and the Dr. Anthony Volpe Research Center (formerly known as Paffenbarger Research Center), and that ADAF previously funded some research projects that were recommended by CSA. The Council recommended further discussion of this liaison relationship in the near future.

Summary of Resolutions

This report is informational and no resolutions are presented.

Council Minutes

For more information, ADA members are encouraged to review the [minutes](#) of recent CSA meetings.

ADA Business Enterprises, Inc.

Wholly Owned Subsidiary

Mercer, James, 2015, South Carolina, chairman
Kiesling, Roger, 2014, Montana
Kolman, Paul, 2015, Indiana
Kunik, Burton, 2013, Texas
Meckler, Edward, 2016, Ohio
Maher, John, 2017, Wisconsin

Doherty, Deborah, managing vice president

Vision and Mission

ADA Business Enterprises, Inc. (ADABEI) is a wholly owned subsidiary of the American Dental Association ("Association").

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.

Activities, Results and Accomplishments

ADABEI Financials

ADABEI financials are unaudited and subject to change. ADABEI finished 2013 with net income (pre-tax) of \$352,723, driven in large part by the strong revenue performance of the financial services products.

In 2013, ADABEI earned \$2,407,003 in gross revenue as a result of service fees to ADABEI from the program (Table 1).

Two products, amalgam recovery with HealthFirst and website and marketing services with PBHS, were added in the second half of 2013. Interest was especially high for marketing. Together, the products added more than \$6,000 in unbudgeted service fees to ADABEI.

Table 1. 2013 ADABEI Financials

	2013 Actuals (Unaudited)	2013 Budget	Variance (\$)	Variance (%)
ADABEI Revenue	\$2,407,003	\$2,407,811	(\$808)	0.0%
Expense	\$2,054,280	\$2,103,419	\$49,139	2.3%
Net (Pre-Tax)	\$352,723	\$304,392	\$48,331	15.9%

ADA Royalties

In 2013, the ADA earned royalties of \$3,735,863 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 services products.

Table 2. 2013 ADA Financials

	2013 Actuals (Unaudited)	2012 Budget	Variance (\$)	Variance (%)
ADA Royalties	\$3,735,863	\$2,640,065	\$1,095,798	41.5%
Expenses	\$534,744	\$535,000	\$256	0.0%
Net (Pre-Tax)	\$3,201,119	\$2,105,065	\$1,096,054	52.0%

State dental societies may choose to co-endorse products and services and share in program revenue through a license agreement. In 2013, the program paid more than \$534,000 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, practice financing with Wells Fargo Practice Finance and patient financing with CareCredit, LLC.

Products

In 2013, the program included 16 products and services from 15 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
- Website and Marketing—PBHS, Inc.
- Amalgam Separators—HealthFirst
- 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

After a scorecard review was completed, six endorsement relationships were renewed in 2013.

- Practice Financing & Commercial Real Estate—Wells Fargo Practice Finance—5 Years
- Payroll Services—SurePayroll, Inc.—5 Years
- Staff Apparel—Lands' End Business Outfitters, Inc.—5 Years
- Digital & Paper Patient Charts—The Dental Record—5 Years
- Computers—Hewlett Packard and Meridian One Corporation—2 Years
- Appliances—Whirlpool VIP Program and Meridian One Corporation—2 Years

One product, shipping, was not renewed after ADABEI conducted a scorecard review. Proposals from both UPS and FedEx were considered and UPS was selected as the new endorsed provider in the category with a four-year agreement.

New Products

Product development continued to be a key focus for ADABEI. In addition to the 82 companies that contacted ADABEI in 2013 with an interest in a business relationship, ADABEI conducted ADA member focus groups and surveys to quantify industry and product trends, as well as to gauge product interest.

In the second half of 2013, ADABEI added two new products offered to ADA members, including a three-year agreement with PBHS, Inc. to provide website and marketing services, and a four-year agreement with HealthFirst to provide amalgam recovery solutions to ADA members.

Extensive due diligence was performed on both new products and providers to ensure they are industry leaders, solid financially, solve a member need and hold a higher service standard. In addition, for HealthFirst, an environmental consulting firm was retained to provide additional due diligence prior to the endorsement. All providers must offer preferred pricing for ADA members and all are monitored to ensure standards and offers are upheld.

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

In 2013, ADABEI made more than seven million impressions in the dental community, approximately a 15% increase versus 2012. The marketing touches including six direct mail pieces, four *ADA News* advertisements, 36 email newsletters and the ADA Business Resources website, with an increased focus on digital channels.

Summary of Resolutions

This report is informational and no resolutions are presented.

ADA Foundation

Whiston, David A., president, 2014, Virginia
Rethman, Michael P., vice president, scientific research, 2014, Hawaii
Szarzynski, Ronald, vice president, finance, 2014, Minnesota
Walker, Lewis C., vice president, development, 2015, Florida
Zarkowski, Pamela, vice president, grants, 2014, Michigan

Members at Large

Breeland, Nona I., 2017, North Carolina
Buckenheimer, Terry L., 2016, Florida
Bushick, Ronald D., 2015, Pennsylvania
Calnon, William, 2017, New York
Gounardes, Steven, 2014, New York
Hearn, Cindy, 2016, California
Hemmen, Pamela, 2016, Illinois
Jeffers, Gary E., 2017, Michigan
McDermott, Bernard K., 2017, District of Columbia
Panagakos, Fotinos S., 2017, New Jersey
Penrose, Michele, 2016, Michigan
Reyes, Reneida E., 2016, New York
Ross, Candy B., 2015, Georgia
Stefanick, John, 2017, Florida
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
Garcia, Cristina, grants program coordinator
Haibach, Cathy, manager, grants program/communications officer
Rabianski, Walter, manager, accounting and reporting
Watson, Shirley, manager, administrative services
Whan, Yoshie, senior manager, planning and development

Schumacher, Gary, director, administration, Volpe Research Center
Skrtic, Drago, director, research, Volpe Research Center

Mission and Purpose

The ADA Foundation provides charitable assistance for the dental community, and works to improve oral health by supporting access to care, research, and education programs (CARE).

Supporting the Strategic Plan: Activities, Results and Accomplishments

In 2013, the ADA Foundation made 249 grants totaling approximately \$1.38 million; every dollar was related to one or more of the aspects of the ADA's core values. These include 107 grants for disaster or financial assistance; 15 grants to support access to care programs, including the ADA's Give Kids A Smile NASCAR program, the ADA's Give Kids A Smile Leadership Institute, the ADA's Give Kids A Smile Mission of Mercy program conducted at the annual meeting in New Orleans, the ADA's Team Smile program, the ADA's Southeast Asia Dental Public Health Training program, as well as the ADA Foundation's Tarrson and Zwemer awards.

That number also includes 113 grants for various types of educational programs including support for the ADA Dentist Health and Wellness Conference, allied dental health students scholarship, predoctoral dental students scholarships, Harris awards for community education programs, support for the ADA's National Children's Dental Health Month activities, and support for the ADA's Prevention Summit.

Financial Matters

In 2013, the ADA grant to the ADA Foundation was once again \$1,906,533. That is the same amount as was granted to the Foundation in the previous year. In addition to the grant from the ADA, the Foundation also realized other contributions totaling \$3.8 million, most notably a \$1 million commitment from Colgate Palmolive Company in support of Foundation research efforts. Total expenses (excluding grants) for the Foundation were down nearly \$500,000 from the previous year.

ADA Foundation/Dr. Anthony Volpe Research Center

As mentioned above, during 2013 the Foundation realized a \$1 million commitment from Colgate Palmolive Company to help support research efforts. That \$1 million was combined with \$250,000 commitments from both the ADA and the ADA Foundation, resulting in the creation of a fund to establish a new named research chair at the research facility, the renaming of the research facility as the ADA Foundation/Dr. Anthony Volpe Research Center, and permanent support for the annual Dental Student Conference on Research, which recently celebrated its 50th anniversary. That conference will hereinafter be known as the Colgate Dental Student Conference on Research. During 2013, the Foundation added three new researchers to the Research Center staff, and was successful in securing a four-year \$2.25 million grant from the National Institute for Dental and Craniofacial Research (NIDCR), an institute within the National Institutes of Health (NIH).

Development

The Foundation also received significant corporate support from Henry Schein, Proctor and Gamble, CareCredit, 3M ESPE, Young Dental, and ADABEI. The commitment from Young Dental allowed the Foundation to create two new allied dental health scholarships, and the ADABEI commitment allowed the Foundation to expand the Tarrson award program from one grant to a dental school in 2012 to six grants in 2013.

Give Kids A Smile Gala

The 2013 Give Kids A Smile gala was a big success once again, earning revenue over expenses of more than \$82,000. Changes in the event from the previous year were very well received by attendees, and plans for 2014 are well under way.

Responses to House of Delegates Resolutions

There were no House resolutions directed specifically at the ADA Foundation this past year.

Summary of Resolutions

This report is informational and no resolutions are presented.

Links

For more information on recent activities, see <http://www.ada.org/adafoundation.aspx>.

2014 Annual Reports Index of Resolutions

Res. 1	<i>Reports:38</i>	Commission on Dental Accreditation Revision of the <i>Rules</i> of the Commission on Dental Accreditation to Replace the Name "American Association of Hospital Dentists" With "Special Care Dentistry Association"
Res. 2	<i>Reports:41</i>	Commission on Dental Accreditation Amendment of the ADA <i>Bylaws</i> Regarding the Duties of the Commission on Dental Accreditation
Res. 3	<i>Reports:42</i>	Commission on Dental Accreditation Amendment of the ADA <i>Bylaws</i> to Give the Commission on Dental Accreditation Authority to Make Editorial Corrections to Its Rules
Res. 4	<i>Reports:83</i>	Council on Dental Benefit Programs Amendment of the Policy, Closed Panel Dental Benefit Plans
Res. 5	<i>Reports:85</i>	Council on Dental Benefit Programs Amendment of the Policy, Medically Necessary Care
Res. 6	<i>Reports:103</i>	Council on Dental Education and Licensure Amendment of the <i>Bylaws</i> to Establish the Commission for Continuing Education Provider Recognition and Approval of the Rules of the ADA Commission for Continuing Education Provider Recognition
Res. 7	<i>Reports:107</i>	Council on Dental Education and Licensure Amendment of the <i>Bylaws</i> Duties of the Council on Dental Education and Licensure
Res. 8	<i>Reports:109</i>	Council on Dental Education and Licensure Amendment of the Policy, Development of Alternate Pathways for Dental Hygiene Training
Res. 9	<i>Reports:109</i>	Council on Dental Education and Licensure Amendment of the Policy, Recognition of Certification Board for Dental Assistants
Res. 10	<i>Reports:109</i>	Council on Dental Education and Licensure Amendment of the Policy, National Board for Certification of Dental Laboratory Technicians' Continued Recognition
Res. 11	<i>Reports:109</i>	Council on Dental Education and Licensure Amendment of the Criteria for Recognition of a Certification Board for Dental Assistants
Res. 12	<i>Reports:111</i>	Council on Dental Education and Licensure Amendment of the Criteria for Approval of a Certification Board for Dental Laboratory Technicians
Res. 13	<i>Reports:113</i>	Council on Dental Education and Licensure Amendment of the Policy, Titles and Descriptions of Dental Hygiene Continuing Education Courses
Res. 14	<i>Reports:132</i>	Council on Dental Practice Amendment of the ADA <i>Bylaws</i> Regarding the Duties of the Council on Dental Practice
Res. 15	<i>Reports:146</i>	Council on Ethics, Bylaws and Judicial Affairs Amendment of the Guidelines Governing the Conduct of Campaigns for All ADA Offices
Res. 16	<i>Reports:148</i>	Council on Ethics, Bylaws and Judicial Affairs Amendment of the Policy, The Dentist's Pledge

- Res. 17** *Reports:150* **Council on Ethics, Bylaws and Judicial Affairs**
Amendment of Chapters XII and XIII of the ADA *Bylaws*
- Res. 18** *Reports:181* **Council on Government Affairs**
Amendment of the ADA *Bylaws* Regarding the Duties of the Council on Government Affairs
- Res. 19** *Reports:202* **Council on Membership**
Amendment of the Policy, Tripartite Membership Application Procedures
- Res. 20** *Reports:213* **Joint Commission on National Dental Examinations**
Revisions to the Standing Rules of the Joint Commission on National Dental Examinations

Notes

ADA 2013 Audited Financial Statements

Notes



**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Consolidated Financial Statements and Supplemental Schedules

December 31, 2013 and 2012

(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, 2013 and 2012, 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, 2013 and 2012, 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 7, 2014

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Consolidated Statements of Financial Position

December 31, 2013 and 2012

Assets	2013	2012
Cash and cash equivalents	\$ 4,826,870	8,370,124
Receivables, net	9,695,762	7,729,198
Deferred taxes	94,363	128,262
Income taxes receivable	480,251	370,031
Prepaid expenses and other assets	2,105,021	2,115,452
Inventories, net	852,867	590,180
Marketable securities	143,558,006	108,826,964
Property and equipment, net	36,368,765	40,246,494
Funds held for deferred compensation	6,340,768	5,445,955
Total assets	<u>\$ 204,322,673</u>	<u>173,822,660</u>
Liabilities and Net Assets		
Accounts payable and accrued liabilities	\$ 14,124,021	13,239,922
Due to constituent societies	27,947	17,652
Deferred revenues	11,449,077	11,740,169
Charitable gift annuities	68,489	77,112
Liability for deferred compensation	6,340,768	5,445,955
Postretirement benefit obligation	9,139,136	10,533,050
Pension liability	29,024,220	56,796,206
Total liabilities	<u>70,173,658</u>	<u>97,850,066</u>
Net assets:		
Unrestricted	118,719,427	63,888,749
Temporarily restricted	13,290,746	9,945,003
Permanently restricted	2,138,842	2,138,842
Total net assets	<u>134,149,015</u>	<u>75,972,594</u>
Total liabilities and net assets	<u>\$ 204,322,673</u>	<u>173,822,660</u>

See accompanying notes to consolidated financial statements.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Consolidated Statements of Activities
Years ended December 31, 2013 and 2012

	2013				2012			
	Unrestricted	Temporarily restricted	Permanently restricted	Total	Unrestricted	Temporarily restricted	Permanently restricted	Total
Membership dues	\$ 56,935,135	—	—	56,935,135	54,551,655	—	—	54,551,655
Advertising	8,086,474	—	—	8,086,474	8,129,803	—	—	8,129,803
Rental income	5,438,819	—	—	5,438,819	5,458,093	—	—	5,458,093
Publication and product sales	7,811,976	—	—	7,811,976	7,448,384	—	—	7,448,384
Testing and accreditation fees	19,805,228	—	—	19,805,228	18,854,668	—	—	18,854,668
Meeting and seminar income	9,439,140	—	—	9,439,140	11,418,883	—	—	11,418,883
Grants, contributions, and sponsorships	2,223,908	3,516,040	—	5,739,948	2,853,102	2,547,391	—	5,400,493
Royalties and service fees	16,963,809	—	—	16,963,809	10,485,490	—	—	10,485,490
Investment income	14,210,857	2,251,857	—	16,462,714	10,256,308	1,346,359	—	11,602,667
Other income	3,002,954	5,522	—	3,008,476	2,777,212	45,092	—	2,822,304
Net assets released from restrictions	2,427,676	(2,427,676)	—	—	3,031,957	(3,031,957)	—	—
Total revenues	146,345,976	3,345,743	—	149,691,719	135,265,555	906,885	—	136,172,440
Expenses:								
Staff compensation, taxes, and benefits	56,516,379	—	—	56,516,379	59,798,557	—	—	59,798,557
Printing, publication, and marketing	9,812,564	—	—	9,812,564	10,815,806	—	—	10,815,806
Meeting expenses	2,237,289	—	—	2,237,289	3,237,651	—	—	3,237,651
Travel expenses	6,295,834	—	—	6,295,834	5,840,996	—	—	5,840,996
Consulting fees and outside services	7,080,714	—	—	7,080,714	9,045,600	—	—	9,045,600
Professional services	9,419,725	—	—	9,419,725	9,215,552	—	—	9,215,552
Office expenses	5,202,909	—	—	5,202,909	5,301,616	—	—	5,301,616
Facility and utility expenses	5,720,325	—	—	5,720,325	6,287,907	—	—	6,287,907
Grants and awards	3,964,938	—	—	3,964,938	4,585,040	—	—	4,585,040
Endorsement expenses	718,231	—	—	718,231	649,550	—	—	649,550
Depreciation and amortization	6,573,158	—	—	6,573,158	6,749,299	—	—	6,749,299
Bank and credit card fees	1,528,568	—	—	1,528,568	1,152,625	—	—	1,152,625
Other expenses	1,178,185	—	—	1,178,185	1,726,171	—	—	1,726,171
Total expenses	116,248,819	—	—	116,248,819	124,406,370	—	—	124,406,370
Net income from operations before income tax expense	30,097,157	3,345,743	—	33,442,900	10,859,185	906,885	—	11,766,070
Income tax expense	2,669,467	—	—	2,669,467	2,009,734	—	—	2,009,734
Net income	27,427,690	3,345,743	—	30,773,433	8,849,451	906,885	—	9,756,336
Pension — and postretirement health plan — related changes other than net periodic pension cost	27,402,988	—	—	27,402,988	(6,252,770)	—	—	(6,252,770)
Change in net assets	54,830,678	3,345,743	—	58,176,421	2,596,681	906,885	—	3,503,566
Net assets at beginning 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
Net assets at end of year	\$ 118,719,427	13,290,746	2,138,842	134,149,015	63,888,749	9,945,003	2,138,842	75,972,594

See accompanying notes to consolidated financial statements.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Consolidated Statements of Cash Flows

Years ended December 31, 2013 and 2012

	<u>2013</u>	<u>2012</u>
Cash flows from operating activities:		
Change in net assets	\$ 58,176,421	3,503,566
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	(27,402,988)	6,252,770
Depreciation and amortization	6,573,158	6,749,299
Deferred income tax expense	265,682	302,496
Change in net unrealized appreciation in fair value of marketable securities	(11,743,426)	(10,122,398)
Net realized (gain) loss on sale of marketable securities	(1,965,677)	921,517
Net assets released from restrictions and used for operations	1,166,409	731,234
Change in actuarial value of gift annuity obligations	11,380	11,272
Provision for uncollectible accounts	192,768	104,800
Changes in assets and liabilities:		
Receivables, net	(2,159,332)	(465,922)
Income taxes receivable	(110,220)	380,126
Prepaid expenses and other assets	(221,352)	(170,746)
Inventories, net	(262,687)	9,865
Accounts payable, accrued liabilities, and other liabilities	894,394	3,063,127
Deferred revenues	(291,092)	(764,293)
Postretirement benefit obligation	(840,246)	(446,553)
Pension liability	(922,666)	487,317
Net cash provided by operating activities	<u>21,360,526</u>	<u>10,547,477</u>
Cash flows from investing activities:		
Purchase of marketable securities	(49,611,881)	(40,623,126)
Sale and maturity of marketable securities	28,589,942	33,601,432
Acquisitions of property and equipment	(2,695,429)	(3,424,189)
Net cash used in investing activities	<u>(23,717,368)</u>	<u>(10,445,883)</u>
Cash flows from financing activities:		
Net assets released from restrictions and used for operations	(1,166,409)	(731,234)
Payments to charitable gift annuitant	(20,003)	(20,003)
Net cash used in financing activities	<u>(1,186,412)</u>	<u>(751,237)</u>
Net decrease in cash and cash equivalents	(3,543,254)	(649,643)
Cash and equivalents at beginning of year	<u>8,370,124</u>	<u>9,019,767</u>
Cash and cash equivalents at end of year	<u>\$ 4,826,870</u>	<u>8,370,124</u>
Supplemental disclosure of cash flow information:		
Cash paid for income taxes	\$ 1,759,549	835,625

See accompanying notes to consolidated financial statements.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

(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, 2013 and 2012 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.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

(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 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 \$98,477 and \$75,023 in 2013 and 2012, 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.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

(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 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 \$5,406,000 and \$6,888,000 at December 31, 2013 and 2012, 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.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

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 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

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

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.

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

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

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 2013 and 2012.

(2) Receivables

Receivables at December 31, 2013 and 2012 consist of the following:

	2013	2012
Trade receivables	\$ 4,345,851	3,649,307
Royalties receivable	1,932,055	2,298,244
Grants and contracts receivable	224,827	210,609
Tenant receivables	2,359,611	1,920,997
Pledges receivable	958,998	38,810
Other	439,576	64,142
Total	10,260,918	8,182,109
Less allowance for doubtful receivables	(565,156)	(452,911)
Net receivables	\$ 9,695,762	7,729,198

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, 2013 and 2012:

	2013	2012
Unconditional promises to give	\$ 1,020,001	38,810
Less unamortized discount	(61,003)	—
	958,998	38,810
Less allowance for uncollectible pledges	—	1,250
Net pledges receivable	\$ 958,998	37,560
Amounts due in:		
Less than one year	\$ 175,983	18,810
One to five years	783,015	20,000
Total	\$ 958,998	38,810

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

Changes in the Association's allowance for doubtful receivables for the years ended December 31, 2013 and 2012 are as follows:

	<u>2013</u>	<u>2012</u>
Beginning balance	\$ 452,911	679,552
Provision for uncollectible accounts	192,768	104,800
Accounts written off	<u>(80,523)</u>	<u>(331,441)</u>
Ending balance	<u>\$ 565,156</u>	<u>452,911</u>

(3) Marketable Securities

Marketable securities at December 31, 2013 and 2012 consisted of the following:

	<u>2013</u>	
	<u>Cost</u>	<u>Market</u>
Money market funds	\$ 12,091	12,091
Bonds and bond funds	56,090,259	56,241,946
Equities and equity funds	<u>70,657,345</u>	<u>87,303,969</u>
	<u>\$ 126,759,695</u>	<u>143,558,006</u>

	<u>2012</u>	
	<u>Cost</u>	<u>Market</u>
Money market funds	\$ 34,296	34,296
Bonds and bond funds	39,323,782	40,253,018
Equities and equity funds	<u>64,425,815</u>	<u>68,539,650</u>
	<u>\$ 103,783,893</u>	<u>108,826,964</u>

The fair value of marketable securities held in the Reserve Division amounted to \$89,922,907 and \$69,553,388 at December 31, 2013 and 2012, respectively.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

Investment income is included in the accompanying consolidated statements of activities for the years ended December 31, 2013 and 2012 as follows:

	<u>2013</u>	<u>2012</u>
Interest and dividends	\$ 1,863,695	1,853,370
Change in net unrealized appreciation in fair value of marketable securities	11,743,426	10,122,398
Net realized gain (loss) on sale of marketable securities	1,965,677	(921,517)
Net unrealized appreciation on funds held for deferred compensation	<u>889,916</u>	<u>548,416</u>
Total investment income	<u>\$ 16,462,714</u>	<u>11,602,667</u>

(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.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

- Level 2 – Pricing inputs are other than quoted prices in active markets, which are either directly or indirectly observable as of the report date. The nature of these securities include investments for which quoted prices are available but which are traded less frequently and investments that are fairly valued using other securities, the parameters of which can be directly observed.
- Level 3 – Securities that have little to no pricing observability as of the report date. These securities are measured using management’s best estimate of fair value, where the inputs into the determination of fair value are not observable and require significant management judgment or estimation.

Inputs are used in applying the various valuation techniques and broadly refer to the assumptions that market participants use to make valuation decisions, including assumptions about risk. Inputs may include price information, volatility statistics, specific and broad credit data, liquidity statistics, and other factors. A financial instrument’s level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. However, the determination of what constitutes “observable” requires significant judgment by the 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.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

The following table sets forth by level, within the fair value hierarchy, the Association's assets at fair value as of December 31, 2013 and 2012:

	2013				Redemption or liquidation	Days notice
	Level 1	Level 2	Level 3	Total		
Cash and cash equivalents	\$ 4,826,871	—	—	4,826,871	Daily	One
Marketable securities:						
Money market funds	12,091	—	—	12,091	Daily	One
Fixed income mutual funds	56,140,548	—	—	56,140,548	Daily	One
Equity mutual funds	75,126,777	—	—	75,126,777	Daily	One
Corporate bonds	—	101,398	—	101,398	Daily	One
Alternative investment funds:						
Common Sense Offshore Fund	—	3,078,793	—	3,078,793	Quarterly	100
Blackstone Partners Offshore Fund	—	3,682,282	—	3,682,282	Semiannual	95
Barlow Partners Offshore Fund	—	2,701,440	—	2,701,440	Monthly	60
Wellington Archipelago Fund	—	2,714,677	—	2,714,677	Quarterly	45
Total alternative investment funds	—	12,177,192	—	12,177,192		
Total marketable securities	131,279,416	12,278,590	—	143,558,006		
Funds held for deferred compensation:						
Money market funds	815,638	—	—	815,638	Daily	One
Equity mutual funds	3,996,176	—	—	3,996,176	Daily	One
Fixed income mutual funds	559,116	—	—	559,116	Daily	One
Corporate bonds	—	969,838	—	969,838	Daily	One
Total funds held for deferred compensation	5,370,930	969,838	—	6,340,768		
Total assets at fair value	\$ 136,650,346	13,248,428	—	149,898,774		

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

There were no transfers in or out of Level 1, Level 2, or Level 3 assets during the year ended December 31, 2013.

	2012				Redemption or liquidation	Days notice
	Level 1	Level 2	Level 3	Total		
Cash and cash equivalents	\$ 8,370,124	—	—	8,370,124		
Marketable securities:						
Money market funds	34,296	—	—	34,296	Daily	One
Fixed income mutual funds	40,185,291	—	—	40,185,291	Daily	One
Equity mutual funds	59,728,034	—	—	59,728,034	Daily	One
Corporate bonds	—	67,727	—	67,727	Daily	One
Alternative investment funds:						
Common Sense Offshore Fund	—	5,468,449	—	5,468,449	Quarterly	100
Blackstone Partners Offshore Fund	—	3,343,167	—	3,343,167	Semiannual	95
Total alternative investment funds	—	8,811,616	—	8,811,616		
Total marketable securities	99,947,621	8,879,343	—	108,826,964		
Funds held for deferred compensation:						
Money market funds	801,768	—	—	801,768	Daily	One
Equity mutual funds	2,931,004	—	—	2,931,004	Daily	One
Fixed income mutual funds	707,077	—	—	707,077	Daily	One
Corporate bonds	—	1,006,106	—	1,006,106	Daily	One
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 transfers in or out of Level 1, Level 2, or Level 3 assets during the year ended December 31, 2012.

The Association is invested in four alternative investment funds at December 31, 2013 and two as of December 31, 2012 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 balances in these funds were \$12,177,192 and \$8,811,616 at December 31, 2013 and 2012, respectively, and have been reflected as Level 2 assets in the fair value tables presented above. The Association is in process of redeeming its investment in the Common Sense Offshore Fund. As of the date of this report, the Association has

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

received about 87% of its investment in the Common Sense Offshore Fund. The Association expects to receive the remaining balance during 2014.

(5) Property and Equipment

Property and equipment at December 31, 2013 and 2012 consisted of the following:

2013			
	Chicago, IL	Washington, D.C.	Total
Land	\$ 712,113	3,030,000	3,742,113
Building	12,381,169	9,602,195	21,983,364
Building improvements	70,811,306	2,915,688	73,726,994
Furniture and equipment	45,928,480	1,200,533	47,129,013
Tenant leasehold improvements	1,146,587	2,239,178	3,385,765
	<u>130,979,655</u>	<u>18,987,594</u>	<u>149,967,249</u>
Less accumulated depreciation and amortization	<u>101,807,034</u>	<u>11,791,450</u>	<u>113,598,484</u>
	<u>\$ 29,172,621</u>	<u>7,196,144</u>	<u>36,368,765</u>
2012			
	Chicago, IL	Washington, D.C.	Total
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>

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

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, 2013 are as follows:

2014	\$ 2,987,475
2015	2,689,708
2016	2,582,709
2017	2,128,262
2018	2,070,079
Thereafter	<u>1,968,270</u>
	<u>\$ 14,426,503</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 \$94,963 and \$128,262 as of December 31, 2013 and 2012, respectively, is attributable primarily to carryforwards for state net operating losses and other timing differences. The

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

Association has set up a valuation allowance for 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, 2013 and 2012 of \$157,409 and \$162,221, respectively. 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, 2013 and 2012. Income tax expense for the years ended December 31, 2013 and 2012 is as follows:

	<u>2013</u>	<u>2012</u>
Current:		
Federal	\$ 1,311,289	984,107
State	395,779	327,900
Creation of income tax reserve	928,500	395,231
Current income tax expense	<u>2,635,568</u>	<u>1,707,238</u>
Deferred:		
Federal	27,390	132,900
State	11,321	7,375
Change in valuation allowance	(4,812)	162,221
Deferred income tax expense	<u>33,899</u>	<u>302,496</u>
Income tax expense	<u>\$ 2,669,467</u>	<u>2,009,734</u>

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

Net deferred tax assets at December 31, 2013 and 2012 consisted of the following:

	<u>2013</u>	<u>2012</u>
Deferred tax assets (liabilities) resulting from:		
Postretirement health benefits	\$ 61,923	80,590
Charitable contributions	9,505	18,467
Capital loss carryforward	157,409	162,221
Net operating loss carryforward	<u>22,935</u>	<u>29,205</u>
Total deferred tax assets, net	251,772	290,483
Valuation allowance	<u>(157,409)</u>	<u>(162,221)</u>
Total deferred tax assets, net of valuation allowance	<u>\$ 94,363</u>	<u>128,262</u>

As of December 31, 2013 and 2012, net operating loss carryforwards totaling \$365,788 and \$465,788, respectively, are available to offset future taxable income of ADABEI for state tax purposes. As of December 31, 2013, these carryforwards expire as follows for state tax purposes: \$365,788 in 2021.

As of December 31, 2013 and 2012, 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 \$1,543,650 and \$452,844, respectively. The 2013 amount is based on finalizing a settlement with the IRS related to discontinued operations of ADAIDM. ADABEI records uncertain tax positions in income tax expense in the accompanying consolidated financial statements. 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 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.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

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 \$0 and \$44,210 at December 31, 2013 and 2012, 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.

The following table sets forth the plans' funded status and amounts recognized in the Association's consolidated financial statements:

	2013		
	Employees' Retirement Trust	Employees' Supplemental Trust	Total
Change in projected benefit obligation:			
Projected benefit obligation, beginning of year	\$ 182,430,718	1,513,228	183,943,946
Service cost	1,798,505	—	1,798,505
Interest cost	8,167,139	66,992	8,234,131
Actuarial gain	(15,935,454)	(114,887)	(16,050,341)
Benefits paid	(7,102,943)	(92,796)	(7,195,739)
Projected benefit obligation, end of year	\$ <u>169,357,965</u>	<u>1,372,537</u>	<u>170,730,502</u>
Change in plan assets:			
Fair value of plan assets, beginning of year	\$ 127,147,740	—	127,147,740
Actual return on plan assets	15,511,485	—	15,511,485
Employer contributions	6,150,000	92,796	6,242,796
Benefits paid	(7,102,943)	(92,796)	(7,195,739)
Fair value of plan assets, end of year	\$ <u>141,706,282</u>	<u>—</u>	<u>141,706,282</u>

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

	2013		
	Employees' Retirement Trust	Employees' Supplemental Trust	Total
Funded status, end of year:			
Fair value of plan assets	\$ 141,706,282	—	141,706,282
Benefit obligation	169,357,965	1,372,537	170,730,502
Funded status	<u>\$ (27,651,683)</u>	<u>(1,372,537)</u>	<u>(29,024,220)</u>
Amounts recognized in the accompanying consolidated statements of financial position:			
Pension liability	\$ 27,651,683	1,372,537	29,024,220
Accumulated benefit obligation	169,357,965	1,372,537	170,730,502
Amounts not yet reflected in net periodic benefit expense and included as accumulated charges to unrestricted net assets:			
Prior service cost	\$ (9,921,025)	—	(9,921,025)
Net actuarial loss	52,965,822	—	52,965,822
Net amounts included as an accumulated charge to unrestricted net assets	<u>\$ 43,044,797</u>	<u>—</u>	<u>43,044,797</u>
Components of net periodic benefit cost:			
Service cost	\$ 1,798,505	—	1,798,505
Interest cost	8,167,139	66,992	8,234,131
Expected return on plan assets	(10,327,545)	—	(10,327,545)
Prior service cost	(1,491,883)	—	(1,491,883)
Recognized net loss	7,106,922	—	7,106,922
Net periodic benefit cost	<u>\$ 5,253,138</u>	<u>66,992</u>	<u>5,320,130</u>

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

	2013		
	Employees' Retirement Trust	Employees' Supplemental Trust	Total
Calculation of change in unrestricted net assets:			
Accumulated unrestricted net assets, end of year	\$ 43,044,797	—	43,044,797
Reversal of accumulated unrestricted net assets, prior year	<u>(69,894,117)</u>	<u>—</u>	<u>(69,894,117)</u>
Change in unrestricted net assets	<u>\$ (26,849,320)</u>	<u>—</u>	<u>(26,849,320)</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:			
Net gain experienced during the year	\$ (21,234,281)	—	(21,234,281)
Amortization of prior service cost due to plan amendments	1,491,883	—	1,491,883
Amortization of unrecognized net loss	<u>(7,106,922)</u>	<u>—</u>	<u>(7,106,922)</u>
Net amounts recognized in unrestricted net assets	<u>\$ (26,849,320)</u>	<u>—</u>	<u>(26,849,320)</u>
Estimate of amounts that will be amortized out of unrestricted net assets into net pension expense in 2014:			
Net loss	\$ 4,037,432	—	4,037,432
Prior service cost	(1,491,883)	—	(1,491,883)
Weighted average assumptions as of December 31:			
Discount rate	5.28%	5.28%	
Expected return on plan assets	8.00	8.00	
Rate of compensation increase	3.00	3.00	

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

	2012		
	Employees' Retirement Trust	Employees' Supplemental Trust	Total
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>
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

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

	2012		
	Employees' Retirement Trust	Employees' Supplemental Trust	Total
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
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	(64,719,847)	—	(64,719,847)
Change in unrestricted net assets	\$ 5,174,270	—	5,174,270

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

	2012		
	Employees' Retirement Trust	Employees' Supplemental Trust	Total
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	4.56%	4.56%	
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.

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.

The Association expects to contribute approximately \$8,042,796 to the Plan in 2014. The minimum funding contributions for the Plan years' 2013 and 2012 were \$6,387,598 and \$5,081,578,

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

respectively. The Association plans to contribute at least the minimum contribution of \$2,699,812 in 2014 related to the 2013 Plan year. The assets of the Plan are held in various investment manager funds and comprised of mutual funds and a guaranteed investment contract.

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:

2014	\$ 7,957,249
2015	8,426,977
2016	8,875,255
2017	9,373,071
2018	9,668,333
Thereafter	<u>55,832,799</u>
	<u>\$ 100,133,684</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.

The actual allocations for the pension assets as of December 31, 2013 and 2012, and target allocations by asset category, are as follows:

<u>Asset category</u>	2013	
	<u>Actual allocation</u>	<u>Target allocation</u>
Fixed income	37%	40%
Equity:		
Domestic small cap	10	11
Domestic large cap value	16	14
Domestic large cap growth	16	14
International	<u>21</u>	<u>21</u>
	<u>100%</u>	<u>100%</u>

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

Asset category	2012	
	Actual allocation	Target allocation
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
	100%	100%

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, 2013 and 2012.

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.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

(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, 2013 and 2012.

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2013 and 2012:

	2013				Redemption or liquidation	Days notice
	Total	Level 1	Level 2	Level 3		
Guaranteed investment contract	\$ 765,074	—	—	765,074	Daily	One
Equity mutual funds:						
Dodge & Cox Stock Fund	22,861,329	22,861,329	—	—	Daily	One
INTECH Growth Fund	22,559,712	22,559,712	—	—	Daily	One
Wells Fargo Small Cap Value Fund	14,541,409	14,541,409	—	—	Daily	One
Templeton Institutional Funds, Inc. International Equity Series	16,097,790	16,097,790	—	—	Daily	One
GMO International equity fund	13,954,341	13,954,341	—	—	Daily	One
Total equity mutual funds	<u>90,014,581</u>	<u>90,014,581</u>	<u>—</u>	<u>—</u>		
Fixed income mutual funds:						
PIMCO Long Duration Total Return Fund	12,444,470	12,444,470	—	—	Daily	One
PIMCO Long-Term Credit Fund	11,658,317	11,658,317	—	—	Daily	One
Vanguard Long-Term Investment-Grade Fund	26,823,840	26,823,840	—	—	Daily	One
Total fixed income mutual funds	<u>50,926,627</u>	<u>50,926,627</u>	<u>—</u>	<u>—</u>		
Total	<u>\$ 141,706,282</u>	<u>140,941,208</u>	<u>—</u>	<u>765,074</u>		

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

	2012				Redemption or liquidation	Days notice
	Total	Level 1	Level 2	Level 3		
Guaranteed investment contract	\$ 438,755	—	—	438,755	Daily	One
Equity mutual funds:						
Dodge & Cox Stock Fund	19,329,004	19,329,004	—	—	Daily	One
INTECH Growth Fund	18,762,449	18,762,449	—	—	Daily	One
Wells Fargo Small Cap Value Fund	12,653,883	12,653,883	—	—	Daily	One
Templeton Institutional Funds, Inc. International Equity Series	13,470,111	13,470,111	—	—	Daily	One
RS Investments (Baillie Gifford) International Equity Fund	12,422,822	12,422,822	—	—	Daily	One
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	—	—	Daily	One
PIMCO Long-Term Credit Fund	12,195,544	12,195,544	—	—	Daily	One
Vanguard Long-Term Investment-Grade Fund	26,298,186	26,298,186	—	—	Daily	One
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>		

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, 2013 to December 31, 2013:

	Investment contract
Investment contract:	
Balance, beginning of year	\$ 438,755
Interest income	25,158
Purchases	8,000,000
Sales	<u>(7,698,839)</u>
Balance, end of year	<u>\$ 765,074</u>

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

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:

	<u>Investment contract</u>
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>\$ 438,755</u>

(d) 401(k) Plan

The Association has a savings and retirement plan for all eligible employees (Savings Plan). The Association, at its discretion, contributes a predetermined amount to the plan. The plan was amended during 2013 whereby the Association may contribute to the accounts of eligible employees in lieu of the matching contributions provisions, which are suspended. For 2013, the Association contributed 4% of each eligible employee's base salary. For 2012, the Association contributed 4% of each eligible employee's base salary. The Association's contributions under the plan were \$1,526,963 and \$1,484,529 in 2013 and 2012, 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 \$75,225 were earned and payments totaling \$47,178 were made to participants in 2013. Awards of \$113,489 were earned and payments totaling \$212,099 were made to participants in 2012.

(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.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

The following table sets forth the plan's funded status:

	<u>2013</u>	<u>2012</u>
Change in benefit obligation:		
Benefit obligation, beginning of year	\$ 10,533,050	9,901,103
Service cost	375,295	359,019
Interest cost	439,067	463,052
Actuarial (gain) loss	(1,459,179)	213,337
Benefits paid	(749,097)	(403,461)
Plan amendments	—	—
Benefit obligation, end of year	<u>\$ 9,139,136</u>	<u>10,533,050</u>
Change in plan assets:		
Employer contributions	\$ 1,165,288	817,471
Benefits paid	<u>(1,165,288)</u>	<u>(817,471)</u>
Plan assets, end of year	<u>\$ —</u>	<u>—</u>
Funded status, end of year:		
Benefit obligation	\$ 9,139,136	10,533,050
Accumulated benefit obligation	9,139,136	10,533,050
Components of net periodic benefit cost:		
Service cost	\$ 375,295	359,019
Interest cost	439,067	463,052
Amortization of transition obligation	—	—
Amortization of prior service cost	(1,459,910)	(1,459,910)
Recognized net loss	<u>554,399</u>	<u>594,747</u>
Net periodic benefit cost	<u>\$ (91,149)</u>	<u>(43,092)</u>
Amounts recognized in the accompanying consolidated statement of financial position:		
Postretirement benefit obligation	\$ 9,139,136	10,533,050
Amounts not yet reflected in net periodic benefit expense and included as accumulated charges to unrestricted net assets:		
Net actuarial loss	\$ 5,292,262	7,305,840
Prior service cost	<u>(10,598,943)</u>	<u>(12,058,853)</u>
Net amounts included as an accumulated charge to unrestricted net assets	<u>\$ (5,306,681)</u>	<u>(4,753,013)</u>

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

	<u>2013</u>	<u>2012</u>
Calculation of change in unrestricted net assets:		
Accumulated unrestricted net assets, end of year	\$ (5,306,681)	(4,753,013)
Reversal of accumulated unrestricted net assets, prior year	<u>4,753,013</u>	<u>5,831,513</u>
Change in unrestricted net assets	<u><u>\$ (553,668)</u></u>	<u><u>1,078,500</u></u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net (gain) loss experienced during the year	\$ (1,459,179)	213,337
Amortization of net loss	(554,399)	(594,747)
Amortization of prior service cost	<u>1,459,910</u>	<u>1,459,910</u>
Net amounts recognized in unrestricted net assets	<u><u>\$ (553,668)</u></u>	<u><u>1,078,500</u></u>
Estimate of amounts that will be amortized out of unrestricted net assets into net postretirement benefit expense in 2013 and 2012:		
Net loss	\$ 423,438	605,866
Prior service cost	(1,459,910)	(1,459,910)
Weighted average assumptions used to determine obligations at December 31:		
Discount rate	5.28%	4.56%
Weighted average assumptions used to determine net periodic benefit cost for the years ended December 31:		
Discount rate	4.56%	5.16%
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	2014	2013

The Association expects to contribute approximately \$642,424 to the postretirement health plan in 2014.

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 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

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

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, 2013 and 2012 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 2013 and 2012 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 2013 and 2012, 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 2013 and 2012 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:

	Gross payments	Net payments after Medicare Part D adjustment
2014	\$ 357,883	357,883
2015	372,294	372,294
2016	393,151	393,151
2017	423,590	423,590
2018	452,872	452,872
2019–2022	2,808,258	2,808,258

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

(9) Net Assets

Temporarily restricted net assets at December 31, 2013 and 2012 were available for the following purposes:

	<u>2013</u>	<u>2012</u>
Campaign for innovation in dental education	\$ 571,934	598,680
Trusts	1,095,753	987,345
Extramural programs	113,520	113,520
Research	1,316,153	50,643
Awards	197,742	190,548
Education	216,705	162,126
Access	2,316,911	2,032,586
Political and legislative	676,908	182,253
Relief program	6,785,120	5,627,302
	<u>\$ 13,290,746</u>	<u>9,945,003</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 2013 and 2012 by incurring expenses satisfying the restricted purposes as follows:

	<u>2013</u>	<u>2012</u>
Campaign for innovation in dental education	\$ 7,779	230
Trusts	496	380
Research	67,903	3,131
Awards	35,305	10,060
Education	90,234	10,145
Access	903,025	631,857
Political and legislative	1,261,266	2,300,724
Relief program	61,668	75,430
	<u>\$ 2,427,676</u>	<u>3,031,957</u>

Permanently restricted net assets at December 31, 2013 and 2012 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

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

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.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

During 2013 and 2012, the ADAF had the following activities related to endowment net assets:

	2013			
	Unrestricted	Temporarily restricted	Permanently restricted	Total
Endowment net assets, beginning of year	\$ —	397,145	2,138,842	2,535,987
Investment returns:				
Interest and dividends	—	43,211	—	43,211
Realized gain on sale of investments	—	77,343	—	77,343
Net unrealized appreciation on investments	—	481,609	—	481,609
Total investment returns	—	602,163	—	602,163
Investment management fee	—	(1,295)	—	(1,295)
Appropriation of endowment assets for expenditures	—	(118,647)	—	(118,647)
Total change in endowment net assets	—	482,221	—	482,221
Endowment net assets, end of year	\$ —	879,366	2,138,842	3,018,208

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

	2012			
	Unrestricted	Temporarily restricted	Permanently restricted	Total
Endowment net assets, beginning of year	\$ —	135,817	2,138,842	2,274,659
Investment returns:				
Interest and dividends	—	54,029	—	54,029
Realized gain on sale of investments	—	35,134	—	35,134
Net unrealized appreciation on investments	—	258,028	—	258,028
Total investment returns	—	347,191	—	347,191
Investment management fee	—	(933)	—	(933)
Appropriation of endowment assets for expenditures	—	(84,930)	—	(84,930)
Total change in endowment net assets	—	261,328	—	261,328
Endowment net assets, end of year	\$ —	397,145	2,138,842	2,535,987

(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, 2013 and 2012:

	2013	2012
General fund:		
Administrative services	\$ 7,383,143	7,187,875
Legal affairs	3,559,451	4,004,954
Government affairs	8,468,569	8,969,342
Communications	4,900,058	4,196,857
Membership and dental society services	8,705,188	8,648,262
Global affairs	1,279,644	1,331,571
Conference and meeting services	8,009,091	9,616,611
Finance and operations	3,741,548	4,352,665
Headquarters building	5,298,056	6,025,679
D.C. building	1,018,415	1,086,870
Salable materials	4,033,166	4,205,301

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

	2013	2012
Central administration	\$ 10,360,925	9,814,972
Information technology and standards	9,386,708	8,995,432
Dental practice	3,032,289	3,406,383
Health policy resources center	2,328,745	2,507,280
Education	13,412,807	14,360,646
Science	5,668,844	6,491,976
Publishing	8,712,982	8,900,921
Corporate relations	1,119,233	590,199
Activities funded from reserves	800,105	1,895,967
Grant from ADA to ADAF	1,906,533	1,906,533
	<u>113,125,500</u>	<u>118,496,296</u>
Reserve division investment account	1,215,147	1,168,006
Eliminations of intercompany activities:		
Grant from ADA to ADAF	(1,906,533)	(1,906,533)
Reserve division earnings transfer	(1,196,194)	(1,168,006)
Headquarters building management office rent expense	(31,392)	(31,392)
	<u>111,206,528</u>	<u>116,558,371</u>
ADPAC total expenses including income tax expense	2,030,938	3,091,198
ADAF total expenses	5,230,366	5,794,585
ADABEI total expenses including income tax expense	2,906,156	2,553,975
Eliminations of intercompany activities:		
ADABEI rental charges	(108,870)	(89,336)
Professional services	(49,883)	(65,930)
Printing, publication, and marketing	(270,846)	(26,500)
Meeting expenses	—	(160)
Research expenses	(822,947)	(493,981)
Other expenses	(328,830)	(10,000)
Overhead recovery	(104,655)	(105,644)
In-kind administrative expenses	(769,672)	(790,474)
	<u>118,918,285</u>	<u>126,416,104</u>
Total expenses including income tax expense	\$ <u>118,918,285</u>	<u>126,416,104</u>

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

December 31, 2013 and 2012

(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 Internal Revenue Services (IRS). In late 2013, ADA and ADABEI received a settlement offer from the IRS for each of the years under audit (2007-2011). The audit adjustments were also carried forward to the 2013 returns. ADA and ADABEI accepted the IRS offer and paid the amount due in April 2014. The total amount due reflecting tax and interest expense is reflected in the 2013 year-end liabilities and expenses.

(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 consolidated statement of financial position date of December 31, 2013 through June 7, 2014, which was the date the consolidated financial statements were available to be issued.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Consolidated Statement of Financial Position with Supplementary Consolidating Information

December 31, 2013

Assets	General fund					ADPAC	ADAF	ADABEI	Eliminations	Total
	Operating division	Reserve division								
	Operating account	Capital formation account	Capital Fund	Investment account	Total general fund					
Cash and cash equivalents	\$ 3,221,457	—	—	—	3,221,457	661,008	314,857	629,548	—	4,826,870
Receivables, net	7,167,545	—	—	—	7,167,545	—	1,988,279	539,938	—	9,695,762
Due from affiliates	2,106,096	—	—	(2,301,045)	(194,949)	—	150,411	44,538	—	—
Deferred taxes	—	—	—	—	—	—	—	94,363	—	94,363
Income taxes receivable	—	—	—	—	—	—	—	480,251	—	480,251
Prepaid expenses and other assets	2,024,968	—	—	—	2,024,968	66,997	324	—	12,732	2,105,021
Inventories, net	852,867	—	—	—	852,867	—	—	—	—	852,867
Marketable securities	18,457,714	—	3,500,000	89,922,907	111,880,621	—	29,676,272	2,001,113	—	143,558,006
Investment in subsidiaries	—	2,227,163	—	—	2,227,163	—	—	—	(2,227,163)	—
Property and equipment, net	36,281,162	—	—	—	36,281,162	—	87,603	—	—	36,368,765
Funds held for deferred compensation	6,340,768	—	—	—	6,340,768	—	—	—	—	6,340,768
Total assets	\$ 76,452,577	2,227,163	3,500,000	87,621,862	169,801,602	728,005	32,217,746	3,789,751	(2,214,431)	204,322,673
Liabilities and Net Assets										
Accounts payable and accrued liabilities	\$ 11,736,466	—	—	242,166	11,978,632	51,097	531,704	1,562,588	—	14,124,021
Due to constituent societies	—	—	—	—	—	—	27,947	—	—	27,947
Deferred revenues	11,444,735	—	—	—	11,444,735	—	18,542	—	(14,200)	11,449,077
Charitable gift annuities	—	—	—	—	—	—	68,489	—	—	68,489
Liability for deferred compensation	6,340,768	—	—	—	6,340,768	—	—	—	—	6,340,768
Postretirement benefit obligation	—	—	—	9,139,136	9,139,136	—	—	—	—	9,139,136
Pension liability	29,024,220	—	—	—	29,024,220	—	—	—	—	29,024,220
Total liabilities	58,546,189	—	—	9,381,302	67,927,491	51,097	646,682	1,562,588	(14,200)	70,173,658
Net assets:										
Common stock	—	—	—	—	—	—	—	100,100	(100,100)	—
Additional paid-in capital	—	—	—	—	—	—	—	500,000	(500,000)	—
Unrestricted	17,906,388	2,227,163	3,500,000	78,240,560	101,874,111	—	16,818,384	1,627,063	(1,600,131)	118,719,427
Temporarily restricted	—	—	—	—	—	676,908	12,613,838	—	—	13,290,746
Permanently restricted	—	—	—	—	—	—	2,138,842	—	—	2,138,842
Total net assets	17,906,388	2,227,163	3,500,000	78,240,560	101,874,111	676,908	31,571,064	2,227,163	(2,200,231)	134,149,015
Total liabilities and net assets	\$ 76,452,577	2,227,163	3,500,000	87,621,862	169,801,602	728,005	32,217,746	3,789,751	(2,214,431)	204,322,673

See accompanying independent auditors' report.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Consolidated Statement of Activities with Supplementary Consolidating Information

December 31, 2013

	Operating division Operating account	General fund Reserve division			Total general fund	ADPAC	ADAF	ADABEI	Eliminations	Total
		Capital formation account	Capital Fund	Investment account						
Revenues:										
Membership dues	\$ 56,935,135	—	—	—	56,935,135	—	—	—	—	56,935,135
Advertising	8,144,774	—	—	—	8,144,774	—	—	—	(58,300)	8,086,474
Rental income	5,579,081	—	—	—	5,579,081	—	—	—	(140,262)	5,438,819
Publication and product sales	7,919,522	—	—	—	7,919,522	—	—	—	(107,546)	7,811,976
Testing and accreditation fees	19,805,228	—	—	—	19,805,228	—	—	—	—	19,805,228
Meeting and seminar income	9,341,590	—	—	—	9,341,590	—	97,550	—	—	9,439,140
Grants, contributions, and sponsorships	2,689,787	—	—	—	2,689,787	1,750,113	2,197,400	—	(897,352)	5,739,948
Grant from ADA	—	—	—	—	—	—	1,906,533	—	(1,906,533)	—
Royalties and service fees	13,053,500	—	—	—	13,053,500	—	1,502,350	2,407,959	—	16,963,809
Investment income (loss)	2,271,300	(499,153)	—	10,198,535	11,970,682	309	5,191,364	(2,601)	(697,040)	16,462,714
Other income	3,501,499	—	—	—	3,501,499	5,500	10,132	1,645	(510,300)	3,008,476
In-kind services	—	—	—	—	—	769,671	—	—	(769,671)	—
Total revenues	129,241,416	(499,153)	—	10,198,535	138,940,798	2,525,593	10,905,329	2,407,003	(5,087,004)	149,691,719
Expenses:										
Staff compensation, taxes, and benefits	53,283,346	—	—	—	53,283,346	—	2,702,678	530,355	—	56,516,379
Printing, publication, and marketing	9,217,173	—	—	—	9,217,173	41,309	16,352	808,576	(270,846)	9,812,564
Meeting expenses	2,080,054	—	—	—	2,080,054	26,226	115,104	15,905	—	2,237,289
Travel expenses	6,075,905	—	—	—	6,075,905	9,668	162,794	47,467	—	6,295,834
Consulting fees and outside services	6,753,130	—	—	—	6,753,130	233,915	63,019	30,650	—	7,080,714
Professional services	8,931,182	—	—	18,953	8,950,135	11,695	285,936	221,842	(49,883)	9,419,725
Office expenses	4,928,818	—	—	—	4,928,818	70,126	187,667	16,298	—	5,202,909
Facility and utility expenses	5,749,680	—	—	—	5,749,680	—	411	110,496	(140,262)	5,720,325
Grants and awards	2,586,256	—	—	—	2,586,256	852,493	1,321,636	27,500	(822,947)	3,964,938
Grant to ADA Foundation	1,906,533	—	—	—	1,906,533	—	—	—	(1,906,533)	—
Endorsement expenses	718,231	—	—	—	718,231	—	—	—	—	718,231
Depreciation and amortization	6,468,939	—	—	—	6,468,939	—	104,219	—	—	6,573,158
Bank and credit card fees	1,321,743	—	—	—	1,321,743	15,361	9,407	182,057	—	1,528,568
Other expenses	1,287,393	—	—	1,196,194	2,483,587	—	261,143	63,134	(1,629,679)	1,178,185
In-kind administrative expenses	—	—	—	—	—	769,671	—	—	(769,671)	—
Total expenses	111,308,383	—	—	1,215,147	112,523,530	2,030,464	5,230,366	2,054,280	(5,589,821)	116,248,819
Net income (loss) from operations before income tax expense	17,933,033	(499,153)	—	8,983,388	26,417,268	495,129	5,674,963	352,723	502,817	33,442,900
Income tax expense	1,817,117	—	—	—	1,817,117	474	—	851,876	—	2,669,467
Net income (loss)	16,115,916	(499,153)	—	8,983,388	24,600,151	494,655	5,674,963	(499,153)	502,817	30,773,433
Pension – and postretirement health plan – related changes other than net periodic pension cost	26,849,320	—	—	553,668	27,402,988	—	—	—	—	27,402,988
Increase (decrease) in net assets	42,965,236	(499,153)	—	9,537,056	52,003,139	494,655	5,674,963	(499,153)	502,817	58,176,421
Net assets (deficit) at beginning 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
Equity transfers	(14,796,647)	—	3,500,000	11,296,647	—	—	—	—	—	—
Net assets (deficit) at end of year	\$ 17,906,388	2,227,163	3,500,000	78,240,560	101,874,111	676,908	31,571,064	1,627,063	(1,600,131)	134,149,015

See accompanying independent auditors' report.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Consolidated Statement of Cash Flows with Supplementary Consolidating Information
Year ended December 31, 2013

	General fund					ADPAC	ADAF	ADABEI	Eliminations	Total
	Operating division	Reserve division			Total general fund					
	Operating account	Capital formation account	Capital fund	Investment account						
Cash flows from operating activities:										
Increase (decrease) in net assets	\$ 42,965,236	(499,153)	—	9,537,056	52,003,139	494,655	5,674,963	(499,153)	502,817	58,176,421
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	(26,849,320)	—	—	(553,668)	(27,402,988)	—	—	—	—	(27,402,988)
Depreciation and amortization	6,468,939	—	—	—	6,468,939	—	104,219	—	—	6,573,158
Deferred income tax expense	231,783	—	—	—	231,783	—	—	33,899	—	265,682
Net unrealized (appreciation) depreciation in fair value of marketable securities	118,958	—	—	(7,468,130)	(7,349,172)	—	(4,397,012)	2,758	—	(11,743,426)
Net realized loss (gain) on sale of marketable securities	6,405	—	—	(1,534,691)	(1,528,286)	—	(449,094)	11,703	—	(1,965,677)
Net assets released from restrictions and used for operations	—	—	—	—	—	—	1,166,409	—	—	1,166,409
Change in actuarial value of gift annuity obligations	—	—	—	—	—	—	11,380	—	—	11,380
Provision for uncollectible accounts	192,768	—	—	—	192,768	—	—	—	—	192,768
Equity in net income of other investments	—	499,153	—	—	499,153	—	—	—	(499,153)	—
Changes in assets and liabilities:										
Receivables, net	(1,169,402)	—	—	—	(1,169,402)	—	(1,003,911)	13,981	—	(2,159,332)
Income taxes receivable	—	—	—	—	—	—	—	(110,220)	—	(110,220)
Prepaid expenses and other assets	(172,101)	—	—	—	(172,101)	(36,272)	(247)	—	(12,732)	(221,352)
Inventories, net	(262,687)	—	—	—	(262,687)	—	—	—	—	(262,687)
Due from/to affiliated organizations	(1,650,647)	—	—	901,685	(748,962)	—	520,937	228,025	—	—
Accounts payable, accrued liabilities, and other liabilities	173,635	—	—	28,045	201,680	(45,305)	(99,101)	837,120	—	894,394
Deferred revenues	(318,702)	—	—	—	(318,702)	—	18,542	—	9,068	(291,092)
Postretirement benefit obligation	—	—	—	(840,246)	(840,246)	—	—	—	—	(840,246)
Pension liability	(922,666)	—	—	—	(922,666)	—	—	—	—	(922,666)
Net cash provided by operating activities	18,812,199	—	—	70,051	18,882,250	413,078	1,547,085	518,113	—	21,360,526
Cash flows from investing activities:										
Purchase of marketable securities	(31,311,863)	—	(3,500,000)	(11,366,698)	(46,178,561)	—	(937,843)	(2,495,477)	—	(49,611,881)
Sale and maturity of marketable securities	26,500,000	—	—	—	26,500,000	—	606,325	1,483,617	—	28,589,942
Acquisitions of property and equipment	(2,667,903)	—	—	—	(2,667,903)	—	(27,526)	—	—	(2,695,429)
Net cash used in investing activities	(7,479,766)	—	(3,500,000)	(11,366,698)	(22,346,464)	—	(359,044)	(1,011,860)	—	(23,717,368)
Cash flows from financing activities:										
Net assets released from restrictions and used for operations	—	—	—	—	—	—	(1,166,409)	—	—	(1,166,409)
Payments to charitable gift annuitant	—	—	—	—	—	—	(20,003)	—	—	(20,003)
Net cash used in financing activities	—	—	—	—	—	—	(1,186,412)	—	—	(1,186,412)
Net increase (decrease) in cash and cash equivalents	11,332,433	—	(3,500,000)	(11,296,647)	(3,464,214)	413,078	1,629	(493,747)	—	(3,543,254)
Cash and equivalents at beginning of year	6,685,671	—	—	—	6,685,671	247,930	313,228	1,123,295	—	8,370,124
Equity transfers funded with cash	(14,796,647)	—	3,500,000	11,296,647	—	—	—	—	—	—
Cash and cash equivalents at end of year	\$ 3,221,457	—	—	—	3,221,457	661,008	314,857	629,548	—	4,826,870

See accompanying independent auditors' report.