ADA American Dental Association®

America's leading advocate for oral health

Pages 1–141

2016

Annual Reports and Resolutions

157th Annual Session

Denver, Colorado

October 20–24, 2016

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Council on Access, Prevention and Interprofessional Relations

Sabates, Cesar R., 2016, Florida, chair
Soderstrom, Andrew, 2017, California, vice chair
Allen, Grant R., 2016, Alabama American Medical Association representative
Cashion, Scott W., 2018, North Carolina
Crystal, Yasmi O., 2016, New Jersey
Dean, Brittany T., 2016, Washington*
Fagan, Timothy, 2108, Oklahoma
Gerlach, William H., 2018, Texas
Herman, Richard P., 2109, New York
Jones, Shelly F., 2017, Michigan
Koday, Mark, 2019, Washington
Lang, Melanie S., 2014, Washington, American Hospital Association representative
Mitchell, G. Lewis, 2016, Alabama
Nunokawa, Neil C., 2017, Hawaii
Peckosh, Valerie B., 2017, Iowa
Risner-Bauman, Alicia, 2019, Pennsylvania
Switzer-Nadasdi, Rhonda, 2018, Tennessee
Wasserman, Michael H., Massachusetts
Watson-Lowry, Cheryl D., 2016, Illinois
Wynn, Mary Ellen, 2016, Ohio

Grover, Jane S., director
Geiermann, Steven P., senior manager, Access, Community Oral Health Infrastructure and Capacity
McGinley, Jane S., manager, Fluoridation and Preventive Health
Clancy, Anne M, manager, Interprofessional Relations
Clough, Sharon R., manager, Preventive Health Services

The Council's 2015–2016 liaisons include: Dr. James K. Zenk, (Board of Trustees, Tenth District), Mr. Adam Saltz, (American Student Dental Association), Dr. Mark Bronson, vice chair, Council on Government Affairs and Dr. Barry Howell, chair, Council on Government Affairs.

Mission and Purpose

The Council 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.

Bylaws Areas of Responsibility

As listed in Chapter X. Section 130A of the ADA *Bylaws*, the areas of subject matter responsibility of the Council are:

a. Oral Health Literacy
b. Oral Disease Prevention and Intervention
c. Interprofessional Relations

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

d. Access to Oral Healthcare
e. Community Oral Health

Supporting the Strategic Plan: Activities, Results and Accomplishments

The Council engaged in a Strategic Planning activity in January 2016 designated as a Visioning Session.

As a result of the visioning exercise, the six priority Council activities identified by both volunteers and staff to guide the Council in 2016 included:

- Community Water Fluoridation
- Medicaid
- Medical/Dental Collaboration
- Community Dental Health Coordinator
- Emergency Room Referral
- Oral Health Literacy

Additional topics of moderate priority included:

- Native American Issues
- Elder Care
- Tobacco Issues
- Health Centers
- Prevention Activities addressing nutrition, sugar and sports dentistry
- Oral Health Education and Outreach, including school-based programs and National Children's Dental Health Month

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Action for Dental Health: In keeping with the Strategic Plan Objective that refers to promoting oral health through advocacy and science, the Council has been primarily focused with 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)

The prioritized Action for Dental Health initiatives are contained within the objectives listed below. Metrics provided reflect progress through July 31, 2016.

Objective	Initiative/ Program	Success Measure	Target	Range	Outcome
3- Member Value	Action for Dental Health	Percent of State Societies participating in one or more ADH initiatives	50–52 % of Constituent Societies participate in two or more ADH initiatives	15–30 Societies	29 Societies 56%
1-Leaders and Advocates	Community Dental Health Coordinator	Number of states with CDHC presence	20 states by 2016	15–25	24
6- Act in the best interest of the member when designing programs	Medicaid provider Education	Number of Medicaid program "Boot Camps" Number of dentists taking the CE course	5 regional Medicaid provider "Boot Camps" 1,000 dentists	2–7 arranged	5 for 2016 998 dentists

Objective	Initiative/ Program	Success Measure	Target	Range	Outcome
3- Member Value	Action for Dental Health Community Water Fluoridation	Number of states provided with technical assistance for community water fluoridation challenges	20 states receiving technical assistance	18–30	29
1-Leaders and Advocates	ER Referral via Action for Dental Health	25 states with formal ER Referral programs and outcomes	25 states	18–30	32 states

Interprofessional Relations (Medical – Dental Collaboration):

- Provided Smiles for Life online CE for non-dental health care providers to encourage dentist-physician conversation and bi-directional referral.
- Released ADA online CE, "Diabetes and Oral Health" with over 300 participants learning about diabetes screening and patient education in the dental office.
- Developed toolkit for diabetes screening, education and referral in Hawaii, Tennessee, Michigan, Oregon and Illinois, three states have launched pilot programs

Access, Community Oral Health Infrastructure and Capacity:

- National Elder Care Advisory Committee (NECAC) has worked with stakeholder organizations to engage dental practitioners in nation-wide local programs addressing the importance of oral health in older Americans.
- NECAC assisted stakeholder groups in investigating the possibility of including oral health benefits in Medicare.
- Facilitated Navajo Community Health Representatives into the CDHC program beginning in New Mexico.
- Addressed Medicaid participation and avoidance of unintentional noncompliance via CE at regional dental association meetings.

Prevention:

- Webpage launched: Health Literacy in Dentistry on ADA.org. Provides hyperlinks to online resources that inform members and their staff about health literacy principles.
- Health Literacy Essay Contest: The follow-up from last year (one dental school) to this year (seven schools) promotes collaboration between state associations (Power of Three), dental schools (ASDA) and the Council to support the CODA competency of health literacy in predoctoral dental education.
- Choosing Wisely: Final phase in collaboration with Communications to distribute news .release, *Leadership Update*, *ADA News* article, video, webinar and slideshow on ADA.org.
- Collaborated with Division of Science on Project Coat to increase number of children ages three to 15 receiving sealants by 10%.

Community Water Fluoridation: In collaboration with ADA Division of Communications, fluoridation content has been promoted for member and public use in local fluoridation campaigns. Table 1 indicates the results from 2015 to 2016. It is anticipated that the National Fluoridation Advisory Committee will complete its work on the next edition of *Fluoridation Facts* prior to the end of 2016.

Table 1. Visits to Fluoride in Water Web Page on ADA.org

Year	Q1	Q2	Q3	Q4
2015	10,784	19,427	30,173	33,521
2016	43,816	43,029	-	-

Emerging Issues and Trends

The Council is aware of the following emerging issues:

- **Workforce and workforce models.** Council staff are frequently asked to provide technical assistance, utilizing initiatives within the Action for Dental Health, specifically CDHC.
- **Expansion of state Medicaid programs.** The Council provides technical assistance to states to design and implement strategies to promote dentist participation in Medicaid programs.
- **Potential dental benefits within Medicare.** Foundations are partnering with federal agency representatives to design dental benefit scenarios for the Medicare program. The Council involvement has begun.
- **Native American tribes** have requested Council assistance in formulating Oral Health Plans with implementation steps including CDHC programs, as well as the tribal Community Health Representative program.
- **Oral Health Literacy** continues to be an emerging issue with allied health groups requesting input on dental literacy strategies
- **Code management.** The 2016 development of four dental case management codes at the March Code Management Committee meeting poses significant potential for the recognition of these services.

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
85H-2015	Chief Medicaid Dental Officer and Medicaid Dental Advisory Committee	Number of states with these entities	20	15–30	16
93H-2015	Marketing Campaign Targeting Primary Care and Pediatric Physicians on Value of Dental Care	Campaign Development and Presentations	Launch date: 12/16	1–3 months	Launch date: 12/16
97H-2015	Older Adult Oral Health	Education of General Dentists	Train 1,000 dentists with CE course	500–2,000 dentists trained	250 dentists trained

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2017.

Policy Review

The Council reviewed twelve policies the last annual report.

Council Minutes

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

Council on ADA Sessions

Van Sicklen, James, H., Jr. 2016, California, chair
Fulton, David J., Jr. 2017, Illinois, vice-chair
Curcuru, Grace A., 2016, Michigan
Evans, Henry F. III, 2018, Washington
Foy, Charles B., Jr. 2017, Louisiana
Jarvis, Raymond A., 2018, Louisiana*
Janik, Andrea K. 2016, Texas*
Kirkegaard, Paul F., 2019, Minnesota
LaMorte, Gregory, 2017, New Jersey
Lancaster, Harold T., 2016, North Carolina
Lieb, Howard I.A., 2018, New York
Lum, Calbert, M., 2016, Hawaii
Macias, C. Roger, Jr. 2018, Texas
Murray, Rhett L., 2016, Colorado
Radack, III, Stephen T., 2019, Pennsylvania
Richman, Andrea, 2018, Massachusetts
Stockwell, Karyn L., 2017, Georgia
Terry, Beatriz E., 2019, Florida
Tertel, Nanette C., 2019, Ohio
Thakkar, Nipa R., 2017, New York*
Tourial, Sidney R. 2016, Georgia
Wyckoff, Douglas A., 2017, Missouri

Mills, Catherine, H., director

The Council's 2015–16 liaisons include: Dr. Jeffrey M. Cole (Board of Trustees, Fourth District), Mr. Kyle C. Kirk, Kentucky, (American Student Dental Association) and Dr. Karyl C. Patten, Georgia (American Association of Women Dentists Consultant).

Bylaws Areas of Responsibility

As listed in Chapter X, Section 130B of the ADA *Bylaws*, the areas of subject matter responsibility for the Council are:

a. The conduct of the annual session of the Association, except the House of Delegates, subject to the approval of the Board of Trustees as provided in the ADA Bylaws: and
b. Plan and coordinate other Association sessions or regional meetings.

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

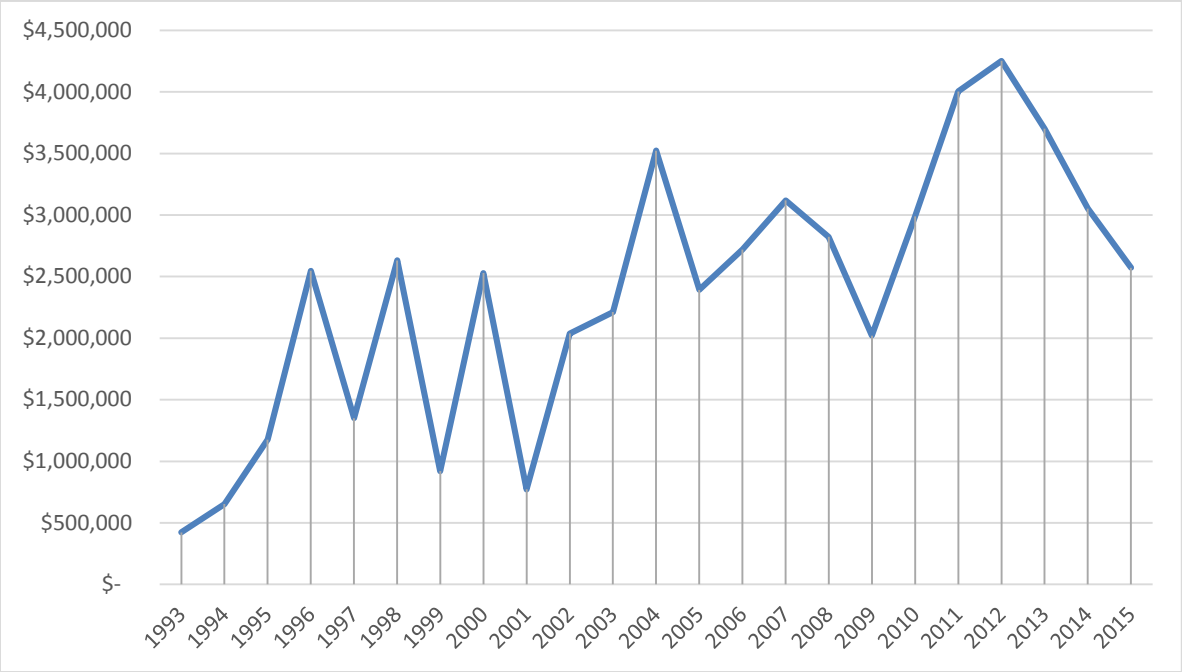
Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome
Non dues revenue will be at least 65% of total revenue.	Member Value-Business Development	Meet 95% (range between 90% and 100%) of budgeted annual meeting net. (ED Goals 5.2)	95%	90%–100%	To be determined**

The figures below depict how the annual meeting supports the objective of non-dues revenue. Both overall annual meeting and revenue per attendee are reflected. Revenue per attendee is tracked due to the annual meeting net revenue's disparity between different cities.

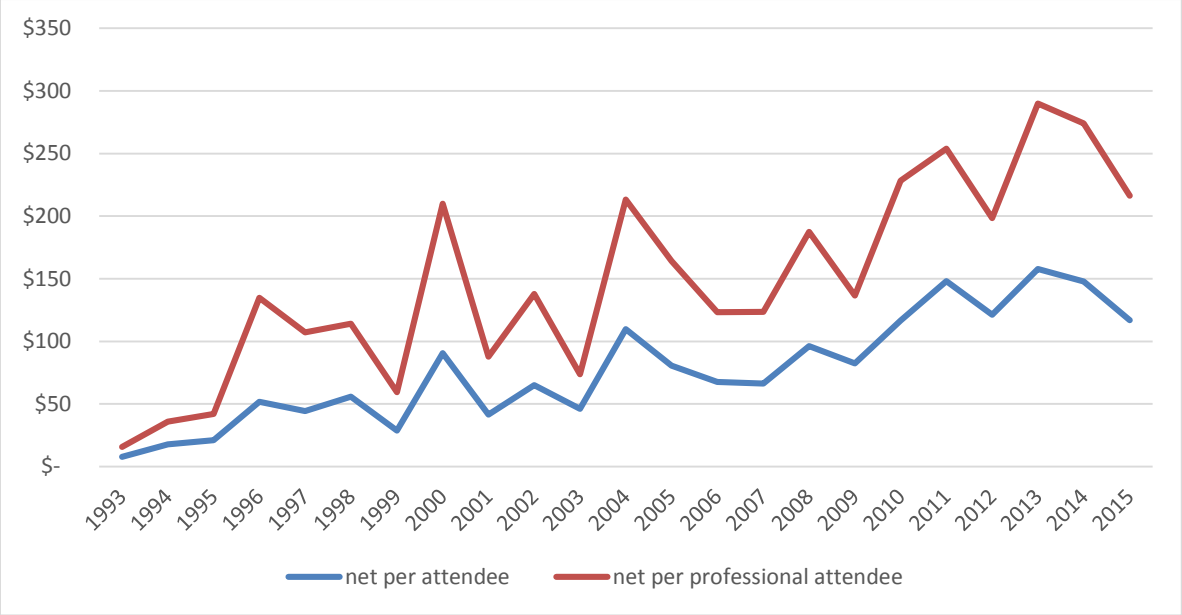
For example, in 2012 San Francisco, the Council generated the largest meeting net revenue in the past 19 years with the highest attendance in the past five years. San Francisco is an expensive city to hold a meeting and the Council compensated the CDA per our Society Reimbursement Policy, thus, the Council netted less per attendee.

Figure 1. Annual Meeting Total Net Non-dues Revenue History



***Results are as of the date of report preparation and do not reflect full-year results.*

Figure 2. Net Per Attendee and Net Per Professional Attendee History



In support of helping our members succeed while generating net non-dues revenue, CE, in-person and online, will remain a priority in 2016.

Annual Meeting CE Trends 2010–2015

Table. 1 Usage – Revenue

Year	Location	Total CE Seats Occupied	Total CE Hours	Total Courses per Dental Professional	Revenue per Seat Occupied	Total Revenue for CE Sales
2010	Orlando	35,972	86,333	2.8	$20	$801,378
2011	Las Vegas	46,800	112,320	3.0	$22	$936,955
2012	San Francisco	49,450	118,680	2.2	$28	$1,384,640
2013	New Orleans	40,427	97,025	3.1	$28	$1,151,581
2014	San Antonio	35,462	85,109	3.2	$31	$1,103,116
2015	Washington, D.C.	35,957	84,202	3.0	$28	$1,008,807

The focus for 2017 CE will be to develop blended learning opportunities. Blended learning will correlate both face-to-face CE options at the annual meeting with complementary online offerings. Cross marketing strategies based on a member's interests are also being looked at to be implemented for ADA 2017.

Emerging Issues and Trends

The trend of exhibiting companies consolidating and/or reducing their booth size continues. The Council introduced Radio Frequency Identification (RFID) on the exhibit hall floor during ADA 2015 in order to gather actual data on attendee behavior. The information the Council learned from ADA 2015 is being applied to the different experiences on the floor to help promote traffic for both ADA 2016 and as the Council plans for ADA 2017. Exhibitors are looking for additional information to improve their value proposition and the aggregate information garnered by RFID was a helpful addition.

At ADA 2015, the Council had the addition of the New Dentist Conference. The attendance goal for the meeting was 350–400; this was met with 396 actual new dentist attendees. Exhibitors were very positive about this co-location as the new dentist is a key target market. Attendee satisfaction was overall positive and the Council garnered some great improvement suggestions. Programing changes have been made for the 2016 conference based on the attendee survey and input from the New Dentist Committee.

Responses to House of Delegates Resolutions

The Council did not have any resolutions to respond to.

Self-Assessment

Although the next Council self-assessment was not due until 2019, recent evolution of the council spurred 2015 Council chair, Dr. Robert Roesch to form a task force to self-assess in May of 2015. The work of the Task Force has resulted in a unanimous Council vote at its February 2016 meeting to take the necessary steps to sunset the council and become an advisory committee of the Board of Trustees. A resolution has been sent to the 2016 House of Delegates through Reference Committee E – Membership and Related Matters. At its July/August meeting, the Board of Trustees voted unanimously to recommend a yes vote by the House of Delegates.

Policy Review

The Council did not have any policies to review in accord with Resolution 170H-2012.

Council Minutes

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

Council on Communications

Austin, Joshua A., 2016, Texas, chair
Herre, Craig W., 2017, Kansas, vice chair
Bean, Canise Y., 2018, Ohio
Hanley, Yvonne S., 2018, Minnesota
Hight, James R., Jr., 2017, Tennessee
Howell, Ralph L. Jr., 2016, Virginia
Hymes, Rachel, 2016 Tennessee*
Karp, William H., 2019, New York
Kenyon, David J., 2019, Wisconsin
Lindemann, Kurt S., 2018, Montana
Manzanares, Robert J., 2016, New Mexico
Meinecke, Gigi, 2019, Maryland
Paul. John H., 2016, Florida
Reich, Robin S., 2018, Georgia
Sahota, Ruchi K., 2016, California
Schefke, Philip L., 2019, Illinois
Tauberg, James A. H., 2017, Pennsylvania
Woods, Karl P., 2017, Maine, ad interim

MacLachlan, Janine, director

The Council's 2015–16 liaisons include: Dr. Joseph P. Crowley (Board of Trustees, Seventeenth District), and Ms. Laura A. Nelson (American Student Dental Association).

Bylaws Areas of Responsibility

As listed in Chapter X, Section 130C of the ADA *Bylaws,* the subject matter responsibility for the Council are:

a. Advise on the management of the Association's reputation.
b. Develop, recommend and maintain ADA strategic communications plans.
c. Advise ADA agencies on branding.
d. Advise on prioritization and allocation of communications resources; and
e. Advise on communications and marketing for state and local dental societies, upon request.

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome
Increase member value and engagement	Integrated marketing plan	Percent completion of integrated marketing project plan	25%		25%
Increase member value and engagement	Public relations outreach to national media and PSA	3% fewer negative media sentiment per quarter	5% 3.5 million		4% 2.5 million

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

Objective	Initiative/Program	Success Measure	Target	Range	Outcome
		3.5 million audience reach per quarter (social media) 750 million audience reach per quarter (broadcast, print, online)	750 million		926 million
Increase member value and engagement	Public digital communications	Increase total ADA website visits 10% over 2015, 10.8 million by year end	1.7 million		2.47 million
Increase member value and engagement	Advocacy communications (with CAPIR)	Increase visitors 15% year over year	15%		171%

A new integrated marketing plan was introduced to the board and is underway. The new approach addresses shared goals of multiple divisions of the ADA.

For public relations outreach, the ADA experienced increased audience reach in media coverage citing the ADA due to increased placements in top tier media such as *The Huffington Post, The Wall Street Journal, Forbes* online, Yahoo Finance, and AOL.com, which demonstrates the Council's proactive content strategy is working.

Digital communications also exceeded plan through an increase in visits to ADA websites, also credited to the Council's proactive content strategy.

A highlight of the past year is the success of paid support for advocacy messages. Action for Dental Health and Fluoridation campaigns saw a huge increase in page visits, in part due to paid search and other efforts outlined below in the update on Resolution 44H-2015.

In addition, the second quarter of 2016 brought a number of achievements: the credentialing pilot launch, integrated marketing campaigns, Project COAT to promote sealants, and the 2015 ADA highlights. Results of these programs are described in Appendix 1 of this report. The social media measure is off plan because a new Facebook algorithm enacted in February has cut the ADA's (and all other content publishers) reach by requiring paid promotion.

See Appendix 1 for additional information.

Emerging Issues and Trends

Issue 1: Helping ADA members be busier via utilization campaign
The Council is leading an initiative to address what the Health Policy Institute calls the "busyness" issue where ADA members report that they have capacity to see more patients. This member need spurred an initiative to drive utilization of dental services. In other words, to get people into the chairs of ADA dentists.

In order to identify the audiences that will represent the best opportunity to drive utilization of dental services, the Division of Integrated Marketing and Communications and HPI are working with C Space Health, a research company, to conduct comprehensive consumer research, concluding in the development of consumer personas, similar in nature to the professional personas developed in 2015. By using a combination of quantitative and qualitative research, the initiative will identify the attitudes and behaviors that will help to best utilize ADA marketing funds.

On a parallel path, the Council chair and vice chair participated in an RFP process to select a new integrated marketing/PR agency to help drive utilization efforts. GMMB was awarded a contract to develop this campaign based on their proposal. GMMB is now working with the ADA and research company C Space Health on finalizing message strategy. In addition, the team is working on a paid media plan focusing primarily on social and digital channels targeted to the two personas that represent the best opportunity for the ADA.

This initiative supports Resolution 90H-2015 Improving the Brand of the ADA Member, which was referred to Communications. The research findings and subsequent media buying plan will not be finished until late August. The Council intends to submit a further update, along with a resolution for a budget to support this initiative, for the September Board of Trustees meeting. Because they key audiences are on the younger side, the media buy will focus on digital outlets rather than television, thus delivering maximum impact within an appropriate budget.

Issue 2: Helping ADA members be busier via physician outreach
A Council workgroup is addressing Resolution 93H-2015 Investigate a Marketing Campaign Targeting Primary Care and Pediatric Physicians on Value of Dental Care, which was referred to the Council on Access, Prevention and Interprofessional Relations (CAPIR) with Communications supporting.

In collaborating with CAPIR, the Council has determined a number of opportunities to provide ADA members with tools to reach out to their physician counterparts to encourage referrals to ADA members. Some program options include:

- Create toolkits for members on how to develop relationships with neighboring physicians, including template presentations to conduct in-service education for physician office teams on the importance of oral health and ongoing dental care. A toolkit may include videos, sample introductory letters, presentations and downloadable patient materials.
- Work with pediatricians and other physician groups to deliver messages to their members through their own communications channels. For pediatricians, this may be tagged to National Children's Dental Health Month in February or back-to-school time in August.
- Amplify Healthy Smiles for Life program, created in partnership with the ADA Alliance to deliver to hospital maternity departments. This content includes how to care for baby teeth and could be appropriate for pediatrician audiences.

In addition, the consumer personas can help inform messages and materials that will resonate with physician patients who may not have made a dental appointment within the last year. The Council will continue to provide strategic direction to staff in the creation and execution of physician outreach programs. Staff will work with CAPIR to outline an appropriate strategy and final recommendation.

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
Res. 49H-2015. Added Sugar Philosophy and **Res. 50H-2015.** Public Information Campaigns to Reduce Added Sugar Consumption aim to acknowledge and proactively share information with the public about how diets high in added and natural sugars, as well as processed starches and low pH-level acids can have negative effects on oral health.	Drive consumer education via leveraging national holidays or timely national news to proactively share ADA communications via channels (paid, shared, owned). Fourth Quarter 2015: Capitalized on timely news story to promote Mouth Healthy nutrition content First Quarter 2016: Created new content for various ADA channels in honor of National Children's Dental Health Month and National Nutrition Month content promotion (March) Second Quarter 2016: Wove nutrition content into promotions around Oral Health Month	Create nutrition content for consumers via MouthHealthy and ADA's Facebook and Twitter that performs within the top 10% of content each quarter. Simultaneously promote this content to members via ADA channels such as ADA.org, *ADA News, ADA Morning Huddle* and *Leadership Update.*	Content about nutrition performs within the top 10% of content consistently each quarter		In the first quarter of 2016, the Council focused on producing a suite of new content: • 5,000+ MouthHealthy.org page views educated readers about spotting added sugar on food labels, its effects on dental health, plus how to choose healthy snacks. • Social posts about added sugar were very popular on Facebook, driving 61% more shares compared to other ADA content. • Of all the new content produced in the first quarter, this topic was the top performer for MouthHealthy.
Res. 44H-2015. Resolved, that the Council urge the Board of Trustees to add $150,000 to the proposed 2016 budget for the continuation of digital and social media promotion of water fluoridation in 2016. Continue digital and social media promotion of community water fluoridation	Community Water Fluoridation	Average click-thru rate for Google AdWords campaign. Increase traffic to Fluoride and Fluoridation pages on ADA.org Average engagement rate for Promoted Tweets and Video campaign on Twitter.	<1% +20% 1%–4%	0.75%–1.25% +15 – 25% 0.85%–4.5%	0.5%–4.51% +446% 3.5%–31%

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
Res. 90H-2015 (referred). Improving the Brand of the ADA Member	See Emerging Issues and Trends				
Res. 93H-2015. Investigate a Marketing Campaign Targeting Primary Care and Pediatric Physicians on Value of Dental Care	See Emerging Issues and Trends				

See Appendix 2 for additional narrative on Resolutions 49H-2015 and 50H-2015.

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2018.

Council Minutes

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

Appendix 1

Integrated Marketing and Communications Highlights Q2 2016

Credentialing Pilot Launch

Conducted a month-long pilot campaign with KS, NJ, and NV. State leadership were very supportive of this initiative. Various messages and incentives were tested, and the clear winner was the raffle of a free 2017 ADA membership that was tested in NJ. As of July 22, 2016, 313 dentists have begun registration and 84 dentists have completed and attested their credentials. For the pilot, 36 members completed the attestation process in NJ, compared to six in KS, and two in NV. These results, along with state and member feedback will help inform the national rollout tactics, which are scheduled to launch in late August.

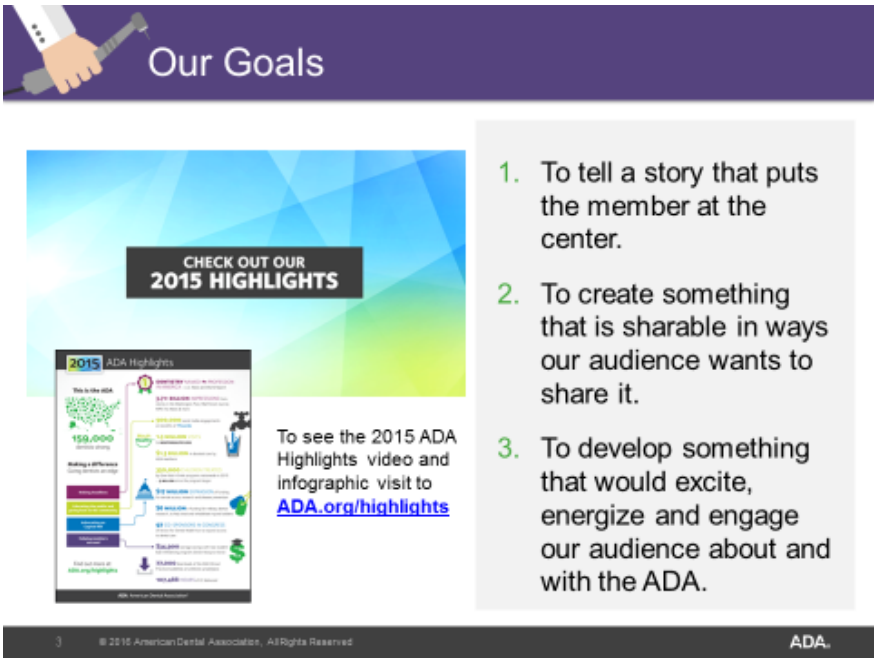
Integrated Marketing Campaigns

The cross-divisional integrated marketing campaign process is well underway. The three member campaigns focus on ADA resources that can help members be their best clinically and professionally, help them with resources to make their lives easier, and also highlight how their work and the work of the profession makes a difference in patients' lives as well as the overall health of the public. The planning process is complete, and rollout of these campaigns is underway in Q3, and will continue through Q4 and 2017.

Project COAT – Sealants. Lead by Science Institute in collaboration Integrated Marketing Communications (IMC) and Publishing, Project COAT launched and aims to enhance understanding around the usage of sealants. The *JADA* BPA study and PPR report on sealants will be communicated through the ADA's channels, paid digital and social media for greater reach among both dentists and consumer patients.

2015 ADA Highlights video - Focus the Message

The first-ever ADA digital annual report debuted at Recruitment/Retention Conference April 6. Promoted via member communications and a $1,200 paid social media spend targeted dental students. Response from leaders, dental societies and grassroots members has been overwhelmingly positive.



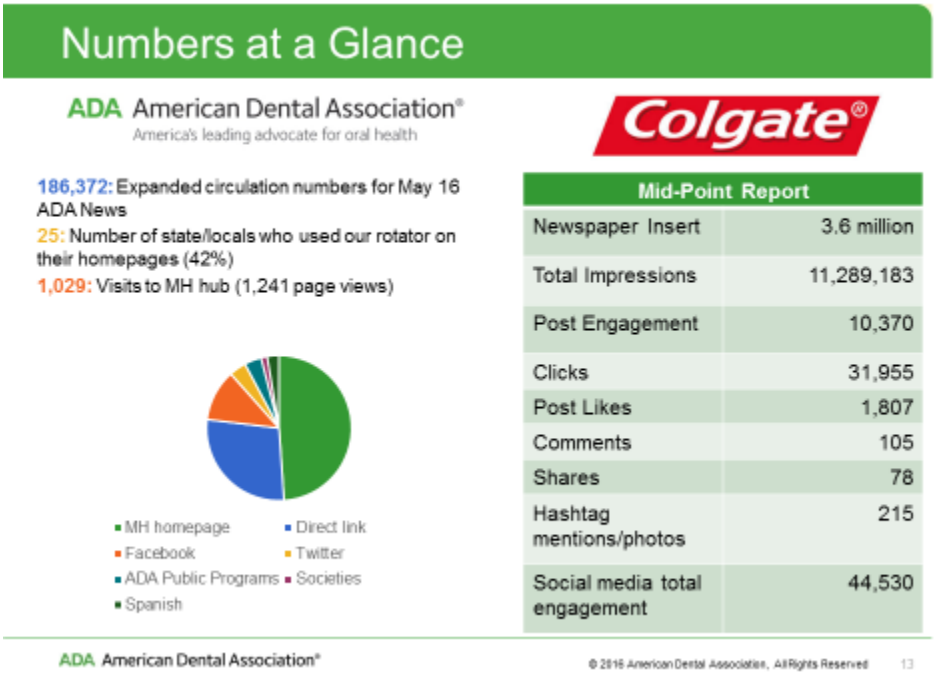
- YouTube: 3,756 views (more views in 1 week than ADA's previously most viewed video received in 6 months)
- Twitter: 17,370 reach and 342 views
- Facebook organic post: 121,404 audience reach and 39,204 video views
- ADA.org/highlights: 1,621 visits
- Facebook: $200 of the $1,200 spent targeted dental students with Facebook's ad service called Canvas - it creates interactive experiences. Results: 30,500 reach 131 website visits

Oral Health Month (Public education collaboration with Colgate) – Focus the Message

Oral Health Month is Colgate's annual campaign to educate Hispanic families about the importance of proper oral care.

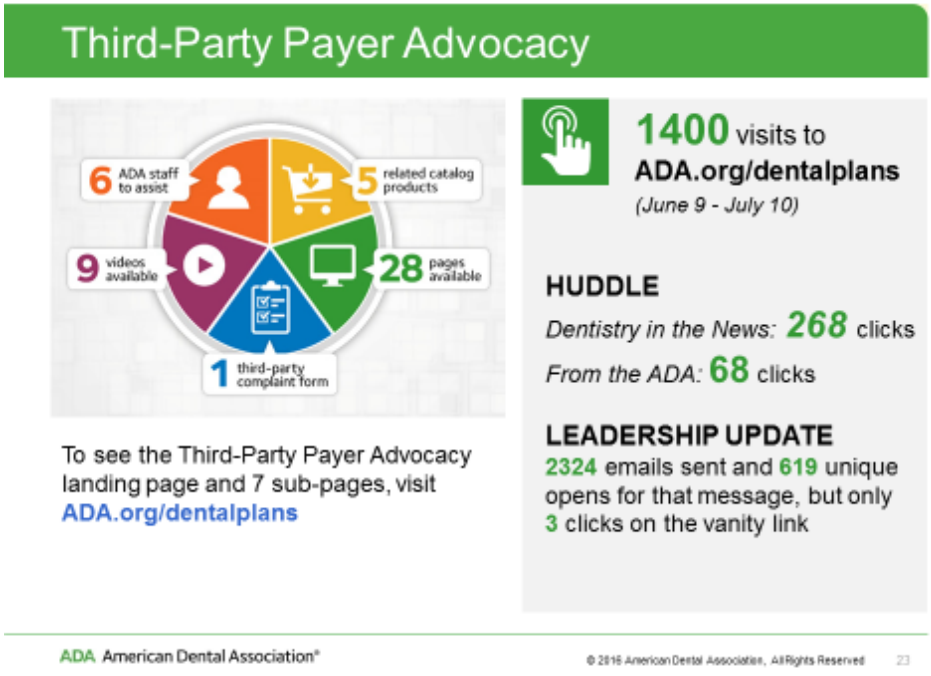
- Reaching Hispanic millennial moms through “Lead by Example” theme, developed primary by ADA staff
- $1 donated to Give Kids A Smile each time #TimetoSmile is used in June ($10k minimum, $40k maximum)
- Collaboration with the resources Colgate brings to bear fostered large public reach, exposure for the ADA brand and positive positioning of the ADA as leading oral health resource

The Board will received a detailed report at their September meeting on the results of Oral Health Month. Results for the first half of the Oral Health Month outreach in June are as follows:



Third Party Payer Issues (Focus the Message). Practice Institute and Integrated Marketing Communications (IMC) are collaborating to launch a “one stop shop” of ADA resources for members on third-party payers through The Center for Professional Success.

Portal launched June 10 and results just one month later are as follows:



Appendix 2

Res. 49H-2015; Res. 50H-2015

Fourth quarter, 2015 (Dec. 1): Communications kicks off by leveraging MouthHealthy.org nutrition content via ADA Morning Huddle, in conjunction with timely news story;

DENTISTRY IN THE NEWS

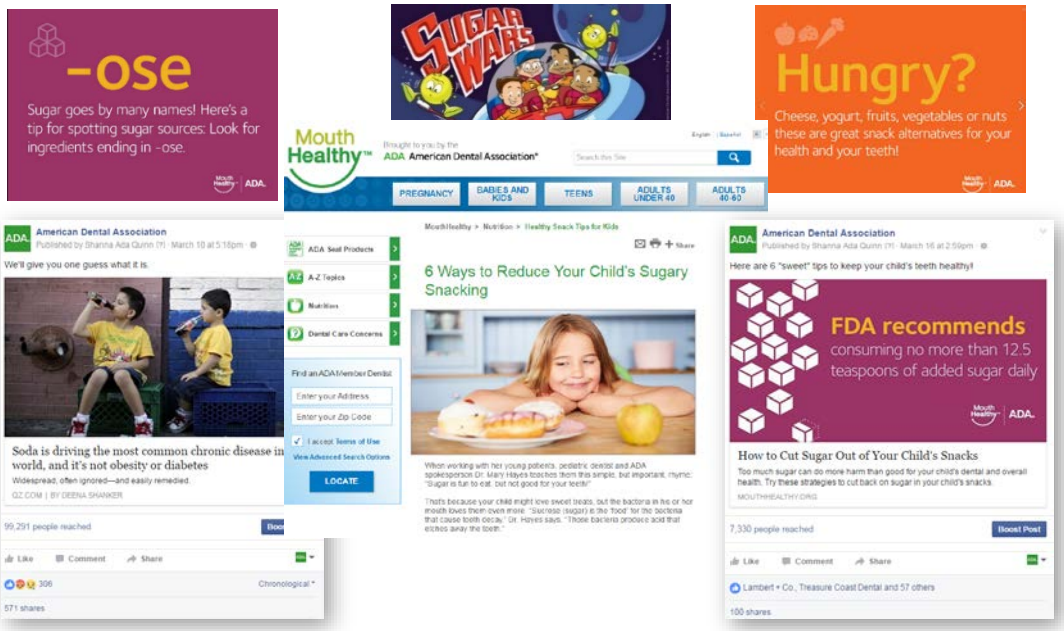
Sugar-Free Drinks, Candy May Lead To Dental Erosion, Study Finds.

The Washington Post (12/1, Cha) "To Your Health" reports that researchers from the Melbourne University's Oral Health Cooperative Research Centre "tested a wide rage of sugar-free soft drinks, sports drinks and sweets and found that many of them can be just as harmful to teeth as their sugared counterparts due to their chemical composition." Researchers found that because these sugar-free beverages "contain acids like phosphoric acid (found in colas) or citric acid (found mainly in lemon and lime flavored drinks)," they can "strip away a tooth's outer layer – leading to chalkiness of the tooth's surface, pitting, opacity, tooth sensitivity and other issues." The findings (pdf) were published in the Australian Dental Journal.

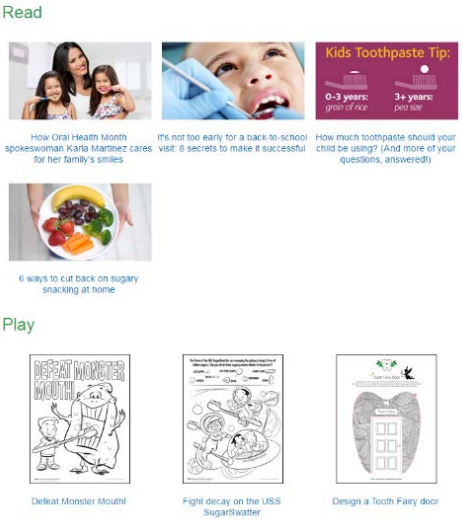
HealthDay (12/1, Preidt) reports that the researchers found that the acid in these beverages "dissolves the tooth's hard tissues," causing "dental erosion." The study showed that "most soft drinks and sports drinks caused dental enamel to soften by between 30 percent and 50 percent."

The ADA provides more information on diet and dental health at mouthhealthy.org. The ADA also lists the top nine food and beverages that damage your teeth, which includes soda, sports drinks, citrus, and candy.

First quarter, 2016: Communications creates new, highly visual, health-literacy appropriate content for owned, shared and earned channels rolling out over an eight week period in conjunction with National Children's Dental Health Month (February), with a "Sugar Wars" theme, and National Nutrition Month (March). All of these programs are also reported by ADA News, ADA Morning Huddle and documented on ADA.org.



Second quarter, 2016: Nutrition content is woven into promotions for Oral Health Month in June as another touch point for consumers to share resources and tips for reducing added sugar consumption.



Commission for Continuing Education Provider Recognition

Leary, Paul, 2017, New York, chair
Tavares, Mary A., 2016, Massachusetts, vice chair
Beitel, Brian A., 2017, Alabama
Chehal, Hardeep K., 2017, Nebraska
Dixon, Debra, 2018, Illinois
Fiorellini, Joseph P., 2018, Pennsylvania
Garcia-Aguirre, Augusto C., 201 9, Puerto Rico
Hammond, Barry, 2019, Georgia
Hutten, Mark C., 2018, Illinois
Kirkpatrick, Timothy C., 2017, Mississippi
Lipp, Mitchell J., 2019, New York
McGuire, Eugene J., 2016, Pennsylvania
McNulty, Conor, 2018, Oregon
Rosenthal, Nancy R., 2019, Pennsylvania
Steiner, Ann, 2017, California

Borysewicz, Mary A., director

The Commission's 2015–16 Board of Trustees liaison is Dr. Judith M. Fisch (Board of Trustees, First District).

Bylaws Areas of Responsibility

As listed in Chapter XV, Section 130C of the ADA *Bylaws*, the duties of the Commission are 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.

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome
3.1. Pursue programs that members value and are "best in class"	Comprehensive revision of CERP Recognition Standards	Draft of revised Standards circulated to communities of interest for comment	September 30	September 1–November 1	In process

The ADA Continuing Education Recognition Program (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 licensing jurisdictions for maintenance of licensure. At the time this report was prepared, there were 445 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. In 2014, the most recent year for which data is available, CERP recognized providers reported offering a total of over 32,000 courses, including more than 220,000 hours of continuing education. Information on the size and scope of ADA CERP providers' activities is published in the 2015 CCEPR Annual Report to communities of interest available on ADA.org/CCEPR.

Standards Review. The ADA CERP Recognition Standards form the basis for the Commission's evaluation and approval of continuing dental education providers. The Standards were last reviewed in 2008. Periodic review of accreditation and recognition standards is a best practice. The Commission is currently engaged in a comprehensive review of the CERP Standards to ensure the Standards continue to establish relevant criteria for quality continuing dental education. In March 2016 the Commission conducted a validity and reliability survey of the Standards. The survey was conducted to obtain feedback from stakeholders regarding perceptions of the relevance of the Standards to a continuing dental education provider's ability to deliver effective CE. Survey results are being considered by the Commission, along with general comments from the communities of interest, and benchmarking accreditation standards for continuing education in other healthcare professions. Any revisions to the Standards proposed by the Commission as a result of its review will be circulated to the communities of interest for comment.

CERP Application. To streamline the application process, the Commission is developing a web-based application form using the Aptify platform, with implementation targeted for 2017.

Strategic Planning. At its September meeting, the Commission will conduct a strategic planning process to develop a mission statement, goals and objectives to support and guide the Commission's future activities and administration of the ADA Continuing Education Recognition Program.

Emerging Issues and Trends

As the science and delivery of health care continue to evolve, it is increasingly important for health care professionals to engage in self-assessment and continuing professional development. As education methodologies change and new information on the effectiveness of continuing professional development emerges, the Commission believes that standards for continuing dental education must support providers in delivering CE that is evidence-based and promotes improvements in health care, with increased emphasis on educational outcomes.

Responses to House of Delegates Resolutions

No resolutions currently assigned to the Commission.

Self-Assessment

The Commission is next scheduled to conduct a self-assessment in 2019.

Policy Review

The Commission is not charged with reviewing any policies in accord with Resolution 170H-2012, Reaffirming Existing ADA Policy.

Commission Minutes

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

Commission on Dental Accreditation

West, Karen, P., 2016, Nevada, American Dental Education Association, chair
Livingston, Harold Mark, 2017, Mississippi, Special Care Dentistry Association and American Dental Education Association, vice chair
Attanasi, Ralph, C., 2018, Florida, 2018, American Dental Association*
Callahan Barnard, Susan, 2019, New Jersey, American Dental Hygienists' Association
Campbell, Stephen, D., 2017, Illinois, American College of Prosthodontists
Cushing, David, P., 2019, New Jersey, Public Member
Feldner, Loren, J., 2019, Illinois, American Dental Association
Flaitz, Catherine, M., 2019, Ohio, American Association of Pediatric Dentists
Gagliardi, Lorraine, I., 2016, California, American Dental Assistants Association
Geist, James, R., 2019, Michigan, American Academy of Oral and Maxillofacial Radiology
Glicksman, Milton, A., 2016, Massachusetts, American Association of Dental Boards
Hebert, Alexandra, P., 2017, California, American Student Dental Association and American Dental Education Association
Hershey, H. Garland, Jr., 2019, North Carolina, American Association of Orthodontists
Javed, Tariq, 2019, South Carolina, American Dental Education Association
Kahn, Richard B., 2016, New Jersey, American Dental Association
Kassebaum, Denise, K., 2017, Colorado, American Dental Education Association
Kinney, Bruce, P., 2019, Washington, American Association of Dental Boards
Lanier, Dennis, A., 2017, Georgia, National Association of Dental Laboratories
Leffler, William, G., 2018, Ohio, American Association of Dental Boards
Lerman, Mark, A., 2018, Massachusetts, American Academy of Oral and Maxillofacial Pathology
Lobb, William, K., 2018, Wisconsin, American Dental Education Association
Mascarenhas, Ana Karina, 2016, Florida, American Association of Public Health Dentistry
Mills, Michael P., 2018, Texas, American Academy of Periodontology
Schindler, William G., 2016, Texas, American Association of Endodontists
Sherman, Robert, G., 2017, Hawaii, American Association of Dental Boards
Stanton, David, C., 2017, Pennsylvania, American Association of Oral and Maxillofacial Surgeons
Stergar, Cindy, J., 2018, Montana, Public Member
Surabian, Stanley, R., 2017, California, American Dental Association
Unser, Glenn, J., 2019, California, Public Member
Wheeler, Matthew B., 2018, Illinois, Public Member

Tooks, Sherin, director
Ackerman, Alyson, manager, Allied Dental Education
Baumann, Catherine, manager, Advanced Specialty Education
Horan, Catherine, manager, Predoctoral Dental Education
Marquardt, Gregg, manager, Communication and Technology Strategies
Renfrow, Patrice, manager, Allied Dental Education
Snow, Jennifer, manager, Advanced Specialty Education
Soeldner, Peggy, manager, Postdoctoral General Dentistry Education

The Commission's 2015–16 liaison is Dr. Raymond A. Cohlmia (Board of Trustees, Twelfth District).

Bylaws Areas of Responsibility

As listed in Chapter XV, Section 130A of the ADA *Bylaws*, the duties of the Commission are:

a. Formulate and adopt requirements and guidelines for the accreditation of dental, advanced dental and allied dental educational programs.

* *Replaced Blanton, Patricia, L., 2018, South Carolina, American Dental Association*

b. Accredit dental, advanced dental and 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.

Advancing CODA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Initiative/Program	Success Measure	Target	Range	Outcome
CODA: Continue to be the United States Department of Education recognized accrediting agency for dental and dental-related education programs	Maintain current USDE recognition and prepare re-recognition document for submission deadline of January 2017.	Maintain current recognition and by December 15 draft 100% of re-recognition document	December 1–30	In progress.
CODA: Develop 2017–2021 Strategic Plan and Outcomes Assessment Plan	Working with CODA Standing Committee on Quality Assurance and Strategic Planning, draft and present to CODA a Strategic Plan in Summer 2016 for anticipated publication and use 2017–2021.	Publish 2017-2021 CODA Strategic Plan and communicate with communities of interest	December 1–30	CODA approved new strategic plan at Summer 2016 meeting.
CODA: Enhance technology usage through development of an electronic accreditation management system for programs and CODA volunteers	Develop electronic accreditation management system to streamline and enhance CODA accreditation program for CODA-accredited programs and CODA volunteers.	Work with ADA IT to finalize build-out of accreditation management tool and test tool. Identify training materials for staff, programs, and volunteers	December 1–30	In progress; however, delay anticipated due to current Aptify security functionality restrictions which impact CODA business process.

The Commission 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 education programs *(CODA Mission, 2012)*.

The Commission took 828 accreditation actions at its August 2015 and February 2016 meetings based upon site visit reports, progress reports and other information (reports of program change, change in sponsorship, authorized enrollment requests, etc.) submitted by educational programs and their sponsoring institutions. As indicated in Table 1, the total number of educational programs accredited is 1,452. This represents a decrease of 10 programs from the previous reporting period.

Seventy-one programs hold the status of "Approval with Reporting Requirements" and have been given a specified time period to demonstrate compliance with all accreditation standards. Failure to do so will

result in accreditation being withdrawn. The Commission also investigated six complaints against programs during this time. No education programs had accreditation withdrawn during this reporting period.

During this timeframe, 11 programs were granted accreditation; these include two predoctoral dental education programs, four dental assisting education programs, one dental hygiene education program, one advanced education in general practice residency education program, and three oral and maxillofacial surgery education programs.

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

Table 1. Total Number of Accredited Programs as of February 2016

	Dental	Specialty	Advanced General Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Initial Accreditation	5	12	9	1	6	0	33
Approval Without Reporting Requirements	61	434	284	237	316	16	1,348
Approval With Reporting Requirements	0	24	9	23	14	1	71
Total Number of Accredited Programs	66	470	302	261	336	17	1,452

Major Actions of the Commission on Dental Accreditation: The Unofficial Report of Major Actions of the August 2015 and February 2016 meetings of the Commission on Dental Accreditation can be found at ADA.org.

ADA/CODA Relationship Workgroup: The ADA/CODA Relationship Workgroup has met annually since 2014 at the ADA Headquarters, Chicago, Illinois. Members of the 2015–2016 Workgroup include: Dr. Gary Jeffers (Ninth District trustee, Co-Chair), Dr. Karen West (CODA, Co-Chair), Dr. Robert Bitter (Eighth District trustee and Board liaison to CDEL), Dr. Raymond Cohlmia (Twelfth District trustee and Board liaison to CODA), Dr. Loren Feldner (CODA), Dr. Chad Gehani (Second District trustee), Dr. Denise Kassebaum (CODA), Dr. William Leffler (CODA), and Dr. Red Stevens (Fifth District trustee). The Workgroup continues to focus on two general areas, finance and governance oversight of the Commission. At this year's meeting, the Workgroup discussed the Commission's budget oversight authority and the shared services (indirect expenses) model within the ADA structure. The next meeting of the ADA/CODA Relationship Workgroup is scheduled for May 2017.

Standing Committee on International Accreditation Activities

Mission and Purpose: The Joint Advisory Committee on International Accreditation (JACIA) was formed as a joint committee of the ADA and the Commission to provide guidance to the Commission in the selection, development and implementation of a program of consultation and accreditation for international, predoctoral dental education programs. In October 2015, the ADA House of Delegates sunset the JACIA and the Commission established the Standing Committee on International Accreditation

with full oversight of the international consultative process and operational budget, but with retained membership of the former JACIA.

Members of the Standing Committee included Dr. Chad P. Gehani, chair ADA; Dr. Gary Herman, ADA; Dr. Tariq Javed, CODA (from October 2015 to present); Dr. Denise Kassebaum, CODA; Dr. Steven Tonelli, ADA; and Dr. Karen West, CODA (through October 2015). During their terms, ADA presidents, Dr. Maxine Feinberg and Dr. Carol Gomez Summerhays, and CODA chairs, Dr. Perry Tuneberg and Dr. Karen West, served as non-voting members of this committee. Dr. Michael Reed served as a consultant to the Standing Committee, with staff support provided by Dr. Catherine Horan, manager, Predoctoral Dental Education, and Dr. Sherin Tooks, director, CODA.

Background: Since January 1, 2007, the Standing Committee on International Accreditation (formerly JACIA until October 2015) has accepted Preliminary Accreditation Consultation Visit (PACV) surveys from international predoctoral programs that are interested in the Commission's accreditation program. The Standing Committee 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. Twelve international programs have submitted PACV surveys since 2007. Following review and discussion, the Standing Committee approved each of the programs to attend a US 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. Six programs (Dharwad, India; Jeddah, Saudi Arabia; Leon, Mexico; Istanbul, Turkey; Seoul, South Korea, and Monterrey, Mexico) provided sufficient documentation and received a comprehensive PACV site visit. Staff were directed to make arrangements for a committee of dental professionals with experience in dental education in the United States and/or who have served as site visitors to predoctoral programs to complete a consultation visit to the schools.

No international predoctoral dental education programs have been accredited by the Commission at this time. Currently, only the programs in Jeddah, Saudi Arabia and Leon, Mexico have been notified by the Standing Committee on International Accreditation of the potential to pursue accreditation by the Commission.

The following is a summary of the activities, results and accomplishments of the August 24, 2015 and June 8, 2016 meetings of the Standing Committee on International Accreditation.

- The Standing Committee considered the PACV self-study for the dental education program offered by faculty of odontology at the Universidad Autónoma de Nuevo León, Monterrey, Mexico. Following review, the JACIA determined the program has the potential to meet the Accreditation Standards for Dental Education Programs and a comprehensive PACV was conducted in February 2016.
- The Standing Committee reviewed a letter from the Yeditepe University in Istanbul, Turkey, that a response to the report of the PACV would be submitted by March 1, 2017.
- The Standing Committee considered the PACV Survey submitted by the Hebrew University Hadassah School of Dental Medicine, Jerusalem, Israel, and directed that the program proceed to the next step of the PACV process by observing a CODA site visit, pending documentation for review by the Standing Committee.
- The Standing Committee discussed international travel safety for volunteers and directed staff to gather information on procedures used by other accreditors that conduct international accreditation for review at a future meeting.
- The Standing Committee noted Resolution 53H-2015, and its new name, the Standing Committee on International Accreditation. The Commission established the Standing Committee in September/October 2015 in anticipation of the House's action to sunset the Joint Advisory

Committee on International Accreditation. The Standing Committee revised the Guidelines for International Consultation and PACV to reflect the name change.

- At the request of CODA, the Committee considered the 2017 international consultation fees and recommended to the CODA Standing Committee on Finance, and Commission, that there be no increase in fees at this time.
- The Standing Committee considered the difficulty in identifying individuals to serve in the clinical practitioner role for the consultation committee and directed staff to communicate with the ADA to request assistance in development of a formal mechanism for selection of the clinical practitioner role, which represents the ADA during the PACV site visit.

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;
Activities related to the reauthorization of the Higher Education Act; and
Requests from the communities of interest.

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/Program	Success Measure	Outcome
78H-2015: Amend the ADA *Bylaws* Regarding the Duties of the Commission on Dental Accreditation	CODA	ADA *Bylaws* and CODA *Rules* Amended	ADA *Bylaws* and CODA *Rules* amended to delete from duty "e" the phrase "either through or in cooperation with the Council on Dental Education and Licensure."
53H-2015: Sunset the Joint Advisory Committee on International Accreditation and Support CODA establishment of the CODA Standing Committee on International Accreditation	CODA	Sunset the Joint Advisory Committee on International Accreditation and support CODA's establishment of an international standing committee	ADA House of Delegates sunset the Joint Advisory Committee on International Accreditation. CODA established the Standing Committee on International Accreditation, including budgetary oversight of international consultative process, with no changes to membership of the Standing Committee.
54H-2015: Revision of the *Rules* of the Commission on Dental Accreditation	CODA	Approve general revisions to the CODA *Rules*	CODA *Rules* were revised as proposed.

Self-Assessment

The Commission is next scheduled to conduct a self-assessment in 2018.

Policy Review

There were no policies reviewed by the Commission in accord with Resolution 170H-2012.

Commission Minutes

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

Council on Dental Benefit Programs

Riggins, Ronald D., 2017, Illinois, chair
Hill, Steven J., 2017, Texas, vice chair
Brady, Thomas V., 2016, Connecticut
Bulnes, Christopher M., 2019, Florida
Davenport, Carson S., 2018, North Carolina
Dean, Brittany, 2016, Washington*
Eder, B. Scott, 2017, West Virginia
Gordon, Douglas J., 2017, California
Hamel, David L., 2018, Kansas
Kessler, Brett H., 2019, Colorado
Krantz, Daniel B., 2016, New Jersey
Larson, David R., 2016, Pennsylvania
Makowski, Martin J., 2019, Michigan
Mihalo, Mark J., 2019, Indiana
Pak, Sammy B., 2016, Washington
Rives, Robert W., 2016, Mississippi
Snyder, Steven I., 2018, New York
Vaillant, Matthew J., 2018, Minnesota

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

The Council's 2015–16 liaisons include: Dr. Terry L. Buckenheimer (Board of Trustees, Seventeenth District), and Ms. Mandy Alamwala (American Student Dental Association).

Bylaws Areas of Responsibility

As listed in Chapter X, Section 130D of the ADA *Bylaws,* the areas of subject matter responsitility of the Council are:

a. Administration and financing of all dental benefit programs including both commercial and public programs;
b. Dental Quality Alliance;
c. Monitoring of quality reporting activities of third party payers;
d. Peer review programs;
e. Code sets and code taxonomies including, but not limited to, procedure and diagnostic codes
f. Electronic and paper dental claim content and completion instructions; and
g. Standards pertaining to the capture and exchange of information used in dental benefit plan administration and reimbursement for services rendered.

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

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/ Program	Success Measure	Target	Range	Outcome
3 - ADA will achieve a 10% increase in the assessment of member value from membership.	Current Dental Terminology (CDT) Code/ Third Party Payer Advocacy	Maintain efficient and satisfactory call center responses to member questions.	At least 80% of members whose call was closed by Tier 2 and 3 are "satisfied" or "very satisfied" with the service.	Level of satisfaction of Tier 2 closures is between 75% and 85%. Timeliness of call closure by Tier 2 is between 95% and 100%.	As of June 30, 2016: The level of satisfaction of Tier 2 closures is 89.3% The timeliness of call closure is 99.45%
3 - ADA will achieve a 10% increase in the assessment of member value from membership. 5 - Non-dues revenue will be at least 65% of total revenue.	CDT Code	Deliver CDT 2017 ASCII file by May 15, 2016. Deliver CDT 2017 and CDT 2017 Companion by June 30, 2016.	Delivery of CDT 2017 ASCII file by May 15, 2016. Delivery of CDT 2017 & CDT Companion by July 1, 2016.	100% on time delivery of all 2017 CDT manuals.	As of June 30, 2016, all deliverables have been submitted.
3 - ADA will achieve a 10% increase in the assessment of member value from membership. 1 - The public will recognize the ADA and its members as leaders and advocates in oral health.	CDT Code / Quality Assessment & Improvement (QAI)	Ensure that Code Maintenance Committee (CMC) and Dental Quality Alliance (DQA) member organizations are satisfied or very satisfied with the work/processes of these entities.	At least 85% of CMC and DQA member organizations are satisfied or very satisfied with the work/processes of these entities.	CMC and DQA Member Satisfaction of Work Process between 80% and 90%.	As of June 30, 2016: 87% of CMC member organizations are "satisfied" or "very satisfied". 92% of DQA member organizations are satisfied or very satisfied. 100% of assessed DQA organizations, paid dues in full.
1 - The public will recognize the ADA and its members as leaders and	Quality Assessment & Improvement	At least two new DQA measures addressing underuse of	Two measures approved	One to three measures approved	As of June 30, two measures are being validated.

Objective	Initiative/ Program	Success Measure	Target	Range	Outcome
advocates in oral health.		preventive dental services are approved by the DQA.			
3 - ADA will achieve a 10% increase in the assessment of member value from membership.	CDT Code / Dental Benefits and Third Party Issues	Total visits to dental benefits content on Center for Professional Success (CPS) to increase over 2015.	Total visits increase by 5% over 2015.	3–5%	As of June 30, 2016, total visits increased by 5%.
3 - ADA will achieve a 10% increase in the assessment of member value from membership	CDT Code / Dental Benefits and Third Party Issues / QAI	Ensure that attendees responding to a post workshop / webinar survey are “satisfied” or “very satisfied”. Publish articles on DQA and quality measurement in state dental association journals by December 1, 2016.	At least 2000 individuals will participate in workshops or webinars by November 1, 2016. 80% of those responding to the post presentation survey are “satisfied” or “very satisfied” with the education programs. Articles on DQA and quality measure measurement published in at least two state dental association journals by December 1, 2016.	Between 1,500 and 2,500 individuals participate in CDBP workshops and webinars. Between 80% and 85% of attendees responding to the post presentation survey as “satisfied” or “very satisfied” with the education programs. Articles on DQA and quality measuremen t published in two to three state dental association journals by December 1, 2016.	As of June 30, 2016: 884 individuals have participated in Webinars and Workshops. Over 90% of respondents were “satisfied” or “very satisfied”. three articles are published/ accepted for publication by editor.

Objective	Initiative/ Program	Success Measure	Target	Range	Outcome
3.1 - Pursue programs that members value and are "Best in Class"	Dental Informatics	Publish American National Standards Institute (ANSI) standard SNODENT® Refset, jointly with International Health Terminology Standards Development Organization (IHTSDO), the first of which is General Dentistry.	1 General Dentistry Refset developed jointly with IHTSDO	One to two RefSets developed: One general Dentistry and one specialty refset	As of June 30 2016, The General Dentistry Refset development is completed. The Refset will be published with the next release of SNODENT® ANSI standard.

CDT Code: The Council's Code Maintenance Committee (CMC) convened its annual meeting on March 3, 2016 to consider CDT Code action requests for inclusion in CDT 2017. This decision-making body approved sixteen substantive changes—11 additions, five revisions, one deletion and 40 editorial changes. There are five noteworthy additions that enable accurate documentation and reporting of services now being provided by dentists.

One addition, "D4346 scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation" enables a dental practice to report treatment of patients with gingival disease, but who do not have any attachment loss. This procedure is more extensive than a prophylaxis (e.g., D1110), but less so than a scaling and root planing (e.g., D4341).

There are four related additions that enable a dental practice to record and report efforts to deliver oral health services to patients who need care. Such efforts are described as "case management" and the CDT Codes are: "D9991…addressing appointment compliance barriers;" "D9992…care coordination;" "D9993…motivational interviewing;" and "D9994…patient education to improve oral health literacy."

Quality Measures: The Implementation of quality measures for public and private dental plans is a mechanism to hold plans and programs accountable for results regarding access to preventive services. The DQA sealant measure has been inserted in the CMS Child Health Insurance Program Reauthorization Act (CHIPRA) core set for reporting by Medicaid and CHIP programs. Results on this measure will be included in the report to Congress in 2017. The Oregon Health Authority is also using DQA measures to evaluate their Coordinated Care Organizations (CCOs). Covered California, the California health insurance marketplace, is now requiring all dental benefit plans offering the pediatric dental benefit to report scores on the DQA measures as of January 1, 2016.

At least 14 state Medicaid programs have reported using at least one or more DQA measures to evaluate their programs. (Medicaid and CHIP State Dental Association survey). Each time DQA measures are adopted, the ADA succeeds in preventing inappropriate quality measures and numerous duplicative measures from being place in use within the dental system.

The DQA is currently collaborating with University of Washington to develop a Starter Set of adult measures. This project is expected to result in the first set of validated measures for the adult population by end of 2016.

Third Party Advocacy: A new third-party payer portal has been established at http://ada.org/dentalplans to help members easily access all content related to ADA's third-party advocacy efforts and to learn more about dental benefits.

Emerging Issues and Trends

MARKET DATA

Overall Market Size for Dental Benefits [Source: ADA Health Policy Institute]

- National dental care expenditure was $113.5 billion in 2014. Per capita dental spending in 2014 was $351.
- In 2013, Medicaid/CHIP accounted for 38% of the children's dental benefits market up from 21% in 2000. Private dental benefits accounted for 50% of the market and 12% were uninsured in 2013.
- 56% of adults receive dental benefits through private coverage, while 10.5% utilize Medicaid and 33% are uninsured as of 2013.
- Only 27% of adults over 65 have private dental benefits, while 11% have Medicaid and 62% are uninsured.

Dental Benefits Market Trends [Source: National Association of Dental Plans]

Enrollment

- 204.6 million people (64% of the U.S. population) had a dental benefit in 2014—up from 170.5 million (57%) in 2006.
- In 2014, preferred provider organizations (PPO) accounted for 82% of the dental plans in the market—up from 62% in 2006.
- In 2014, the commercial market had 77.9 million people (52%) with fully insured dental benefits versus 71.1 million (48%) with self-funded plans.
- 7% of the population covered by commercial benefits have their benefits through individual policies in 2014.

Network Statistics

- More than 193,000 dentists participate in at least one PPO network. Among those who participate in PPO networks, on average, each dentist participates in almost six networks.

Premiums & Plan Design

- In 2014, 47% of PPO plan maximums (in-network) were $1,500 or more per year.
- The number of plans offering "rollover" of annual maximums and "preventive and diagnostic credit" (i.e., some preventive and diagnostic services do not count towards the patient's annual maximum) is increasing.
- In 2015, the average PPO premium per enrollee, per month, was $31.9, down 1.5% from 2014. Dental HMO (DHMO) premiums increased 2.3% and indemnity premiums increased 8.5% from a year ago.
- 23.5% of group dental policies are fully employee paid (i.e., voluntary), up 1.5% from last year. 6.5% of group dental coverage is completely paid for by the employer, up from 5.4% a year ago.

Utilization

- In 2014, the percentage of enrollees reaching or exceeding plan maximums was 2.8% of PPO enrollees (in-network), while 1% (out-of-network) reached the same annual maximum.
- Number of covered procedures per enrollee has been trending down.
- Use of in-network services from PPO networks is clearly trending up with 79.6% of procedures performed in network for PPO plans.
- The industry median for electronic claims was 68% in 2014.

KEY OBSERVATIONS

Some observations from the latest data indicate that:

- Consumers with a dental benefit are more than twice as likely to visit their dentist.
- The market share of PPO plans is on the rise and constitutes more than 80% of the current market; there is an increased focus on directing plan beneficiaries to in-network dentists; most dentists participate in networks with a dentist, on average participating in 5.5 network plans.
- Pressure on dental plans to maintain (or lower) premiums is high and is accompanied by lower reimbursement rates to dentists, increasing administrative complexity (e.g., increased appeals) and increasingly complex processing policies (e.g., denials and disallow policies.)
- “Consumerism” is on the rise with most consumers preferring a low cost plan. There is an increase in transparency related to cost information with the intent to promote “healthcare shopping” although the dental market continues to be saturated by group dental benefit plans.
- More of the costs (premiums and co-insurance) are being shifted to employees with some employers choosing to make the dental benefit “voluntary” (i.e., 100% of premium is paid by the employee).
- “My mouth is healthy” and “cost” are the reasons reported by consumers with a benefit plan for not seeing a dentist.
- The role confusion between a “benefit” versus an “insurance” product results in many misperceptions for member dentists and consumers.

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/ Program	Success Measure	Target	Range	Outcome
H-2015. Interference in the Doctor/Patient Relationship by Third-Party Carriers Through the Practice of "Disallowing" Claims. This resolution calls for the ADA to draft a specific policy proposal opposing dental provider contracts that permit the practice of disallowing claims by third-party payers for consideration by the 2016 House of Delegates. This resolution also calls for the ADA to pursue lawful remedies that will seek to prevent third-party payers from utilizing provider contracts that allow restriction of payments directly from the patient to the provider in situations where dental benefit payment has been disallowed.	Third-Party Payer Advocacy	Develop a draft policy for submission to 2016 HOD. Develop a communications strategy to highlight the flaws of "disallow" policies and express ADA's opposition to such policies.	Develop draft policy by June 1, 2016. Communicate dissatisfaction to payers by June 30, 2016.	N/A N/A	The Council has proposed a new policy titled, "Comprehensive ADA Policy Statement on Inappropriate or Intrusive Provisions and Practices by Third Party Payers" which includes on a statement on the practice of "disallowing" claims. Resolution 12H-2016. On April 27, the Council sent a statement to Delta Dental Plans Association (DDPA) expressing its disagreement with Delta's proposed policy to disallow claims for more than two quadrants of scaling and root planning on the same date of service. This was followed by a broader letter from the ADA's President and Executive Director sent to DDPA on June 21, 2016 expressing the ADA's displeasure with the practice of disallowing claims for services rendered. Follow-up communications are ongoing with third party payers and their consultants.

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2018.

Policy Review

In accordance with 170H-2012, Reaffirming Existing ADA Policy, the Council on Dental Benefit Programs reviewed the following Association policies and determined they should be maintained.

Inclusion of Radiographic Examinations in Dental Benefits Programs (*Trans.*1991:634)
Coverage for Treatment of Temporomandibular Joint Dysfunction (*Trans.*1989:549)
Payment for Prosthodontic Treatment (*Trans.*1989:547)
Appropriate Use of Dental Benefits by Patients and Third-Party Payers (*Trans.*1993:688)
Plan Coverage for Treatment of Teeth Needing Restoration Due to Attrition, Wear and Abrasion (*Trans.*1993:693)
Eligibility and Payment Dates for Endodontic Treatment (*Trans.*1994:674)
Payment for Temporary Procedures (*Trans.*1999:922)
Third-Party Acceptance of Descriptive Information on Dental Claim Form (*Trans.*1978:507; 2013:308)
ADA's Dental Claim Form (*Trans.*1991:633; 2001:428; 2013:307)
Age of "Child" (*Trans.*1991:635; 2013:307)
Use of DEA Numbers for Identification (*Trans.*2000:454; 2013:306)
Tooth Designation Systems (*Trans.*1994:652; 2002:394; 2013:301)
Authority for the Code on Dental Procedures and Nomenclature (*Trans.*1989:552; 2008:453)
Monitoring and Resolution of Code Misuse (*Trans.*2007:419)
Development of ADA SNODENT Clinical Terminology (*Trans.*1995:619; 2013:309)
Submission of Attachments for Electronic Claims (*Trans.*1997:677)
Recognition of Tooth Designation Systems for Electronic Data Interchange (*Trans.*1994:675; 2013:324)
Proposal for the ADA Dental Claim Form to be Maintained in a Form That Coincides With the HIPAA-Required ANSI X12 837—Dental Transaction Set (*Trans.*2001:434)
Disputes Concerning Dental Treatment Provided Under Dental Benefits Programs (*Trans*. 1992:600)
Use of Peer Review Process by Patients and Third-Party Payers (*Trans*. 1990:534)
Dentist Participation in Peer Review Organizations (*Trans*. 1987:501)
Constituent Society Peer Review Systems (*Trans*. 1981:573)
Legislation Regulating All Dental Benefits Programs (*Trans.*1993:694)
Programs in Conflict With ADA Policies (*Trans.*1979:638)
Opposition to Dental Benefit Plans or Programs Conflicting With ADA Policies (*Trans.*1995:620)
Opposition to Fraudulent and Abusive Practices Under Public and Private Dental Benefits Programs (*Trans*.1990:537)
Supporting Constituents With Third-Party Payer Issues (*Trans.*2004:307)
Evaluation of Dental Care Programs (*Trans.*1989:548)
Education of Prospective Purchasers of Dental Benefit Programs (*Trans.*1986:515)
Third-Party Payers Overpayment Recovery Practices (*Trans.*1999:930; 2013:312)
Audits of Private Dental Offices by Third-Party Payers (*Trans.*1990:540; 2005:325)
Prohibition of "Hold Harmless" Clauses (*Trans.*1995:651)
Continuation of Doctor/Patient Relationship (*Trans.*1991:627)
Full Disclosure of Financial Incentives and Other Health Plan Information (*Trans.*1996:692)
Medical Loss Ratio (*Trans*. 2015:226)
Administrative Practices Encouraging Dentist Selection Based on Cost (*Trans.*1995:610**)**
Statement on Dental Consultants (*Trans.*2010:555)
Identification of Claims Reviewer (*Trans.*1985:584)
Legislation to Require Dental Benefit Plans to Provide Dental Consultant Information (*Trans.*2010:546)
Practitioner Protections in Managed Care Plans (*Trans.* 1994:643)
Regulation of Utilization Management Organizations (*Trans.*1991:636)
Maximum Fees for Non-Covered Services (*Trans.*2010:616)
Fee Reimbursement Differentials (*Trans.*1993:697)
Statement on Reporting Fees on Dental Claims (*Trans.*2009:419)

Policy on Fees for Dental Services (*Trans.*1990:540; 2013:319)
Fee Profiles (*Trans.*1987:502; 2013:309)
Statement on Determination of Maximum Plan Benefit (Formerly "Customary Fees") by Third Parties (*Trans.*1991:633; 2010:545; 2011:453)
Automatic Review of Denied Claims by Independent Dental and/or Medical Experts (*Trans.*1994:645)

Council Minutes

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

Council on Dental Education and Licensure

Gesek, Daniel, 2017, Florida, chair, American Association of Dental Boards
Price, Jill M., 2017, Oregon, vice chair, American Dental Association
Aksu, Mert, 2019, Michigan, American Dental Education Association
Brysh, L. Stanley, 2016, Wisconsin, American Dental Association
Cassella, Edmund A, 2019, Hawaii, American Dental Association
Edgar, Bryan, 2018, Washington, American Association of Dental Boards
Feldman, Cecile A., 2016, New Jersey, American Dental Education Association
Glickman, Gerald N., 2018, Texas, American Dental Education Association
Halpern, David F., 2018, Maryland, American Dental Association
Hebert, Edward J., 2018, Louisiana, American Dental Association
Holm, Steven J., 2016, Indiana, American Dental Association
Jennifer Korzeb, 2019, Massachusetts, American Dental Association
Manning, Dennis E., 2016, Illinois, American Association of Dental Boards
Paul, Mina, 2019, Massachusetts, American Association of Dental Boards
Raman, Prabu, 2017, Missouri, American Dental Association
Ritchie, Ryan, 2016, Minnesota, New Dentist Committee*
Sarrett, David C., 2017, Virginia, American Dental Education Association

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

The Council's 2015–16 liaisons include: Dr. Robert N. Bitter (Board of Trustees, Eighth District), and Dr. Christian Piers (American Student Dental Association).

Bylaws Areas of Responsibility

As listed in Chapter X, Section 130E of the *Bylaws*, the areas of subject matter responsibility for the Council are:

a. Dental, advanced dental and allied dental education and accreditation;
b. Recognition of dental specialties and interest areas in general dentistry;
c. Dental anesthesiology and sedation;
d. Dental admission testing;
e. Licensure;
f. Certifying boards and credentialing for specialists and allied dental personnel; and
g. Continuing dental education.

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

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome
3.1 Pursue programs that members value	Licensure Portability and Licensure Task Force	Letters to state dental boards	25 states	25 states	25 States Achieved
		States contemplating changes to licensure requirements	Five states	One to five states	Six States Exceeded
		Report and outcomes of Licensure Task Force	September Board meeting	September 25	On plan
		Objective Structured Clinical Examination (OSCE) business plan	Council on Dental Education and Licensure (CDEL) meeting December 2016	December 5–6	On plan
3.1 Pursue programs that members value	Revise the Sedation and Anesthesia Guidelines	Literature review in collaboration with Council on Scientific Affairs (CSA)	May 2016		Achieved
		Conduct hearing for ADA members	May 2016		Achieved
		Seek comment from communities of interest	February and June 2016		Achieved
		Transmit response to 2016 House of Delegates	August 2016		On plan
5.1 Increase non-dues revenue	Admission Testing	DAT used by all dental education programs	100%	90–100%	100% Achieved
		DAT generates at least $5 million	$5 million	$4.5–$5 million	On plan
		Sufficient number of Advanced Dental Admission Test (ADAT) administrations to support psychometric analysis and score reporting	600	400–1,000	On plan

Dental Education and Accreditation: In accord with 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 reports on observations of major policy and procedural actions taken by CODA. The Council also reviews matters related to accreditation of dental, advanced dental and allied dental education programs for the Association. Actions taken by the Council regarding these matters are reflected in the Council's meeting minutes.

Again this year, the Council sponsored two tuition scholarships to the Academy for Academic Leadership's Institute for Teaching and Learning to recognize members pursuing careers in academia. This year's recipients, Dr. Mahnaz Fatahzadeh from the Rutgers School of Dental Medicine and Dr. Randal L. Vaught from the University of Louisville, School of Dentistry were presented with the tuition scholarships.

Recognition of Interest Areas in General Dentistry: The Council received an application from the Academy of Operative Dentistry (AOD) requesting that operative dentistry be recognized by the ADA as an interest area in general dentistry (*Reports* 2014:101). Using the Criteria for Recognition of Interest Areas in General Dentistry, the Council followed its established review process, including the conduct of an open hearing at the 2014 ADA Meeting and calling for comment from the communities of interest regarding the application. The Council reviewed the application and comments received and transmitted its preliminary report to the AOD. Following the AOD representatives appearance before the Council on December 11, 2015 and further consideration of the matter, the Council concluded that the application meets the *Criteria for Recognition of Interest Areas in General Dentistry*. The Council's findings and Resolution 19, Recognition of Operative Dentistry as an Interest Area in General Dentistry, are presented in a separate report to the 2016 House of Delegates (Worksheet:4010).

Dental Anesthesiology: The Council's response to Resolution 77H-2015, is presented with Resolution 37, Proposed Amendments to the Sedation and Anesthesia Guidelines, in a separate report to the 2016 House of Delegates (Worksheet:4057). The Council wishes to thank CSA and the Science Institute for preparing this year a detailed report titled "Risks and Benefits of Using Capnography in Dental Patients Undergoing Moderate Sedation." The report analyzed two systematic reviews of the literature and found that available scientific evidence demonstrates that capnography identifies significantly more respiratory complications during procedural sedation in adults than standard monitoring. That report and CSA member, Dr. William Parker's consultation with the Anesthesiology Committee, assisted the Council in developing its response to Resolution 77H-2015.

Dental Admission Testing Programs: The Council oversees the Dental Admission Testing Program, exclusively administered as a computer-based examination via Prometric Testing Centers throughout the United States and its territories. Trends in the DAT Program for 2015 included:

- Average scores for first-time examinees in 2015 on all tests in the DAT battery were similar to those from 2014.
- During 2015, 13,093 DATs were administered, slightly up from 12,973 in 2014
- The total number of DAT administrations has decreased overall each year since 2011.
- 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 2015 were as follows: White (60.6%), Asian (29%), Hispanic (10.6%), Black (8.3%), American Indian/Alaska Native (1.3%), and Native Hawaiian/Pacific Islander (0.8%). Six percent (6%) of respondents did not provide ethnicity information.

In 2015, based on a business plan supported by the Council, the Board of Trustees approved funding to develop ADAT. A new admissions tool was needed because many dental schools are reporting grades as pass/fail, and many no longer report student class rank. Additionally, since 2012, the Joint Commission on National Dental Examinations has been reporting National Board results as pass/fail. Advanced dental education program directors asked for a reliable and fair method of evaluating

candidates for their programs. The ADAT is an important tool that will assist program directors the ability to identify and distinguish among the strongest candidates.

At the time this report was prepared, 528 applications for the ADAT had been received. Forty-nine advanced education programs indicated that they would "require" the ADAT exam for admission; 95 indicated that they "will accept" ADAT exam results for admission. The number of candidates and the number of advanced education programs requiring the ADAT are expected to continue to increase in coming years.
A number of resources to help program directors and candidates prepare for the ADAT and reduce anxiety have been developed. Practice questions are available online, and validity evidence with respect to the ADAT is presented in an online report entitled "Using the Advanced Dental Admission Test (ADAT) for Admission Purposes: A Guide for Advanced Dental Education Programs." More information about the ADAT is posted at www.ada.org/ADAT.

Initial Dental Licensure and Clinical Licensing Examinations: As noted in the Operating Plan metrics above, the Council has participated in the Board of Trustees 2016 Licensure Task Force. The Council supports the goals of the Licensure Task Force which are to advocate for current ADA policy, i.e., support the professional mobility of dentists by increasing portability of licensure and to eliminate the patient-based component of the licensing exam and replace it with alternative methodologies for assessing readiness for practice that are reliable, valid and protect the safety of the public.

The Council developed unique new state-by-state licensure tables that are posted to the ADA website. The state licensure tables outline clinical exam requirements as well as statutes and regulations pertaining to both initial licensure and licensure by credentials. The data will be especially useful to dental students and new dentists; it will be updated as new licensure laws are adopted and as dental boards change their regulations and policies.

The five clinical dental testing agencies consist of member states that utilize the agencies' examinations for the purposes of granting initial licensure in their states. The regional agencies include the Central Regional Dental Testing Service (CRDTS), Council of Interstate Testing Agencies, Inc. (CITA), the Commission on Dental Competency Assessments (CDCA) [formerly the North East Regional Board of Dental Examiners, Inc. (NERB)], Southern Regional Testing Agency (SRTA), and Western Region Examining Board (WREB). 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. Nearly all US licensing jurisdictions utilize services of one or more of the clinical testing agencies; only Delaware and New York do not.

The American Board of Dental Examiners (ADEX) is an examination development agency whose member representatives provide for the ongoing development of the ADEX Dental and Dental Hygiene Licensing Examinations. Currently, CDCA, CITA, Hawaii, Nevada and Florida administer the ADEX Examinations. The results of the ADEX examination, administered by CITA and CDCA are now accepted by 45 licensing jurisdictions for initial licensure. The states that do not accept the results of the ADEX examination are: Alaska, California, Delaware, Iowa, Georgia, New York, Oklahoma and South Dakota.

In response to Resolution 50H-2013 (*Trans*.2013:327*)*, the Council monitors the Dental Board of California's (DBC) development and implementation of a portfolio-style licensure examination and reports progress via its Annual Report. Regulations for the portfolio examination became effective in November 2014. Dental schools participating in the portfolio pathway include the University of Southern California-Ostrow, University of the Pacific-Dugoni, University of California at San Francisco and the University of California at Los Angeles. In the first half of 2016, the DBC issued seven licenses through the portfolio pathway. Six of the applicants graduated from the University of the Pacific and one graduated from the University of California, San Francisco.

The following states accept for licensure the National Dental Examining Board of Canada's two-part examination (a written test and non-patient based Objective Structured Clinical Examination [OSCE]): Minnesota (for graduates of the University of Minnesota School of Dentistry graduating after 2009);

Colorado and New Hampshire. Ohio and Iowa are also considering accepting some type of OSCE for licensure, but no action has been taken.

New York and Delaware continue to mandate a PGY-1 for initial licensure. Several other states (California, Colorado, Connecticut, Minnesota and Ohio) offer the option to complete a PGY-1 instead of taking a clinical licensure exam. Washington also offers the option to complete a post-doctoral residency program in lieu of a clinical examination if that residency is completed in the state of Washington and meets other specific requirements set forth by state law. 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 2015 annual report. Dental boards in 46 states plus the District of Columbia and Puerto Rico have authority to grant licensure by credentials, although the specific provisions for granting licensure by credentials vary considerably among the states. Delaware, Florida, Hawaii, Nevada and the Virgin Islands do not grant licensure by credentials.

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

California – CA AB 880 amended the provision of the Dental Practice Act that prohibits the practice of dentistry by any person without a valid license; exempts from that prohibition the practice of dentistry by a final year dental student, working without compensation or expectation of compensation and under the supervision of a licensed dentist with a clinical faculty appointment at a sponsored event, as defined, if specified conditions are met. The sponsoring entity of the sponsored event must provide the board with a list of the names of the students practicing dentistry at the sponsored event, the name of the school of enrollment of those students, and the name and license number of the supervising licensed dentist.

Illinois – IL AB 1496 amended the Dental Practice Act to clarify that applicants for Illinois dental licenses who graduated from dental schools outside of the U.S. or Canada must have completed a minimum of two academic years of general dental clinical training at an approved dental college or school in the U.S. or Canada; this amendment also removes the following provision that allowed for substitution: "however, an accredited advanced dental education program approved by the Department of no less than 2 years may be substituted for the 2 academic years of general dental clinical training and an applicant who was enrolled for not less than one year in an approved clinical program prior to January 1, 1993 at an Illinois dental college or school shall be required to complete only that program." The following equivalency certification requirement was also removed: "the applicant has received certification from the dean of an approved dental college or school in the United States or Canada or the program director of an approved advanced dental education program stating that the applicant has achieved the same level of scientific knowledge and clinical competence as required of all graduates of the college, school, or advanced dental education program."

Maine – ME LD 1596 is a complete recodification of the Dental Practice Act: sets forth licensure requirements and exemptions; expressly defines "dentist license," "limited dentist license," "faculty dentist license," "charitable dentist license," "clinical dental educator license," and "resident license." The legislation defines and creates qualifications for a "dental radiographer license;" defines and creates qualifications for "expanded function dental assistant license;" defines and creates qualifications for a "dental hygienist license;" defines and creates qualifications for a "denturist license;" and finally sets out licensure by endorsement requirements.

Iowa – IA HB 2387 requires the dental board and University of Iowa Dental School to study the use of a station-based, non-human examination for the licensure of dentists; requires development of a strategy for alternative and improved testing methods involving the use of live patients.

Oklahoma – OK HB 2627 added a new category of eligibility "retired volunteer dental license" for those retired dentists who practiced for 30 consecutive years.

Hawaii – HI SB 2675 authorizes the Board of Dental Examiners, Hawaii Medical Board, Board of Nursing, and Board of Pharmacy to deny a license to an applicant or impose disciplinary action against a licensee who has been disciplined by another state or by a federal agency; it also prohibits a licensee from practicing until a final order of discipline is issued if the licensee has been prohibited from practicing in another state.

Idaho – ID HB 341 requires all licensing boards to provide public access to provider information on licensure status and any final board disciplinary action.

Missouri – MO HB 1682 was enacted in May and is awaiting the Governor's signature. The bill creates the Medical Practice Freedom Act that prohibits the conditioning of physician and dental licenses on, upon or related to participation in any public or private health insurance plan, public health care system, public service initiative, or emergency room coverage.

New York – NY AB 9129 was enacted and send to the Governor for signature in June. The bill extends the expiration of provisions relating to the restricted dental faculty license from 2017 to 2019.

ADA-Recognized Dental Specialty Certifying Boards: The Council annually surveys the ADA-recognized dental specialty certifying boards. The *2016 Report of the ADA-Recognized Dental Specialty Certifying Boards* shows that all nine specialty certifying boards certified diplomates in 2015. All boards, with the exception of the American Board of Oral and Maxillofacial Radiology, recertified diplomates in 2015. 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.

Continuing Education Matters: The Council's interagency Continuing Education (CE) Committee provides member oversight and input for CE development, including ADA CE Online and CE offered in the ADA Headquarters Building. The interagency committee includes a representative from each of the following agencies: CDEL (appointee to serve as chair plus one member), Council on Dental Practice/Center for Professional Success, ADA CE Online (editor-in-chief), *JADA* Editorial Board, Council on ADA Sessions, Council on Ethics, Bylaws and Judicial Affairs, (or other agency, on a rotating, as-needed basis), Council on Scientific Affairs/Evidence Based Dentistry, Council on Membership and the New Dentist Committee. Actions taken by the Council regarding CE matters are reflected in the Council's meeting minutes.

ADA CE Online usage continues to grow. The 2016 year-to-date revenue is $70,089, up from $67,041 this time last year. More importantly, an in-house learning management system is being developed using Aptify; the third party learning management vendor will no longer be used. The greatest benefit of the change will be a new revenue model. Currently ADA CE Online is in a revenue share agreement with the outside vendor. Bringing the technology in-house will allow ADA CE Online to retain 100% of the revenue. The new system is expected to launch in October 2016.

Table 1. ADA CE Online FY 2015

Active Users	New Registrants	Total Courses	Courses Added	Courses Eliminated
7,032	4,575	170	16	5

Emerging Issues and Trends

Specialty Recognition Issues: The Council collaborated with the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) by providing comment on CEBJA's proposed revisions to 5.H. of the *Ethics and Code of Professional Conduct* regarding broadening the specialists' ability to announce as a specialist and the exclusivity of the limitation to practice.

The Council is studying the ADA process for the recognition of dental specialties noting the potential risks and benefits of the present process for recognition to the extent that such recognition may be found to have an economic benefit and carries with it certain risks. Believing that the recognition process is very important to the profession and noting that it is a complicated subject, the Council determined the inclusion of all of the communities of interests in the discussion is necessary. The Council will host a Dental Specialty Recognition Summit in February 2017, leading the communities of interest in discussing the specialty recognition process for the profession.

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
35H-2014. A Comprehensive Study of the Current Dental Education Models	With Council input, the Health Policy Institute (HPI) leads research study on dental education models	Research plan developed by May 2015	May 2015		Achieved
		Final drafts of reports by April 2016	April 2016		Achieved
		Transmit report to 2016 House of Delegates (Board Report 4)	August 2016		Achieved
77H-2015. Proposed Amendments to the Sedation and Anesthesia Guidelines	Requested the Council to consider eliminating the mandate to monitor end tidal CO_2 for moderate sedation; make patient evaluation provisions consistent throughout the document; and reconsider the section "Moderate Sedation Course Duration," as proposed by level of sedation	Literature review in collaboration with CSA	May 2016		Achieved
		Conduct hearing for ADA members	May 2016		Achieved
		Seek comment from communities of interest	February and June 2016		Achieved
		Transmit response to 2016 House of Delegates (Resolution 37)	August 2016		Achieved

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2019.

Policy Review

In accordance with Resolution 170H-2012, Reaffirming Existing ADA Policy, the Council reviewed Association policies related to accreditation and dental education.

The Council on Dental Education and Licensure reviewed the following policies and determined they should be maintained.

Consultation and Evaluation of International Dental Schools (*Trans.*2005:298)
Participation in International Higher Education Collaborative Networks (*Trans.*2003:368)

Assistance to Dental Schools Upon Closure (*Trans.*1992:610)
Definition of Continuing Competency (*Trans.*1999:939)
Single Accreditation Program (*Trans.*1999:696; 2010:577)

The Council determined that several policies should be amended and several others should be rescinded. Resolutions urging amendments or rescissions to policies are being submitted in separate reports on worksheets to the 2016 House of Delegates.

Council Minutes

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

Council on Dental Practice

Brown, Andrew B., 2016, Florida, chair
O'Toole, Terry G., 2015, District of Columbia, vice chair
Bengtson, Gregory J., 2016, Idaho
Cammarata, Rita M., 2017, Texas
Childs, Eric T., 2016, Wisconsin*
Connell, Christopher M., 2019, Ohio
Creasey, Jean L., 2016, California
Hale, Hal E., 2019, Kansas
Kent, Leigh W., 2018, Alabama
Landes, Christine M., 2017, Pennsylvania
Marshall, Todd W., 2016, Minnesota
Mazur-Kary, Michelle L., 2017, Maine
Mikell, Julia K., 2019, South Carolina
Ratner, Craig S., 2018, New York
Smith, J. Christopher, 2016, West Virginia
Theurer, Scott L., 2018, Utah
Van Scoyoc, Stacey K., 2019, Illinois
Wojcik, Michael S., 2018, Michigan

Porembski, Pamela M., director

The Council's 2015–16 liaisons include: Dr. Andrew J. Kwasny (Board of Trustees, Third District), and Ms. Helen Yang (American Student Dental Association).

Bylaws **Areas of Responsibility**

As listed in Chapter X, Section 130F of the ADA *Bylaws*, the areas of subject matter responsibility of the Council are:

a. Dental Practice, including:
   (1) Dental practice management;
   (2) Practice models and economics;
   (3) Scope of practice;
   (4) Impact of and compliance with regulatory mandates; and
   (5) Assessment of initiatives directed to the public and the profession;
b. Allied Dental Personnel, including:
   (1) Utilization, management and employment practices; and
   (2) Liaison relationships with organizations representing allied dental personnel;
c. Dentist Health and Wellness, including:
   (1) Dental professional well-being, wellness and ergonomics;
   (2) Patient safety and wellness; and
   (3) Liaison relationships with state well-being programs and related national organizations;
d. Dental Informatics and Standards for Electronic Technologies; and
e. Activities and Resources Directed to the Success of the Dental Practice and the Member.

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

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome
3.1 Pursue programs that members value and are "best in class"	Provider's Clinical Support System-Opioid (PCSS-0) Webinar Grant	150 dentists participate in each of four Opioid-related webinars	150 participants for each webinar	125–175 participants for each webinar	Web. 1- 509 participants Web. 2- 524 participants Web. 3- 8/16/16 Web. 4- 9/2/16
3.1	Provider's Clinical Support System-Opioid (PCSS-0) Webinar Grant	85% of post-webinar evaluations rate webinars a 4 on a scale of 1 to 4, with 4 being the highest.	4.0 on 4.0 scale	80%–90% evaluations	Web. 190% satisfaction rate Web. 2 88% satisfaction rate Web. 3 and 4 TBD
3.1	Guidelines for Practice Success™ (GPS)	Develop guideline for: Managing Marketing and post to Center for Professional Success (CPS)	Submit guideline to CPS 9/12/16	Submit between August and October 2016	On schedule for 9/12/16 submission
3.1	GPS	Develop guideline for Dental Team and post to CPS	Submit guideline to CPS 10/14/16	Submit between September and November 2016	On schedule for 10/14/16 submission
3.1	GPS	Develop guideline for the Regulatory Environment and post to CPS	Submit guideline to CPS 12/21/16	Submit between November 2016 and January 2017	On schedule for 12/21/16 submission
3.1	GPS	Launch Benchmark Tool: Compare. Adjust. Succeed.	Launch at ADA 2016	N/A	Will launch at ADA 2016

Objective	Initiative/Program	Success Measure	Target	Range	Outcome
3.1	Center for Professional Success (CPS)	Utilization and Satisfaction Metrics—An increase in total visits, total visitors and pages viewed per visit when compared with the same time period of 2015.	5% increase in total visits 5% increase in total visitors 5% increase in pages viewed per visit	3%–7% increase 3%–7% increase 3%–7% increase	Demonstrated underperformance through second quarter, which was expected (due to very strong second quarter numbers in 2015). Recovery into acceptable target range is anticipated by end of year 2016.
3.1	American National Standards Institute (ANSI) ADA Standards	1. Develop standards, guidelines and technical reports to address emerging issues 2. Approval of four new work items 3. Liaison representation in outside standards organizations emerging issues affecting dentistry 4. Development of procedures/process flow charts to track emerging issues new work projects	Four new standards	Two to six new standards	1. Seven new standards and technical reports were published. 2. Six new work items were approved. 3. Liaison representatives attended 100% of assigned meetings. 4. Revised procedures on track to be approved by the Council on Dental Benefit Programs, CDP and the Council on Scientific Affairs by July 2016.

The CPS experienced extremely high traffic numbers between March and June 2015 due to an original enforcement deadline of June 1, 2015 of the Medicare enrollment/opt-out decision dentists were to make. A site design refresh project, along with mobile enablement, and several emerging issues throughout the remainder of the year, including compliance with the newly released rules on Section 1557 of the Affordable Care Act, should return engagement measures into the acceptable range by end of year 2016.

Emerging Issues and Trends

ANSI and Standards Development: The ADA's voluntary standards program is an American National Standards Institute (ANSI)—accredited program that develops voluntary consensus standards in support of the Strategic Plan, Members First 2020, Objective 3.1: Pursue programs that members value. The Standards program goal is to "Develop standards and technical reports to address emerging issues." In addition, the program is instrumental in the development of national and international standards that impact virtually every product used in the dental practice to ensure safety, efficacy and interoperability.

New Standards Addressing Emerging Issues: The following new standards were the first to address these emerging issues: ANSI/ADA Standard No. 136, *Products for External Tooth Bleaching*; ANSI/ADA

Standard No. 131; *Dental CAD/CAM Machinable Zirconia Blanks;* ANSI/ADA Standard No. 132, *Scanning Accuracy of Dental Chair Side and Laboratory CAD/CAM Systems;* ANSI/ADA Standard No. 1079, *Standard Content of Electronic Attachments for Dental Claims;* ADA Technical Report No. 1081, *FDA's Unique Device Identification Program for Dental Devices and Biologics Regulated as Medical Devices*; ANSI/ADA Standard No. 1085, *Implementation Guidelines for the Secure Transmission of Protected Health Information for Dentistry*; ADA Technical Report No. 1089, *Track and Trace for Human Cells, Tissues and Cellular and Tissue-based Products.*

Successful Liaison Representation: ADA liaisons are subject matter consultants who represent the ADA at standards organizations that may develop standards that affect dentistry. The liaisons present ADA positions on standards and strive to have them accepted by the organization standards committee. Over the past year, ADA liaisons achieved the following two notable successes in acceptance of ADA's positions:

- ***National Fire Protection Association (NFPA):*** NFPA is a non-profit, ANSI accredited codes and standards making organization. The organization develops 300 codes and standards designed to minimize the risk and effects of fire by establishing criteria for building, design, and installation around the world. Health care-specific documents are compiled into one complete standard, NFPA 99: Health Care Facilities Code. NFPA 99 designates dental air or instrument air separately from medical air to more accurately reflect the use of compressed air in dental facilities. The Committee recently proposed a new chapter on dental gas and vacuum systems because of the unique and specific needs of those systems. This is a significant milestone because it will enable the dental profession to make the requirements specifically tailored to dental applications and, hopefully, help regulators to differentiate dental applications from those health care facilities which have more stringent requirements. ADA staff liaisons attended the June 6-7, 2016 meeting of NFPA and were highly successful in setting more appropriate standards for the various categories. Patient safety remains a high priority, but the standards must be based on a reasonable assessment of the safety risk.
- ***National Committee on Vital and Health Statistics (NCVHS):*** NCVHS is the Federal advisory committee with the responsibility of providing recommendations on the adoption of health informatics standards for the Health Insurance Portability and Accountability Act (HIPAA) transactions to the Secretary of the Department of Health and Human Services (DHHS). Dental Informatics staff submitted written testimony to NCVHS for a February 16, 2016 hearing on standards for attachments for electronic medical and dental claims. The ADA recommended adoption of the new ANSI-approved ADA Standard No. 1079, *Standard Content of Electronic Attachments for Electronic Dental Claims* for dental claim attachments. NCVHS accepted ADA Standard No. 1079 and has recommended its adoption to the Secretary of HHS.

SNODENT: SNODENT® is in the process of being adopted as an American National Standard. Over the past year, the Department of Standards initiated the ANSI accredited canvass process to implement the Canvass Committee procedure for the adoption of SNODENT. The ADA SNODENT Canvass Committee is a volunteer group that is administered by the ADA Department of Standards and agrees to review, comment and vote on whether SNODENT should be forwarded to ANSI for approval as an American National Standard. The balloting process has begun and two ballots have been circulated to date. A meeting was held at the ADA on October 23, 2015 with the Canvass Committee to discuss possible revisions to SNODENT to resolve the comments received on the first two ballots. The standard was approved by the Canvass Committee and is currently undergoing ANSI Public Review.

Although the votes to approve SNODENT were strongly in favor of adoption, a minority of the Canvassees had suggestions to improve SNODENT. Many of the comments came from proponents of the Dental Diagnostic System, (DDS). DDS is also a dental clinical terminology developed and owned by Harvard University's School of Dental Medicine.

Through the combined efforts of the ANSI ballot comment reconciliation process and lengthy discussions with the DDS authors and other Canvassees, most negative comments have been resolved. The DDS authors agreed to the idea of adding proposed concepts from DDS into SNODENT.

The outcome of this harmonization process between SNODENT and DDS has created a model that will make SNODENT a universally adopted oral health terminology standard, without competing terminologies used within the dental schools and by the electronic dental record (EDR) vendors. The vision is to have vendors and Dental Schools implement only one terminology, as opposed to having to choose between the two.

SNODENT is an official subset of SNOMED CT. SNOMED CT is the most comprehensive clinical health terminology product in the world, distributed around the world by The International Health Terminology Standards Development Organization (IHTSDO). As a consequence of the collaboration and harmonizing of SNODENT and DDS through the ANSI process, it was appropriate to name a subset of SNODENT called SNO-DDS to acknowledge the contributions from DDS. A smaller, companion subset of SNO-DDS for use in general dental practice, called SNO-DDS GD, has been completed as well.

In the future, SNODENT and its subsets SNO-DDS and SNO-DDS GD are expected to be adopted in dental school electronic record systems and by EDR system vendors. This is significant as it provides dentistry with a unified, coded, nationally recognized standard clinical terminology.

New Work Projects Addressing Emerging Issues: Over the past year, additional emerging issues were identified and new work proposals approved for the following new standards and technical reports are now in development: Proposed ADA Technical Report No. 1091, *Cloud Computing: Implications and Recommendations for Dental Practice;* Proposed ADA Technical Report No. 1092, *Implementation Guide to Utilization of Diagnostic Codes in Dental Records;* Proposed ADA Technical Report No. 1094, *Quality Assurance for Intra-oral Digital Radiography;* Proposed ADA Technical Report No. 1088, *Identification of Human Remains by Dental Means;* Proposed ANSI/ADA Standard No. 144, *Alloy for Dental Amalgam;* Proposed ANSI/ADA Technical Report No. 152, *Oral Health Risk Assessment Tools;* Proposed White Paper No. 153, *Genetic Testing for Oral Diseases.*

***Secure Exchange of Electronic Data and Images*:** In response to House Resolution 83H-2009 (*Trans.*2009:420) Secure Transmission of Dental Images, which specifies the ADA Standards Committee on Dental Informatics (SCDI) develop a standard procedure and guidelines for a HIPAA-compliant method of secure exchange of electronic patient data and images via email, the SCDI developed ADA Technical Report No. 1085, *Direct Secure Messaging for Dentistry*. In 2014. The SCDI inaugurated a continuing education Course at ADA 2014, “Teledentistry: Secure Exchange of Digital Images and Data for Dental Practices,” which demonstrated in real time how HIPAA compliant, secure and interoperable message exchange, with digital patient image attachments, can be exchanged among various dental systems by email. The program was repeated at ADA 2015 and is planned again for ADA 2016.

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
Resolution 95H-2015 Increasing Member Value Proposition Through the Center for Professional Success	Appropriate ADA volunteers were to conduct a review of Salable and other available materials to evaluate select items that reflect significant member value for placement on CPS and report back to the 2016 House of Delegates.	Review of materials by volunteers.	N/A	N/A	Report back to the House—see narrative below

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
Resolution 96H-2015 Development of ADA Policy on Dentistry's Role In Sleep-Related Breathing Disorders	Develop policy as to the dentist's role in sleep-related breathing disorders.	Review of materials and discussion by Ad Hoc Committee volunteers.	N/A	N/A	Development of policy is in progress

Resolution 95H-2015 was assigned to CPS, with input from the Divisions of Publishing and Finance and Operations. The available materials and the income generated by each piece were identified. The CPS Advisory Committee reviewed an exhaustive list of salable materials and subsequently determined that 32 titles from the *ADA Catalog* should be presented to the full Council for their consideration and ranking. These titles were then circulated among all Council volunteers and the CPS User's Group, with the outcome resulting in a ranked wish list of the top eight items for potential placement on CPS as listed in Table 1. Discussions with the Council were held to consider the feasibility of selecting excerpted material from these top-ranked items in such a fashion that value would be added to CPS, yet traffic might be driven to ADA salable materials, should the reader want more information on the same topic. This method would allow for value to be added for the members, as well as potentially adding dollars to the non-dues revenue stream. This approach was deemed acceptable by the volunteers and is currently being implemented in various modules of the GPS™, as well as individual content pieces throughout the site.

ADA Success Program material was also given consideration, as were discontinued salable materials. Content creation for CPS will continue to look to these two sources as relevant content drivers, with no impact on non-dues revenue if either source is tapped.

Table 1. Top Eight Items for Potential Placement on CPS

Product Name	CPS Content Plan
The ADA Practical Guide to Creating and Updating an Employee Office Manual	Three different content pieces planned: an outline of steps to creation; a checklist of topics for inclusion; and a specific article of the use of social media in verifying credentials of job applicants.
A Dentist's Guide to the Law: 228 Things Every Dentist Should Know	Numerous content pieces related to this resource are in place (e.g., the Dentist Employment Contracts resource, HIPAA Business Associate information, series of Legal Tip videos). As topics rise in interest, particularly with regard to regulatory action, such material receives priority attention.
The ADA Practical Guide to Valuing a Practice	Some material from this resource already appears on CPS (e.g., "Time to Value Your Dental Practice?"). Will evaluate for other appropriate excerpts.
101 Scripts for Every Dental Office	The actual catalog resource listed here ended up being a stalled product, and is not available at this time either for sale or distribution via CPS. Script samples have been, and will continue to be, developed for the GPS™ modules.
The ADA Practical Guide to Expert Business Strategies: Advice from Top Dental Consultants	Many of the content contributors for this resource have direct pieces on CPS, or are contributors to the GPS content materials. The salable piece has been a resource throughout the development of

	the Guidelines, and is thus very much present on CPS.
Charles Blair's Diagnostic Coding for Dental Claim Submission	While CPS has a significant amount of material on coding, there is nothing specific to this piece of content. The material has been placed on the list for evaluation, and CPS will work with Sales, Dental Benefits and Dr. Blair to seek identification of appropriate content to be placed on the site.
ADA HIPAA and OSHA Compliance Kit	These specific materials are a significant source of revenue for the ADA, and thus are not ripe for placement without disturbing non-dues revenue. Nor are the kits particularly suited to excerpting small samples, as it likely would result in an incomplete piece of information, on which members could not rely. CPS has a great deal of supporting material on each topic, to which new or updated content is frequently added. The regulatory section of the GPS will also cover this area, and that also will provide a wealth of information on these topics.
The ADA Practical Guide to Associateships: Success Strategies for Dentist-Owners and Prospective Associates	Again, CPS has materials on associateships, but nothing specifically drawn from this piece of content. Evaluation and identification of material will be placed in the content queue.

Resolution 96H-2015, Development of ADA Policy on Dentistry's role in Sleep-Related Breathing Disorders (SRBD), was assigned to the Council on Scientific Affairs (CSA) as the lead, and directed CSA to collaborate with appropriate ADA agencies to develop policy as the dentist's role in SRBD. CSA requested that the Council assist in developing draft policy following CSA's completion of a state-of-the-science Evidence Brief on oral appliances for SRBD. It is expected that this work will be completed next year.

The Council developed a new policy Statement on Teledentistry and subsequently Resolution 45H-2015 Comprehensive ADA Policy on Teledentistry was adopted by the 2015 HOD. The policy is published in ADA's *Current Policies*. Originally, Resolution 61H-2011 (*Trans.*2011:460) directed that the Council, in collaboration with the Council on State Government Affairs, investigate the emerging issue of teledentistry as it relates to dental practice and a supplemental report was submitted to the 2012 House of Delegates.

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2019.

Policy Review

In accordance with Resolution 170H-2012 (*Trans.*2012:370), Reaffirming Existing ADA Policy, the Council reviewed Association policy related to the definition of Individual Practice Associations.

The Council reviewed the following policy and determined that is should be maintained:

Individual Practice Association (*Trans.*1990:540)

Council Minutes

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

Council on Ethics, Bylaws and Judicial Affairs

Auld, Douglas A., 2016, Oklahoma, chair
Halasz, Michael H., 2017, Ohio, vice chair
Anderson, David, A., 2019, Pennsylvania
Edwards, Adam A., 2017, New York
Herman, Gary N., 2018, California
Ilkka, Don J., 2018, Florida
Ishkanian, Emily R., 2016, Nevada*
Kochhar, Puneet, 2018, New Hampshire
Merritt, Kennedy W., 2017, New Mexico
Moss, J. David, 2018, South Carolina
Muller, G. Jack, II, 2016, South Dakota
Raimann, Thomas E., 2016, Wisconsin
Rice, Marvin E., 2019, Missouri
Scarbrough, A. Roddy, 2016, Mississippi
Shekitka, Robert A., 2017, New Jersey
Smith, James A., 2019, Oregon
von Heimburg, Petra, 2019, Illinois
Walton, William M., 2016, Texas

Elliott, Thomas C., Jr., director
Elster, Nanette, manager

The Council's 2015–16 liaisons include: Dr. Chad P. Gehani (Board of Trustees, Second District), and Ms. Paula Cohen (American Student Dental Association).

Bylaws Areas of Responsibility

As listed in Chapter X, Section 130G of the ADA *Bylaws*, the areas of subject matter responsibility of the Council on Ethics, Bylaws and Judicial Affairs are:

a. Ethics and professionalism, including disciplinary matters relating thereto;
b. The *Constitution and Bylaws* of this Association, including:
   (1) Review of the constitutions and bylaws of state and local societies to ensure consistency with the Association's *Bylaws*; and
   (2) Correct punctuation, grammar, spelling and syntax, change names and gender references and delete moot material where such revisions do not alter the material's context or meaning in the *Bylaws* and the ADA Procedures for Member Disciplinary Hearings and Appeals upon the unanimous vote of the Council members present and voting; and
c. Acting as the Standing Committee of Constitution and *Bylaws* of the House of Delegates pursuant to CHAPTER V, Section 140A of the *Bylaws*.

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

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome
1 The Public will recognize the ADA and its members as leaders and advocates in oral health	Public Differentiation of ADA Member Dentists via the ADA *Principles of Ethics and Code of Professional Conduct*	Development of consumer based information about the ADA *Code* and its importance	Survey conducted indicated that with an understanding of the ADA *Code*, consumers are more likely to choose an ADA Dentist	In process based on informational campaign to the public	To be assessed as campaign is rolled out to the public
3.1 Pursue programs that members value and are "Best in class"	Support member success by providing varied ethics programming accessible to membership through multiple venues	Membership access to excellent ethics continuing education programming	Highly favorable participant evaluation of continuing education ethics programming	Favorable to highly favorable participant evaluation of continuing education ethics programming	On target at time of submission (August 2016)
3.1 Pursue programs that members value and are "Best in class"	Support member success by providing communications vehicle allowing members to obtain advice on ethical questions in a very timely manner	Membership access to timely advice concerning ethics questions that arise in members' practices	Highly favorable participant evaluation of ethics advice program	Favorable to highly favorable participant evaluation of ethics advice program	On target at time of submission (August 2016)

Public Relations/Marketing Campaign to Increase Public Awareness of the ADA *Principles of Ethics and Code of Professional Conduct*: With the collaboration of the ADA Division of Communications and Marketing, the Council conducted a survey of members of the public designed to provide knowledge on this topic which supports the first objective of ADA's strategic plan. The survey gauged the level of public awareness of the ADA *Principles of Ethics and Code of Professional Conduct* ("the ADA *Code*") and that one of the primary purposes of the ADA *Code* is to put the welfare of patients first. In addition, the survey tested if knowledge of the ADA *Code* would positively differentiate ADA member dentists in the minds of the public. Results indicated that it would, with 69% of respondents, when made aware of the ADA *Code* indicating that they would be more likely to choose an ADA dentist. Based on those results the Council is working with Communications to develop video, print and web based materials to increase the public's awareness of the ADA *Code*.

Continuing Education Programming in Ethics: During the 2015 Annual Meeting, the Council presented a two-hour continuing education course entitled "Ethical Considerations of Difficult Discussions with Patients."

Additional activity by the Council in support of its goal of providing varied ethics programming accessible to membership through multiple venues include:

- Developing an ethics continuing education course for the 2016 annual meeting, entitled "The ADA *Code*: 150 Years of Putting the Patient First," which will cover topics including: treating patients with special needs (both adults and children); managing patients in long term care facilities and how to address conflicts with alternative or holistic care providers.
- Continuing to develop videotaped ethics continuing education courses that will be available through ADA.org. Currently four videos are in the editing stages; and
- Providing continuing education courses to state dental associations. Developed at the request of the state associations, the courses have provided both general dental ethics education as well as targeted subject matter. In 2016, a live webinar was presented to the Virginia Dental Association (VDA). A copy of the webinar will be archived for viewing by members who were unable to participate in the live VDA session.

Ethical Advice Communications Vehicle: The Council maintains a service, the Ethics Hotline, which members can call to discuss ethical issues confronting them. Members call and leave a message on a confidential voicemail; messages are retrieved and forwarded to a Council member who calls and assists the member in examining the ethical question posed. The responding member of the Council attempts to return calls within two to three business days and sooner if requested by the member.

The Council, through Council staff, has begun to investigate the collection of data from participants to evaluate the Ethics Hotline. However, the gathering of data from participants is hampered by the fact that the requests for advice are confidential and most of the ethics consultations are performed via telephone. Anecdotally, Council members providing the consultations report that the members availing themselves of the service seem very satisfied with the program and its operation. It was originally thought that the Aptify system could be used to capture data by which ethics trends and emerging issues could be identified. That has not been the case, as Aptify captures primarily demographic rather than substantive information. Because the use of Aptify for this purpose has not been successful, other means of capturing such data, such as databases to capture the information the Hotline seeks to capture or to tabulate the information collected on call intake forms are being assessed, but development cost and time are impediments. The results of a short user satisfaction survey might be another way to gage the success of the program. Currently the Hotline receives an average of two calls per month and other inquiries have been presented to Hotline volunteers through other channels including communications with colleagues and inquiries made to other departments.

Sesquicentennial Anniversary of the ADA *Code*: 2016 is the 150th anniversary of the adoption of the ADA *Code*. The Council is planning a number of events to commemorate that milestone, including the presentations about the ADA *Code* at national ethics meetings (one presentation was made in February at the Association for Practical and Professional Ethics Annual Meeting and another will be made at the Annual Meeting of the American Society for Bioethics and the Humanities in October. Among other things, a full text copy of the ADA *Code* with a 150th anniversary logo will be available at ADA 2016. The 150th anniversary of the ADA *Code* will also be commemorated by the use of the slogan "The ADA *Code of Ethics* – 150 Years of Putting Patients First."

Student Ethics Video Contest: As it has since 2009, in 2015 the Council sponsored the student ethics video contest. The contest is designed to instill an awareness of the ADA *Code* and to provide an opportunity for students to consider ethical decision making as they prepare to start careers in dentistry. The contest creates greater awareness among pre-doctoral 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*. Since inception, between five and ten student video entries are received each year; in 2015, eight entries were received. In 2015, the Council awarded the contest grand prize to a team of students from the University of Missouri-Kansas City School of Dentistry; the runner-up prize was awarded to students from the University of Maryland, School of Dentistry.

In 2015, the Council received additional support for the contest from insurance provider CNA. The additional support provided has allowed the creation of a second category. Submissions for the new contest category depict ethical treatment promoting patient safety. The grand prize in this new category

was awarded to students from Arizona School of Dentistry and Oral Health; the runner-up prize was awarded to Virginia Commonwealth University School of Dentistry. The entry period for the 2016 contest has opened and closed at the end of July 2016. Videos received are being assessed and the winning videos will be displayed at ADA 2016.

Emerging Issues and Trends

Specialty Announcement: Prompted by the significant changes that have occurred in specialty recognition, the Council has reviewed Section 5.H. of the ADA *Code, Announcement of Specialization and Limitation of Practice.* To ensure that the *Code* remains aligned with the legal landscape of specialty recognition in all jurisdictions, the Council has proposed amendments to that section. The resolution to amend Section 5.H. of the Code appears in a separate report from the Council.

Search Engine Optimization: In 2014, the Council was directed to consider whether the ethical implications of various internet techniques to promote a dentist's website was adequately addressed by the ADA *Code*. The Council responded in the affirmative. As a part of its continuing duty to ensure that the ADA *Code* provide ethical guidance to members by including advisory opinions that provide interpretations of how the ADA *Code* might apply to certain fact situations, the Council adopted an advisory opinion on the subject of websites and a technique known as search engine optimization. The new advisory opinion will be included in the next printed version of the ADA *Code*, scheduled to be available by the start of ADA 2016 and is also included in the electronic version of the *Code* found on ADA.org.

> **5.F.6. Web Sites and Search Engine Optimization.**
> Many dentists employ an Internet web site to announce their practices, introduce viewers to the professionals and staff in the office, describe practice philosophies and impart oral health care information to the public. Dentists may use services to increase the visibility of their web sites when consumers perform searches for dentally-related content. This technique is generally known as "search engine optimization" or "SEO." Dentists have an ethical obligation to ensure that their web sites, like their other professional announcements, are truthful and do not present information in a manner that is false and misleading in a material respect. Also, any SEO techniques used in connection with a dentist's web site should comport with the ADA *Principles of Ethics and Code of Professional Conduct*.

Additionally, members of the Council are preparing a manuscript that will address ethical issues surrounding search engine optimization in greater detail than permitted by the style and purpose of the ADA *Code.* When that manuscript is completed, solicitations for publication will be made to suitable professional journals, including *JADA*.**

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
118H-2014. Review of ADA *Constitution and Bylaws*	*Constitution and Bylaws* Review	Complete review and revision of the ADA Constitution and *Bylaws*	Completion of draft proposals by December 2016	Completion of draft proposals between December 2016 and February 2017	Final Presentation to the 2017 House of Delegates

** *The ethical implications of SEO are also discussed in an Ethical Moment article written by a CEBJA member that appeared in the March 2010 issue of* JADA. *Wentworth R. What are the ethical issues to consider in the design of my web site?* JADA. *2010:141(3):342-344.*

An informational summary of the status of the *Constitution and Bylaws* review project and a projection for the path the project will take leading to the resolutions proposing adoption of the revised and rewritten *Constitution and Bylaws* will be separately submitted. It will include a resolution to amend the ADA *Constitution* with a request that the resolution be laid over to the 2017 House of Delegates session pursuant to Article VIII of the ADA *Constitution*.

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2019.

Policy Review

In accord with Resolution 170H-2012, Reaffirming Existing ADA Policy, all policies assigned to the Council have been reviewed within the last five years. Consequently, no policy review was performed since the Council's last annual report.

Council Minutes

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

Council on Government Affairs

Howell, J. Barry, 2016, Illinois, chair
Bronson, Mark E., 2017, Ohio, vice chair
Armstrong, Craig S., 2019, Texas
Beauchamp, K. Jean, 2018, Tennessee
Cheek, Daniel K., 2019, North Carolina
Cobb, Regina E., 2017, Arizona
Garrett, Marty B., 2018, Louisiana
Graham, Frank J., 2018, New Jersey
Harrington, John F., 2016, Georgia
Huot, Richard A., 2016, Florida
Hutchison, Bruce R., 2016, Virginia**
Incalcaterra, Charles J., 2017, Pennsylvania
Jaeger, Frederick J., 2016, Wisconsin
Martin, Raymond K., 2016, Massachusetts
Medrano-Saldana, Lauro, 2019, New York
Minahan, David M., 2018, Washington
Morrison, Scott L., 2017, Nebraska
Saba, Michael D., New Jersey*
Terlet, Ariane R., 2019, California

Spangler, Thomas J., director

The Council's 2015–16 liaisons include: Dr. Julian Hal Fair III (Board of Trustees, Sixteenth District), Dr. Cesar R. Sabates (Council on Access, Prevention and Interprofessional Relations), Ms. Teresa Theurer (Alliance of the American Dental Association), and Mr. Jordan Janis (American Student Dental Association).

Bylaws Areas of Responsibility

As listed in Chapter X, Section 130H of the ADA *Bylaws,* the areas of subject matter responsibility of the Council are:

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 legislation, regulatory activity, policies and governmental programs relating to dentistry and oral health for submission to Congress;
c. Serve and assist as liaison with those agencies of the federal government which employ dental personnel or have dental care programs, and formulate polices which are designed to advance the professional status of federally employed dentists; and
d. Disseminate information which will assist the constituent and component societies involving legislation and regulation affecting the dental health of the public.

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

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/ Program	Success Measure	Target	Range	Outcome
Assessment of Member Value	Advocacy for Science, Education, Appropriations, Wellness Issues	Increase appropriations in dental programs	4% increase over the same period 2015	3%–5% over the same period 2015	At the time of this report, funding for the National Institute of Dental and Craniofacial Research will increase about 3% for FY 2017, as reported out by the House Appropriations Committee. The funding for pediatric and general residencies ($10 million each) is the same as FY 2016.
Assessment of Member Value	Advocacy for Dental Practice, Federal Dental Services Issues	Prevail on ADA's position	4% increase over the same period 2015	3%–5% over the same period 2015	As a percentage of bills supported by the ADA, the ADA's progress toward passage increased by about 4% over the same period in 2015. Some examples include the following bills. On June 21, the U.S. House of Representatives passed the ADA-supported "Small Business Relief Act" (H.R. 5447) which would permit small businesses (fewer than 50 employees) to offer health reimbursement arrangements without penalties. The ADA-supported "Dental and Optometric Care Access Act" (H.R. 3323) prohibits all health plans offering a dental or vision benefit from dictating what a doctor may charge a plan enrollee for items or services not covered by the plan. The bill has 56 cosponsors, and ADA is actively seeking a Senator to sponsor a companion bill in the 115th Congress. The "Protecting Seniors Access to Proper Care Act" (H.R. 4062) would exempt dentists (and some other providers who do not submit Medicare claims) from the Medicare Part D requirements to enroll or opt-out of Medicare pursuant to Affordable Care Act requirements. Enforcement of this provision has been delayed until February 1, 2017. The legislation now has 44 cosponsors.
Assessment of Member Value	Advocacy for Access, Dental Coverage Issues	Passing Dental Health Access bills	one bill passed	one bill passed	None passed, to date. However, the "Action for Dental Health Act of 2015" (H.R. 539) would establish two federal grant programs. One program would

Objective	Initiative/ Program	Success Measure	Target	Range	Outcome
					address pro bono dental programs, such as Give Kids A Smile and Mission of Mercy programs. The other program would authorize funding for Action for Dental Health initiatives. The bill has strong support in the House of Representatives with 120 cosponsors. The ADA is actively seeking a Senator to sponsor a companion bill in the 115th Congress.
Assessment of Member Value	ADPAC Administration	Growth in ADPAC basic membership over same period in 2015	2% growth	1%–3% growth	The targeted growth rate was not met. At the end of June 2015, ADPAC basic membership was 20,748 compared to 18,501 at the end of June 2016. It is believed that some states are sending in dues money later this year because of the transition to Aptify (the new software that is replacing outdated membership record systems) and some major staff turnovers. Also, some states are now receiving partial payments from their members and forwarding those payments to ADPAC. However, ADPAC only counts those members when the full $50 basic membership payment is received.

Emerging Issues and Trends

Federal Issues: Elections have consequences. Depending on what happens in the 2016 presidential and congressional elections, the effect on federal health care policy could be significant or it could be more of the same. A President Trump promises to repeal the Affordable Care Act (ACA) and current Speaker of the House Paul Ryan issued a June 22, 2016 proposal on health care that opens with the principle that the ACA must be repealed. On the other hand, a President Clinton would attempt to expand the ACA with a "public option" choice, which would be a Medicare-like plan designed to compete with private plans in the ACA health care marketplaces in states where competition is limited. Establishing this option at the federal level would require an amendment to the ACA. Ms. Clinton's campaign is quoted as saying she would work with interested governors to take advantage of an existing ACA provision (section 1332) that allows states to develop alternative programs, so a governor could elect to establish a public option.

Speaker Ryan has also proposed that the current Medicaid funding structure (federal matching funds of state spending pursuant to a federal formula) be replaced with a program that would let states choose federal Medicaid funding as either per capita caps or block grants. Mr. Ryan believes this new system would empower states and increase flexibility. Critics believe this proposal would shift significant health care costs to the states and ultimately adversely affect the beneficiaries.

Any of the above discussed changes (repeal ACA, implement public option, and fundamentally changing the way Medicaid is funded) will be difficult to achieve irrespective of the election results. But the elections will help determine which issues take center stage (or at least become the starting point) in a health care policy debate. Without a will to compromise, however, the most likely result will be more of the same.

State Issues: Dental benefit programs as part of the larger health insurance spectrum are showing some interesting trends. A few states have passed laws or explored the matter of improving insurers' provider directories. The trend has been to require plans to ensure their directories are up-to-date, especially online directories, and that they are easily searchable and user friendly. Additionally, a few states are moving to address patient confusion on whether their covered services are being provided with participating providers/facilities. Progress continues to occur with new laws requiring transparency when a dental plan leases its network to another entity; the trend has been steady and should continue into 2017. Also, look for more laws requiring dental plans to notify dentists in advance of significant contract changes.

Several states have bolstered efforts to establish incentives for dentists to provide services to Medicaid enrollees, such as California, Colorado and Minnesota, and that is likely to continue. For 2017, we could see a greater focus on how states administer prior authorizations. At least one state is studying the matter under a steadily growing level of concern from the provider community.

The United States Supreme Court's decision in *North Carolina Board of Dental Examiners v. Federal Trade Commission* prompted several states to introduce and enact legislation altering the composition and oversight of their professional licensing boards. Legislation has focused primarily on increased oversight and review of board-promulgated rules and appointment authority, with the objective of lessening the potential for board actions to violate antitrust laws. This trend may continue into 2017.

Additionally, efforts to enact dental therapy or other midlevel models in states across the nation will continue in 2017. Ultimately, in 2016 advocates were only successful in making their proposal law in one state (Vermont) and that only after many years of effort. The other primary development on dental therapy in 2016 is tribal nations in the lower 48 instituting the Alaska DHAT model for the first time. In the state of Washington, a tribe has begun using therapists, funded by a grant from the Kellogg Foundation. Those same efforts are underway to create tribal pilots in Oregon. Tribes in other states have considered this pathway as well but to date, only the projects in Washington and Oregon have begun.

In response to the national crisis of opioid addiction and abuse, multiple states have developed and enacted legislation pertaining to opioid prescriptions and prescription monitoring mechanisms. 2016 has seen an uptick in legislative activity regarding state prescription monitoring databases and limitations on the amount of opioid medication that may be prescribed. Several states also have enacted legislation requiring health care professionals to take CE courses on opioid abuse and pain management.

A steady stream of laws are being enacted requiring public notice well in advance of votes by public entities regarding fluoridation. The benefit of these laws enables fluoridation supporters to be better prepared for these meetings in 2017.

Silver diamine fluoride (SDF) continues to capture members' attention as well as media coverage as noted in a recent *New York Times* article where SDF was highlighted as a treatment alternative. The positives and negatives were discussed in the article. Heightened publicity of this treatment modality could have an impact on public policy approaches to coverage and scope. ADA's Science Institute has developed a Science in the News article about the issue (available here or under ADA.org-Science/Research-Science in the News).

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/ Program	Success Measure	Target	Range	Outcome
Resolution 51H-2015. Legislative and Regulatory Action to Increase Consumer Awareness about Added Sugar Consumption	Increase consumer awareness about the role dietary sugar consumption may play in maintaining optimal oral and general health.	Get relevant governmental agencies to work with ADA to educate consumers.	NA	NA	ADA convinced the Food and Drug Administration to require a separate line for added sugars on the Nutrition Facts labels required for packaged foods. The ADA offered to help the federal Food and Nutrition Service develop technical assistance materials to help state and local nutrition agencies incorporate oral health into their consumer education materials. Additionally, the ADA has offered to help recruit dentists to serve on local school wellness policy planning committees, and lobbied Congress to continue funding Team Nutrition and the nutrition education and obesity prevention grant program, with an emphasis on educating consumers about the potential oral health benefits of limiting added sugar consumption over the life span. Additional information is available at ADA.org.
Resolution 52H-2015. Federal Research to Investigate the Relationship Between Diet, Nutrition and Oral Health	Encourage federal agency research on relationship between diet and oral health.	The ADA continues to encourage federal research agencies to develop the body of high-quality scientific literature on dietary patterns, nutritional status, and oral health.	NA	NA	In May 2016, the ADA communicated to the Food and Drug Administration (FDA) that it would like to see more data about the extent to which dental caries rates fluctuate with changes in total added sugar consumption, and over what time periods. The ADA lobbied for similar research when commenting on the National Institute of Dental and Craniofacial Research (NIDCR) proposed research initiatives for fiscal year 2017, the National Institutes of Health (NIH) on the Interagency Committee on Human Nutrition Research National Nutrition Research Roadmap 2015-2020 (ICHNR), and the Scientific Report of the 2015 Dietary Guidelines Advisory Committee. Additional information is available at ADA.org.

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2020.

Policy Review

In accord with Resolution 170H-2012, Reaffirming Existing ADA Policy, the Council on Government Affairs reviewed the following policies and determined they should be maintained:

Dentists' Choice of Practice Settings (*Trans.*1994:637)
Legislation to Guarantee Patient's Freedom of Choice of Dentist (*Trans.*1995:631)
Continuation of Doctor/Patient Relationship (*Trans.*1991:627)
Dentist's Freedom to Exercise Individual Clinical Judgment (*Trans.*1997:705)
Infringement on Dentists' Judgment (*Trans.*1991:634)
Confidentiality and Privacy Regarding Health Information (*Trans.*1999:951; *Trans.*2000:507)
Institutional Advertising (*Trans.*1979:598)
Dental Programs for Remote Alaskan Residents *(Trans*.2004:323)
Legislation to Increase Federal and State Funding of Oral Health Care Services Provided at Academic Dental Institutions *(Trans*.2002:404)
Prevention Research to Aid Low Income Populations (*Trans.* 2001:441)
Dissemination of Information Contrary to Science (*Trans.* 2006:346)
Fabrication of Oral Appliances Used with Tooth Whitening Products (*Trans.* 2002:397)
Federally Funded Dental Health Education and Prevention (*Trans.*1971:528)

Council Minutes

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

Council on Members Insurance and Retirement Programs

Miller, Paul R., 2016, Florida, chair
McLean, David E., 2017, Vermont, vice chair
Barnashuk, Frank C., 2016, New York
Coleman, J. Preston, 2017, Texas
Ellison, Naomi L., 2019, California
Grogan, Patrick M., 2016, Washington, D.C.
Hehli, Peter D., 2018, Wisconsin
Hokanson, Brian N., 2017, Wyoming
Houten, David E., 2016, Washington
Jolly, Sr., Robert L., 2019, Arkansas
Kilcollin, Katie 2019, West Virginia
Lipton, James M., 2018, Indiana
Mann, Marshall H., 2018, Georgia
Olenyn, Paul T., 2017, Virginia, *ad interim*
Pirmann, Peter J., 2019, Illinois
Shirley, Eric L., 2016, Pennsylvania
Wieting, Scott, 2018, Nebraska
Yates, Lindsey J., 2017, Illinois*

Tiernan, Rita, senior manager

The Council's 2015–16 liaisons include: Dr. Gary E. Jeffers (Board of Trustees, Ninth District) and Mr. Sohaib Solimon (American Student Dental Association).

Bylaws Areas of Responsibility

As listed in Chapter X, Section 130I of the ADA *Bylaws*, the areas of subject matter responsibility for the Council are:

a. Insurance and retirement plan products and resources; and
b. Risk management education programs and resources.

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

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/ Program	Success Measure	Target	Range	Outcome
Increase non-dues revenue; Increase utilization of existing products and services.	ADA Members Insurance Plans underwritten by Great-West Financial	Growth in member participation across all six ADA Members Insurance Plans	1.25% number of participants growth over same period in 2015	1%–1.5% growth	Dentist member participation across all six Plans reported a net loss of 2.4%. New products and efforts to reduce lapses for ADA nonmembership and increase student conversions should improve results in 2017.
Increase non-dues revenue; Increase utilization of existing products and services.	ADA Members Insurance Plans, underwritten by Great-West Financial	Growth in total plan assets (surplus and reserves) under management across all six ADA Members Insurance Plans	2% asset growth for the ADA Members Insurance Plans.	1%–3% growth	Total assets across all six Plans were relatively flat with a slight reduction of 0.14%. However, total premiums across all Plans grew by 4%, a positive indication of plan stability.

The Council supports the ADA Strategic Plan 2020 by providing insurance and retirement plan products and risk management resources designed exclusively to enhance the value of ADA membership across all segments. The members insurance and retirement programs also generate royalty revenue for use of the ADA membership list, brand logo and intellectual property which helps support the ADA financial goals.

ADA Members Insurance Plans: The ADA Members Insurance Plans (ADA Plans) portfolio consists of six group plans including 1) Level Term Life; 2) Annually Renewable Term Life; 3) Universal Life; 4) Disability Income Protection; 5) Office Overhead Expense; and 6) MedCASH, supplemental hospital indemnity and critical illness coverage. As a tangible benefit of ADA membership, the competitive value of the portfolio is designed to attract new members and increase retention of existing members. In addition, a “six-month no-cost term life insurance offer” is included in recruitment campaigns to provide added incentive for new members to join the ADA.

Table 1. ADA Members Insurance Plans Aggregate Participation 2013–June 30, 2016

ADA Members Insurance Plans	2013	2014	2015	YTD June 30 2016
Members Annually Renewable Term Life[1]	59,172	56,366	54,734	51,435
Spouse Term Life	18,649	18,191	17,705	17,276
Child Term Life[2]	7,391	7,211	6,960	6,738
Members Universal Life	1,418	1,362	1,302	1,274
Level Term (Members and dependents)	N/A	N/A	336	740
Disability Income Protection	19,956	20,455	19,793	16,426[4]
Office Overhead Expense	11,594	12,383	12,064	8,159[4]
Members MedCASH	4,084	3,782	3,620	3,502
Spouse MedCASH	2,260	2,100	2,028	1,960
Child MedCASH	928	829	809	775
Student Members Term Life[3]	10,908	11,448	11,473	13,515
Student Members Disability	10,834	11,323	10,963	12,782
TOTAL: All Members & Student Plans	**147,194**	**145,450**	**141,787**	**134,582**

[1]Member participants plus in-year graduates reclassified as active ADA members on December 31.
[2]Number of members insuring dependent children.
[3]Student participants less in-year graduates reclassified as active ADA members on December 31.
[4]Year-end figures not yet available; decrease as of 6/30/16 is a timing issue in the reporting of prior year graduates and conversions from the Student Disability Plans to the Members Plans.

As shown in Table 1, June 30, 2016 mid-year results indicate a decline in aggregate participation as measured across the ADA Plans which is primarily attributed to 1) the aging population (e.g., Baby Boomers age off the plans); 2) declining trend in the number of ADA active full dues paying members; 3) an increase in the number of voluntary coverage lapses by dentists choosing to non-renew ADA membership; and 4) fewer conversions of new members and graduating students at the expiration of the no-cost coverage period.

Despite these challenges, the ADA Plans remain strong financially and solidly competitive with over 57,000 dentist members insured in at least one plan and nearly 17,000 participating in multiple plans. In addition, the Life and MedCASH Plans protect the lives of more than 28,000 member spouses and dependent children. A key metric which signifies the financial strength of the ADA Plans is the 4% increase in total premiums resulting in part from a higher number of cross-sell product sales and coverage upgrades. New 2016 marketing strategies and digital advertising efforts to promote the value of the ADA brand portfolio contributed to these results and will help build momentum for further growth and improved retention in 2017.

One of the Council's most significant accomplishments in 2016 was the introduction of the New ADA Hospital indemnity, Extended Care Rider and Critical Illness Insurance Plans. More specifically, these new supplemental plans have been uniquely designed at low, competitive rates for ADA members to insure their families against the rising out-of-pocket costs of healthcare including but not limited to, hospital confinement, outpatient care, skilled nursing care, nursing home care and home health care. These new products demonstrate ADA's commitment to deliver member value through the offering of quality coverage at a substantial price advantage.

The ADA Student Term Life and Disability Insurance Plans provide guaranteed issue coverage at no cost to student members while completing their dental education—including post graduate and residency programs. As reported in Table 1, student participation has risen in both the life and disability plans over last year, in part to the Dental School Auto-Enrollment Program, underwritten by Great-West Financial. More specifically, 10 dental schools currently participate in the auto-enrollment program which ensures that all registered dental students, including post-docs and residents, are covered at no cost under the ADA student member insurance plans. A key initiative underway in 2016 is to expand communications with dental schools to promote auto-enrollment of ADA student members and increase awareness of the ADA Members Insurance Plans available to faculty members.

ADA Members Retirement Programs: The Council also oversees management of the ADA-endorsed Members Retirement Programs, administered by the AXA Insurance Company. The Program offers tax-qualified retirement savings plans, including all types of 401(k) plans, new comparability plans and traditional defined contribution pension and profit-sharing plans. The ADA-endorsed Members Retirement Programs is annually reviewed by an outside consultant to ensure the investment management services and product offerings are competitive with market best practices.

Table 2. ADA Members Retirement Program Participation

	2013	2014	2015	YTD June 30, 2016
Number of Dentist Employers	3,748	3,321	3,178	3,010
Total Participants (Dentist Employers and Employees)	16,747	14,599*	14,251	13,495

*Reporting criteria was redefined in 2014 to remove inactive plans without a balance and/or underfunded plans which explains the decrease.

Table 2 shows the decline in 2016 year-to-date participation. This table reflects the aging plan population and the dramatic rise in the number of dentist employers and employees who have maximized their ADA retirement plan contributions or are transitioning into retirement. To address these trends and the need for distribution plan options, there was a focused effort in 2015–2016 on new product development to broaden the diversity of the portfolio. More specifically, the ADA Members Retirement Programs was expanded to include a suite of fixed indexed annuity and customized variable annuity products, competitively designed and priced to increase the marketability of the ADA Programs to a larger segment of the ADA membership, including non-practice owners. The addition of the new Retirement Gateway and the Structured Capital Strategies products are structured to help preserve existing accounts and have a positive impact on plan retention in future years.

Additionally this past year AXA introduced a new recordkeeping system platform with comprehensive web capabilities and resources to enhance the user experience for dentist employers and employee participants. AXA also developed new online educational resources to include interactive tools, savings calculators, videos and articles to assist members and their employees in planning, saving and investing for a financially secure retirement.

For 2016, AXA marketing plans build on the success of the 2013–2016 AXA Strategic Plan to heighten awareness of the competitive value of the ADA Members Retirement Programs in providing members access to institutional quality retirement products and customized administrative services not commonly available to small business owners and their employees. This year AXA has increased its presence at new dentist, local and state meetings and expanded into digital media channels to supplement direct mail campaigns and print advertising. Preliminary results are showing signs of success with 26 new retirement accounts established as of June 30, 2016.

The ADA Members Retirement Programs portfolio remains well positioned financially, with over $1.58 billion in assets under management. The ADA-endorsed programs generate approximately $500,000 in royalty revenue annually, with a reported $271,000 paid as of June 30, 2016.

Table 3. Individual Retirement Accounts Participation

	2013	2014	2015	YTD June 30 2016
Number of Participants	1,632	1,588	1,504	1,539

The Individual Retirement Account (IRA) can be adopted as a traditional IRA, Roth IRA, Rollover IRA or Self-Employed IRA (SEP-IRA). As of June 30, 2016, 35 new participants have established IRA accounts.

American Health Insurance Exchange.com Web Resource: The ADA-endorsed American Health Insurance Exchange.com (AHIX.com) web portal was introduced in response to market changes imposed by the Affordable Care Act and the goal to ensure there were resources available for ADA members needing to navigate the new health insurance exchange marketplace. In collaboration with the states, the ADA web portal serves as a consolidated member resource of the health insurance plan options available on and off the exchange, and those plans endorsed by the state dental associations. ADA royalty revenue received for endorsement of the web portal has been minimal at $10,620 for year-end 2015 and approximately $4,200 to date in 2016.

Emerging Issues and Trends

Pursuant to its *Bylaws* responsibilities, the Council continues to monitor the insurance and financial markets for emerging issues and trends which could potentially impact the profession including:

- New insurance and retirement savings plans product trends to ensure the ADA-endorsed programs remain competitive and relevant to meet the needs of ADA's diverse membership.
- Malpractice insurance market trends that could impact the dental profession and advancements in dental risk management educational resources for members.
- The Healthcare Insurance Exchange Marketplace, legislative and regulatory changes impacting the cost and availability of insurance.
- Emerging trends in small and large group as well as corporate owned dental practice models to assess the impact on the ADA members insurance and retirement plans; and identify opportunities to promote ADA member value to dentists in these practice settings.

Responses to House of Delegates Resolutions

There were no assignments from the 2015 ADA House of Delegates.

Self-Assessment

In accordance with Resolution 1H-2013, the Council conducted a self-assessment at its August 2016 meeting, using a customized survey instrument based on the topical outline developed by the Board of Trustees. The Council discussed the effectiveness of its current structure and composition, including participant criteria, diversity, geographic representation, size, term limits, frequency of meetings and reporting structure. There was a general, but not unanimous, consensus in many of the areas discussed, therefore the Council agreed it would be beneficial to form a work group to further explore all possible options before making recommendations for increasing governance efficiency and report back to the Council at its March 2017 meeting.

Policy Review

The Council did not have any policies to review in accord with Resolution 170H-2012, Reaffirming Existing ADA Policy.

Council Minutes

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

Council on Membership

Wilson, K. Drew, 2016, New Hampshire, chair
Maranga, Maria C., 2017, New York, vice chair
Aguirre, Alejandro M., 2016, Minnesota
Durbin, Michael G., 2017, Illinois
Ellinwood, Steven P., 2018, Indiana
Ingram, William L., 2016, Alabama
Irani, Karin, 2019, California
Jones, Gary O., 2017, Arizona
Muncy, Marc, 2018, Arkansas
Pascarella, Jonathan, 2016, California*
Pohl, Gregory J., 2016, Ohio
Romano, Rodrigo, 2018, Florida
Sherwin, Ted, 2019, Virginia
Smith, Carmen P., 2017, Texas
Stachewicz Johnson, Nicole, 2016, Pennsylvania
Tigani, Stephen, 2019, District of Columbia
Vitek-Hitchcock, Alexa, 2019, Michigan
Willis, Heather A., 2018, Alaska

Reynolds, Andrew S., senior manager

The Council's 2015–16 liaisons include: Dr. Rickland G. Asai (Board of Trustees, Eleventh District), and Dr. Adrien Lewis (American Student Dental Association).

Bylaws Areas of Responsibility

As listed in Chapter X, Section 130J of the ADA *Bylaws*, the areas of subject matter responsibility for the Council are:

a. Membership recruitment and retention and related issues
b. Monitor and provide support and assistance for the membership activities of constituent and component dental societies and
c. Membership benefits and services

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome
Objective 2: ADA's member market share is 70% or greater of active licensed dentists.	New/Reinstated Member Acquisition Campaigns	Increased membership among dentists who were not members in the prior year.	2,739 new or reinstated members at the end of June 2016. 6,000 new or reinstated members at the end of 2016.	2,609–2,876 at the end of June 2016. 5,700–6,300 at the end of 2016.	As of June 2016, 2,831 new or reinstated members (103.4% of target)

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

Objective	Initiative/Program	Success Measure	Target	Range	Outcome
Objective 2: ADA's member market share is 70% or greater of active licensed dentists.	Targeted communications to new dentists progressing through the reduced dues program.	Increase retention rate among 2012–2015 dental school graduates.	77.2% retention of 2012–2015 grads by end of second quarter. 85.8% at the end of 2016.	73.3%–81.1%	As of June 30, 2016: 77.9% retention (100.9% of target)
Objective 2: ADA's member market share is 70% or greater of active licensed dentists.	Increase the number of graduate student members	Larger number of graduate student members.	2,092 graduate student members at the end of June 2016. 3,100 graduate student members at the end of 2016.	1,987–2,197 at the end of June. 2,945–3,255 at the end of 2016.	As of June 30, 2016: 1,992 graduate student members (95.2% of target)

Focused messaging and communication, combined with reductions in process hurdles, is beginning to yield positive results.

Emerging Issues and Trends

The ADA is faced with the same question that is being experienced by every professional association in the country—how do both experienced and younger professionals want to interact with the organization that supports their profession? Given the large number of changes in recent years, including demographics of dentists, the rise of alternative business models and group practice, a changing regulatory environment, and generational changes in whether or not one joins an organization, the Council is monitoring trends and formulating strategies to ensure that the ADA remains relevant to the profession.

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
Resolution 92H-2009 (*Trans.2009:*415)	Yearly report to House of Delegates showing five-year anticipated (projected) dues revenues impact from members' transition to life membership.	Report completed (see narrative below)	Not applicable	Not applicable	Report completed (see narrative below)

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
Resolution 47H-2015 (*Trans. 2015:xxx*)	Implementation of a Uniform Dues Transaction	Not applicable	Not applicable	Not applicable	A Council report will be presented to the 2016 House of Delegates proposing a scope for the development of a uniform dues transaction.
Resolution 83H-2015 (*Trans. 2015:xxx*)	Removing Membership Barriers—Rewrite Chapter I of the *Bylaws*	Not applicable	Not applicable	Not applicable	With assistance from CEBJA, a Council report will be presented to the 2016 House of Delegates proposing a draft rewrite of Chapter I of the *Bylaws*.
Resolution 94H-2015 (*Trans. 2015:xxx*)	Investigate Enhancements to Tripartite's Product and Service Offerings to Meet the Needs of Member Dentists	Not applicable	Not applicable	Not applicable	An informational report will be presented to the 2016 House of Delegates.

Response to Resolution 92H-2009: These projections of the dues revenue impact from members' transition to life membership are based on data from the ADA dentist masterfile and through analysis and assumptions made in the ADA Health Policy Institute (HPI) research brief from 2014 titled "Supply of Dentists in the United States is Likely to Grow." The projections for the number of dentists expected to retire (outflows) discussed in the brief were developed through statistical modeling for the 10-year 2003–2013 period which includes the five year period prior to the start of the recession in 2008, 2003–2007 and the five year period from 2008 through 2013.

Overall, it was concluded that future outflow rates of dentists would be the same as the low outflow period of 2008–2013. This conclusion was influenced by the steady trend of increasing average retirement age, a trend that preceded the recession, which was also based on new research that the dental economy is unlikely to return to prerecession growth levels and the HPI further concluded retirement patterns are not likely to return to prerecession levels. Based on historical patterns and the current age and member longevity, it is estimated that the dues revenue reduction from members transitioning to life membership will be as shown in Table 1:

Table 1. Five Year Impact from Members Moving to Life Membership

Year of Impact	2016	2017	2018	2019
Dues Revenue Reduction From Members Transitioning to Life Membership	($359,587)	($389,268)	($447,593)	($438,871)

Note: Assumes no dues increase and no assessment in years 2016–2020 and assumes retirement to remain about the same as it has been the past five to six years. Assumes no deaths.

Table 2 shows the number of projected members who will become life members during the period 2016 to 2020. The number of members who begin paying Life membership dues over the next five years is estimated to increase from 2,580 in 2016 to 3,025 by 2020. It should be noted that the further out in the projection, the less accurate the forecast.

Table 2. Forecast for Active and Retired Life Members 2016–2020

Year Paying Life Dues for First Time	**2016**	**2017**	**2018**	**2019**	**2020**
Expected Active Life	1,988	2,199	2,334	2,297	2,278
Expected Retired Life	516	597	601	589	566
Total Projected to Become Life Members	2,580	2,796	3,215	3,151	3,025

Note: 23% are expected to become retired life based on membership as of 8-4-16. 23% was then used to project the number expected to become Retired Life members for each year for those becoming eligible for life membership through 2020.

This projection assumes that there will be no dues increase during the next five years and that all members will retain membership. There is also an assumption that the retirement rate will remain the same during the same time period based on the information in the 2014 HPI research brief, “Supply of Dentists in the United States is Likely to Grow.”

At the end of 2015, there were 15,075 Active Life members and 26,045 Retired Life members. The ADA experienced an increase in Active Life non-renews in 2013, the first year of the dues increase for Active Life members from 50% of full dues to 75% of full dues. Typically the non-renew rate for Active Life members was about 2.7% before the dues increase and the non-renew percentage at end of year 2013 was 4.8%. As anticipated, in 2015, there was a further reduction in the percentage of Active Life members who dropped their membership. The Active Life non-renew percentage was 3.2% at the end of 2015.

Self-Assessment

The Council is next scheduled to conduct a self-assessment 2020.

Policy Review

The Council conducted a comprehensive review of its policies in 2015 and is not presenting any policies for review in this report.

Council Minutes

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

Joint Commission on National Dental Examinations

Fujimoto, Luis J., 2017, New York, chair, American Association of Dental Boards
Levitan, Marc E., 2016, South Carolina, vice chair, American Dental Education Association
Chamberlain, Dale R., 2018, Montana, American Association of Dental Boards
Efurd, Melissa G., 2018, Arkansas, American Dental Hygienists' Association
Haley, Cheryl D., 2019, Missouri, American Dental Association
Heinrich-Null, Lisa, 2018, Texas, American Dental Association
Licari, Frank W., 2017, Utah, American Dental Education Association
Murray, Rhett L., 2017, Colorado, American Dental Association
Nadershahi, Nader A., 2019, California, American Dental Education Association
Parker, Patricia A., 2017, Oregon, American Association of Dental Boards
Perkins, David W., 2017, Connecticut, American Association of Dental Boards
Robinson, William F., 2020, Florida, American Association of Dental Boards
Shank, Greg P., 2016, New York, American Student Dental Association
Shelton-Jenkins, Issie L., 2018, Maryland, Public Member
Weiss, Leonard P., 2019, Ohio, American Association of Dental Boards

Waldschmidt, David M., secretary and director
Hinshaw, Kathleen J., senior manager
Bonk, Christopher, manager
Hussong, Nick, manager
Ryske, Ellen, manager
Wright, Terrence, manager
Yang, Chien-Lin, manager

The Joint Commission's 2015–16 liaisons and observers include: Dr. Alvin W. Stevens (Board of Trustees, Fifth District) and Mr. Jordan J. Telin (American Student Dental Association).

Bylaws **Areas of Responsibility**

As listed in Chapter XV, Section 130B of the ADA *Bylaws,* the duties of the Joint Commission are:

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.

Mission

The Joint Commission 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.

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/ Program	Success Measure	Target	Range	Outcome
Objective 1: The public will recognize the ADA and its members as leaders and advocates in oral health.	Joint Commission on National Dental Examinations	All state boards use information from Joint Commission examinations for dental and dental hygiene licensure decisions.	100% utilization	90–100% utilization	100% utilization

At its June 2016 meeting, the Joint Commission accomplished the following:

1. *Budget Proposal and Fees.* Approved the Joint Commission's budget proposal, including 2017 candidate fees. Subject to final approval by the ADA House of Delegates, the total examination fees charged in 2017 to candidates will be $395 for the National Board Dental Examination (NBDE) Part I, $440 for the NBDE Part II, and $415 for the National Board Dental Hygiene Examination (NBDHE). Candidates from nonaccredited institutions will be assessed a $135 processing fee at the time of application. Score report request fees will be $36.
2. *Integrated National Board Dental Examination (INBDE).* Reviewed Joint Commission actions taken since its prior annual meeting in April 2015, including the following:
   A. Approved the implementation plan for the INBDE, a written examination that will supplant NBDE Parts I and II in the future. The INBDE is anticipated to be available in August 2020, with full replacement of the NBDE expected to occur by August 2022.
   B. Directed Department of Testing Services (DTS) staff to communicate the INBDE implementation plan to stakeholders and communities of interest; this includes a targeted mailing to the leadership of US dental boards on an annual basis and as needed.
   C. Directed its Committee on Administration to review Joint Commission and ADA *Bylaws* regarding the duties of the Joint Commission, to allow more flexibility for the Joint Commission to develop licensure exams in other areas of allied dentistry.
   D. Directed DTS staff to issue an announcement indicating the Joint Commission's interest in building a National Board Dental Therapy Examination (NBDTE) for licensure purposes.
3. *INBDE Implementation and Communication.* Approved actions and reviewed progress in support of the INBDE and its implementation, including the following:
   A. Directed DTS staff to provide additional targeted INBDE communications to the dental education and student communities by sending the INBDE Implementation Plan directly to academic deans, dental deans, the American Dental Education Association (ADEA) (CEO and president), and the American Student Dental Association (executive director and president), on an annual basis.
   B. Reaffirmed field testing protocols for the *INBDE Short Form* and *INBDE Standard Form*, which will be administered in the fall of 2016 and 2017, respectively.
   C. Approved INBDE retesting policies during the NBDE-INBDE transition period. These policies are posted at ADA.org.

D. Reviewed recommendations to stakeholders and communities of interest regarding preparation for the INBDE, such as the following:
    a. Review and monitor INBDE information on the Joint Commission's website, including validity evidence and the results of field testing.
    b. Attend INBDE presentations at the National Dental Examiners' Advisory Forum (NDEAF) and/or ADEA annually.
    c. State boards should prepare to receive INBDE results, making sure to review practice acts, rules, policies, and regulations to determine if changes will be required to accept the INBDE on day one of availability.
    d. Dental education programs should prepare their school and students for the INBDE through any necessary revisions to curricula and academic policy.
    e. Licensure candidates should determine which examination track to pursue (NBDE or INBDE) during the transition period, preparing accordingly in consultation with the following: the most recent INBDE implementation plan, dental school requirements, dental boards of states in which licensure is sought, and current Joint Commission policies.

4. *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:

    A. Approved instituting an Image Review Test Construction Committee charged with the responsibility for 1) maintaining image implementation guidelines and acceptability standards in accordance with industry best practices, 2) evaluating and accepting high-quality images, and 3) categorizing and adjusting images as appropriate, to help ensure that images appearing on National Board Examinations are of sufficient quality that entry-level candidates who possess the necessary knowledge and skills would be able to correctly answer questions involving these images.
    B. Adopted the recommendations of a standard setting committee convened for the NBDHE. Standard setting involves the establishment of a cut score that separates passing and failing candidates. The Joint Commission's standards are criterion-referenced (i.e., established based on specific skill requirements), as opposed to normatively based. The new standard will be scheduled for implementation no sooner than January 2017.
    C. Adopted 30 revised clinical content areas for the NBDHE, to represent the clinical content areas required for the safe, entry-level practice of dental hygiene. These clinical content areas had previously been subject to review by both the dental and dental hygiene communities.
    D. Endorsed a practice analysis approach for the NBDHE, and directed DTS staff to implement this approach. The aforementioned dental hygiene clinical content areas will be incorporated into a practice analysis survey that will be distributed to entry-level dental hygienists in 2016. Results for this survey will be used to help establish the content domain for the NBDHE.
    E. Approved reappointment of current NBDE and NBDHE test construction committee (TCC) members, and selected new NBDE and NBDHE TCC members for committees meeting in 2017.
    F. Adopted a resolution in response to a letter from the ADA Council on Dental Practice. Consistent with sentiments expressed in the letter, the resolution encourages all National Board Examination TCCs to write questions where applicable within their individual test specifications that relate to issues of provider health and wellness, addiction, and opioid prescribing.
    G. Approved procedures for granting permission for use of the Joint Commission's released examination materials by dental and dental hygiene educational programs.
    H. 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.

I. 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.
J. Approved the 2015 Technical Reports for the NBDE and NBDHE.
K. Recommended that the following positions be added to DTS in 2017, to support testing programs and corresponding projects: Associate Psychometrician, Assessment Specialist-Digital Imaging, DTS Editor, and Project Coordinator.
L. Approved a list of 2016 and 2017 research and development projects and expenditures.

5. *Joint Commission Bylaws.* Adopted a resolution to form an ad hoc committee on *Bylaws* duties to consider the scope of the Joint Commission and report its progress to the Joint Commission in 2017.

6. *ADA Standing Rules Revisions Proposal.* Recommended a proposed revision to the *ADA Standing Rules for Councils and Commissions*, contingent upon approval by the ADA Board of Trustees. The proposed revision modifies the procedure for tabulating Joint Commission mail ballots involving candidate appeals, such that votes not received shall be considered abstentions. Current procedures require non-votes to be considered affirmative votes (i.e., in favor of granting the appeal).

7. *Joint Commission Bylaws, Standing Rules and Examination Regulations.* Adopted revisions to the *Joint Commission's Bylaws, Standing Rules,* and *Examination Regulations.* Revisions to *Examination Regulations* are effective immediately; revisions to *Joint Commission Bylaws* and *Standing Rules* are contingent upon approval by the ADA House of Delegates. Noteworthy revisions are as follows:

    - *JCNDE Examination Regulations:* Candidates will no longer be required to wait 12 months to retest, after their third failed attempt on a National Board Examination.
    - *JCNDE Examination Regulations:* National Board Examination results reporting will undergo minor modifications to facilitate electronic reporting through the DTS Score Reporting Hub in late 2016. This includes elimination of state board reporting of subject-based scale scores for examination attempts made under conjunctive scoring models, and removal of report language concerning the implications of cut score achievement.
    - *JCNDE Standing Rules:* New Commissioners will be subject to a simultaneous service policy, to help avoid potential conflicts of interest.
    - *JCNDE Bylaws:* A change was made to Joint Commission officer elections. The Vice Chair of the Joint Commission will now become Chair of the Joint Commission, at the end of his or her term as Vice Chair.

8. *Joint Commission Self-Assessment.* Reviewed a draft 2017 self-assessment report, and approved formation of an ad hoc committee to review the self-assessment process and communicate its findings to the Joint Commission in 2017.

9. *Joint Commission Elections.* Elected Dr. Frank Licari as Chair and Dr. Lisa Heinrich-Null as Vice Chair of the Joint Commission. Their terms will begin in October of 2016.

10. *Meeting Dates.* Approved June 14, 2017 as the scheduled meeting date for 2017.

Emerging Issues and Trends

The following presents trends in administration volume and examinee performance on the NBDE and NBDHE over a 10-year period beginning in 2006. These trends are presented with respect to candidates' status as first-time or repeat test takers, and their enrollment in accredited or nonaccredited programs.

NBDE Part I: Table 1 presents performance trends for NBDE Part I over the past 10 years, while Figure 1 provides a graphic depiction of administration volume. Generally speaking, Table 1 shows 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 nonaccredited programs also increased during this 10-year timeframe, with 2010 representing the low at 1,218 candidates and 2015 representing the

peak at 2,329 candidates. The total number of administrations (i.e., first-time candidates and repeating candidates from accredited and nonaccredited programs) increased from 8,750 in 2006 to 9,668 in 2015. This represents an overall increase of 918 candidates (i.e., 10.5%).

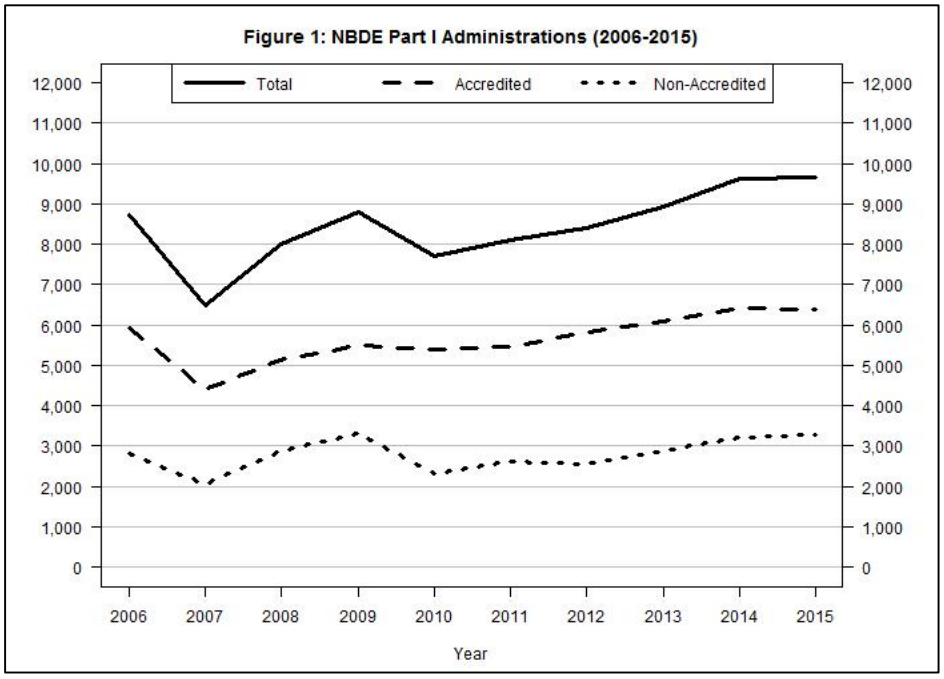
Across the 10-year period indicated, failure rates for first-time candidates from accredited programs ranged from 3.4% (2015) to 7.8% (2006). Failure rates for first-time candidates from nonaccredited programs were relatively higher, ranging from 31.9% (2014) to 39.5% (2008).

In interpreting this table, please 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, please note that effective 2010, candidates who have passed NBDE Part I may not retake the examination unless required by a state board or relevant regulatory agency.

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
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
2014	6,041	3.7	377	26.3	2,211	31.9	988	56.4	9,617	16.5
2015	6,092	3.4	308	28.6	2,329	33.4	939	57.6	9,668	16.7

*In 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 performance trends for 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 3,775 in 2006, jumped precipitously in 2007, and then showed continued growth through 2011. Volume decreased from 2011 to 2012, and then increased in 2015 to a 10-year high (N=5,834). There has been quite a bit of variability since 2006, ranging from a low of 3,775 candidates in 2006 to a high of 5,834 in 2015 (i.e., a 55% increase). The total number of first-time and repeating candidates from nonaccredited programs increased from 850 in 2006 to 2,413 in 2015. Comparing the number of total administrations occurring in 2006 (N=5,042) with 2015 (N=8,851) shows a 76% increase in overall administration volume, with gains occurring in both accredited and nonaccredited candidates.

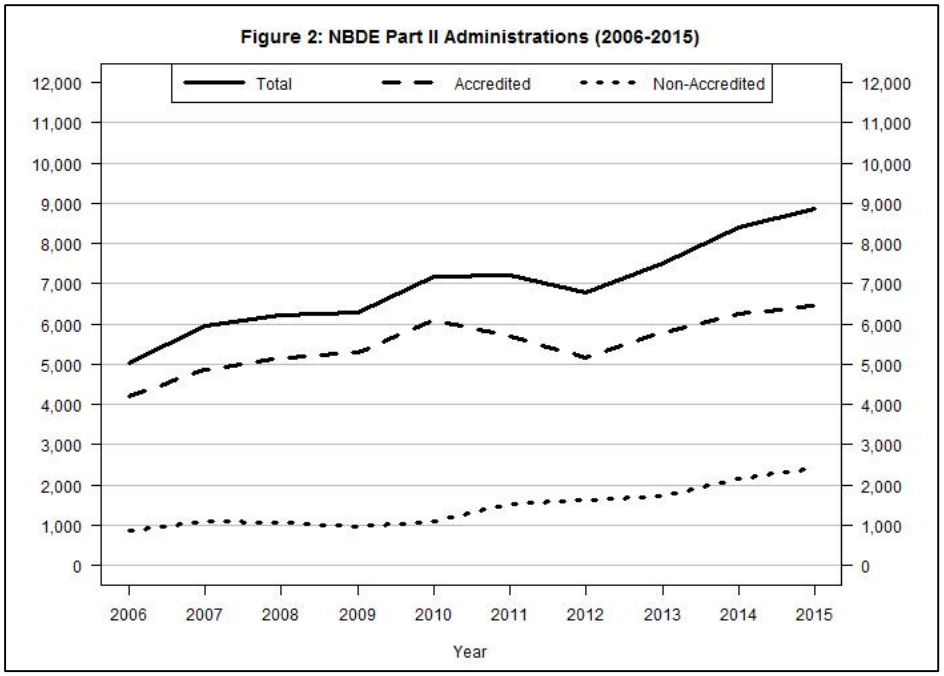
Across the 10-year period indicated, failure rates for first-time candidates from accredited programs ranged from 5.1% (2011) to 13.7% (2009). The failure rate for NBDE Part II first-time candidates from accredited programs was 7.5% in 2015, representing a very slight increase from 2014. Failure rates for first-time candidates from nonaccredited programs were relatively higher, ranging from 23.4% (2008) to 43.4% (2009).

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.

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
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
2014	5,704	7.4	543	21.4	1,557	37.3	593	45.2	8,397	16.5
2015	5,834	7.5	604	22.7	1,630	42.0	783	48.8	8,851	18.5

* A new standard was introduced this year, based on updated standard setting activities.



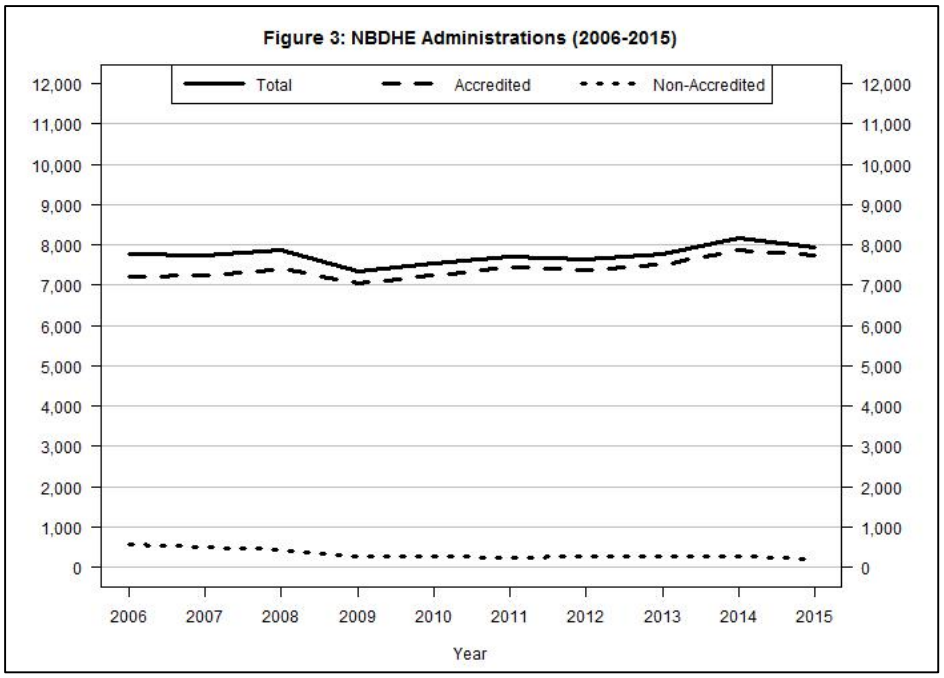
NBDHE: Table 3 presents performance trends for the NBDHE over the past 10 years, while Figure 3 provides a graphic depiction of administration volume. As shown in Table 3, the number of first-time candidates from accredited programs increased from 6,395 in 2006 to 7,227 in 2015 (i.e., a 13% increase). The total number of candidates from nonaccredited programs was relatively small compared to the total number of candidates from accredited programs, representing approximately 7% of administrations occurring in 2006 and approximately 3% of administrations occurring in 2015. Comparing the number of total administrations occurring in 2006 with 2015 shows an overall increase of 158 first-time and repeating candidates from accredited and nonaccredited programs (i.e., a 2% 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 nonaccredited programs were higher during the earlier years, and lower in more recent years, with the lowest rate occurring in 2013 (17.3%). The general trend shows a substantial decrease in failure rates for first-time candidates from nonaccredited programs, decreasing from 63.5% in 2006 to 22.9% in 2015.

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
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
2014	7,357	4.8	527	47.4	204	23.0	68	63.2	8,156	8.5
2015	7,227	4.4	499	46.3	179	22.9	40	55.0	7,945	7.7

* A new standard was introduced this year, based on updated standard setting activities.



Testing Accommodations: The Joint Commission provides reasonable and appropriate accommodations, in accordance with the Americans with Disabilities Act, for individuals with documented disabilities who demonstrate a need for accommodation and request an accommodation prior to testing. Table 4 presents performance trends for candidates from accredited programs who took the NBDE or NBDHE with accommodations over the past 5 years. As shown in Table 4, the number of accommodated examination attempts has remained small for all three National Board Examination programs over the five-year period. In 2015, accommodated examination attempts made up 2.7% of the total attempts for the NBDE Part I, 1.7% of the total attempts for the NBDE Part II, and 0.8% of the total attempts for the NBDHE. Only the NBDE Part I has shown a noticeable increase in the percentage of accommodated attempts during the five-year period, increasing from 1.7% in 2011 to 2.7% in 2015. Across the five year period indicated, failure rates were less for first-time candidates than for repeating candidates across three exam programs.

TABLE 4*
Numbers and Failure Rates for Accredited Candidates
Attempts Involving Accommodations

	Part I				Part II				Dental Hygiene			
Year	First-time		Repeating		First-time		Repeating		First-time		Repeating	
	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing
2011	73	11.0	19	31.6	78	12.8	13	30.8	38	2.6	12	16.7
2012	90	11.1	18	55.6	59	10.2	20	45.0	52	7.7	8	25.0
2013	98	16.3	36	30.6	54	14.8	12	16.7	54	3.7	8	50.0
2014	96	9.4	31	22.6	105	16.2	25	36.0	54	9.3	10	60.0
2015	148	8.8	24	20.8	83	18.5	25	40.0	44	6.8	14	21.4

*The number of candidates from non-accredited institutions receiving accommodations was too small to provide meaningful trend information in this report.

Self-Assessment

The Joint Commission is next scheduled to conduct a self-assessment in 2017.

Policy Review

While the Joint Commission is an agency of the ADA, it maintains independent authority to provide and administer licensure exams in dentistry and dental hygiene. The Joint Commission maintains its policies and procedures in three separate documents: 1) the *JCNDE Standing Rules*, 2) the *JCNDE Examination Regulations*, and 3) the *JCNDE Test Construction Committees and Member Selection Criteria*. On an annual basis, each of these documents is reviewed in accordance with Resolution 170H-2012, Reaffirming Existing ADA Policy. Changes to these documents were noted previously in this report.

Council Minutes

For more information on recent activities, see the Joint Commission's minutes on ADA.org.

Council on Scientific Affairs

Abt, Elliot C., 2016, Illinois, chair
Platt, Jeffrey A., 2017, Indiana, vice chair
Aminoshariae, Anita, 2018, Ohio
Braun, Thomas W., 2019, Pennsylvania
Dmytryk, John J., 2017, Oklahoma
Eleazer, Paul D., 2018, Alabama
Fallon, Andrea C., 2016, Connecticut*
Hale, Robert G., 2016, Texas
Jefferies, Steven R., 2016, Pennsylvania
Mariotti, Angelo J., 2019, Ohio
Moore, Paul A., 2018, Pennsylvania
Offenbacher, Steven, 2018, North Carolina
Parker, William, 2019, Florida
Roberts, Howard W., 2018, Mississippi
Slayton, Rebecca L., 2017, Washington
Tinanoff, Norman, 2019, Maryland
Weyant, Robert J., 2017, Pennsylvania
Young, Douglas A., 2016, California

Lyznicki, James M., senior manager

The Council's 2015–16 liaisons include: Dr. Lindsey A. Robinson (Board of Trustees, Thirteenth District) and Dr. Gregory Sabino (American Student Dental Association).

Bylaws Areas of Responsibility

As listed in Chapter X, Section 130K of the ADA *Bylaws,* the areas of subject matter responsibility for the Council are:

a. Science and scientific research, including:
    1. Evidence-based dentistry;
    2. Evaluation of professional products;
    3. Promulgation of a biennial research agenda; and
    4. Promotion of student involvement in dental research;
b. Scientific aspects of the dental practice environment related to the health of the public, dentists, and allied health personnel;
c. Standards development for dental products;
d. The safety and efficacy of concepts, procedures, and techniques for use in the treatment of patients;
e. Liaison relationships with scientific regulatory, research, and professional organizations and science-related agencies of professional healthcare organizations; and
f. The ADA Seal of Acceptance Program.

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

The following table presents outcomes of Council programs from January to July 2016 and tracks their progress to date in support of the ADA Strategic Plan Members First 2020 and the ADA Science Institute's Operating Plan.

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

Objective	Initiative/ Program	Success Measure	Target	Range	Outcome**
3-Member Value	Provide efficacy and safety evidence for the use of over-the-counter (OTC) products through the ADA Seal of Acceptance Program. o Enhance consumer information on OTC oral health products: • Revision of *ADA Acceptance Program Requirements*.	Evaluation/ revision of three *Acceptance Program Requirements* per quarter.	12 per year	10–14 require-ments	Seven *ADA Acceptance Program Requirements* have been updated. Five additional *Acceptance Program Requirements* also under review as of July 2016 [Objective is on schedule].
3-Member Value	Conduct and disseminate research and educational programs developed to meet members' and patients' needs. o Define scientific projects that will include the various CSA/Science Institute programs.	Two projects per year	Two projects per year	One to three projects per year	Six projects completed: evidence-based systematic review & updated clinical practice guideline on dental sealants; study of bisphenol A release from resin-based sealants; reports on oral appliances for sleep-related breathing disorders, the use of capnography in patients undergoing moderate sedation, and a review of intraoral tattooing safety. [Objective completed/exceeded]
1-Leaders & advocates	Ensure that ADA oral health information is scientifically sound and clinically relevant. o Revise Scientific Information topics found on ADA websites that are relevant to practice.	Two topics per quarter; eight per year	Eight per year	Six to 10 topics per year	12 Oral Health Topic pages created/updated on ADA.org (e.g., new pages on Antibiotic Prophylaxis and Antibiotic Stewardship) [Objective completed/exceeded].
1–Leaders & advocates	Create opportunities for members to earn ADA continuing education (CE) based on work of the various Science Institute programs. o Develop ADA CE based on EBD and PPR programs.	80 hours per year; 20 per quarter	80 hours per year.	60–100 hours per year	66 CE hours offered (61 from EBD Center, four from Research/Standards, one from a webinar on HPV-related oropharyngeal cancer). EBD Center will offer 84 CE credit hours by year-end; CSA will also support courses with 24 CE hours at ADA 2016 [Objective is on schedule].

** *Results are as of the date of report preparation and do not reflect full-year results.*

Objective	Initiative/ Program	Success Measure	Target	Range	Outcome**
1–Leaders & advocates	Define projects and products that benefit "Power of Three" initiatives. Support the "Power of Three" and membership education and clinically relevant initiatives via Standards, PPR and EBD data and publications.	12 documents per year; three per quarter.	12 documents per year.	10–14 documents.	21 documents completed through July 2016: three critical summaries from ADA Evidence Reviewers/EBD Center; Scientific Information—16 articles for ADA.org's Science in the News; Research & Standards—approval of two ANSI/ADA standards [Objective completed/exceeded].

Center for Evidence-Based Dentistry (*EBD Center):* In spring 2016, the ADA EBD Center completed the update of the clinical practice guideline and evidence-based systematic review on the effect of dental sealants for the prevention and management of pit-and-fissure occlusal carious lesions. Both documents were published in the August 2016 issue of *JADA.* A Chairside Guide to assist clinicians with the new dental sealant guideline has also been developed, and will be posted on the EBD Center website in summer 2016

In 2016, the EBD Center initiated the next update of the Council's clinical practice guideline on screening for oral cancer, which was last published in 2010. Two Council subcommittees have developed a proposed list of expert panelists, including the panel chair nominee and internal/external stakeholder institutions to participate in the guideline development process, which will be forwarded to the Council chair for approval.

Through July 2016, ADA Evidence Reviewers (clinicians who critically appraise systematic reviews and develop critical summaries for publication on the EBD website and/or *JADA*) prepared three critical summaries of systematic reviews that were published in *JADA*, plus five additional critical summaries that are under editorial review. The EBD Center also posted one ADA Science Podcast on oral medicine, which featured Dr. Thomas Sollecito, professor of oral medicine (University of Pennsylvania) and immediate-past CSA member.

EBD Educational Programs. In 2016, the EBD Center has presented the following CE workshops and programs: a one-week Advanced EBD Workshop held in collaboration with the New York University College of Dentistry (January 2016); a three-hour CE course at the Colegio de Cirujanos Dentistas de Puerto Rico (February 2016); a three-hour CE course held in collaboration with the American Association for Dental Research (AADR) during the 2016 AADR annual meeting; and a three-hour EBD faculty development workshop at the Texas A&M University Baylor College of Dentistry, in collaboration with the Texas Dental Association.

In August 2016, the EBD Center hosted a three-day, invitation-only "Train the Trainers" workshop at ADA Headquarters to build an ongoing collaborative network of EBD practitioners and educators. The EBD Center will also host its annual EBD Champions conference at ADA 2016-America's Dental Meeting. ADA delegates who would like to attend the EBD Champions Conference are welcome to register online.

ADA Seal of Acceptance Program. In 2016, the Council initiated a year-long project to review all existing Acceptance Program Requirements (progress to date on this objective is addressed in the "Advancing ADA Strategic Goals and Objectives" section of this report).

In February 2016, the Council approved several changes as part of a strategic initiative to enhance the ADA Seal of Acceptance Program, including:

- approved the implementation of a simple, consumer-friendly, bulleted statement to appear on ADA-Accepted product packaging;
- revised requirements for cosmetic claims, such as whitening or bad breath, to be optional when submitting for the ADA Seal of Acceptance;
- rescinded the *Acceptance Program Guidelines for Determination of Efficacy in Product Evaluation*, which described requirements for comparison and/or superiority claims; and
- recommended that identical Acceptance Program fees be implemented for all Seal products, regardless of whether they are brand-name or private-label products. In June 2016, the Board of Trustees approved this new fee schedule for products submitted to the Seal Program.

The Council is exploring the feasibility of developing Acceptance Program requirements for two new product categories: products that help prevent dental erosion, and sugar-free mint or lozenge products, similar to the current requirements that are used to provide the Seal of Acceptance to sugar-free chewing gums.

Scientific Information: As of July 2016, the Council and the ADA Science Institute met their respective objectives in preparation for the launch of an ADA Dental Sealants campaign, a comprehensive initiative to promote dental sealant safety and effectiveness to the profession through various Association media. Dental sealant studies and resources developed in support of the project include: two peer-reviewed manuscripts and a "For the Patient" article published in the August 2016 *JADA*; a 2016 PPR publication featuring the analysis of bisphenol A (BPA) content in sealants, along with a "Caries Corner" column on the effectiveness of sealants in caries prevention; a scientific session that will be presented at ADA 2016-America's Dental Meeting; and a new webinar titled "Putting the ADA Caries Classification System Into Practice," which addresses appropriate use of sealants.

In spring 2016, the Council and the ADA Science Institute collaborated to develop a well-received webinar on Human Papillomavirus (HPV) and Oral Cancer, which is available on ADA.org. This course and the webinar on "Putting the ADA Caries Classification System into Practice" each offer one hour of CE credit to attendees. Both webinars are also available to ADA members and non-members.

In direct support of the Strategic Plan, the Council established workgroups to address each of its primary focus areas for 2016 and beyond. Each Council workgroup is authorized to provide guidance and oversight to address key clinical issues pertaining to the prevention, treatment and management of primary oral disease. The Council's Dental Caries Workgroup submitted a commentary piece on the management of dental caries, which was prepared in collaboration with Dr. Lindsey A. Robinson, current Board liaison to the Council. The Caries Workgroup will also offer a presentation on the utility of the ADA Caries Classification System as a scientific session at ADA 2016-America's Dental Meeting.

In 2016, the CSA Oral Cancer Workgroup updated the ADA.org Oral Health Topic page addressing oral and oropharyngeal cancer to present clinical relevant information in one location on the ADA.org website. The Oral Cancer Workgroup also plans to develop a webinar on the impact of HPV on oral cancer epidemiology, and to provide a course at the 2016 ADA Annual Meeting on the "State of Science of Oral Carcinoma." The CSA Oral Cancer Workgroup is collaborating with the EBD Center to conduct a systematic review and develop clinical practice guidelines on early detection of oral squamous cell carcinoma. In addition, the Council established a Periodontal Disease Workgroup, which is in the process of determining primary knowledge gaps in the diagnosis, care and treatment of periodontal disease that the workgroup wants to address going forward.

Also in 2016, the Council developed two Evidence Briefs for use by other ADA councils to inform their decision making in response to House resolutions on the following topics: Risks and Benefits of Using Capnography In Dental Patients Undergoing Moderate Sedation (for the Council on Dental Education and Licensure [CDEL], in response to House Resolution 77H-2015); and Oral Appliances for Sleep-Related Breathing Disorders (for the Council on Dental Practice [CDP], in response to House Resolution 96H-2015).

ADA Product Evaluation. The August 2016 *ADA Professional Product Review* (PPR) highlighted an ADA laboratory evaluation of potential bisphenol A release from resin-based dental sealants, plus a "question-and-answer" section with expert panelists and a "Caries Corner" discussion of dental sealant effectiveness with the Council's Dental Caries Workgroup.

Beginning in fall 2016, the Council plans to reactivate the ADA Clinical Evaluators (ACE) panel that is used to provide feedback for the PPR newsletter. The ACE panel will periodically be asked to propose topics and particular professional brands or products of interest to be included in PPR evaluations. The ACE panel will also provide feedback in terms of overall product experience, which will support PPR readers during the decision-making process.

During the ADA 2016 meeting in Denver, the PPR will offer a hands-on course on CAD/CAM crown-preparation techniques, which will educate dentists in the primary steps to achieve optimal results with CAD/CAM crown technology. Interested delegates are encouraged to attend one of the 16 CAD/CAM crown-prep sessions that will be offered at ADA 2016; members can obtain one CE credit for participating in this activity. In addition, a reception will be held for current ACE panelists at ADA 2016 in Denver, which will promote the reactivation of the ACE panel and provide an opportunity to recruit ADA members to participate on the ACE panel.

ADA Research and Standards. ADA Research and Standards (R&S) staff conduct research on dental materials, instruments, and equipment, including experimental research collaborations, grant generation, patent creation and research dissemination. ADA R&S staff delivered three presentations at the 2016 AADR meeting, and R&S scientists were included in presentations given by two collaborators.

To foster relationships with dental and post-graduate students, R&S staff have continued research collaborations with US dental schools, including an Indiana University dental student's study on characterizing the beam homogeneity of dental curing lights. A draft publication addressing this project is under development as of summer 2016. R&S staff were also awarded a joint grant with the University of Illinois-Chicago (UIC) School of Dentistry to investigate the effect of seven cleaning solutions on the flexibility, surface roughness, and the translucency of three different "clear" retainer materials. These experiments were completed in July 2016, and a manuscript is being prepared for publication.

R&S staff are also collaborating with US Air Force scientists on an evaluation of the scanning accuracy of dental chairside and laboratory CAD/CAM systems. In July 2016, an R&S-developed article was published in *Dental Materials* journal, as part of a collaborative project with the UIC and Marquette University Schools of Dentistry. The article presents an investigation of the transformation temperatures of heat-activated nickel-titanium orthodontic archwires by two different techniques, one of which was developed in the ADA research laboratory. In February 2016, the ADA received a patent on a "Method and Apparatus for Characterizing Handpieces," as a result of research conducted by R&S scientists.

R&S staff are also leading the development of dental standards and guidelines for product testing and evaluation. R&S staff participated in three laboratory studies for ISO test method development: an ADA-led study on the power of air-turbine dental handpieces; an evaluation of the sensitivity of polymer-based restorative materials to ambient light; and a study on a proposed standard on the scanning accuracy of dental chairside and laboratory CAD/CAM systems. Through July 2016, R&S staff have provided comments on 12 ISO standards and voted on 13 ISO standards.

ANSI/ADA Standards Development. The ADA's voluntary ANSI-accredited standards program develops consensus standards that provide direct value to ADA members. In 2016, the Council worked with the Standards Committee on Dental Products to complete ANSI/ADA Standard 46-2016--Dental Patient Chair, and ANSI/ADA Standard 27-2016 Polymer-based Restorative Materials.

Emerging Issues and Trends

The Council continuously monitors the research literature and emerging issues affecting clinical practice. The Council devoted considerable time and discussion at its 2016 meetings to address two specific

issues that drew considerable attention in research circles and the public media: (a) the growing epidemic of opioid misuse and abuse in the United States, and (b) the dental profession's need for evidence-based guidelines that support and promote therapeutic antibiotic stewardship. The Council recognizes that there are few antibiotic-prescribing resources available that are specific to oral health, and few evidence-based recommendations for therapeutic antibiotic stewardship in the treatment of oral infections. The Council will work through its EBD and Scientific Information subcommittees to determine how best to develop appropriate guidance for the profession on this key clinical issue.

In August 2016, the Council and the Science Institute worked with ADA Communications to address media coverage that questioned the value of daily flossing. The ADA provided context for understanding that the strength of the evidence did not equate with lack of benefit. Dentists were encouraged to tailor appropriate messages for daily oral hygiene based on each individual patient's needs, preferences and caries risk factors.

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/Program	Success Measure	Target	Outcome
Resolution 52H-2015. Federal Research to Investigate the Relationship Between Diet, Nutrition and Oral Health	Resolution 52H-2015 calls for ADA to encourage federal research agencies to further investigate the relationship between diet, nutrition, and oral health, particularly the extent to which dental caries incidence may fluctuate with changes in overall added sugar consumption.	Implement directive in collaboration with the Council on Government Affairs (CGA) and the Council on Access, Prevention and Interprofessional Relations (CAPIR).	The Council's Research Subcommittee recommends Council approval of this topic as part of its targeted goals/ objectives in the ADA Research Agenda.	Integrate directive into the 2017–2018 Research Agenda [Progress toward objective is in progress]
Resolution 77H-2015. Proposed Amendments to the Sedation and Anesthesia Guidelines	Resolution 77H-2015 called for the referral of the proposed Guidelines for the Use of Sedation and General Anesthesia by Dentists and the Guidelines for Teaching and Pain Control and Sedation to Dentists and Dental Students to CDEL, in collaboration with the Council, with a recommendation to consider: elimination of the mandate for monitoring end-tidal CO_2 for moderate sedation to allow for the choice of options, such as: continuous use of a precordial or pretracheal stethoscope, continuous monitoring of end tidal carbon dioxide, and continual verbal communication with the patient"—and other considerations.	Council conducts requested evaluation and submits "Evidence Brief" to CDEL's Committee on Anesthesiology	Completion of a state-of-the-science Evidence Brief addressing the benefits and safety considerations regarding the use of capnography in dental patients undergoing moderate sedation.	The Council developed and approved an Evidence Brief titled "Risks and Benefits of Using Capnography in Dental Patients Undergoing Moderate Sedation," which was prepared for the CDEL Committee on Anesthesiology in their work to amend the ADA Sedation and Anesthesia Guidelines. [Objective completed]

Resolution Objective	Initiative/Program	Success Measure	Target	Outcome
Resolution 96H-2015 Development of ADA Policy on Dentistry's Role in Sleep Related Breathing Disorders	Resolution 96H-2015 called for the ADA to develop policy as to dentistry's role in Sleep Related Breathing Disorders (SRBD), and the Council was assigned to collaborate with other appropriate ADA agencies designate the appropriate agency to develop said policy as to the dentist's role in SRBD.	Submit Evidence Brief to CDEL to inform policymaking	Completion of a state-of-the-science Evidence Brief on oral appliances for SRBD. is topic.	Scientific review completed/approved and transmitted to the CDP. CDP is coordinating the development and review of policy language for consideration at 2017 HOD meeting. [Objective in progress]
Resolution 67H-2014 Educating Children and Parents About the Dangers of Oral Piercings	Investigate the safety of intraoral tattoos; expand educational program and preparation of material on the dangers of oral piercing and intraoral tattoos that targets younger children, young adults, adolescents and parents.	Complete investigation and forward recommendations to 2016 House of Delegates (HOD).	Present final report on this activity to 2016 House of Delegates.	Scientific review completed. The review article will be sent as a standalone report to 2016 HOD. [Objective is on target.]
Resolution 68H-2014 Promotion of Evidence Regarding Premedication for Patients With Prosthetic Joint Implants	Actively promote to appropriate medical organizations and practitioners the results of the 2014 systematic review regarding the efficacy of premedication prior to dental procedures performed on patients with prosthetic joints.	Implement directive by 2016 HOD meeting	Present report on Council's promotion of the evidence on this topic to 2016 House of Delegates.	Objectives have been completed. More information is presented in the Resolution 68H-2014 paragraph following this table.[Objective completed]
Resolution 69H-2014 Optimizing Dental Health Prior to and Concurrent with Surgical/Medical Procedures and Treatment	Appropriate ADA agencies investigate the fiscal implication of the development of a policy statement and evidence-based guidelines for physicians and surgeons to eliminate the impact of untreated dental disease prior to and concurrent with complex medical or surgical procedures.	HOD adopts Councils' proposed policy and work plan resolutions in October 2016	Present draft policy and information on the fiscal impact of Resolution 69H-2014 in a report to the 2016 House of Delegates.	Report submitted for consideration by 2016 House of Delegates [Objective is in progress]

Resolution 68H-2014—Promotion of the Evidence Regarding Premedication for Patients with Prosthetic Joint Implants. In accordance with Resolution 68H-2014, the Council served as lead reporting agency, with support from CAPIR, to "actively promote to appropriate medical organizations and practitioners the results of the 2014 systematic review regarding the efficacy of premedication prior to dental procedures performed on patients with prosthetic joint replacements."

The evidence-based clinical practice guideline on the use of prophylactic antibiotics prior to dental procedures for patients with prosthetic joints was published in the January 2015 issue of *JADA*. Articles promoting the release of this Council guideline appeared in *ADA News*, the *ADA Morning Huddle* and an ADA Science Podcast by two Council members who coauthored the guideline.

The primary Council outcome with regard to Resolution 68H-2014 has been the success and popularity of the new Council guideline on prophylactic antibiotic use prior to dental procedures in patients with prosthetic joints. Overall, the January 2015 Council guideline was *JADA*'s most downloaded article in 2015, receiving over 77,000 downloads by the end of the year. The guideline also remains *JADA*'s most-downloaded article in the first half of 2016, with over 13,200 downloads from January to June 2016. With more than 90,000 downloads of the guideline in the past 18 months, it can be safely concluded that this Council guideline has been widely promoted and disseminated to the profession.

The Council's January 2015 guideline on prophylactic antibiotic use in dental patients with prosthetic joints is also widely promoted in the ADA's CE courses, and it will be featured in a course offering at ADA 2016-America's Dental Meeting (course number 5352). The 2015 Council guideline will be integrated into teaching materials in the appropriate use of clinical practice guidelines in dentistry, and this effort will be enhanced as the Science Institute pursues continuing efforts to expand CE course offerings to ADA members. Based on these promotional efforts, the Council concludes that the objectives of Resolution 68H-2014 have been duly supported and fulfilled.

Self-Assessment

In 2016, the Council initiated a thorough self-assessment of its programs, activities and effectiveness in accordance with Resolution 1H-2013, which calls for all ADA councils and commissions to complete self-assessment on a five-year rotating schedule. In spring 2016, Council members completed a detailed survey to provide anonymously submitted feedback on various Council operations, programs and activities. Council members were encouraged to offer suggestions or specific recommended actions for improving the Council's effectiveness in achieving program-specific outcomes and helping ADA members succeed.

At its July 2016 meeting, the Council held a full discussion of its self-assessment findings pertaining to current Council programs, operations, programmatic outcomes and areas or procedures that can be improved. The Council's primary recommendations are presented below:

- *Improving Dental Science Communications Across the ADA to Help Members Succeed:* The Council recommended by consensus that the Council and the ADA use the best available evidence when communicating with ADA members, and to present the available research and evidence in the best possible format for member dentists (e.g., translating the Council's evidence-based clinical practice guidelines into "digestible," "bite-size" resources for ADA members). This Council recommendation is aimed to support ADA members by ensuring the ADA provides leadership and remains proactive in developing relevant scientific information that members can use at the point of care, and in building clinicians' awareness of the available science on key dental issues (e.g., effectiveness of sealants in caries prevention). The Council also recommended wider integration of scientific information in *ADA News*, the *ADA Morning Huddle* and other Association media, within the context of current resources.

- *Allowing Council Members to Suggest Names for Future Council Members to the Board of Trustees:* The Council proposed that it work directly with its appointed Board liaison on an annual basis to submit the names of specific dentists, scientists or dental researchers who may best fit the Council's immediate needs for research or scientific expertise. In recent years, the Council has presented its expertise needs primarily through a list of high-priority areas of desired research expertise, rather than providing specific names of prospective future Council members. The Council supported an informal recommendation to develop suggestions for its current Board liaison to help the Board of Trustees with the Council-member nomination and selection process. In July 2016, the Board approved a resolution that supports an approach to accommodate this recommendation.

- *Encouraging Council Vice-Chair Attendance at ADA House of Delegates' Meetings:* The Council agreed by consensus that its current vice chair should attend the Reference Committee Hearings

and ADA House of Delegates' meeting, if appropriate, to obtain a better understanding ADA governance and operations, and to advocate on behalf of the Council if necessary.

Council members agreed that the development of evidence-based guidelines, scientific reports based on best evidence, high-quality scientific information and resources are highly significant programs for ADA members, but these activities also require considerable time, funding and staff support. The self-assessment included a review of the Council's current *Bylaws*-mandated duties and areas of responsibility, but the Council did not propose any modifications to those duties or areas at this time.

Policy Review

The Council reviewed several science-based ADA policies in 2016, and will present recommendations for policy amendment or rescission in reports to the 2016 House of Delegates.

Council Minutes

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

ADA Business Enterprises, Inc.

Wholly Owned Subsidiary Annual Report and Financial Affairs

Mercer, James, 2019, South Carolina, chair
Cole, Jeffrey, 2017, Delaware
Kolman, Paul, 2019, Indiana
Meckler, Edward, 2016, Ohio
Maher, John, 2017, Wisconsin

Doherty, Deborah, managing director

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

ADABEI leads in the development of revenue generation by providing best-in-class products, services and opportunities that create value.

In 2015, ADABEI Goals Included:

- Strategic Management of Endorsement Relationships to Increase Revenue to the ADA
- Manage and Grow State Relationships and Endorsements
- Increase Commitment to New Product Development to add Member Value
- Improve Marketing Analytics & Targeting to Increase Value to Providers and Program
- Increase Strategic Alignment with the ADA

Throughout 2015, ADABEI staff achieved each of the goals. Examples, among others efforts, included:

- Exceeded Financial Goals *(Tables 1 and 2)*
- Completed Five Year Contract Renewal with Chase Paymentech *($750,000 per)*
- Added Two New Products *(HIPAA Compliant Email and Sharps Recycling)*
    - HIPAA Compliant Email: Approximately 1,800 Users to Date
    - Sharps Recycling: Approximately 1,500 Purchases to Date
- Improved Marketing Analysis to Increase Provider Leads and Program Revenue
    - Implemented ADABEI Buyer Analysis
        - 92,000+ Single Buyers
        - 15,000+ Multi Buyers
    - Segmented Email and Direct Mail Lists
- Increased State Royalty Sharing and Co-Endorsements
    - Five New State Co-Endorsements *(45 total)*
    - 72 Individual Product Co-Endorsements *(407 total)*
    - $977,000 State Royalty Sharing *(56.9% Increase)*

ADABEI Financials

In 2015, ADABEI earned $2,273,332 in gross revenue as a result of service fees to ADABEI from the program and finished 2015 with net income (pre-tax) of $311,986, driven in large part by the strong revenue performance of the financial services products *(credit card, practice financing, patient financing, credit card processing).*

Table 1. 2015 ADABEI Financials

	2015 Actuals	2015 Budget	Variance ($)	Variance (%)
ADABEI Revenue	$2,273,332	$2,245,066	$28,266	1.3%
Expenses	$1,961,346	$2,041,047	$79,701	3.9%
Net (Pre-Tax)	**$311,986**	**$204,019**	**$107,967**	**52.9%**

ADA Royalties: In 2015, the ADA earned royalties of $4,403,713 from endorsed providers in the program, exceeding the budget by $598,341. The variance was driven by the timing of the ADA budget preparation and better than expected performance, primarily from the financial services products.

State dental societies may choose to co-endorse products and services and share in program revenue through a license agreement. In 2015, the ADA paid $976,584 in royalties to state dental societies and exceeded the budget due to additional state endorsements.

Table 2. 2015 ADA Financials

	2015 Actuals	2015 Budget	Variance ($)	Variance (%)
ADA Royalties	$4,403,713	$3,805,372	$598,341	15.7%
State Royalty Share	$976,584	$544,275	$432,309	(79.4%)
Net (Pre-Tax)	**$3,427,129**	**$3,261,097**	**$166,032**	**5.1%**

Emerging Issues and Trends

Products: ADABEI continues to focus on the strategic management of endorsed provider relationships, to develop short and long term approaches to improve member value through product features, pricing and service.

In 2015, 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—UPS and Meridian One Corporation
- Appliances—Whirlpool VIP Program and Meridian One Corporation
- Computers—Hewlett Packard and Meridian One Corporation

Renewed and New Business: ADABEI completed a five-year renewal with a key provider, ChasePaymentech. Agreements with ChasePaymentech will continue through January 2020. ADABEI also renewed agreements with InTouch Communications through June 2018. ADABEI did not renew agreements with Energy Plus and Hewlett Packard.

Product development continued to be a key focus for ADABEI. Two products were added in 2015, HIPAA Compliant Email (PBHS) and Sharps Recycling (HealthFirst). Both products received high interest in ADA Member surveys and more than 3,000 users have enrolled to date.

ADA Foundation

Reyes, Reneida, president, 2016, New York
Green, Edward J., vice president, grants, 2017, Georgia
Calnon, William R. vice president, scientific research, 2017, New York
Maggio, Frank A., vice president, development, 2018, Illinois
Hemmen, Pamela, vice president, finance, 2016, Illinois

Members at Large
Asai, Rickland G., 2018, Oregon*
Black, Richard C., 2019, Texas*
Buckenheimer, Terry L., 2016, Florida*
Dolan, Teresa, 2019, Pennsylvania
Fujimoto, Patsy, 2019, Hawaii
Gallant, Marshall, 2019, Florida
Hearn, Cindy, 2016, California
Himmelberger, Linda K., 2018, Pennsylvania
Icyda, Teri-Ross, 2018, Florida
Jeffers, Gary E., 2017, Michigan*
Kiesling, Roger, 2018, Montana
Lynch, Michael, 2019, New Jersey
McDermott, Bernard, 2017, District of Columbia
Morell, Maritza, 2016, Massachusetts
Panagakos, Fotinos S., 2017, New Jersey
Penrose, Michele, 2016, Michigan

Wurth, Gene, executive director

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

1. Advancing ADA Goals and Objectives

The American Dental Association Foundation (ADAF) is a public charity whose mission is to provide **c**haritable assistance for the dental community, and works to improve oral health by supporting **a**ccess to care, **r**esearch, and **e**ducation programs. This mission is exemplified by the acronym C.A.R.E.

ADAF programs are consistent with, and complementary to, various ADA Strategic Goals and other important organizational efforts. The work of the ADAF is mentioned either directly (as in the *Bylaws*) or implicitly as part of the ADA Constitution, Core Values, Strategic Plan, Action for Dental Health, and relationships with dental students. The following summary describes how the work of the ADAF complements the works and goals of the ADA, with the relevant language of each document underlined.

The ADA Constitution

Article II of the ADA Constitution states that:

> The object of this Association shall be to encourage the improvement of the health of the public and to promote the art and science of dentistry.

This same purpose is reflected in the ADAF's mission above.

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* *ADA Trustee*

The ADA *Bylaws*

> CHAPTER XIV - AMERICAN DENTAL ASSOCIATION FOUNDATION - Section 10. FINANCIAL SUPPORT: …The Association shall annually furnish sufficient financial support, as an addition to generated non-Association funding, to assure the continued viability of the Foundation's research activities.

This relates directly to research activities conducted at the ADAF Volpe Research Center (VRC).

The ADA Core Values Statement

> ADA Core Values
> (1) Commitment to Members
> (2) Integrity
> (3) Excellence
> (4) Commitment to Improving Oral Health
> (5) Science and Evidence-Based

All of these Core Values are embodied in the mission and programs of the ADAF. The ADAF's Charitable assistance grants for financial aid and disaster relief exhibit our commitment to helping all dentists, including ADA members. ADAF's careful management of donations, grants, financial reports, etc. demonstrates integrity.

The ADAF strives for excellence in all of its efforts. Many of its programs are focused on improving oral health, including the GKAS program, the Tarrson and Zwemer Awards, and the Semi-Annual Access to Care grants.

The ADAF supports the commitment to science by the nearly 90 years of research and development completed at the VRC and its predecessor organizations, and in its efforts to identify and encourage promising young researchers.

ADA Strategic Plan - Helping All Members Succeed

> Strategy 1.1 Align public awareness efforts across the tripartite concerning oral health issues.
> Strategy 1.3 Promote oral health through advocacy and science.

While the ADAF programs are not—and cannot—be directed specifically at ADA members because of our legal status as a public charity, the ADAF's work complements the aims of the ADA strategic plan. The activities of the ADAF fulfills its C.A.R.E. mission, and reflect well on the ADA and the dental profession. The ADAF increases public awareness of dentistry's good works through its stories for the *ADA News*, press releases, its website, and in communications with dental schools. The ADAF's commitment to the research fulfilled at the VRC, and in grants to young researchers is consistent with Objective 1.3 in the ADA strategic plan.

The ADA Action for Dental Health Campaign

Action for Dental Health addresses the dental health crisis in three distinct areas:

- Provide care now to people who are suffering from untreated disease.
- Strengthen and expand the public/private safety net.
- Disease prevention and dental health education.

The ADAF's GKAS events, Tarrson and Zwemer Awards, and community-based access to care and education programs all support the Action for Dental Health campaign.

Relationships with students The ADA has undertaken significant efforts to strengthen its ties to dental students, and the work of the ADAF enhances those efforts. It is estimated that the ADAF has "touch

points" with dental schools about 50 times each year through written, electronic, and telephonic communications to inform administrators and students about ADAF scholarships, research grant opportunities, Tarrson and Zwemer Awards announcements, the Dental Student Conference on Research, announcements of winners of our grants, and subsequent stories about the winners.

Additionally, the ADAF interacts directly with students in many ways. From 2010 to 2016 nearly 60 dental schools in the US, including Puerto Rico conducted GKAS events. These involved more than 20,000 volunteers, including dental students, faculty, school alumni, local dentists, and hygienists in events that educated and treated more than 90,000 children. Similarly, our Tarrson and Zwemer Awards, research awards, and Dental Student Conference on research all touch students directly. These student-run programs show that ADAF grants support the students who will become active in the profession—and in organized dentistry—in the future. Potential future members and leaders of the ADA are likely be present in these student groups.

2. ADAF Programs and Structure – Philanthropic Programs and Scientific Research

Philanthropy programs at the ADAF include a wide range of grants (in which funds are provided to help start or sustain a program) and awards (in which funds are provided to recognize programs, volunteers, students or others for past accomplishments) that are associated with one or more of the Four Pillars–C.A.R.E. These include:

- **Charitable Assistance** programs that provide financial aid for dentists or their families in need, and emergency disaster grants, including nine financial assistance grants and seven emergency disaster grants in the past 12 months.

- **Access to Care** grants and awards to volunteer programs that provide care to vulnerable populations including those organized and managed by dental students and community volunteers. Access to care programs include:

    - **E. "Bud" Tarrson Awards** for programs organized by dental students for U.S. populations (six Tarrson Awards in the past 12 months. Each program involves about 50 students per school, so in 2015–2016 the ADAF supported the volunteer efforts of about 300 dental students—future leaders of the profession.

    - The **Dr. Thomas Zwemer Awards,** like the Tarrson Awards but for student run programs which are conducted in foreign countries. One award was made in 2016.

    - **The Give Kids A Smile (GKAS)** program, involving 30,000 volunteers each year including about 10,000 dentists, in about 1,300 locations. Those volunteers are engaged in educating, screening, and in some cases treating, as many as 350,000 children each year in the U.S., and more than five million since 2003.

    - **Semi-annual Grants-Access to Care** for community-based access to care programs. The ADAF made 11 such grants this year.

    - Support for the ADA **Mission of Mercy (MOM)** events, by way of securing financial and product donations that make the events possible.

- **Research** support includes several grants, awards, and programs which are separate from the operation of the ADAF/VRC, which is managed under the Research business unit. Those activities which are part of the Philanthropy business unit are:

    - The **Dental Student Conference on Research (DSCR)** in which every dental school in the U.S. and Canada is invited to send a student who is interested in, or who has participated in, research to a two-and-a-half day program at the VRC and the National Institute for Dental and Craniofacial Research (NIDCR.)

- The **Dr. Rafael Bowen Research Award**, presented in conjunction with the Academy for Operative Dentistry.

- The **Intel International Science Award** for high school students interested in a career in research.

- The **Promising Researcher Development Program (PRDP)** to enable promising young researchers to begin their careers. In 2016 the ADAF has secured commitments from corporate sponsors for two new types of research awards.

- **Education** grants and awards include:

  - **Dental Student Scholarships** 29 scholarships for dental students in 2016.

  - **Underrepresented Minority Dental Student Scholarships** for dental students from ethnic groups that are underrepresented in the student body and in the profession—25 in 2016, from a pool of 68 applicants.

  - **Allied Dental Student Scholarships** for 30 students enrolled in dental hygiene, laboratory technology, or dental assisting programs.

  - **Dr. Samuel J. Harris Awards** to help community groups educate new mothers about the importance of infant oral health care. In 2016, the ADAF issued 25 grants totaling nearly $120,000.

  - **Semi-Annual Education Grants** for community groups that provide health education to the public 13 in 2016.

The **Scientific Research Program** of the ADAF is focused on the work done at the ADAF/Volpe Research Center. The VRC and its predecessor the Paffenbarger Research Center, have a nearly 90 year history of conducting basic and clinical research that has made major advancements in oral care possible. That includes development of the high speed handpieces, improved dental composites, panographic imaging technology, new generations of bonding agents, and much more. That work continues in emerging areas such as precision dental care, nanotechnology, tissues engineering and work on new dental materials and dental standards.

3. ADAF Results and Success Measures by Program Area

Development – Development efforts over the past 12 months have been effective. 2015 donations exceeded 2014 results with total cash gifts of $1,163,677, about $90,000 higher. That was the third consecutive year of increased giving to the ADAF. In addition, the ADAF received $1,414,000 worth of product donations to support the GKAS program and the ADA MOM event. In 2015, dentists donated a total of $98,445 representing 8.5% of the total. Friends and associations gave $102,766, or 8.8% of the total. Corporate supporters donated a total of $962,446, or 82.7% of ADAF total support. Year-end activities to secure gifts included:

1. Informational packets for the House of Delegates and Alternates during the ADA 2015.
2. Personalized letters to past donors of $500 or more (834 donors).
3. Two e-blast messages to ADA members—one on Monday, November 30, the day before Giving Tuesday (147,706 sent, 145,610 delivered), and a second in December.

Grants, Awards and Scholarships over the past 12 months *(unless noted otherwise)*

Grant, Scholarship, Award Program	Number Awarded	Total Dollar Amount of the Award	Number of Applications Received
ADA 2015 Mission of Mercy	1	$90,150	1
ADA 2016 National Children's Dental Health Month campaign	1	$42,750	1
E. "Bud" Tarrson Dental School Student Community Leadership Award	6	$30,000	13
Dr. Thomas J. Zwemer Award	1	$5,000	11
Semi-annual Grants: Access to Care	11	$108,376	139
Semi-annual Grants: Education *(including one $5,000 grant to the ADA 2017 National Children's Dental Health Month Campaign)*	13	$64,765	48
Dr. Ray Bowen Student Research Award	1	$7,000	____
Dr. David Whiston Leadership Program	2	$10,000	7
Dental Student Scholarship Program	25	$62,500	27
Underrepresented Minority Dental Student Scholarship Program	25	$62,500	68
Robert J. Sullivan Scholarships	2	$5,000	------
Dr. Robert B. Dewhirst Scholarship	2	$5,000	____
Allied Dental Student Scholarship Program	30	$30,000	96
Samuel D. Harris Fund for Children's Dental Health	25	$119,930.62	42
TeamSmile	2	$20,000	2
Relief Grant Program *(January 2016–August 9, 2016)*	9	$134,925.19	9
Emergency Disaster Assistance Grant Program *(January 2016–August 9, 2016)*	6	$9,500	9
Emergency Disaster Grants for 501(c)(3) Organizations *(January 2016–August 9, 2016)*	1	$10,000	1
TOTAL	**163**	**$817,396.81**	

International Programs The ADAF has initiated a strategic planning process to better position this program for growth in the future, and has conducted a survey of all US dental schools to determine how they promote the opportunities for international volunteerism to their students.

Science – the Volpe Research Center In the past 12 months the staff at the VRC has:

- had 10 manuscripts accepted for publication,
- submitted nine grant applications,
- secured a new, major grant from the National Institutes for Health (NIH) for a five year, $1.67 million project titled "Antimicrobial and remineralizing composites for Class V restorations." The goal of that research is to develop improved, bifunctional composite materials that will include

both antimicrobial and remineralizing capabilities in order to improve the treatment of root caries in older adults.

Emerging Issues and Trends

- Expansion of GKAS and using the national scope of GKAS as an asset in a comprehensive outcomes study to evaluate the effect of it and similar programs.

- Continued development of cutting-edge research at the ADAF/VRC address emerging areas of research, including improvements in dental materials, precision medicine/dentistry, nanotechnology, and the role of genetics/genomics.

AMERICAN DENTAL ASSOCIATION AND SUBSIDIARIES

Consolidated Financial Statements and Supplemental Schedules

December 31, 2015 and 2014

(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, 2015 and 2014, 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, 2015 and 2014, 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

Chicago, Illinois
June 14, 2016

AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES

Consolidated Statements of Financial Position

December 31, 2015 and 2014

Assets		2015	2014
Cash and cash equivalents	$	8,643,807	18,485,631
Receivables, net		8,829,830	8,817,759
Deferred taxes		59,106	60,557
Income taxes receivable		—	40,124
Prepaid expenses and other assets		2,243,136	1,995,394
Inventories, net		588,304	562,506
Marketable securities		150,125,357	142,198,618
Property and equipment, net		35,846,362	35,533,420
Funds held for deferred compensation		6,375,829	6,452,479
Total assets	$	212,711,731	214,146,488
Liabilities and Net Assets			
Accounts payable and accrued liabilities	$	13,500,381	13,632,987
Due to constituent societies		35,155	35,155
Deferred revenue		12,281,009	13,447,152
Income taxes payable, net		167,405	194,013
Charitable gift annuities		64,540	68,889
Liability for deferred compensation		6,375,829	6,452,479
Postretirement benefit obligation		11,093,105	11,494,812
Pension liability		54,146,067	50,386,561
Total liabilities		97,663,491	95,712,048
Net assets:			
Unrestricted		99,968,506	102,626,846
Temporarily restricted		12,940,892	13,668,752
Permanently restricted		2,138,842	2,138,842
Total net assets		115,048,240	118,434,440
Total liabilities and net assets	$	212,711,731	214,146,488

See accompanying notes to consolidated financial statements.

AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES

Consolidated Statements of Activities

December 31, 2015 and 2014

	2015				2014			
	Unrestricted	**Temporarily restricted**	**Permanently restricted**	**Total**	**Unrestricted**	**Temporarily restricted**	**Permanently restricted**	**Total**
Membership dues	$ 55,626,857	—	—	55,626,857	56,433,393	—	—	56,433,393
Advertising	6,168,587	—	—	6,168,587	8,079,989	—	—	8,079,989
Rental income	3,544,193	—	—	3,544,193	3,520,447	—	—	3,520,447
Publication and product sales	6,186,714	—	—	6,186,714	7,449,265	—	—	7,449,265
Testing and accreditation fees	23,553,912	—	—	23,553,912	21,704,972	—	—	21,704,972
Meeting and seminar income	8,445,640	—	—	8,445,640	8,677,236	—	—	8,677,236
Grants, contributions, and sponsorships	1,942,292	3,836,517	—	5,778,809	2,403,818	2,694,495	—	5,098,313
Royalties and service fees	18,406,511	—	—	18,406,511	16,199,332	—	—	16,199,332
Investment (loss) income	(2,835,023)	(446,839)	—	(3,281,862)	2,520,463	779,283	—	3,299,746
Other income	3,763,524	480	—	3,764,004	3,456,880	—	—	3,456,880
Net assets released from restrictions	4,118,018	(4,118,018)	—	—	3,095,772	(3,095,772)	—	—
Total revenue	128,921,225	(727,860)	—	128,193,365	133,541,567	378,006	—	133,919,573
Expenses:								
Staff compensation, taxes, and benefits	59,497,296	—	—	59,497,296	54,286,440	—	—	54,286,440
Printing, publication, and marketing	8,654,877	—	—	8,654,877	11,232,754	—	—	11,232,754
Meeting expenses	2,761,620	—	—	2,761,620	1,943,995	—	—	1,943,995
Travel expenses	7,337,132	—	—	7,337,132	6,588,913	—	—	6,588,913
Consulting fees and outside services	10,545,120	—	—	10,545,120	8,961,790	—	—	8,961,790
Professional services	9,085,613	—	—	9,085,613	10,251,125	—	—	10,251,125
Office expenses	5,509,828	—	—	5,509,828	4,903,376	—	—	4,903,376
Facility and utility expenses	5,630,942	—	—	5,630,942	5,385,398	—	—	5,385,398
Grants and awards	5,856,170	—	—	5,856,170	4,509,090	—	—	4,509,090
Endorsement expenses	1,246,417	—	—	1,246,417	853,932	—	—	853,932
Depreciation and amortization	6,481,142	—	—	6,481,142	6,242,267	—	—	6,242,267
Bank and credit card fees	1,311,636	—	—	1,311,636	1,282,387	—	—	1,282,387
Other expenses	1,326,230	—	—	1,326,230	1,950,846	—	—	1,950,846
Total expenses	125,244,023	—	—	125,244,023	118,392,313	—	—	118,392,313
Net income (loss) from operations before income tax expense	3,677,202	(727,860)	—	2,949,342	15,149,254	378,006	—	15,527,260
Income tax expense	1,732,110	—	—	1,732,110	1,617,313	—	—	1,617,313
Net income (loss)	1,945,092	(727,860)	—	1,217,232	13,531,941	378,006	—	13,909,947
Pension – and postretirement health plan – related changes other than net periodic pension cost	(4,603,432)	—	—	(4,603,432)	(29,624,522)	—	—	(29,624,522)
Change in net assets	(2,658,340)	(727,860)	—	(3,386,200)	(16,092,581)	378,006	—	(15,714,575)
Net assets at beginning of year	102,626,846	13,668,752	2,138,842	118,434,440	118,719,427	13,290,746	2,138,842	134,149,015
Net assets at end of year	$ 99,968,506	12,940,892	2,138,842	115,048,240	102,626,846	13,668,752	2,138,842	118,434,440

See accompanying notes to consolidated financial statements.

AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES

Consolidated Statements of Cash Flows

December 31, 2015 and 2014

	2015	2014
Cash flows from operating activities:		
Change in net assets	$ (3,386,200)	(15,714,575)
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	4,603,432	29,624,522
Depreciation and amortization	6,481,142	6,242,267
Gain on disposal of equipment	—	(63,140)
Deferred income tax expense	1,451	(1,509,845)
Net change in unrealized depreciation in fair value of marketable securities	10,587,080	11,716,597
Net realized gain on sale of marketable securities	(5,181,325)	(10,810,807)
Net assets released from restrictions and used for operations	2,467,629	973,921
Change in actuarial value of gift annuity obligations	15,655	20,403
Provision for uncollectible accounts	33,469	542,120
Changes in assets and liabilities:		
Receivables, net	(45,540)	335,883
Income taxes payable, net	13,516	634,140
Prepaid expenses and other assets	(247,742)	109,627
Inventories, net	(25,798)	290,361
Accounts payable, accrued liabilities, and other liabilities	(132,606)	1,059,825
Deferred revenue	(1,166,143)	1,998,075
Postretirement benefit obligation	(401,707)	(516,381)
Pension liability	(843,926)	(5,390,124)
Net cash provided by operating activities	12,772,387	19,542,869
Cash flows from investing activities:		
Purchase of marketable securities	(68,592,834)	(63,106,648)
Sale and maturity of marketable securities	55,260,340	63,560,246
Acquisitions of property and equipment	(6,794,084)	(5,406,922)
Cash proceeds from the sale of equipment	—	63,140
Net cash used in investing activities	(20,126,578)	(4,890,184)
Cash flows from financing activities:		
Net assets released from restrictions and used for operations	(2,467,629)	(973,921)
Payments to charitable gift annuitant	(20,004)	(20,003)
Net cash used in financing activities	(2,487,633)	(993,924)
Net (decrease) increase in cash and cash equivalents	(9,841,824)	13,658,761
Cash and equivalents at beginning of year	18,485,631	4,826,870
Cash and cash equivalents at end of year	$ 8,643,807	18,485,631
Supplemental disclosure of cash flow information:		
Cash paid for income taxes	$ 1,748,513	2,622,776

See accompanying notes to consolidated financial statements.

(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 revenue, 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, 2015 and 2014 consist primarily of interest-bearing deposits under overnight repurchase agreements. The Association, ADPAC, ADAF, and ADABEI each maintain their cash balances in financial institutions, which at times may exceed federally insured limits. The Association, ADPAC, ADAF, and ADABEI have not experienced any losses in such accounts and believe they are not exposed to any significant credit risk on cash.

(e) Receivables and Allowance

The allowance for doubtful receivables is determined after considering a number of factors, including the length of time receivables are past due, the Association's previous loss history, the customer's current ability to pay its obligations, and the condition of the general economy as a 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 $120,214 and $100,573 in 2015 and 2014, respectively, are included in professional services in the accompanying consolidated financial statements.

(g) Inventories

Inventories, consisting principally of salable educational materials and supplies, are carried at the lower of cost or market (net realizable value). Cost is primarily determined using the first-in, first-out method.

(h) Property and Equipment

Property and equipment are stated at cost, less accumulated depreciation and amortization. Depreciation is computed on the straight-line method once assets are put into service over the estimated useful lives of the assets, which are as follows:

Buildings	30–55 years
Building improvements	7–20 years
Furniture, equipment, and libraries	3–20 years

Tenant leasehold improvements are amortized over the shorter of their estimated useful lives or the remaining term of the lease.

(i) Valuation of Long-Lived Assets

The Association periodically evaluates the carrying value of its long-lived assets, including, but not limited to, property and equipment and other assets. The carrying value of long-lived assets are considered impaired when the undiscounted cash flows from such assets are separately identifiable and estimated to be less than their carrying value. In that event, a loss is recognized based on the amount by which the carrying value exceeds the fair value of the long-lived assets. Fair value is determined primarily using the anticipated cash flows discounted at a rate commensurate with the 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 revenue in the accompanying consolidated financial statements, amounted to approximately $3,507,157 and $5,781,000 at December 31, 2015 and 2014, 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 scored.

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 revenue. Grants to other organizations are recorded as expense when authorized by the Board of Trustees.

Royalties and service fees are recognized when earned.

(n) Pension and Other Postretirement Benefits

Pension costs are determined under the projected unit credit cost method. This method determines the present value of benefits projected to retirement with increases in salary and service, and allocates (attributes) pension costs to prior and current periods based upon the relationship of service to date versus service projected to retirement. Pursuant to ASC Subtopic 715-10, *Compensation – Retirement Benefits – Overall*, the Association is required to fully recognize and disclose an asset or liability for the overfunded or underfunded status of its benefit plans in its consolidated financial statements and to recognize changes in that funded status as a change in unrestricted net assets in the year in which the changes occur.

(o) Income Taxes

Deferred taxes are established for temporary differences between the financial reporting basis and the tax basis of assets and liabilities. Deferred taxes are based upon enacted tax rates, which would apply during the period in which taxes become payable or recoverable, and the adjustment of cumulative deferred taxes for any changes in the tax rate.

The Association accounts for uncertain tax positions in accordance with ASC Topic 740, *Income Taxes*. ASC Topic 740 addresses the determination of how tax benefits claimed or expected to be claimed on a tax return should be recorded in the consolidated financial statements. Under ASC Topic 740, the Association must recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such a position are measured based on the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement. ASC Topic 740 also provides guidance on derecognition, classification, interest, and penalties on income taxes and accounting in interim periods and requires increased disclosures.

(p) Net Assets

Net assets subject to donor-imposed stipulations are classified as temporarily or permanently restricted net assets while net assets not subject to such restrictions are classified as unrestricted net assets. If a restriction is fulfilled in the same time period in which the contribution is received, the Association reports the support as unrestricted.

ASC Section 958-205-45, *Not-for-Profit Entities: Other Presentation Matters, Endowments for Not-for-Profit Organizations: Net Asset Classification of Funds Subject to an Enacted Version of the Uniform Prudent Management of Institutional Funds Act of 2006 (UPMIFA), and Enhanced Disclosures for All Endowment Funds*, provides guidance on the net asset classification of donor-restricted endowment funds for a not-for-profit organization that is subject to an enacted version of UPMIFA. ASC Subtopic 958 enhances disclosures related to both donor-restricted and board-designated endowment funds, whether or not the organization is subject to UPMIFA.

(q) Fair Value Measurements

The Association applies the provisions of ASC Topic 820, *Fair Value Measurement*, for fair value measurements of financial assets and liabilities and for fair value measurements of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis. ASC Topic 820 defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC Topic 820 also establishes a framework for measuring fair value and expands disclosures about fair value measurements.

This pronouncement did not require any new fair value measurements and its adoption did not affect the results of operation or financial position of the Association. ASC Topic 820 establishes a fair value hierarchy that prioritizes the inputs to valuation technique used to measure fair value (note 4).

The Association also applies the provisions of Accounting Standards Update (ASU) No. 2010-06, *Improving Disclosures about Fair Value Measurements*. ASU No. 2010-06 amends ASC Subtopic 820-10, *Fair Value Measurement – Overall*, to provide additional disclosure requirements for transfers in and out of Levels 1 and 2 and for activity in Level 3 and to clarify certain other existing disclosure requirements.

The Association applies the provisions of ASC Subtopic 825-10, *Financial Instruments – Overall*. ASC Subtopic 825-10 provides the Association with an option to elect fair value as the initial and subsequent measurement attribute for most financial assets and liabilities and certain other items. The fair value option election is applied on an instrument-by-instrument basis (with some exceptions), is irrevocable, and is applied to an entire instrument. The fair value option election may be made as of the date of initial adoption for existing eligible items. Subsequent to initial adoption, the Association may elect the fair value option at initial recognition of eligible items, on entering into an eligible firm commitment, or when certain specified reconsideration events occur. Unrealized gains and losses on items for which the fair value option has been elected will be reported in the consolidated statements of activities. The Association did not elect any changes to fair value measurements upon the adoption of ASC Subtopic 825-10 in 2015 or 2014.

In May 2015, the FASB issued ASU No. 2015-07, *Fair Value Measurement (Topic 820), Disclosures for Investment in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*. ASU 2015-07 removes the requirement to categorize within the fair value hierarchy all investments for which fair value is measured using the net asset value per share practical expedient. It also removes the requirement to make certain disclosures for all investments that are eligible to be measured at fair value using the net asset value per share practical expedient. The requirements of the standard are

effective for reporting periods in fiscal years that begin after December 13, 2016 with early adoption permitted. ASU 2015-07 is to be applied retrospectively. The Association has elected to early adopt ASU 2015-07 in 2015.

(2) Receivables

Receivables at December 31, 2015 and 2014 consist of the following:

		2015	2014
Trade receivables	$	5,292,561	5,081,291
Royalties receivable		2,516,757	2,227,197
Grants and contracts receivable		71,036	167,854
Tenant receivables		1,624,597	1,556,684
Pledges receivable		410,887	803,065
Other		27,666	64,445
Total		9,943,504	9,900,536
Less allowance for doubtful receivables		(1,113,674)	(1,082,777)
Net receivables	$	8,829,830	8,817,759

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, 2015 and 2014:

		2015	2014
Unconditional promises to give	$	430,526	841,533
Less unamortized discount		(19,639)	(38,468)
		410,887	803,065
Less allowance for uncollectible pledges		—	—
Net pledges receivable	$	410,887	803,065
Amounts due in:			
Less than one year	$	224,676	219,333
One to five years		186,211	583,732
Total	$	410,887	803,065

Changes in the Association's allowance for doubtful receivables for the years ended December 31, 2015 and 2014 are as follows:

		2015	2014
Beginning balance	$	1,082,777	565,156
Provision for uncollectible accounts		76,080	631,753
Accounts written off		(50,181)	(127,876)
Recoveries		4,998	13,744
Ending balance	$	1,113,674	1,082,777

(3) Marketable Securities

Marketable securities at December 31, 2015 and 2014 consisted of the following:

		2015	
		Cost	Market
Money market funds	$	12,654	12,654
Bonds and bond funds		50,667,979	49,511,033
Equities and equity funds		88,659,738	84,045,629
Alternative investment funds		14,837,461	16,556,041
	$	154,177,832	150,125,357

		2014	
		Cost	Market
Money market funds	$	3,432	3,432
Bonds and bond funds		51,351,934	50,888,698
Equities and equity funds		70,390,960	76,082,665
Alternative investment funds		13,917,437	15,223,823
	$	135,663,763	142,198,618

The fair value of marketable securities held in the Reserve Division amounted to $85,700,141 and $83,112,550 at December 31, 2015 and 2014, respectively.

Investment income is included in the accompanying consolidated statements of activities for the years ended December 31, 2015 and 2014 as follows:

		2015	2014
Interest and dividends	$	2,123,893	4,205,536
Change in net unrealized depreciation in fair value of marketable securities		(10,587,080)	(11,716,597)
Net realized gain on sale of marketable securities		5,181,325	10,810,807
Total investment (loss) income	$	(3,281,862)	3,299,746

(4) Fair Value Measurements

(a) Fair Value of Financial Instruments

The following methods and assumptions were used by the Association in estimating the fair value of its financial instruments:

- The carrying amount reported in the consolidated statements of financial position for the following approximates fair value because of the short maturities of these instruments: cash equivalents, accounts payable, and accrued liabilities.
- Fair values of the Association's investments held as marketable securities are estimated based on prices provided by its investment managers and its custodian bank. Fair value for money market funds, equities and equity funds, alternative investment funds, fixed income mutual funds, and quoted corporate bonds and U.S. government bonds are measured using quoted market prices at the reporting date multiplied by the quantity held.

(b) Fair Value Hierarchy

The Association follows ASC Topic 820 for fair value measurements of financial assets and liabilities and for fair value measurements of nonfinancial items that are recognized or disclosed at fair value in the financial statements on a recurring basis. ASC Topic 820 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 – Quoted prices are available in active markets for identical assets or liabilities as of the report date. A quoted price for an identical asset or liability in an active market provides the most reliable fair value measurement because it is directly observable to the market.
- Level 2 – Pricing inputs are other than quoted prices in active markets, which are either directly or indirectly observable as of the report date. The nature of these securities include investments for which quoted prices are available but which are traded less frequently and investments that are fairly valued using other securities, the parameters of which can be directly observed.

- Level 3 – Securities that have little to no pricing observability as of the report date. These securities are measured using management's best estimate of fair value, where the inputs into the determination of fair value are not observable and require significant management judgment or estimation.

Inputs are used in applying the various valuation techniques and broadly refer to the assumptions that market participants use to make valuation decisions, including assumptions about risk. Inputs may include price information, volatility statistics, specific and broad credit data, liquidity statistics, and other factors. A financial instrument's level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. However, the determination of what constitutes "observable" requires significant judgment by the Association. The Association considers observable data to be that market data that is readily available, regularly distributed or updated, reliable and verifiable, not proprietary, and provided by independent sources that are actively involved in the relevant market. The categorization of a financial instrument within the fair value hierarchy is based upon the pricing transparency of the instrument and does not necessarily correspond to the Association's perceived risk of that instrument. The Association's policy is to recognize transfers between levels of the fair value hierarchy on the actual date of the event or change in circumstances that caused the transfer.

The following table sets forth by level, within the fair value hierarchy, the Association's assets at fair value as of December 31, 2015 and 2014:

	2015				Redemption or liquidation	Days' notice
	Level 1	Level 2	Level 3	Total		
Cash and cash equivalents	$ 8,643,807	—	—	8,643,807	Daily	One
Marketable securities:						
Money market funds	12,654	—	—	12,654	Daily	One
Fixed income mutual funds	49,422,512	—	—	49,422,512	Daily	One
Equity mutual funds	84,045,629	—	—	84,045,629	Daily	One
Corporate bonds	—	88,521	—	88,521	Daily	One
Alternative investment funds:						
Blackstone Partners Offshore Fund (1)	—	—	—	6,640,910	Semiannual	95
Barlow Partners Offshore Fund (1)	—	—	—	4,020,552	Annual	60
Wellington Archipelago Fund (1)	—	—	—	5,894,579	Quarterly	45
Total alternative investment funds	—	—	—	16,556,041		
Total marketable securities	133,480,795	88,521	—	150,125,357		
Funds held for deferred compensation:						
Money market funds	1,049,579	—	—	1,049,579	Daily	One
Equity mutual funds	3,910,939	—	—	3,910,939	Daily	One
Fixed income mutual funds	451,771	—	—	451,771	Daily	One
Corporate bonds	—	963,540	—	963,540	Daily	One
Total funds held for deferred compensation	5,412,289	963,540	—	6,375,829		
Total assets at fair value	$ 147,536,891	1,052,061	—	165,144,993		

(1) Certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in the table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated statements of financial position.

	2014				Redemption or liquidation	Days' notice
	Level 1	Level 2	Level 3	Total		
Cash and cash equivalents	$ 18,485,631	—	—	18,485,631	Daily	One
Marketable securities:						
Money market funds	3,432	—	—	3,432	Daily	One
Fixed income mutual funds	50,788,710	—	—	50,788,710	Daily	One
Equity mutual funds	76,082,665	—	—	76,082,665	Daily	One
Corporate bonds	—	99,988	—	99,988	Daily	One
Alternative investment funds:						
Common Sense Offshore Fund (1)	—	—	—	57,036	Quarterly	100
Blackstone Partners Offshore Fund (1)	—	—	—	5,432,423	Semiannual	95
Barlow Partners Offshore Fund (1)	—	—	—	4,135,465	Annual	60
Wellington Archipelago Fund (1)	—	—	—	5,598,839	Quarterly	45
Total alternative investment funds	—	—	—	15,223,763		
Total marketable securities	126,874,807	99,988	—	142,198,558		
Funds held for deferred compensation:						
Money market funds	1,085,954	—	—	1,085,954	Daily	One
Equity mutual funds	3,857,274	—	—	3,857,274	Daily	One
Fixed income mutual funds	586,925	—	—	586,925	Daily	One
Corporate bonds	—	922,326	—	922,326	Daily	One
Total funds held for deferred compensation	5,530,153	922,326	—	6,452,479		
Total assets at fair value	$ 150,890,591	1,022,314	—	167,136,668		

(1) Certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in the table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated statements of financial position.

There were no transfers between levels during the years ended December 31, 2015 and 2014.

The Association is invested in four alternative investment funds at December 31, 2015 and 2014 for which the net asset value is used as a practical expedient to determine fair value in accordance with ASC 820-10. The Association has no contractual commitments to fund the alternative investment funds. The balances in these funds were $16,556,041 and $15,223,823 at December 31, 2015 and 2014,

respectively. The Association is in process of fully redeeming its investment in the Barlow Partners Offshore Fund. In January 2016, the Association had received, 90% or $3,618,496 of its investment in the Barlow Partners Offshore Fund. The Association expects to receive the remaining balance of $402,056 during 2016.

(5) Property and Equipment

Property and equipment at December 31, 2015 and 2014 consisted of the following:

	2015		
	Chicago, IL	Washington, D.C.	Total
Land	$ 712,113	3,030,000	3,742,113
Building	12,381,169	11,572,309	23,953,478
Building improvements	73,289,177	3,608,976	76,898,153
Furniture and equipment	50,626,800	1,253,596	51,880,396
Tenant leasehold improvements	2,208,374	2,726,462	4,934,836
	139,217,633	22,191,343	161,408,976
Less accumulated depreciation and amortization	112,280,983	13,281,631	125,562,614
	$ 26,936,650	8,909,712	35,846,362

	2014		
	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	72,145,200	2,988,807	75,134,007
Furniture and equipment	48,193,365	1,200,533	49,393,898
Tenant leasehold improvements	1,893,581	2,467,929	4,361,510
	135,325,428	19,289,464	154,614,892
Less accumulated depreciation and amortization	106,588,003	12,493,469	119,081,472
	$ 28,737,425	6,795,995	35,533,420

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, 2015 are as follows:

2016	$ 3,928,018
2017	3,525,533
2018	3,497,301
2019	2,756,023
2020	1,473,349
Thereafter	5,712,150
	$ 20,892,374

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 net deferred tax asset of $59,106 and $60,557 as of December 31, 2015 and 2014, respectively, is attributable primarily to postretirement benefits and other timing differences. ADABEI has established a valuation allowance for its 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 ADABEI will realize the benefits of these deductible differences, net of the existing valuation allowance of $92,037 and $161,747 at December 31, 2015 and 2014, respectively.

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, 2015 and 2014. Income tax expense for the years ended December 31, 2015 and 2014 is as follows:

		2015	2014
Current:			
Federal	$	1,351,830	1,239,211
State		380,280	344,296
Current income tax expense		1,732,110	1,583,507
Deferred:			
Federal		60,594	(25)
State		9,116	29,493
Change in valuation allowance		(69,710)	4,338
Deferred income tax expense		—	33,806
Income tax expense	$	1,732,110	1,617,313

Net deferred tax assets at December 31, 2015 and 2014 consisted of the following:

		2015	2014
Deferred tax assets resulting from:			
Postretirement health benefits	$	59,106	59,362
Charitable contributions		—	1,195
Capital loss carryforward		92,037	161,747
Total deferred tax assets, net		151,143	222,304
Valuation allowance		(92,037)	(161,747)
Total deferred tax assets, net of valuation allowance	$	59,106	60,557

(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.

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. There are no investments designated for the supplemental plan for 2015 and 2014.

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:

	2015		
	Employees' Retirement Trust	**Employees' Supplemental Trust**	**Total**
Change in projected benefit obligation:			
Projected benefit obligation, beginning of year	$ 203,132,036	1,497,870	204,629,906
Service cost	2,035,115	—	2,035,115
Interest cost	9,012,912	67,338	9,080,250
Actuarial loss	(5,335,069)	(42,657)	(5,377,726)
Benefits paid	(12,413,940)	(92,796)	(12,506,736)
Projected benefit obligation, end of year	$ 196,431,054	1,429,755	197,860,809
Change in plan assets:			
Fair value of plan assets, beginning of year	$ 154,258,417	—	154,258,417
Actual return on plan assets	(3,129,735)	—	(3,129,735)
Employer contributions	5,000,000	92,796	5,092,796
Benefits paid	(12,413,940)	(92,796)	(12,506,736)
Fair value of plan assets, end of year	$ 143,714,742	—	143,714,742
Funded status, end of year:			
Fair value of plan assets	$ 143,714,742	—	143,714,742
Benefit obligation	196,431,054	1,429,755	197,860,809
Funded status	$ (52,716,312)	(1,429,755)	(54,146,067)

	2015		
	Employees' Retirement Trust	**Employees' Supplemental Trust**	**Total**
Amounts recognized in the accompanying consolidated statements of financial position:			
Pension liability	$ 52,716,312	1,429,755	54,146,067
Accumulated benefit obligation	196,431,054	1,429,755	197,860,809
in net periodic benefit expense and included as accumulated charges to unrestricted net assets:			
Prior service cost	$ (6,937,259)	—	(6,937,259)
Net actuarial loss	81,388,379	—	81,388,379
Net amounts included as an accumulated charge to unrestricted net assets	$ 74,451,120	—	74,451,120
Components of net periodic benefit cost:			
Service cost	$ 2,035,115	—	2,035,115
Interest cost	9,012,912	67,338	9,080,250
Expected return on plan assets	(12,175,837)	—	(12,175,837)
Prior service cost	(1,491,883)	—	(1,491,883)
Recognized net loss	6,750,799	—	6,750,799
Net periodic benefit cost	$ 4,131,106	67,338	4,198,444
Calculation of change in unrestricted net assets:			
Accumulated unrestricted net assets, end of year	$ 74,451,120	—	74,451,120
Reversal of accumulated unrestricted net assets, prior year	(69,797,262)	—	(69,797,262)
Change in unrestricted net assets	$ 4,653,858	—	4,653,858

	2015		
	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	$ 9,927,846	—	9,927,846
Amortization of prior service cost due to plan amendments	1,491,883	—	1,491,883
Amortization of unrecognized net loss	(6,750,799)	—	(6,750,799)
Net amounts recognized in unrestricted net assets	$ 4,668,930	—	4,668,930
Estimate of amounts that will be amortized out of unrestricted net assets into net pension expense in 2016:			
Net loss	$ 7,105,225	—	7,105,225
Prior service cost	(1,491,883)	—	(1,491,883)
Weighted average assumptions as of December 31:			
Discount rate	4.86%	4.86%	
Expected return on plan assets	8.00	8.00	
Rate of compensation increase	3.00	3.00	

	2014		
	Employees' Retirement Trust	**Employees' Supplemental Trust**	**Total**
Change in projected benefit obligation:			
Projected benefit obligation, beginning of year	$ 169,357,965	1,372,537	170,730,502
Service cost	4,805,974	—	4,805,974
Interest cost	8,775,553	70,145	8,845,698
Actuarial loss	728,858	1,647	730,505
Change in mortality assumption	8,945,228	24,391	8,969,619
Change in discount rate	18,029,916	121,946	18,151,862
Benefits paid	(7,496,386)	(92,796)	(7,589,182)
Projected benefit obligation, end of year	$ 203,147,108	1,497,870	204,644,978
Change in plan assets:			
Fair value of plan assets, beginning of year	$ 141,706,282	—	141,706,282
Actual return on plan assets	13,048,521	—	13,048,521
Employer contributions	7,000,000	92,796	7,092,796
Benefits paid	(7,496,386)	(92,796)	(7,589,182)
Fair value of plan assets, end of year	$ 154,258,417	—	154,258,417
Funded status, end of year:			
Fair value of plan assets	$ 154,258,417	—	154,258,417
Benefit obligation	203,147,108	1,497,870	204,644,978
Funded status	$ (48,888,691)	(1,497,870)	(50,386,561)

	2014		
	Employees' Retirement Trust	**Employees' Supplemental Trust**	**Total**
Amounts recognized in the accompanying consolidated statements of financial position:			
Pension liability	$ 48,888,691	1,497,870	50,386,561
Accumulated benefit obligation	203,147,108	1,497,870	204,644,978
in net periodic benefit expense and included as accumulated charges to unrestricted net assets:			
Prior service cost	$ (8,429,142)	—	(8,429,142)
Net actuarial loss	78,226,404	—	78,226,404
Net amounts included as an accumulated charge to unrestricted net assets	$ 69,797,262	—	69,797,262
Components of net periodic benefit cost:			
Service cost	$ 1,670,666	—	1,670,666
Interest cost	8,775,553	70,145	8,845,698
Expected return on plan assets	(11,497,013)	—	(11,497,013)
Prior service cost	(1,491,883)	—	(1,491,883)
Recognized net loss	4,175,204	—	4,175,204
Net periodic benefit cost	$ 1,632,527	70,145	1,702,672
Calculation of change in unrestricted net assets:			
Accumulated unrestricted net assets, end of year	$ 69,797,262	—	69,797,262
Reversal of accumulated unrestricted net assets, prior year	(43,044,797)	—	(43,044,797)
Change in unrestricted net assets	$ 26,752,465	—	26,752,465

	2014		
	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	$ 29,435,786	—	29,435,786
Amortization of prior service cost due to plan amendments	1,491,883	—	1,491,883
Amortization of unrecognized net loss	(4,175,204)	—	(4,175,204)
Net amounts recognized in unrestricted net assets	$ 26,752,465	—	26,752,465
Estimate of amounts that will be amortized out of unrestricted net assets into net pension expense in 2015:			
Net loss	$ 6,236,110	—	6,236,110
Prior service cost	(1,491,883)	—	(1,491,883)
Weighted average assumptions as of December 31:			
Discount rate	4.55%	4.55%	
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 contributed $5,592,796 to the Plan in 2016. The minimum funding contributions for the Plan years 2015 and 2014 were $1,657,338 and $4,497,471, respectively. The assets of the Plan

are held in various investment manager funds and comprised 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:

2016	$ 9,062,474
2017	9,570,105
2018	9,817,185
2019	10,315,053
2020	10,852,259
Thereafter	62,611,152
	$ 112,228,228

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, 2015 and 2014, and target allocations by asset category, are as follows:

	2015	
Asset category	**Actual allocation**	**Target allocation**
Fixed income	41%	40%
Equity:		
Domestic small cap	11	11
Domestic large cap value	10	10
Domestic large cap growth	18	18
International	20	21
	100%	100%

	2014	
Asset category	**Actual allocation**	**Target allocation**
Fixed income	42%	40%
Equity:		
Domestic small cap	10	11
Domestic large cap value	10	14
Domestic large cap growth	8	14
International	19	21
Temporary cash (pending investment)	11	—
	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, 2015 and 2014.

Guaranteed investment contract: Valued at contract value, which approximates fair value. The guaranteed investment contract is included in the consolidated financial statements at fair value, which represents contributions made under the contract plus earnings, less withdrawals, and expenses.

Equity and fixed income mutual funds: Mutual funds are valued at the net asset value of shares held by the Plan at year-end at the closing price reported in the active market in which the individual securities are traded.

The preceding methods may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

(c) Fair Value Hierarchy

The Plan has adopted ASC Section 715-20-50 for fair value measurements of financial assets and liabilities and for fair value measurements of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis. ASC Section 715-20-50 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value.

The Plan’s policy is to recognize transfers between levels of the fair value hierarchy on the actual date of the event or change in circumstances that caused the transfer. There were no significant transfers into or out of Level 1, Level 2, or Level 3 during the years ended December 31, 2015 and 2014.

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2015 and 2014:

	2015				Redemption or liquidation	Days' notice
	Total	Level 1	Level 2	Level 3		
Guaranteed investment contract	$ 4,414,580	—	—	4,414,580	Daily	One
Equity mutual funds:						
Dodge & Cox Stock Fund	14,206,584	14,206,584	—	—	Daily	One
Vaughan Nelson Opportunity Fund	8,075,708	8,075,708	—	—	Daily	One
Vanguard Institutional Index Fund	11,557,354	11,557,354	—	—	Daily	One
LKCM Institutional Fund	7,340,518	7,340,518	—	—	Daily	One
T. Rowe Price Growth Fund	14,442,718	14,442,718	—	—	Daily	One
Templeton Institutional Funds, Inc. International Equity series	14,259,605	14,259,605	—	—	Daily	One
GMO International equity fund	14,095,068	14,095,068	—	—	Daily	One
Total equity mutual funds	83,977,555	83,977,555	—	—		
Fixed income mutual funds:						
Vanguard Intermediate-Term Index Bond Fund	10,706,607	10,706,607	—	—	Daily	One
Vanguard Long-Term Bond Index Fund	13,251,099	13,251,099	—	—	Daily	One
Vanguard Long-Term Corporate Bond Fund	31,395,271	31,395,271	—	—	Daily	One
Total fixed income mutual funds	55,352,977	55,352,977	—	—		
Accrued fees	(30,370)	—	—	—		
Total	$ 143,714,742	139,330,532	—	4,414,580		

	2014				Redemption or liquidation	Days' notice
	Total	Level 1	Level 2	Level 3		
Guaranteed investment contract	$ 1,116,987	—	—	1,116,987	Daily	One
Equity mutual funds:						
Dodge & Cox Stock Fund	15,842,022	15,842,022	—	—	Daily	One
Vaughan Nelson Opportunity Fund	8,356,005	8,356,005	—	—	Daily	One
Vanguard Institutional Index Fund	12,858,918	12,858,918	—	—	Daily	One
LKCM Institutional Fund	7,774,468	7,774,468	—	—	Daily	One
Templeton Institutional Funds, Inc. International Equity series	14,733,073	14,733,073	—	—	Daily	One
GMO International equity fund	14,025,193	14,025,193	—	—	Daily	One
Total equity mutual funds	73,589,679	73,589,679	—	—		
Fixed income mutual funds:						
Vanguard Intermediate-Term Index Bond Fund	14,499,822	14,499,822	—	—	Daily	One
Vanguard Long-Term Bond Index Fund	14,262,200	14,262,200	—	—	Daily	One
Vanguard Long-Term Corporate Bond Fund	35,060,579	35,060,579	—	—	Daily	One
Total fixed income mutual funds	63,822,601	63,822,601	—	—		
Temporary cash – pending investment	15,729,150	15,729,150	—	—	Daily	One
Total	$ 154,258,417	153,141,430	—	1,116,987		

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, 2015 to December 31, 2015:

	Investment contract
Investment contract:	
Balance, beginning of year	$ 1,116,987
Interest income	44,868
Purchases	16,500,000
Sales	(13,247,275)
Balance, end of year	$ 4,414,580

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, 2014 to December 31, 2014:

	Investment contract
Investment contract:	
Balance, beginning of year	$ 765,074
Interest income	39,501
Purchases	8,500,000
Sales	(8,187,588)
Balance, end of year	$ 1,116,987

(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 Association may contribute to the accounts of eligible employees in lieu of the matching contributions provisions, which are suspended. For 2015 and 2014, the Association contributed 4% of each eligible employee's base salary. The Association's contributions under the plan were $1,567,870 and $1,543,503 in 2015 and 2014, 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. Payments totaling $75,501 were made to participants in 2015. Payments totaling $148,571 were made to participants in 2014. In 2013, the Association decided to terminate the plan, and accordingly, no awards were earned in 2015 or 2014. The plan will phase-out by the end of 2016 per the vesting schedules of the remaining participants.

(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.

The following table sets forth the plan's funded status:

		2015	2014
Change in benefit obligation:			
Benefit obligation, beginning of year	$	11,494,812	9,139,136
Service cost		392,118	325,472
Interest cost		491,087	483,908
Actuarial (gain) loss		(999,147)	132,985
Benefits paid		(285,765)	(315,296)
Change in mortality rates		—	683,464
Change in discount rate		—	1,045,143
Benefit obligation, end of year	$	11,093,105	11,494,812
Change in plan assets:			
Employer contributions	$	285,766	315,296
Benefits paid		(285,766)	(315,296)
Plan assets, end of year	$	—	—
Funded status, end of year:			
Benefit obligation	$	11,093,105	11,494,812
Accumulated benefit obligation		11,093,105	11,494,812
Components of net periodic benefit cost:			
Service cost	$	392,118	325,472
Interest cost		491,087	483,908
Amortization of transition obligation			—
Amortization of prior service cost		(1,459,910)	(1,459,910)
Recognized net loss		511,189	449,445
Net periodic benefit cost	$	(65,516)	(201,085)
Amounts recognized in the accompanying consolidated statement of financial position:			
Postretirement benefit obligation	$	11,093,105	11,494,812
Amounts not yet reflected in net periodic benefit expense and included as accumulated charges to unrestricted net assets:			
Net actuarial loss	$	5,194,073	6,704,409
Prior service cost		(7,679,123)	(9,139,033)
Net amounts included as an accumulated charge to unrestricted net assets	$	(2,485,050)	(2,434,624)

		2015	2014
Calculation of change in unrestricted net assets:			
Accumulated unrestricted net assets, end of year	$	(2,485,050)	(2,434,624)
Reversal of accumulated unrestricted net assets, prior year		2,434,624	5,306,681
Change in unrestricted net assets	$	(50,426)	2,872,057
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:			
Net (gain) loss experienced during the year	$	(999,147)	1,861,592
Amortization of net loss		(511,189)	(449,445)
Amortization of prior service cost		1,459,910	1,459,910
Net amounts recognized in unrestricted net assets	$	(50,426)	2,872,057
Estimate of amounts that will be amortized out of unrestricted net assets into net postretirement benefit expense in 2015 and 2014:			
Net (gain) loss	$	(131,778)	541,944
Prior service cost		(1,459,910)	(1,459,910)
Weighted average assumptions used to determine obligations at December 31:			
Discount rate		4.86%	4.55%
Weighted average assumptions used to determine net periodic benefit cost for the years ended December 31:			
Discount rate		4.55%	5.28%
Healthcare cost trend rate		N/A	N/A
Dental care trend rate		4.00	4.00
Assumed healthcare cost trend rates at December 31:			
Healthcare cost trend rate assumed next year		N/A	N/A
Ultimate trend rate		N/A	N/A
Year that trend reached ultimate rate		N/A	N/A

The Association expects to make no contributions to the postretirement health plan in 2016.

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 coverage using actuarial equivalencies and reflecting the retiree premiums and cost sharing provisions of the various plans. The Association concluded that the prescription drug benefit provided under these plans is actuarially equivalent to the benefit provided under the Act, and is and will be entitled to the employer subsidy available under the Act.

The employer contribution under the Association's retiree health plan is limited to increases of not more than 6% per year, cumulative from 1993/1994. The Association has chosen the application of ASC Subtopic 715-60, *Defined Benefit Plans – Other Postretirement*, at December 31, 2015 and 2014 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 2015 and 2014 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 2015 and 2014, 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 2015 and 2014 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
2016	$ 441,197	441,197
2017	463,180	463,180
2018	499,677	499,677
2019	554,217	554,217
2020	604,399	604,399
2021–2024	3,501,212	3,501,212

(9) Net Assets

Temporarily restricted net assets at December 31, 2015 and 2014 were available for the following purposes:

	2015	2014
Campaign for innovation in dental education	$ 133,103	369,282
Trusts	1,112,841	1,125,220
Extramural programs	113,520	113,520
Research	1,331,597	1,322,361
Awards	162,076	170,770
Education	405,095	384,533
Access	2,324,911	2,577,627
Political and legislative	627,419	554,482
Relief program	6,730,330	7,050,957
	$ 12,940,892	13,668,752

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 2015 and 2014 by incurring expenses satisfying the restricted purposes as follows:

		2015	2014
Campaign for innovation in dental education	$	166,681	118,158
Trusts		471	634
Research		27,059	56,004
Awards		37,186	36,240
Education		103,754	87,684
Access		2,051,430	527,686
Political and legislative		1,650,389	2,121,851
Relief program		81,048	147,515
	$	4,118,018	3,095,772

Permanently restricted net assets at December 31, 2015 and 2014 totaled $2,138,842 in each respective year. 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 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.

During 2015 and 2014, the ADAF had the following activities related to endowment net assets:

	2015			
	Unrestricted	**Temporarily restricted**	**Permanently restricted**	**Total**
Endowment net assets, beginning of year	$ —	995,198	2,138,842	3,134,040
Investment returns:				
Interest and dividends	—	60,582	—	60,582
Realized gain on sale of investments	—	277,530	—	277,530
Net unrealized depreciation on investments	—	(488,486)	—	(488,486)
Total investment returns	—	(150,374)	—	(150,374)
Investment management fee	—	(2,178)	—	(2,178)
Appropriation of endowment assets for expenditures	—	(123,169)	—	(123,169)
Total change in endowment net assets	—	(275,721)	—	(275,721)
Endowment net assets, end of year	$ —	719,477	2,138,842	2,858,319

	2014			
	Unrestricted	**Temporarily restricted**	**Permanently restricted**	**Total**
Endowment net assets, beginning of year	$ —	879,366	2,138,842	3,018,208
Investment returns:				
Interest and dividends	—	85,620	—	85,620
Realized gain on sale of investments	—	211,255	—	211,255
Net unrealized depreciation on investments	—	(64,090)	—	(64,090)
Total investment returns	—	232,785	—	232,785
Investment management fee	—	(1,712)	—	(1,712)
Appropriation of endowment assets for expenditures	—	(115,241)	—	(115,241)
Total change in endowment net assets	—	115,832	—	115,832
Endowment net assets, end of year	$ —	995,198	2,138,842	3,134,040

(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, 2015 and 2014:

	2015	2014
General fund:		
Administrative services	$ 7,186,652	5,750,219
Human resources	1,916,179	2,196,160
Legal affairs	3,887,031	3,793,958
Government affairs	8,656,103	8,898,309
Communications	5,672,108	5,674,907
Membership and dental society services	8,672,027	8,685,563
Global affairs	—	1,478,040
Conference and meeting services	8,759,893	8,070,517
Finance and operations	10,426,951	9,836,605
Salable materials	4,056,884	4,418,190
Central administration	8,762,545	2,288,568
Information technology and standards	13,841,298	11,645,402
Dental practice	5,404,438	4,929,458
Health policy resources center	2,827,559	2,763,149
Education	14,328,556	14,926,165
Science	4,414,488	5,069,185
Publishing	7,789,662	9,170,182
Corporate relations	805,256	1,140,793
Activities funded from reserves	353,983	495,422
Grant from ADA to ADAF	2,320,153	1,906,533
	120,081,766	113,137,325
Reserve division investment account	(1,151,753)	1,923,371
Eliminations of intercompany activities:		
Grant from ADA to ADAF	(2,320,153)	(1,906,533)
Reserve division earnings transfer	—	(1,923,371)
Headquarters building management office rent expense	(31,392)	(31,392)
Total expenses of general fund including income tax expense	116,578,468	111,199,400

	2015	2014
ADPAC total expenses including income tax expense	2,589,599	2,968,785
ADAF total expenses	8,221,978	6,214,048
ADABEI total expenses including income tax expense	2,054,303	2,129,223
Eliminations of intercompany activities:		
ADABEI rental charges	(100,376)	(103,073)
Staffing, compensation, and benefits	(776,794)	—
Professional services	(28,237)	(37,085)
Printing, publication, and marketing	(249,851)	(307,387)
Research expenses	(269,090)	(687,558)
Other expenses	—	(415,138)
Overhead recovery	(104,655)	(104,655)
In-kind administrative expenses	(939,212)	(846,934)
Total expenses including income tax expense	$ 126,976,133	120,009,626

(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 ADABEI were selected for audit by the IRS. In late 2013, ADA and ADABEI negotiated a settlement with the IRS for each of the years under audit (2007–2011). The audit adjustments were also carried forward to the other open returns. ADA and ADABEI paid the net amount for 2007–2011 of $1,299,807 in April 2014.

(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, 2015 through June 14, 2016, which was the date the consolidated financial statements were available to be issued, noting no events requiring recording or disclosure.

Schedule 1

AMERICAN DENTAL ASSOCIATION AND SUBSIDIARIES

Consolidated Statement of Financial Position with Supplementary Consolidating Information

December 31, 2015

	General fund										
	Operating division	Reserve division									
Assets	Operating account	Capital formation account	Capital fund	Reserve royalties fund	Investment account	Total general fund	ADPAC	ADAF	ADABEI	Eliminations	Total
Cash and cash equivalents	$ 6,461,278	—	—	—	—	6,461,278	636,097	723,890	822,542	—	8,643,807
Receivables, net	7,608,776	—	—	—	—	7,608,776	—	621,977	599,077	—	8,829,830
Due from affiliates	2,443,473	—	—	—	(2,625,785)	(182,312)	—	282,486	(100,174)	—	—
Deferred taxes	—	—	—	—	—	—	—	—	59,106	—	59,106
Prepaid expenses and other assets	2,191,118	—	—	—	—	2,191,118	50,018	—	2,000	—	2,243,136
Inventories, net	588,304	—	—	—	—	588,304	—	—	—	—	588,304
Marketable securities	11,509,627	—	7,399,639	18,263,075	85,700,141	122,872,482	—	25,937,339	1,315,536	—	150,125,357
Investment in subsidiaries	—	2,670,262	—	—	—	2,670,262	—	—	—	(2,670,262)	—
Property and equipment, net	35,526,329	—	—	—	—	35,526,329	—	320,033	—	—	35,846,362
Funds held for deferred compensation	6,375,829	—	—	—	—	6,375,829	—	—	—	—	6,375,829
Total assets	$ 72,704,734	2,670,262	7,399,639	18,263,075	83,074,356	184,112,066	686,115	27,885,725	2,698,087	(2,670,262)	212,711,731
Liabilities and Net Assets											
Accounts payable and accrued liabilities	$ 12,649,619	—	—	—	18,096	12,667,715	57,696	561,883	213,087	—	13,500,381
Due to constituent societies	—	—	—	—	—	—	—	35,155	—	—	35,155
Deferred revenue	12,276,009	—	—	—	—	12,276,009	—	5,000	—	—	12,281,009
Income taxes payable, net	351,667	—	—	—	—	351,667	1,000	—	(185,262)	—	167,405
Charitable gift annuities	—	—	—	—	—	—	—	64,540	—	—	64,540
Liability for deferred compensation	6,375,829	—	—	—	—	6,375,829	—	—	—	—	6,375,829
Postretirement benefit obligation	—	—	—	—	11,093,105	11,093,105	—	—	—	—	11,093,105
Pension liability	54,146,067	—	—	—	—	54,146,067	—	—	—	—	54,146,067
Total liabilities	85,799,191	—	—	—	11,111,201	96,910,392	58,696	666,578	27,825	—	97,663,491
Net assets:											
Common stock	—	—	—	—	—	—	—	—	100,100	(100,100)	—
Additional paid-in capital	—	—	—	—	—	—	—	—	500,000	(500,000)	—
Unrestricted	(13,094,457)	2,670,262	7,399,639	18,263,075	71,963,155	87,201,674	—	12,766,832	2,070,162	(2,070,162)	99,968,506
Temporarily restricted	—	—	—	—	—	—	627,419	12,313,473	—	—	12,940,892
Permanently restricted	—	—	—	—	—	—	—	2,138,842	—	—	2,138,842
Total net assets	(13,094,457)	2,670,262	7,399,639	18,263,075	71,963,155	87,201,674	627,419	27,219,147	2,670,262	(2,670,262)	115,048,240
Total liabilities and net assets	$ 72,704,734	2,670,262	7,399,639	18,263,075	83,074,356	184,112,066	686,115	27,885,725	2,698,087	(2,670,262)	212,711,731

See accompanying independent auditors' report.

Schedule 2

AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES

Consolidated Statement of Activities with Supplementary Consolidating Information

December 31, 2015

	General fund										
	Operating division	Reserve division									
	Operating account	Capital formation account	Capital fund	Reserve royalties fund	Investment account	Total general fund	ADPAC	ADAF	ADABEI	Eliminations	Total
Revenue:											
Membership dues	$ 55,626,857	—	—	—	—	55,626,857	—	—	—	—	55,626,857
Advertising	6,385,649	—	—	—	—	6,385,649	—	—	—	(217,062)	6,168,587
Rental income	3,675,962	—	—	—	—	3,675,962	—	—	—	(131,769)	3,544,193
Publication and product sales	6,219,503	—	—	—	—	6,219,503	—	—	—	(32,789)	6,186,714
Testing and accreditation fees	23,553,912	—	—	—	—	23,553,912	—	—	—	—	23,553,912
Meeting and seminar income	8,421,640	—	—	—	—	8,421,640	—	24,000	—	—	8,445,640
Grants, contributions, and sponsorships	1,717,192	—	—	—	—	1,717,192	1,722,467	2,608,240	—	(269,090)	5,778,809
Grant from ADA	—	—	—	—	—	—	—	2,320,153	—	(2,320,153)	—
Royalties and service fees	16,045,312	—	—	—	—	16,045,312	—	94,903	2,266,296	—	18,406,511
Investment income (loss)	1,632,427	219,029	—	(402,645)	(3,506,847)	(2,058,036)	377	(1,011,983)	6,809	(219,029)	(3,281,862)
Other income	3,895,791	—	—	—	—	3,895,791	480	398	227	(132,892)	3,764,004
In-kind services	—	—	—	—	—	—	939,212	776,794	—	(1,716,006)	—
Total revenue	127,174,245	219,029	—	(402,645)	(3,506,847)	123,483,782	2,662,536	4,812,505	2,273,332	(5,038,790)	128,193,365
Expenses:											
Staff compensation, taxes, and benefits	56,418,635	—	—	—	(1,155,959)	55,262,676	—	4,362,498	648,916	(776,794)	59,497,296
Printing, publication, and marketing	7,968,184	—	—	—	—	7,968,184	56,828	29,947	849,769	(249,851)	8,654,877
Meeting expenses	2,622,842	—	—	—	—	2,622,842	55,061	61,782	21,935	—	2,761,620
Travel expenses	6,942,855	—	—	—	—	6,942,855	21,228	323,292	49,757	—	7,337,132
Consulting fees and outside services	9,942,193	—	—	—	—	9,942,193	274,343	305,399	23,185	—	10,545,120
Professional services	8,526,207	—	—	—	4,206	8,530,413	39,313	432,796	111,328	(28,237)	9,085,613
Office expenses	5,151,440	—	—	—	—	5,151,440	52,896	291,264	14,228	—	5,509,828
Facility and utility expenses	5,641,537	—	—	—	—	5,641,537	—	18,386	102,788	(131,769)	5,630,942
Grants and awards	2,753,058	—	—	—	—	2,753,058	1,122,411	2,224,791	25,000	(269,090)	5,856,170
Grant to ADA Foundation	2,320,153	—	—	—	—	2,320,153	—	—	—	(2,320,153)	—
Endorsement expenses	1,246,417	—	—	—	—	1,246,417	—	—	—	—	1,246,417
Depreciation and amortization	6,397,504	—	—	—	—	6,397,504	—	83,638	—	—	6,481,142
Bank and credit card fees	1,278,930	—	—	—	—	1,278,930	27,807	4,355	544	—	1,311,636
Other expenses	1,233,158	—	—	—	—	1,233,158	—	83,830	113,897	(104,655)	1,326,230
In-kind administrative expenses	—	—	—	—	—	—	939,212	—	—	(939,212)	—
Total expenses	118,443,113	—	—	—	(1,151,753)	117,291,360	2,589,099	8,221,978	1,961,347	(4,819,761)	125,244,023
Net income (loss) from operations before income tax expense	8,731,132	219,029	—	(402,645)	(2,355,094)	6,192,422	73,437	(3,409,473)	311,985	(219,029)	2,949,342
Income tax expense	1,638,654	—	—	—	—	1,638,654	500	—	92,956	—	1,732,110
Net income (loss)	7,092,478	219,029	—	(402,645)	(2,355,094)	4,553,768	72,937	(3,409,473)	219,029	(219,029)	1,217,232
Pension – and postretirement health plan – related changes other than net periodic pension cost	(4,653,858)	—	—	—	50,426	(4,603,432)	—	—	—	—	(4,603,432)
Increase (decrease) in net assets	2,438,620	219,029	—	(402,645)	(2,304,668)	(49,664)	72,937	(3,409,473)	219,029	(219,029)	(3,386,200)
Net assets (deficit) at beginning of year	(9,289,039)	2,451,233	4,807,401	12,208,372	77,073,371	87,251,338	554,482	30,628,620	1,851,133	(1,851,133)	118,434,440
Equity transfers	(6,244,038)	—	2,592,238	6,457,348	(2,805,548)	—	—	—	—	—	—
Net assets (deficit) at end of year	$ (13,094,457)	2,670,262	7,399,639	18,263,075	71,963,155	87,201,674	627,419	27,219,147	2,070,162	(2,070,162)	115,048,240

See accompanying independent auditors' report.

Schedule 3

AMERICAN DENTAL ASSOCIATION AND SUBSIDIARIES

Consolidated Statement of Cash Flows with Supplementary Consolidating Information

December 31, 2015

	General fund										
	Operating division	Reserve division									
	Operating account	Capital formation account	Capital fund	Reserve royalties fund	Investment account	Total general fund	ADPAC	ADAF	ADABEI	Eliminations	Total
Cash flows from operating activities:											
Increase (decrease) in net assets	$ 2,438,620	219,029	—	(402,645)	(2,304,668)	(49,664)	72,937	(3,409,473)	219,029	(219,029)	(3,386,200)
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	4,653,858	—	—	—	(50,426)	4,603,432	—	—	—	—	4,603,432
Depreciation and amortization	6,397,504	—	—	—	—	6,397,504	—	83,638	—	—	6,481,142
Gain on disposal of equipment	—	—	—	—	—	—	—	—	—	—	—
Deferred income tax expense	—	—	—	—	—	—	—	—	1,451	—	1,451
Net unrealized (appreciation) depreciation in fair value of marketable securities	11,113	—	—	1,028,011	4,688,363	5,727,487	—	4,853,490	6,103	—	10,587,080
Net realized loss (gain) on sale of marketable securities	8,373	—	—	(333,080)	(1,473,802)	(1,798,509)	—	(3,381,764)	(1,052)	—	(5,181,325)
Provision for uncollectible accounts	—	—	—	—	—	—	—	33,469	—	—	33,469
Net assets released from restrictions and used for operations	—	—	—	—	—	—	—	2,467,629	—	—	2,467,629
Change in actuarial value of gift annuity obligations	—	—	—	—	—	—	—	15,655	—	—	15,655
Equity in net income of other investments	—	(219,029)	—	—	—	(219,029)	—	—	—	219,029	—
Changes in assets and liabilities:											
Receivables, net	(310,228)	—	—	—	—	(310,228)	—	362,753	(98,065)	—	(45,540)
Income taxes receivable	158,154	—	—	—	—	158,154	500	—	(145,138)	—	13,516
Prepaid expenses and other assets	(262,511)	—	—	—	—	(262,511)	16,769	—	(2,000)	—	(247,742)
Inventories, net	(25,798)	—	—	—	—	(25,798)	—	—	—	—	(25,798)
Due from/to affiliated organizations	577,964	—	—	—	(663,672)	(85,708)	—	30,584	55,124	—	—
Accounts payable, accrued liabilities, and other liabilities	(100,389)	—	—	—	(75,501)	(175,890)	52,533	(6,016)	(3,233)	—	(132,606)
Deferred revenue	(1,171,143)	—	—	—	—	(1,171,143)	—	5,000	—	—	(1,166,143)
Postretirement benefit obligation	(50,425)	—	—	—	(351,282)	(401,707)	—	—	—	—	(401,707)
Pension liability	(843,926)	—	—	—	—	(843,926)	—	—	—	—	(843,926)
Net cash provided by (used in) operating activities	11,481,166	—	—	292,286	(230,988)	11,542,464	142,739	1,054,965	32,219	—	12,772,387
Cash flows from investing activities:											
Purchase of marketable securities	(16,633,364)	—	(4,462,000)	(6,749,634)	(10,787,351)	(38,632,349)	—	(29,948,625)	(11,860)	—	(68,592,834)
Sale and maturity of marketable securities	17,130,239	—	1,869,762	—	4,985,199	23,985,200	—	31,275,140	—	—	55,260,340
Acquisitions of property and equipment	(6,639,658)	—	—	—	—	(6,639,658)	—	(154,426)	—	—	(6,794,084)
Net cash provided by (used in) investing activities	(6,142,783)	—	(2,592,238)	(6,749,634)	(5,802,152)	(21,286,807)	—	1,172,089	(11,860)	—	(20,126,578)
Cash flows from financing activities:											
Net assets released from restrictions and used for operations	—	—	—	—	—	—	—	(2,467,629)	—	—	(2,467,629)
Payments to charitable gift annuitant	—	—	—	—	—	—	—	(20,004)	—	—	(20,004)
Equity transfers funded with cash	(6,244,038)	—	2,592,238	6,457,348	(2,805,548)	—	—	—	—	—	—
Net cash used in financing activities	(6,244,038)	—	2,592,238	6,457,348	(2,805,548)	—	—	(2,487,633)	—	—	(2,487,633)
Net increase (decrease) in cash and cash equivalents	(905,655)	—	—	—	(8,838,688)	(9,744,343)	142,739	(260,579)	20,359	—	(9,841,824)
Cash and equivalents at beginning of year	7,366,933	—	—	—	8,838,688	16,205,621	493,358	984,469	802,183	—	18,485,631
Cash and cash equivalents at end of year	$ 6,461,278	—	—	—	—	6,461,278	636,097	723,890	822,542	—	8,643,807

See accompanying independent auditors' report.