ADA American Dental Association®

America's leading advocate for oral health

Pages 1–130

2017

Annual Reports and Resolutions

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Table of Contents

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Council on Advocacy for Access and Prevention

Soderstrom, Andrew P., 2017, California, chair
Fagan, Timothy R., 2018, Oklahoma, vice chair
Bradberry, R. David, 2020, Georgia
Casamassimo, Paul S., 2020, Ohio
Cashion, Scott W., 2018, North Carolina
Gerlach, William H., 2018, Texas
Greene, Colleen, 2017, Wisconsin*
Herman, Richard P., 2109, New York
Humenik, Mark J., 2020, Illinois
Jones, Shelly F., 2017, Michigan
Koday, Mark, 2019, Washington
LoMonaco, Carmine J, 2020, New Jersey
Nunokawa, Neil C., 2017, Hawaii
Peckosh, Valerie B., 2017, Iowa
Risner-Bauman, Alicia, 2019, Pennsylvania
Stevenson, Richard A., 2020, Florida
Switzer-Nadasdi, Rhonda, 2018, Tennessee
Wasserman, Michael H., 2019, Massachusetts

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

The Council's 2016–17 liaisons include: Dr. Rickland G. Asai, (Board of Trustees, Tenth District); Dr. Chelsea Rajagopalan (2017), (American Student Dental Association); Dr. Mark Bronson, chair, Council on Government Affairs; and Dr. Frank Graham, vice chair, Council on Government Affairs.

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. Access to Oral Healthcare
d. Community Oral Health

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 on the continued activities of the Action for Dental Health (ADH) campaign. All initiatives of ADH below highlight member involvement coupled with local advocacy. (Supports Goals 1, 2 and 3)

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

The prioritized Action for Dental Health initiatives are contained within the objectives listed below. Metrics provided reflect progress through July 1, 2017.

Objective 3: Member Value

Initiative/Program: Action for Dental Health

Success Measure: Percent of State Societies participating in one or more ADH initiatives

Target: 70–72% of Constituent Societies participate in two or more ADH initiatives

Range: 35–40 Societies

Outcome: 38 Societies

Objective 1: Leaders and Advocates

Initiative/Program: Community Dental Health Coordinator (CDHC)

Success Measure: Number of states with CDHC presence

Target: 26 states by 2017

Range: 20–30

Outcome: 28 states

Objective 6: Act in the best interest of the member when designing programs

Initiative/Program: Medicaid provider education addressing program integrity and protection from audits through proper documentation of medical necessity.

Success Measure: Number of Medicaid program “Boot Camps;” Number of dentists taking the CE course

Target: 5 regional Medicaid provider “Boot Camps” 1,000 dentists

Range: 2–7 arranged

Outcome: 7 thus far in 2017 educating 1,265 dentists; over 1,050 dentists have taken CDE course

Objective 3: Member Value

Initiative/Program: Action for Dental Health Community Water Fluoridation

Success Measure: Number of states provided with technical assistance for community water fluoridation challenges

Target: 20 states receiving technical assistance

Range: 18–30

Outcome: 24 states

Objective 1: Leaders and Advocates

Initiative/Program: ER Referral via Action for Dental Health

Success Measure: 25 states with formal ER Referral programs and outcomes

Target: 25 states

Range: 22–40

Outcome: 36 states

Access and Advocacy Subcommittee Highlights:

- The National Elder Care Advisory Committee (NECAC) convened eldercare advocacy stakeholder organizations to investigate ways to further engage dental practitioners in addressing the importance of oral health in older Americans, including collaboration with the Administration on Community Living and the Office of Women's Health to catalog significant local programs that seek to improve the oral health of older adults. NECAC continues to encourage dental residents to conduct geriatric research with one of its supported manuscripts making the cover of the April 2017 *JADA*. NECAC assisted various internal and external stakeholder groups in investigating the possibility of including oral health benefits in Medicare.
- The Medicaid Provider Advisory Committee (MPAC) continues its mission of reducing the administrative burdens associated with participation in Medicaid, especially through its online CDE course and numerous "live" presentations to national, regional and state audiences, while educating providers to avoid audit angst through proper documentation of medical necessity. In collaboration with the American Association of Pediatric Dentistry, MPAC is finalizing a Medicaid Provider Reference Guide to be offered free on the ADA Advocacy pages of the Division of Government and Public Affairs.
- The Public Health Advisory Committee (PHAC) continues to provide insight and guidance to the Council on topics of current interest, including medical/dental collaboration, the inclusion of oral health benefits in Medicare, and the future of the dental workforce.
- In collaboration with the Arizona and New Mexico state dental associations, Access and Advocacy staff facilitated the inclusion of Navajo Community Health Representatives into the second cohort of the CDHC program at Central New Mexico Community College. This effort supports the ADA's stance of promoting community-based prevention as the catalyst for improving the oral health of Native Americans.
- Access and Advocacy staff has promoted the importance of oral health to overall health (medical/dental collaboration) with an emphasis on the importance of case management and patient navigation (CDHC) to eight states thus far this year with four more scheduled.

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. Due to the membership of ADA on the National Academy of Medicine Health Literacy Roundtable, CAAP has a goal of increasing hits to the Literacy webpage from the current 317 per quarter to 500 per quarter.
- Health Literacy Essay Contest: Seven dental schools participated this year (up from one in 2015) to promote collaboration between state associations (Power of 3), dental schools (ASDA) and the Council to support the CODA competency of good communication skills in dental education.
- The National Advisory Committee on Health Literacy in Dentistry continues its work on increasing the use of health literacy principles by the ADA and dental providers. The committee is reviewing current CODA standards in order to recommend changes to include health literacy in the CODA competencies, developing a student assessment to determine dental student knowledge about health literacy and planning the 2017 Health Literacy Essay Contest for Dental Students.
- National Children's Dental Health Month (NCDHM): Approximately 56,000 posters were distributed to dental societies, preschools, elementary and middle schools, and other health agencies. In February, the NCDHM webpage was #5 for visits on all of ADA.org (21,651 visits). From October 2016 to March 2017 the NCDHM webpage had 49,094 visits.
- Choosing Wisely: Collaboration with the Science Institute resulted in statement substitution to include more relevant topics such as opioid and antibiotic prescribing.
- Collaborated with the Science Institute on Project Coat to increase number of children ages three to 15 receiving sealants by 10%.

- **Community Water Fluoridation**: The National Fluoridation Advisory Committee continues its work on the next edition of Fluoridation Facts which will be completed prior to the end of 2017. The ADA continues to monitor a study in progress by the National Toxicology Program related to fluoride as potential neurotoxin as well as a lawsuit filed against the EPA related to the safety of fluoridation additives. In calendar year 2016, 47 states had significant fluoridation activity. In the last two years and continuing through the first two quarters of 2017, fluoridation votes have been positive by more than a two to one margin. While the trend over the past five years has been fewer efforts to initiate fluoridation, there was a significant increase in successful efforts in 2016. However, there were few efforts to initiate fluoridation in the first two quarters of 2017. Additionally in the 2017 legislative sessions, there were 23 bills in 13 states that attempted to affect fluoridation at the state level. ADA's fluoridation web pages continue to see increased visits in the first two quarters of 2017 as compared to the first two quarters of 2016.

- Q1 2016 43,816 visits Q2 2016 43,029 visits

- Q1 2017 61,088 visits Q2 2017 51,954 visits

Emerging Issues and Trends

The Council is aware of the following emerging issues:

- Workforce and workforce models continue to be an emerging issue. Council staff are frequently asked to provide technical assistance within the Action for Dental Health, specifically CDHC to assist states in addressing workforce issues.

- Expansion of state Medicaid programs. The Council provides technical assistance to states to design and implement strategies to promote dentist participation in Medicaid programs and avoid unintentional non-compliance.

- Potential dental benefits within Medicare. Foundations such as the DentaQuest and the Santa Fe Group are partnering with federal agency representatives to design dental benefit scenarios for the Medicare program. The Council continues to provide its expertise to this endeavor.

- Native American tribes have requested Council assistance in formulating oral health plans with implementation steps focusing on community-based prevention as the catalyst for improving tribal oral health status, especially utilizing the existing Community Health Representatives trained as Community Dental Health Coordinators.

- Oral health literacy continues to be an emerging issue with allied health groups requesting input on dental literacy strategies.

- New relationship between the Council, ADA, and the American College of Emergency Physicians has resulted in identification of "priority cities" to begin ER Referral models moving patients from the hospital ER to dental "homes" for care.

- A Data Collection Project is underway for the Community Dental Health Coordinator graduates to capture their employment status and care coordination metrics.

Responses to House of Delegates Resolutions

Resolution Objective: 84H-2016—Creating a Native American Pre-Dental Curriculum (*Trans.*2016:305)

84. Resolved, that the ADA seek collaboration with dental educators, representatives of the Society of American Indian Dentists (SAID), and Native American leaders to create a taskforce to develop

appropriate materials and methods to allow Native American pre-dental students to successfully prepare and gain entry into dental school, and be it further
Resolved, that the taskforce seek funding for the project from the Health Resources and Services Administration (HRSA) and other federal sources, as well as private and charitable foundations and corporate sponsors, and be it further
Resolved, that once completed, the Council on Dental Education and Licensure develop a plan to distribute the materials, train pre-dental advisors and mentors in utilizing it and encourage its adoption by pre-dental educational institutions, and be it further
Resolved, that a report be prepared on the progress of the project for the House of Delegates in 2017 and each subsequent year until the project is completed.

Initiative/Program: Creating a Native American Pre-Dental Curriculum

Success Measure: Increasing awareness of health careers (including dentistry) for Native Americans

The Submission of this Annual Report preceded the Council meeting which included a discussion on a Native American education on the agenda. A report addressing this resolution will be submitted to the 2017 House.

Self-Assessment

The Council will conduct a self-assessment in 2020 due to the Visioning Session revisited in January 2017.

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 Communications

Herre, Craig W., 2017, Kansas, chair
Reich, Robin S., 2018, Georgia, vice chair
Bean, Canise Y., 2018, Ohio
Carney, Kerry K., 2020, California
Hall, Jeannette Peña, 2020, Florida
Hanley, Yvonne S., 2018, Minnesota
Hight, James R., 2017, Tennessee
Iuorno, Frank P., 2020, Virginia
Karp, William H., 2019, New York
Kenyon, David J., 2019, Wisconsin
Lindemann, Kurt S., 2018, Montana
Manzanares, David J., 2020, New Mexico
Meinecke, Gigi, 2019, Maryland
Poteet, Sarah Tevis, 2020, Texas
Quartey, Tricia, 2017, New York*
Schefke, Philip L., 2019, Illinois
Tauberg, James A.H., 2017, Pennsylvania
Woods, Karl P., 2017, Maine

MacLachlan, Janine, director

The Council's 2016–17 liaisons include: Dr. Richard C. Black (Board of Trustees, Fifteenth District), and Dr. Tabitha Dunham (American Student Dental Association).

Bylaws Areas of Responsibility

As listed in Chapter X, Section 130B 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: Programs, Projects, Results and Success Measures

Objective 1: Grow Active, Full Dues Paying Membership

Initiative/Program: Integrated Marketing Member Campaigns

To best serve ADA members by focusing the message and filling the pipeline with new dentists, the ADA created three member-focused campaigns:

- **Be Your Best**: Supports prioritized clinical content identified by cross-divisional team, including the Science Institute, Center for Evidence Based Dentistry, *JADA*, ADA Library, Continuing Education and more.
- **Make Life Easier**: Supports practice management, financial and career decision-making content identified by cross-divisional team, including the Practice Institute, ADABEI, Finance, Membership and Continuing Education.

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

- **ADA Pride**: Helps elevate the value proposition of membership for new dentists from transactional to motivational. Discovers and celebrates inspiring stories about ADA dentists who make a difference. Pride attracts new dentists to join the ADA, where they find proud professionals with whom they want to affiliate. In collaboration Council on Advocacy for Access and Prevention (CAAP), Membership, International Relations, and ADA Foundation.

Newsroom. In addition, Integrated Marketing and Communications staff work with reporters and editors to promote the profession, oral health, new products and services as well as news on important topics through earned media, which is editorial media coverage and is not paid.

Digital. Staff also operates all ADA social and web assets, including ADA.org and the consumer site MouthHealthy.org.

Success Measure: These programs are all on plan based on metrics established in advance to determine whether plans are meeting expectations. Metrics for success vary by initiative based on the target audience and tactics, and include click through rates, web traffic, social media engagement, etc. Benchmark scores on a scale of 1–4 were created to measure the effectiveness of the marketing campaigns. A score of 4 indicates a program exceeds the target measures, 3 indicates meeting plan expectations, 2 is behind plan and 1 is off plan.

Target: Composite score of 3 (on plan) for the three Best/Easy/Pride campaigns.

Range: 1 (off plan)–4 (exceeds plan)

Outcome: All plans are on plan and meeting target goals.

Following are results for the member-focused campaigns to date:

Be Your Best Campaign Results

- Promoted ADA sealant guidelines—all met or exceeded expectations
    - 40% increase in traffic to dental sealants landing page
    - ADA's first Facebook Live event about sealants reached 56,230. Posts reached 8,769 on Facebook and 12,488 users on LinkedIn
- Promoted ADA antibiotic prophylaxis resources—all met or exceeded expectations
    - Paid search surpassed goal with 3,180 views and 344 clicks
    - Paid display ads met expectations with 422,000 views and 357 clicks
    - Paid Facebook generated 377,462 and 3,931 clicks
    - 6,555 downloads of *JADA* article
    - 311 dentists signed up for webinar
    - 17,435 actions on LinkedIn and 142 clicks

Note that some of the second quarter tactics did not score as well, specifically ADA channels such as the Morning Huddle. The learning here is that younger members do not use ADA channels as much as more established members, and thus targeted communications and paid social score higher. This learning will help strengthen plans in the second half of 2017.

Make Life Easier Campaign Results

- 1,399 attendees at webinar about coordinating benefits
- Student loan consolidation program with DRB (now Laurel Road) had 7,044 visits to web page, 706 loan activity in first quarter
- Manage My Debt, Market Your Practice and Manage My Dental Team content drove increased website traffic to ADA practice content

ADA Pride Campaign Results

Created 11 stories about member accomplishments, all of which met or exceeded expectations.

- Engagement with Pride stories on the New Dentist Blog exceeds the average number of visits to a New Dentist Blog post by 2.6 times (307 average visits per Pride story).
- Reach of Pride posts on Facebook is double the ADA average reach on Facebook (24,200 is the average reach of a Pride story).

Newsroom. Earned media, which is editorial news stories and not paid, achieved a circulation/viewership of 2.5 billion, an increase of 286% over 2016.

Digital. ADA web traffic also saw an increase. Traffic to consumer site MouthHealthy.org and ADA.org generated a 30% increase versus one year ago with 3.5 million visits. Consumer traffic in particular generated more than one million visits in the first quarter of 2017, up 135% over the same period in 2016. Social media traffic increased 14% over last year.

Objective 2: Improve awareness and positive perception of Action for Dental Health priority programs

Initiative/Program: Policymaker Campaign

Success Measure: Composite engagement score as discussed in Objective 1

Target: Composite score of 3 (on target) based on metrics established in advance

Range: 1 (off plan)–4 (exceeds plan)

Outcome: 3 (on plan, meeting target goals)

Integrated Marketing and Communications supports CAAP and the Council on Government Affairs (CGA) on Action for Dental Health. The narrative for this program will be included in the CAAP annual report.

Communications highlights met or exceeded expectations. Highlights include:

- A content partnership on *The Hill* Congress Blog featured the ADA point-of-view on evidence-based, cost effective solutions to improve dental care access and disease prevention. The Action for Dental Health blog yielded 800,000 impressions and 7,000 clicks.
- Fluoridation search engine marketing through quarter two has generated 7 million impressions and 131,000 interactions with positive information about community water fluoridation on ADA.org.
- Paid social media promotion about ER referral programs drove 43,000 visits to ER referral content on ADA.org, an increase of 6,700% over last year.

Emerging Issues and Trends

The Council is not aware of any new, significant trends or emerging issues not already being addressed by the Council.

Responses to House of Delegates Resolutions

Resolution Objective: 67H-2016—Drive Utilization of Dental Services for ADA Members (*Trans.*2016:278)

> **67H-2016. Resolved,** that the initiative "Drive Utilization of Dental Services for ADA Members" be approved, and be it further
> **Resolved,** that the Council on Communications submit annual status updates to the House of Delegates for the duration of the campaign, and be it further
> **Resolved,** that the House of Delegates urges funding for this program shall come from the reserves for the first year, and be it further
> **Resolved,** that funding for the second and third years shall be at the discretion of the Board of Trustees, and be it further
> **Resolved,** that the Council on Communications shall provide evidence of the value of this media campaign to the 2017 HOD.

Initiative/Program: Increase patient referrals to ADA members

A comprehensive report on this program will be submitted to the House of Delegates in a stand-alone report in September.

Self-Assessment

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

Policy Review

In accordance 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 in 2017.

Council Minutes

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

Commission for Continuing Education Provider Recognition

Leary, Paul, 2017, New York, chair
Fiorellini, Joseph P., 2018, Pennsylvania, vice chair
Beitel, Brian A., 2017, Alabama
Bennett, Jeffrey D., Indiana
Chehal, Hardeep K., 2017, Nebraska
Dixon, Debra A., 2018, Illinois
Garcia-Aguirre, Augusto C., 2019, Ohio
Hammond, Barry, 2019, Georgia
Hughes, Bertram J., 2020, Florida
Hutten, Mark C., 2018, Illinois
Kirkpatrick, Timothy C., 2017, Mississippi
Lipp, Mitchell J., 2019, New York
McNulty, Conor, 2018, Oregon
Reed, Susan G., 2020, South Carolina
Rosenthal, Nancy R., 2019, Pennsylvania
Steiner, Ann, 2017, California

Borysewicz, Mary A., director

The Commission's 2016–17 Board of Trustees liaison is Dr. Kenneth McDougall (Board of Trustees, Tenth District).

Bylaws Areas of Responsibility

As stated 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

The Commission for Continuing Education Provider Recognition is a Commission with independent authority to administer the ADA Continuing Education Recognition Program (CERP). The Commission determines its own strategic goals and objectives. For 2016–2017, the Commission goals and objectives are as follows:

Objective: Standards Review

Initiative/Program: ADA CERP

Success Measure: The Commission's comprehensive revision of ADA CERP Standards proceeds with the goal of approving a complete draft at Commission's April 2018 meeting.

Target: Draft revisions of four standards reviewed by Commission in October 2017.

Range: Draft revisions of three to six standards completed by December.

Outcome: The Commission is on target to review draft revisions of three Standards at its October meeting. The Commission has also issued a call for comments on a proposal to reduce the minimum length for CERP providers' CE activities from one hour to 0.25 hour, with credits to be awarded in increments of 0.25 credit hours. The proposed changes are designed to accommodate newer educational formats and methods for delivering continuing education. Comments from the communities of interest regarding the proposal were being collected at the time this report was written, and will be reviewed by the Commission in October.

Objective: Streamline management of CERP application, review, billing and reporting processes through technology upgrades.

Initiative/Program: ADA CERP

Success Measure: Enhance CERP application and recognition processes through improved database and reporting functions.

Target: Migrate CERP provider database to Aptify and begin build-out of online application modules by December 31.

Outcome: Plans to develop a web-based CERP application on the Aptify platform have been put on hold as a result of Aptify's purchase by Community Brands. At the time this report was prepared, a new development time line was not available. As an interim step, the CERP provider database is being migrated to Access in order to expand record keeping and reporting functions and enhance CERP operations. The new database is anticipated to be functional by August 1.

Emerging Issues and Trends

The Commission oversees CERP, which is designed to recognize providers that meet standards for continuing dental education, promote continuous quality improvement in CE, and help dental professionals meet CE requirements for re-licensure. At the time this report was prepared, there were 450 ADA CERP recognized providers; another 105 providers were approved through the CERP Extended Approval Process (EAP). In 2015, the most recent year for which data is available, CERP recognized providers reported offering a total of over 28,000 CE activities, including more than 245,000 hours of continuing education. Information on the size and scope of ADA CERP providers' activities is published in the 2016 CCEPR Annual Report to communities of interest.

Strategic Planning. In 2017, the Commission adopted a strategic plan to guide future initiatives and support the Commission in fulfilling its responsibilities in a financially and operationally sustainable manner. Priorities identified for 2017–2020 are to: (1) establish and promote standards for effective continuing dental education that supports quality dental care; (2) improve CERP provider assessment processes; and (3) achieve optimal organizational capacity.

Standards Review. The ADA CERP Recognition Standards form the basis for the Commission's evaluation and approval of continuing dental education providers. A comprehensive revision of the Standards is underway. The process includes benchmarking CERP Standards with accreditation standards for continuing education in other healthcare professions. The Commission believes that to support dental practitioners' continuing professional development and continuous quality improvement, CE standards must place increased emphasis on educational outcomes.

Responses to House of Delegates Resolutions

There were no House of Delegates resolutions directed at the Commission in 2016.

Self-Assessment

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

Policy Review

There are currently no ADA policies related to the Commission or CERP that the Commission has been charged with reviewing in accord with Resolution 170H-2012, Reaffirming Existing ADA Policy. The Commission last reviewed CERP policies and procedures in 2015. A time line for periodic review of individual CERP policies and procedures is being developed.

Commission Minutes

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

Commission on Dental Accreditation

Livingston, Harold Mark, 2017, Mississippi, chair, Special Care Dentistry Association and American Dental Education Association
Leffler, William, G., 2018, Ohio, vice chair, American Association of Dental Boards
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
Friedrichsen, Steven, W., 2020, California, American Dental Education Association
Geist, James, R., 2019, Michigan, American Academy of Oral and Maxillofacial Radiology
Hagenbruch, Joseph, F., 2020, Illinois, American Dental Association
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
Jee, Archur, C., 2020, Maryland, American Association of Dental Boards
Johnson, Bradford, R., 2020, Illinois, American Association of Endodontists
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
Lerman, Mark, A., 2018, Massachusetts, American Academy of Oral and Maxillofacial Pathology
Levy, Steven, M., 2020, Iowa, American Association of Public Health Dentistry
Lobb, William, K., 2018, Wisconsin, American Dental Education Association
Mills, Michael P., 2018, Texas, American Academy of Periodontology
Sherman, Robert, G., 2017, Hawaii, American Association of Dental Boards
Stanton, David, C., 2017, Pennsylvania, American Association of Oral and Maxillofacial Surgeons
Stentiford, Deanna, N., 2020, Florida, American Dental Assistants Association
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
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
Smith, Michelle, manager, Allied Dental Education
Snow, Jennifer, manager, Advanced Specialty Education
Soeldner, Peggy, manager, Postdoctoral General Dentistry Education

The Commission's 2016–17 liaison is Dr. Raymond Cohlmia (Board of Trustees, Twelfth District).

Bylaws Areas of Responsibility

As listed in Chapter XV, Section 130A Duties of the ADA *Bylaws, the* duties of the Commission on Dental Accreditation (CODA) are:

a. Formulate and adopt requirements and guidelines for the accreditation of dental, advanced dental and allied dental educational programs.
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 ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective 3: Simplify and Standardize

Initiative/Program: The Commission continues to be a United States Department of Education (USDE) recognized accrediting agency for dental and dental-related education programs

Success Measure: Maintain current USDE recognition and successfully complete re-recognition process in 2017

Target: Maintain current recognition and, by December 15, if necessary, submit progress response to USDE for re-recognition

Range: December 1–December 30

Outcome: Recognition documents submitted in January; attended National Advisory Committee meeting in June; awaiting final recognition letter from USDE

Objective 3: Simplify and Standardize

Initiative/Program: The Commission will study the interval cycle of accreditation based on risk assessment

Success Measure: Conduct research and facilitate meetings of Ad Hoc Committee, with report to the Commission in winter 2018

Target: Working with Ad Hoc Committee, develop materials for the Commission review

Range: December 1–December 30

Outcome: In progress, with report to the Commission in winter 2018

Objective 3: Simplify and Standardize

Initiative/Program: The Commission will develop a long-term plan (timeline) to assume total expenses

Success Measure: Facilitate review of topic and data by Finance Committee, with report to the Commission in summer 2017. Follow up on Commission directives and actions

Target: Establish plan (timeline) to assume total expenses

Range: December 1–December 30

Outcome: In progress, with report to the Commission in summer 2017

Objective 3: Simplify and Standardize

Initiative/Program: The Commission will enhance training of volunteers and/or community of interest through enhanced training mechanisms, including development of two to four webinars to various audiences

Success Measure: Identify webinar and in-person training topics and establish additional training webinars

Target: Develop two to four webinars to various audiences by year end

Range: December 1–December 30

Outcome: In progress, with several topics identified and under development

Objective 3: Simplify and Standardize

Initiative/Program: The Commission will develop a revised structure for Knowledge Center and identify enhancements to fulfill the current priority access needs of staff

Success Measure: Identify and implement modifications to new Knowledge Center layout to enhance The Commission business management

Target: Implement modifications to Knowledge Center layout and identify further needs

Range: December 1–December 30

Outcome: In progress, layout redesign currently underway

The Commission serves the public and profession by developing and implementing accreditation standards that promote and monitor the continuous quality and improvement of dental education programs. (CODA Mission, 2016).

The Commission took 629 accreditation actions at its August 2016 and February 2017 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 1,450. This represents a decrease of two programs from the previous reporting period.

Sixty-four 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 nine (9) 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 one (1) advanced education in general dentistry education program, one (1) advanced general dentistry education program in orofacial pain, one (1) dental assisting education program, one (1) oral and maxillofacial radiology education program, one (1) oral and maxillofacial surgery fellowship-cosmetics education program, one (1) orthodontic and dentofacial orthopedics education program, two (2) pediatric dentistry education programs, one (1) periodontics education program, and two (2) prosthodontics 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, the Commission affirmed the reported voluntary discontinuance effective date or planned closure date of 16 programs.

Table 1. Total Number of Accredited Programs as of February 2017

	Dental	Specialty	Advanced General Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Initial Accreditation	4	18	6	1	2	0	30
Approval Without Reporting Requirements	59	440	289	234	318	15	1347
Approval With Reporting Requirements	3	20	7	22	11	1	64
Total Number of Accredited Programs	66	478	302	257	331	16	1450

Major Actions of the Commission

The Unofficial Report of Major Actions of the August 2016 and February 2017 meetings of the Commission can be found on ADA.org.

ADA/CODA Relationship Workgroup

The ADA/CODA Relationship Workgroup has met annually since 2014 at the ADA Headquarters. Members of the 2016–2017 Workgroup include: Dr. Gary Jeffers (Ninth District Trustee, co-chair), Dr. Harold Mark Livingston (CODA, co-chair), Dr. Robert Bitter (Eighth District Trustee), Dr. Raymond Cohlmia (Twelfth District Trustee and Board liaison to CODA), Dr. Loren Feldner (CODA), Dr. Chad Gehani (Second District Trustee), Dr. Joseph Hagenbruch (CODA) Dr. Denise Kassebaum (CODA), Dr. William Leffler (CODA), and Dr. Roy Thompson (Sixth District Trustee). The Workgroup continues to focus on two general areas, finance and governance oversight of the Commission. The Workgroup's 2017 report was provided to the Board of Trustees at its August meeting. The next meeting of the ADA/CODA Relationship Workgroup is scheduled for June 2018.

Standing Committee on International Accreditation

In October 2015, the ADA House of Delegates sunset the Joint Advisory Committee on International Accreditation (JACIA) and the Commission established the Standing Committee on International Accreditation with full oversight of the international consultation process and operational budget, but with retained membership of the former JACIA. The Standing Committee provides guidance to the Commission in the selection, development and implementation of a program of consultation and accreditation for international, predoctoral dental education programs.

Members of the 2016–-2017 Standing Committee included Dr. Chad Gehani, chair, ADA; Dr. Gary Herman, ADA; Dr. Tariq Javed, CODA; Dr. Denise Kassebaum, CODA; and Dr. Steven Tonelli, ADA. Dr. Michael Reed served as a consultant to the Standing Committee. During their terms, ADA presidents, Dr. Carol Gomez Summerhays and Dr. Gary Roberts, and CODA chairs, Dr. Karen West and Dr. Harold Mark Livingston, served as non-voting members of this committee. Staff support was 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. Fifteen (15) international programs have submitted PACV surveys since 2007. Following review and discussion, the Standing Committee approved each of the programs to attend a U.S. comprehensive visit and submit a PACV self-study.

Since 2009, six (6) international predoctoral programs have submitted PACV self-studies and have requested a PACV site visit. One (1) program in Lima, Peru, did not provide sufficient information to warrant a PACV site visit. Six (6) programs (Dharwad, India; Jeddah, Saudi Arabia; León, 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 León, Mexico have been notified by the Standing Committee on International Accreditation of the potential to pursue accreditation by the Commission. Should an international dental education program apply for accreditation by the Commission and, under the Commission's application process, proceed to an initial site visit, the program will be listed on the Commission's list of upcoming site visits found on ADA.org.

The following is a summary of the activities, results and accomplishments of the January 4, 2017 and July 20, 2017 meetings of the Standing Committee on International Accreditation.

- The Standing Committee considered the PACV Survey submitted by the University of Otago, Dunedin, New Zealand, and directed that the program proceed to the next step of the PACV process by observing a Commission site visit.
- The Standing Committee reviewed an informational update report submitted by the Universidad Autónoma de Nuevo León, Nuevo León, Mexico, noting the program's progress in addressing the findings of its PACV site visit.
- The Standing Committee discussed information gathered on international safety procedures used by other accrediting agencies and recommended that the Commission, through its Standing Committee on Documentation and Policy Review, develop a policy and procedure for planning international PACV and Commission site visits.
- The Standing Committee received an update on a new process and protocol developed by Commission and ADA staff to identify individuals to serve in the ADA clinical practitioner role of the consultation committee during the PACV site visit.
- The Standing Committee considered the PACV Survey submitted by the King's College London Dental Institute, London, England, and directed that the program proceed to the next step of the PACV process by observing a Commission site visit.
- The Standing Committee considered the PACV site visit report and program's response to the report for the Yeditepe University, Istanbul, Turkey. Following review, the Standing Committee determined the program may have the potential to meet the Accreditation Standards for Dental Education Programs and requests a progress report for consideration at a future meeting.

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);
- 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: 83H-2016. Amend the *Rules* of the Commission on Dental Accreditation related to CODA's Mission statement (*Trans.*2016:302)

> **83H-2016. Resolved,** that the Rules of the Commission on Dental Accreditation be amended as noted in Appendix 1 of the Commission's Supplemental Report 1 to the House of Delegates.

Initiative/Program: CODA

Success Measure: CODA *Rules* Amended

Outcome: CODA *Rules* amended to revise the Mission statement.

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
Snyder, Steven I., 2018, New York, vice chair
a'Becket, Thomas R., 2020, Maryland
Bulnes, Christopher M., 2019, Florida
Calitri, Paul, 2020, Rhode Island
Chung, Kenneth L., 2020, Oregon
Davenport, Carson S., 2018, North Carolina
Dean, Brittany T., 2018, Washington*
Eder, B. Scott, 2017, West Virginia
Gordon, Douglas J., 2017, California
Hamel, David L., 2018, Kansas
Hill, Steven J., 2017, Texas
Hollingsworth, James W., 2020, Mississippi
Kessler, Brett H., 2019, Colorado
Makowski, Martin J., 2019, Michigan
Mihalo, Mark J., 2019, Indiana
Olenwine, Cynthia H., 2020, Pennsylvania
Vaillant, Matthew J., 2018, Minnesota

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

The Council's 2016–17 liaisons include: Dr. Lindsey A. Robinson (Board of Trustees, Thirteenth District) and Ms. Kathryn Dickmann (American Student Dental Association).

Bylaws Areas of Responsibility

As listed in Chapter X, Section 130C of the ADA *Bylaws*, the areas of subject matter responsibility 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.

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

Objective 3: ADA will achieve a 10% increase in the assessment of member value from membership.

Initiative/Program: Third-Party Payer Advocacy

Success Measure: Maintain efficient and satisfactory call center responses to member questions.

Target: At least 82% of members whose call was closed by Tier 2 and 3 are satisfied with the service.

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

Range: Level of satisfaction of Tier 2–3 closures is between 80%-90%. Timeliness of call closure by Tier 2–3 (<= 2 work days) is between 95%–100%.

Outcome: As of June 30, 2017, the level of satisfaction of Tier 2–3 closures is 77.3%. The timeliness of call closure is 98.1%.

This program area supports individual member assistance through phone and email. Over 6,000 member issues are addressed annually. As of June 30, 2017, 3,435 member requests have been addressed.

Objective 3: ADA will achieve a 10% increase in the assessment of member value from membership.

Initiative/Program: Code on Dental Procedures and Nomenclature (CDT Code)/Dental Benefits and Third-Party Issues

Success Measure: Ensure that information on dental benefits, third-party payers and CDT Code is disseminated to members through well-attended webinars and attendees responding to a post-webinar survey are satisfied or very satisfied.

Target: At least 3,000 individuals will participate in workshops or webinars by November 1, 2017.

At least 80% of those responding to the post presentation survey are satisfied or very satisfied with the education programs.

Range: Between 2,500 and 3,500 individuals participate in Council workshops and webinars. Between 80% and 85% of attendees responding to the post presentation survey are satisfied or very satisfied with the education programs.

Outcome: As of June 30, 2017, a total of 2,853 individuals have participated in three webinars; 93% expressed satisfaction with the education programs.
This program area assists in disseminating relevant education to members through webinars. As of June 30, 2017, three webinars have been conducted. Topics addressed include:

- Coordinating Benefits
- Coding for Prevention
- Electronic Funds Transfer Payments

A total of 1,405 CE credits have been offered through these webinars.

Objective 5: Non-dues revenue will be at least 65% of total revenue.

Initiative/Program: CDT Code

Success Measure: Deliver CDT 2018 ASCII file by May 15, 2017. Deliver CDT 2018 and CDT 2018 Companion by June 30, 2017.

Target: Delivery of CDT 2017 ASCII file by May 15, 2017. Delivery of CDT 2018 & CDT Companion by July 1, 2017.

Range: n/a

Outcome: As of June 30, 2017, all deliverables have been submitted.

The CDT Code is the recognized standard procedure code set for documenting dental procedures on claim forms. In 2017, 99.6% of organizations participating in the Code Maintenance Committee (CMC) expressed satisfaction with the maintenance processes ensuring that there are no challenges to the ADA's leadership role in maintaining the CDT Code through a multi-stakeholder consensus body.

Objective 1: The public will recognize the ADA and its members as leaders and advocates in oral health.

Initiative/Program: Quality Assessment and Improvement

Success Measure: The Dental Quality Alliance (DQA) will continue to be viewed as the lead agency for quality measures in dentistry.

Target: At least 20 state Medicaid programs report using DQA measures.

Range: 15–25 state Medicaid programs report using DQA measures.

Outcome: 25 states have reported the DQA Sealant Measure to the Centers for Medicare and Medicaid Services (CMS). In addition, 18 states report using DQA measures for internal reporting.

The DQA continues to be viewed as the go-to source for quality measures in dentistry. All organizations originally invited to participate as dues-paying members of the DQA continue to remain engaged with new organizations continuing to submit membership applications. To date, 34 organizations are members of the DQA. Several federal agencies are continuing their participation as technical advisors. Specifically, CMS, the Health Resources and Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ) and the Veterans Administration (VA), all participate in the DQA. Following the 2017 meeting, 100% member organizations expressed satisfaction with the work of the DQA.

The DQA continues to maintain 14 measures with seven that continue to be endorsed by the National Quality Forum (NQF). In addition to measure development the DQA has expanded its role in education and quality improvement. Most notably, the DQA partnered with the Institute of Healthcare Improvement (IHI), a well-recognized entity founded by the former administrator of CMS, Dr. Don Berwick, to develop education specific to dentistry. This new course launched in May 2017.

The 2017 DQA Conference on quality measurement and improvement convened in May. Of the 120 attendees, 96.23% expressed satisfaction with the two-day conference. DQA has collected $119,900 in dues from its members and an additional $ 49,300 as non-dues revenue through the conference. ADA provides in-kind staff support to the DQA with the Council on Dental Benefit Programs serving as the lead ADA agency within the DQA.

HRSA's Maternal Child Oral Health Bureau has funded the Maternal Child Oral Health Resource Center of Georgetown University through a four-year grant. The DQA is a key partner on this grant and will receive approximately $90,000 each year for four years to identify and develop oral health quality indicators to monitor oral health services delivered in public health programs and systems of care to maternal and child populations.

Objective 3.1: Pursue programs that members value and are "Best in class."

Initiative/Program: Dental Informatics

Success Measure: Update SNODENT® and derivative Refsets by December 31, 2017.

Target: Complete a comprehensive update of SNODENT and derivative Refsets by December 1, 2017.

Range: n/a

Outcome: The SNODENT Maintenance Committee approved change requests that were then submitted to the SNOMED International Dentistry Special Interest Group (SIG) for possible inclusion in SNOMED CT.

Emerging Issues and Trends

Dental Benefits Market Data

The below data is the most current available to date.

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

- National dental care expenditure was $117.5 billion in 2015. Per capita dental spending in 2015 was $366.

- In 2014, Medicaid/CHIP accounted for 38.7% of the children's dental benefits market up from 21% in 2000. Private dental benefits accounted for 50.3% of the market and 11% were uninsured in 2014.
- 58.1% of adults receive dental benefits through private coverage, 6.7% utilize Medicaid and 29.4% are uninsured as of 2014.
- Only 27.9% of adults over 65 have private dental benefits, while 10.1% have Medicaid and 62% are uninsured.

Enrollment [Source: National Association of Dental Plans]

- 211.4 million people (66% of the U.S. population) had a dental benefit in 2015—up from 170.5 million (57%) in 2006.
- In 2015, Preferred Provider Organizations (PPO) accounted for 82% of the dental plans in the market—up from 62% in 2006.
- In 2015, the commercial market had 78.2 million people (52%) with fully insured dental benefits versus 72.1 million (48%) with self-funded plans.
- 7% of the population covered by commercial benefits have their benefits through individual policies in 2015.
- Just over 1% of dental benefits are integrated with medical policies.

Network Statistics [Source: National Association of Dental Plans]

- In 2016, more than 211,000 dentists participated in at least one PPO network. Among those who participate in PPO networks, on average, each dentist participates in almost 6 networks.

Premiums & Benefit Utilization Trends [Source: National Association of Dental Plans]

- In 2015, 49% of PPO plan maximums (in-network) were $1,500 or more per year.
- In 2015, the average PPO premium per enrollee, per month, was $24.49, down 1.3% from 2014. Dental HMO (DHMO) premiums increased 0.8% to $14.06 and indemnity premiums increased 2% to $30.57 from a year ago.
- In 2015, the percentage of enrollees reaching or exceeding plan maximums was 9.1% of PPO enrollees (in-network), while 4.6% (out-of-network) reached the same annual maximum, which was much higher than the previous year.
- Number of covered procedures per enrollee has been trending down including a 0.03 decrease from a year ago.
- Use of in-network services from PPO networks is clearly trending up with 64.5% of procedures performed in-network for PPO plans.
- In 2015, 71% of claims were processed electronically up from 68% a year ago.

Over the last two years, the Council has had major discussions on the current state of the dental benefit industry. Following these discussions the Council noted the need to:

- promote the value of oral health and, specifically, the value of dental care to consumers/medical profession;
- improve consumer literacy about dental benefits;
- educate employers on holding plans accountable for the premium dollars paid by the employer;
- develop a model benefits plan to present to employers, if feasible;
- provide data analytic tools to members to help them better position themselves in the changing marketplace;
- educate dentists and their staff about dental benefit issues and emerging administrative practices; and
- continue to advocate to third-party payers and pursue legislation to address abusive payer practices.

The desire to explore the feasibility of developing a model benefits plan that supports a patient's long-term oral health, is affordable, and promotes the doctor-patient relationship has led to the current project supported by PricewaterhouseCoopers (PwC). Research questions addressed through this project include:

- Can we provide to employers/consumers better benefits at the same cost, the same plan at a less expensive cost, or the same plan that pays higher reimbursement rates? If this is possible, then can we make it less administratively burdensome for dental offices?
- For those employers who do not offer a benefit and for consumers without a benefit, is there a less expensive option with reasonable benefits to at least support preventive care?
- For those employers who offer a dental benefit but have significantly lower enrollment in the dental benefit, how can uptake be improved?
- How can we lower cost barriers for consumers who have a dental benefit but forgo using it due to cost?

Based on the project, the Council determined that for patients with an employer sponsored plan, the employer contribution to the premium, and tax exclusion for the employee contribution are important considerations. At this time, it is evident that large employers who support most of the covered lives in the dental sector are reticent to change. Both the self-insured and fully-insured segments of the market remain focused on controlling premium cost and savings from steering towards in-network usage of services and claim reviews.

While some efficiency can be achieved by trimming profit margins, introducing a better benefit at lower cost to the consumer and lower administrative burden for the provider into a mature dental benefit industry remains a difficult target to achieve. Offering a direct to patient in-office discount plan continues to be an option for dental offices to attract new patients, for patients who do not have an employer sponsored benefit, or for practices who have strong patient relationships and wish to transition to being out-of-network providers. The Council will continue to develop resources for members to assist with these efforts.

Third-Party Payer Intrusion

The Council continues to monitor third-party payer intrusion into the dentist-patient relationship and has communicated the policy titled “Comprehensive ADA Policy Statement on Inappropriate or Intrusive Provisions and Practices by Third Party Payers” (*Trans.*2016:290) to a majority of third-party payers.

In addition, the Council has (1) issued letters to Delta Dental expressing the ADA’s discontent with their disallow policies as it interferes with the doctor-patient relationship (2) presented the ADA position to dental consultants and, most recently, (3) supported publication of an article by Dr. Dave Preble, vice president, ADA Practice Institute, in the *Journal of the American Dental Association.* These communications can be accessed at the links below.

- Letter to Delta Dental on Disallow Policy (PDF, June 2016)
- Statement Sent to Delta Dental Regarding Scaling and Root Planing (PDF, April 2016)
- Ethical Considerations in Dental Claims Adjudication (*JADA*, June 2017)

Currently, the Council is developing model legislation to assist states in establishing laws against the disallow policy and uphold the doctor-patient relationship. The Council is in the process of identifying additional strategies to address this issue.

The Council has also been actively supporting the Council on Government Affairs (CGA) in federal advocacy efforts on the non-covered services legislation. Recently, the Council played a significant role in drafting a letter of rebuttal in response to advocacy efforts by the National Association of Dental Plans (NADP).

- Support for Dental and Optometric Care Access Act (PDF, April 2017)

Introducing a Dental Benefit In Medicare

Several external entities are lobbying for a dental benefit within Medicare. The short-term goal appears to get medically necessary care for medically compromised individuals with a long-term goal of securing a dental benefit for all. Some have verbalized this as an effort to get this issue on the presidential election agenda for 2020.

Themes to support the cause for a dental benefit in Medicare:

- Oral health is part of overall health.
- Dental care is medically necessary.
- Medical costs can be impacted with dental care.
- Cost is the biggest barrier to seeking dental care for seniors.
- The baby boomer generation is used to having a dental benefit and are one of the higher utilizers of dental care. They are aging into an environment without a dental benefit and could potentially turn into non-utilizers or demand coverage.

As noted in recent Council meeting minutes, the Council recognized that current ADA policies are supportive of Medicare and that access to dental care for seniors is important for the ADA to support. The Council also recognized that given the national movement supported by multiple entities including consumer groups, the best path forward is to remain engaged in all conversations on this issue. There is recognition that this change is a multi-year effort and will have more impact on today's new and mid-career dentists. Their opinions and views are key to the decision-making process. The Council recognizes the concern regarding increased administrative burden, impact on the current dental delivery system and apprehension on appropriate funding levels.

The Council believes it is important to begin learning about Medicare financing and payment to proactively determine whether there are pathways forward to include dental benefits in Medicare in a manner that makes sense for seniors as well as the practice of dentistry. To this end, the Council is actively looking at benefit plan designs suitable for inclusion within Part B of Medicare or a separate Part.

Responses to House of Delegates Resolutions

Resolution Objective: 85H-2016**.** Third Party Payment Choices (*Trans.*2016:287)

> **85H-2016. Resolved,** that the Council on Dental Benefit Programs develop policy to encourage third party payers to allow dentists to make a choice about the method of timely claims payment, considering challenges such as:
>
> - Matching electronic payments to EOBs
> - Ensuring accurate electronic deposits
> - Reconciling EFT deposits to practice software and accounting software
> - Processing credit card payments, where fees are assessed by payment processing companies, often at 3% or more of the total amount when a card is not present to swipe
> - Insurance company owned credit card companies withholding processing fees
>
> and be it further
> **Resolved,** that the ADA educate members on the costs and ramifications of various methods of claims payment, and be it further
> **Resolved,** that the ADA develop model legislation that requires third party payers to allow dentists the timely choice in the available methods of payment.

Initiative/Program: Third-Party Payer Advocacy

Success Measure: Develop a draft policy for submission to the 2017 House of Delegates. Develop education materials on the costs and ramifications of electronic methods of claims payment. Disseminate principles of model legislation on electronic payment transactions.

Target: Draft policy developed by June 2017. Preliminary education materials and model legislation developed by June 2017.

Range: n/a

Outcome: The Council has proposed a new policy, Statement on Third Party Payment Choices that will be presented to the 2017 House of Delegates in the form of a resolution. Principles for model legislation on Transparency in Third Party Payment Transactions have been posted on ADA.org and disseminated to state dental societies. A webinar on electronic funds transfer was delivered on May 11, 2017. The Council is engaged in a pilot project with two dental practices to document the end-to-end workflow for electronic remittance and payment reconciliation. This effort will result in a detailed guide that will assist dental offices wishing to adopt electronic payments. It will also identify gaps in implementation support that may need to be addressed by software vendors and the standards-making bodies in order to make the process seamless and efficient.

Self-Assessment

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

Policy Review

In accordance with 170H-2012, (*Trans.*2012:370) Reaffirming Existing ADA Policy, the Council reviewed the following Association policies and determined they should be maintained.

Guidelines on Coordination of Benefits for Group Dental Plans (*Trans*.1996:685; 2009:423)
Definitions of "Usual Fee" and "Maximum Plan Benefit" (*Trans*.2010:546; 2011:452)
Benefits for Services by Qualified Practitioners (*Trans*.1989:546)
Dental Benefit Plan Terminology (*Trans*.1991:634; 2012:440)
Dental Claims Processing (*Trans*.1999:930)
Reimbursement Under Third-Party Programs (*Trans*.1983:584; 1992:604)
Benefits for Incomplete Dental Treatment (*Trans.*1994:655)
Fee-for-Service (*Trans*.1994:666)
Balance Billing (*Trans*.1994:653)
Timely Payment of Dental Claims (*Trans*.1991:639)

In addition, the Council adopted a resolution to forward policy change recommendations to the 2017 House of Delegates. These policy change recommendations will be submitted on a separate worksheet.

Authorization of Benefits (*Trans.*1994:665; 2013:306*)*

The Council approved rescission of the following ADA policies to be submitted for consideration by the 2017 House of Delegates. These policy rescission recommendations will be submitted on separate worksheets.

Coordination of Benefits Reform (*Trans.*2008:496*)*
Dentist's Right to Participate in Dental Prepayment Plan (*Trans.*1983:582)
Patient's Right to Assign Payment (*Trans*.1997:708)

Council Minutes

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

Council on Dental Education and Licensure

Price, Jill M., chair, 2017, OR, chair, American Dental Association
Glickman, Gerald, N., 2018, TX, vice chair, American Dental Education Association
Aksu, Mert N., 2019, MI, American Dental Education Association
Boden, David F., 2020, FL, American Dental Association
Cassella, Edmund A., 2019, HI, American Dental Association
Donoff, R. Bruce, 2020, MA, American Dental Education Association
Edgar, Bryan C., 2018, WA, American Association of Dental Boards
Gehani, Rekha, C., 2020, NY, American Dental Association
Gesek, Daniel, J., 2017, FL, American Association of Dental Boards
Halpern, David F., 2018, MD, American Dental Association
Hebert, Edward, J., 2018, LA, American Dental Association
Korzeb, Jennifer, 2019, MA, American Dental Association
Moser, Ronald F., 2019, MD, American Association of Dental Boards
Pascarella, Jon, 2017, New Dentist Committee*
Raman, Prabu, 2017, MO, American Dental Association
Sarrett, David C., 2017, VA, American Dental Education Association
Shaffer, Marybeth, 2020, OH, American Association of Dental Boards

Hart, Karen M., director
Jasek, Jane, F., manager
Puzan, Annette, manager

The Council's 2016–17 liaisons: Dr. Andrew J. Kwasny (Board of Trustees, Third District), and Dr. Shaun O'Neill (American Student Dental Association)

Bylaws Areas of Responsibility

As listed in Chapter X, Section 130D 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.

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

Objective: Strengthen the state and local capacity and capability to meet member needs

Initiative/Program: Support state associations in licensure reform

Success Measure: States assisted

Target: ADA/ADEA Task Force assists three states

Range: 1 to 5 states

Outcome: On Plan

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

At the time this report was prepared, licensure reform assistance had been provided to Iowa and Kentucky. In addition, representatives of the ADA were invited to provide information on the comparability of patient-based clinical licensure examinations to Boards of Dentistry in New Jersey, New Hampshire, Maryland and Indiana.

The following states expanded licensure portability regulations during 2016–17:

Table 1. 2016–17 Expanded Licensure Portability Regulations

State	Regulatory change
Arkansas	Effective March 2017 and retroactive to January 1, 2012, the Arkansas Board of Dental Examiners accepts dental candidates for licensure by examination who have met all mandatory requirements and who have successfully completed one of the five major clinical exams.
Iowa	Effective January 2017, the Iowa Dental Board accepts all five clinical exam results for licensure by exam. Effective December 2016, in response to HF 2387, the Iowa Dental Board and the University of Iowa College of Dentistry adopted the following joint recommendations: • Implement a curriculum integrated format-type exam through CRDTS to be fully in place by the 2016-17 academic year. • Ensure that Board members or Board designees are part of the scoring process.
Kentucky	Effective May 14, 2016, the Kentucky Board of Dentistry voted to accept the California Portfolio for initial licensure in Kentucky
Utah	Effective May 9, 2017, the Utah Legislature amended the practice act to accept the CITA exam for licensure, thus Utah now accepts all five clinical exams. Rulemaking is expected to be complete by the end of 2017.

Objective: Strengthen the state and local capacity and capability to meet member needs

Initiative/Program: Support proposal for establishment of a National Commission on Recognition of Dental Specialties and Certifying Boards

Success Measure: Action taken by the 2017 ADA House of Delegates

Target: Proposal presented to the 2017 ADA House of Delegates

Outcome: On plan for the 2017 House of Delegates

Dr. Jill Price, Dr. Prabu Raman and Dr. David Halpern represented the Council on the Board's Task Force on Specialty and Specialty Certifying Board Recognition. The Board and Task Force sought comment from the communities of interest on a proposal to establish the National Commission on Recognition of Dental Specialties and Certifying Boards. In June, the Council submitted comment, noting its support for the new agency. The Council believes that the proposed *Bylaws* amendments, Rules and budget plan are reasonable and appropriate.

Objective: Strengthen the state and local capacity and capability to meet member needs

Initiative/Program: Implement the Dental Licensure Objective Structured Clinical Examination (DLOSCE)

Success Measure: Execution of the DLOSCE Business Plan

Target: Execute the Business Plan

Range: Business Plan Approved; Steering Committee Appointed; Format and Delivery Options; Identified; Governance Structure Identified

Outcome: On plan to complete by December 2017

As recommended by the Council, the ADA Board of Trustees approved the DLOSCE Business Plan in March 2017. The development of the DLOSCE supports current ADA policy calling for the elimination of patients from the dental licensure examination process. The ADA possesses the in-house expertise to develop the DLOSCE through its Department of Testing Services (DTS), which is staffed by testing professionals with advanced degrees in psychological measurement and related fields. The development of the DLOSCE will help support licensure portability for practicing dentists. In addition, available, albeit limited, published psychometric analyses of current patient-based licensure examinations suggests that the patient-based exams do not consistently (reliably) screen out beginning practitioners with inadequate hand-skills, while psychometric analyses of the Canadian dental licensure OSCE strongly suggests there is more evidence in support of the reliability and validity of scores on the OSCE, as compared to patient-based exams. The DLOSCE Steering Committee was appointed by ADA President Dr. Gary Roberts, consistent with the Board of Trustees-specified composition as noted in Table 2 below. In the third and fourth quarters of 2017, the DLOSCE Steering Committee will consider format and delivery options for the DLOSCE as well as possible governance models for administrative oversight.

Table 2. Board of Trustees-Specified Composition

BOT Directive	Appointee
ADA Board of Trustees Members	Dr. Richard Black, TX, Chair Dr. Roy Thompson, TN
CDEL Members who are general dentists	Dr. Edward J. Hebert, LA Dr. Prabu Raman, MO
Educators with experience teaching comprehensive clinical dentistry	Dr. Michael Kanellis, IA Dr. Frank Licari, UT
Current State Dental Board Members	Dr. David Carsten, WA Dr. Mark R. Stetzel, IN

For more information about the DLOSCE, review DLOSCE Frequently Asked Questions and read the March 10, 2017 and April 24, 2017 articles in *ADA News.*

Emerging Issues and Trends

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 the open portion of 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 ADA members pursuing careers in dental academia. This year's recipients of the scholarships are Dr. Stacey Swilling and Dr. Bonita Wynkoop.

Recognition of Dental Specialties and Interest Areas in General Dentistry: In accord with Resolution 19H-2016 (*Trans*.2016:304), operative dentistry is recognized by the ADA as an interest area in general

dentistry. As part of this resolution, the 2016 House of Delegates requested that the Council work with the Academy of Operative Dentistry to develop a name for a deserved interest area that more closely represents the expertise and focus described in the application. The leadership of the Academy of Operative Dentistry and the American Board of Operative Dentistry were contacted regarding their willingness to revise the name of this recognized general dentistry interest area; both organizations support the proposed name change of the recognized general dentistry interest area to "Operative Dentistry, Cariology and Biomaterials." Accordingly, the Council has submitted Resolution 9 to the 2017 House of Delegates.

In a related matter, the Council adopted a definition for this recognized interest area in general dentistry. The definition has the support of the Academy of Operative Dentistry and the American Board of Operative Dentistry. The definitions of the dental specialties and interest areas in general dentistry are the responsibility of the Council. The Council believes that the definition complements the proposed revised policy statement and clarifies the expertise and focus of the interest area. The definition is as follows:

> *Operative Dentistry, Cariology and Biomaterials:* That branch of general dentistry concerned with the advanced knowledge, expertise and clinical skills in operative dentistry, restorative dental materials, educational theory, techniques and teaching skills. It includes scientific research and knowledge in the areas of cariology and advanced scientific clinical training in restorative materials and biomaterials.

Dental Anesthesiology and Sedation: Notices regarding the revised ADA Sedation and Anesthesia Guidelines adopted by the 2016 ADA House of Delegates were transmitted to the anesthesiology communities of interest in November 2016. Dr. James Tom serves as the ADA 2016–17 representative to the American Society of Anesthesiologists' (ASA) Task Force developing moderate sedation guidelines. In June 2017, the Council expressed support for pursuing ADA co-sponsorship of the final ASA Practice Guidelines for Procedural Moderate Sedation and Analgesia (see website) after they are considered by the ASA House of Delegates on October 25, 2017.

Dental Admission Testing Programs: The Council provides volunteer oversight for the Dental Admission Test (DAT) and the Advanced Dental Admission Test (ADAT), while the Department of Testing Services is responsible for test development, research, administration, and psychometric evaluation.

Trends in the DAT for 2016–17:

- Average scores for first-time examinees in 2016 on all tests in the DAT battery were similar to those from 2015.
- During 2016, 12,811 DATs were administered, slightly down from 13,093 in 2015.
- The total number of DAT administrations has decreased overall each year since 2008, which 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 2016 were as follows: White (60.8%), Asian (28.7%), Hispanic (11%), Black (8.2%), American Indian/Alaska Native (1.5%), and Native Hawaiian/Pacific Islander (0.9%).

Trends in the ADAT for 2016–17:

- The ADAT was administered for the first time in 2016. In total, 460 candidates took the ADAT, 257 were female (55.0%) and 200 were male (43.5%). Three candidates did not identify by gender (0.7%).
- From highest to lowest, the percentage of administrations based on examinee self-report ethnicity in 2016 were as follows: White (266) or 57.8%, Asian (126) or 27.4%, Unknown (49) or 10.7%, Black or African American (9) or 2%, Multi-Ethnic (6) or 1.3%, American Indian or Alaska Native (3) or 0.7%, and Native Hawaiian or Other Pacific Islander (1) or 0.2%.

- As of the end of June 2017, 538 candidates had registered to take the ADAT. The test window for 2017 is April 3–August 31.

Dental Licensure: Council member, Dr. Daniel Gesek, Jr., and former Council member, Dr. Stephen Holm, serve on the ADA/ADEA Joint Licensure Task Force. The Council supports the 2017 strategic recommendations of the ADA/ADEA Licensure Task Force to achieve universal acceptance of a psychometrically sound non-patient based licensing examination that protects the public and to urge acceptance of the portfolio style licensure examination, using competencies cited in the Accreditation Standards for Dental Education Programs to document students'/graduates' clinical experience.

The Council maintains testing and licensure reference information on the ADA website for dental students. For new dentists and dentists seeking licensure by credentials the state tables include clinical examinations accepted and other regulatory information.

In response to Resolution 50H-2013 (*Trans*.2013:327) the Council also monitors the Dental Board of California's (DBC) implementation of its portfolio-style examination and reports information via the Council's Annual Report. Information received from the DBC in June 2017 notes that during the timeframe of June 2016 through May 2017, the DBC issued 37 licenses via the portfolio pathway. Schools participating in portfolio licensure pathway are listed here; the number of June 2016–May 2017 licensees are noted in parentheses: the University of California, Los Angeles (1); University of California, San Francisco (12); University of the Pacific Dugoni Dental School (19); University of Southern California (4); Western University of Health Sciences (no applications); and Loma Linda University (1). The DBC has a number of pending portfolio applications and more expected this year.

State Licensure Legislation: With assistance from the ADA Department of State Government Affairs, the Council monitors proposed and enacted state dentist licensure legislation. Table 3 summarizes legislation enacted by states.

Table 3. Recent State Licensure Legislation

State	Bill Number and Date Enacted	Action
Arizona	S.B. 1362, enacted 4/18/2017	Amends licensure examination and licensure by credential rules
Arkansas	H.B. 1250, enacted 3/15/2017	Amends the law related to specialty licensure
Illinois	S.B. 589, enacted 5/2/2017	Amends licensure requirements for graduates of foreign dental schools
Louisiana	H.B. 210, enacted 6/8/2017	Amends law regarding retired volunteer licenses
Oklahoma	S.B. 787, enacted 5/17/17	Amends requirements for faculty licenses or faculty specialty license holders
Utah	H.B. 262, enacted 3/24/2017	Amends the requirements for licensure by endorsement
Washington	H.B. 1411, enacted 4/21/17	Amends the requirements of the residencies that can be used in lieu of practical examinations to apply for licensure

ADA-Recognized Dental Specialty Certifying Boards: The Council annually surveys the ADA-recognized dental specialty certifying boards. The *2017 Report of the ADA-Recognized Dental Specialty*

Certifying Boards shows that all nine specialty certifying boards certified diplomates in 2016. All boards, with the exception of the American Board of Oral and Maxillofacial Radiology, recertified diplomates in 2016. The *Report* includes synopses of certification and examination data; eligibility requirements; examination, application and registration procedures; reexamination and recertification/certification maintenance policies; and a list of board executive directors and secretaries.

During the review of the annual reports, the Council considered the American Board of Periodontology's (ABP) proposed language change in its Board-issued certificate. The Council noted that the ABP, effective in 2017,

> …will clarify the scope of its certification in periodontics by adding to the statement "…is entitled by the authority of this Board to be enrolled as a Diplomate…" the words "…and is certified in Periodontics and Dental Implant Surgery" on the certificates that are issued to the successful candidates.

The Council believes that the language change in the Board-issued certificate may in fact cause confusion for the public, leading to a potential misinterpretation that board certified periodontists are the only individuals certified to provide dental implant surgery. Several of the other dental specialty certifying boards include content in dental implants in their examinations. Accordingly, the Council expressed its objection to the APB regarding the Board's action to alter the certificate issued to successful candidates to read that the individual is certified in Periodontics *and Dental Implant Surgery.*

ADA-Recognized Allied Dental Certifying Boards: The Council accepted the 2016 Annual Report submitted by the National Board for Certification in Dental Laboratory Technology (NBC) in relation to the ADA's Criteria for Approval of a Certification Board for Dental Laboratory Technicians. Noted were several of the NBC's activities and initiatives during the past year which include: 1) publication of revised Dental Laboratory Technology Examination References; 2) finalization of the Job Task Analysis (JTA) process; and 3) a review, by subject matter experts, of every active examination question in the item bank. NBC's Annual Report indicated that as of August 30, 2016, there are 4,800 active Certified Dental Technicians (CDT) and 230 active retired CDTs.

The Annual Report submitted by the Dental Assisting National Board, Inc. (DANB) was also reviewed in light of the Criteria for Recognition of a Certification Board for Dental Assistants. DANB's Annual Report indicated that between September, 1, 2015 and August 31, 2016, 1,958 examinees took the entire Certified Dental Assistant (CDA) Examination with a pass rate of 74%. The General Chairside portion of the CDA exam was taken by an additional 2,407 examinees with an 81% pass rate. As of September 13, 2016, DANB has 36,691 CDA Certificants.

Continuing Dental Education: The total 2017 year-to-date revenue including sponsorship of online CE ($73,760) is pacing approximately 5% ahead of 2016 total online CE revenue ($70,089) over the same time frame. While total revenue is slightly up due to sponsorships, ADA CE Online usage has decreased approximately 30% based on revenue figures from May 2016. Based on this decline, a more aggressive marketing campaign in collaboration with ADA Marketing and Communications has been launched. Paid search engine tactics will be implemented in July 2017 to stimulate sales. Different pricing strategies are also being explored.

Table 4. ADA CE Online 2017 YTD

	January – June 2017 Totals
Current Course Count	69
Courses Ordered	1690
Number of Orders	1130
Unique Registrants	726
Total CE Hours Awarded	3687
Monthly Online CE Revenue	$59,779

Responses to House of Delegates Resolutions

Resolution Objective: Resolution 19H-2016—Recognition of Operative Dentistry as an Interest Area in General Dentistry (Trans.*2016:304)*

> **19H-2016. Resolved,** that operative dentistry is an interest area in general dentistry recognized by the American Dental Association and sponsored by the Academy of Operative Dentistry, and be it further
> **Resolved,** that the Council on Dental Education and Licensure work with the Academy of Operative Dentistry to develop a name for a deserved interest area that more closely represents the expertise and focus described in the application.

Initiative/Program: Requested the Council to work with the Academy of Operative Dentistry to develop a revised name for the interest area that more closely represents the expertise and focus described in the application.

Success Measure: Work with the Academy of Operative Dentistry and achieve consensus on a revised name for this interest area in general dentistry

Target: Proposed revision agreed upon by June 2017.

Range: May–July

Outcome: Achieved; see Resolution 9 to the 2017 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, Reaffirming Existing ADA Policy, the Council reviewed Association policies related to continuing education and licensure. The Council reviewed the following policies and determined they should be maintained. The Council's review of licensure-related policies will continue through 2017 and 2018, pending outcomes of the Joint ADA-ADEA Licensure Task Force and the DLOSCE Steering Committee:

Examinations for Allied Dental (Non-Dentist) Personnel (*Trans*.2010:595)
Definition of Curriculum Integrated Format (*Trans*.2007:389)
Monitoring Clinical Dental Licensure Examinations (*Trans*.2012:462)
Eliminating Use of Patients in Board Examinations (*Trans*.2013:351)

State Board Support for CODA as Responsible to Accredit Dental Education Programs (*Trans*.2012:463)
Policy on One Standard of Competency (*Trans*.2012:463)
Clinical Licensure Examinations in Dental Schools (*Trans*.2012:462)
Policy on Dual Degreed Dentists (*Trans.*2012:464)
Policy on Licensure of Dental Assistants (*Trans*.2000:474)
Policy on Dental Licensure (*Trans*.2003:341)
Acceptance of Results of Regional Boards (*Trans*.2012:468)
Endorsement of Recommendations of the ADA Guidelines for Licensure by Credentials (*Trans*.2012:464)
Promotion of Freedom of Movement for Dental Hygienists (*Trans*.1990:550)
Policy on Licensure of Graduates of Nonaccredited Dental Programs (*Trans*.2012:477)
Guidelines for Licensure (*Trans*.2012:464)
Position Statement on Federal Intervention in Licensure (*Trans*.2012:468)
Dental Practice by Unqualified Persons (*Trans*.1959:207)
Titles and Descriptions of Continuing Education Courses (*Trans*.2014:463)
Acceptance of Formal Continuing Medical Education Courses Offered by ACCME Accredited Providers (*Trans*.2010:576)
Policy Statement on Lifelong Learning (*Trans*.2000:467)
Lifelong Continuing Education (*Trans*.1999:941)

The Council recommends that the policy, Cardiopulmonary Resuscitation Instruction (*Trans*.1976:860) be rescinded (see Resolution 8) and that the Policy Statement on Continuing Dental Education (*Trans*.2006:331; 2011:465) be amended (see Resolution 10). In addition, the Council urges adoption of a new policy, State Dental Board Recognition of the Commission for Continuing Education Provider Recognition (see Resolution 11).

Council Minutes

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

Council on Dental Practice

O'Toole, Terry G., 2015, District of Columbia, chair
Ratner Craig S., 2018, New York, vice chair
Aflatooni, Nima, 2020, California
Cammarata, Rita M., 2017, Texas
Connell, Christopher M., 2019, Ohio
Edgar, Linda J., 2020, Washington
Hale, Hal E., 2019, Kansas
Kent, Leigh W., 2018, Alabama
Landes, Christine M., 2017, Pennsylvania
Liddell, Rudolph T., 2020, Florida
Mazur-Kary, Michelle L., 2017, Maine
Medovic, Michael D., 2020, West Virginia
Mikell, Julia K., 2019, South Carolina
Saba, Michael, 2017, New Jersey*
Theurer, Scott L., 2018, Utah
Van Scoyoc, Stacey K., 2019, Illinois
Wojcik, Michael S., 2018, Michigan
Wolff, Douglas S., 2020, Minnesota

Porembski, Pamela M., director
Metrick, Diane M., senior manager
Bramhall, Alison M., manager
Kluck-Nygren, Cynthia A., manager

Center for Professional Success
Shapiro, Elizabeth A., director
Hughes, Sarah M., manager
Sarver, Jordan P., manager

The Council's 2016–17 liaisons include: Dr. Chad P. Gehani (Board of Trustees, Second District), and Ms. Danielle Marciniak (American Student Dental Association).

Bylaws Areas of Responsibility

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

a. Dental Practice;
b. Allied Dental Personnel;
c. Dental Health and Wellness;
d. Dental Informatics and Standards for Electronic Technologies; and
e. Activities and Resources Directed to the Success of the Dental Practice and the Member.

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

Objective 3.1: Pursue programs that members value and are "Best in class."
Initiative/Program: Provider's Clinical Support System-Opioid (PCSS-O) sponsored webinars/workshops
Success Measure: Deliver four webinars/workshops on opioid prevention topics.

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

Target: 2,000 webinar participants by the fourth quarter in 2017; 80% of attendees surveyed respond *satisfied* or *very satisfied* with education program; 85% of webinar participants become aware of the ADA opioid webinar offering by viewing promotions on an ADA social media outlet

Range: 1,500–2,500 webinar participants

Outcome: Three PCSS-O webinars, "How to Discuss Safe Use, Storage and Disposal of Medicines, Including Opioids with Your Dental Patients," "Opioid Prescribing in Dental Medicine: Balancing our Compassion for Patients with Social Responsibility" and "Legal and Ethical Issues of Opioid Prescribing for Acute Dental Pain" were presented by the second quarter in 2017, with a total of 1,612 participants. 87% of the first webinar, 93% of the second webinar and 90% of the third webinar participants reported being *satisfied* or *very satisfied* with the program (as of June 14, 2017). 89% of the first webinar, 91% of the second webinar, and 89% of the third webinar participants reported becoming aware of the webinar via ADA social media.

The fourth webinar for the year has been scheduled and will be presented by the third quarter in 2017. It will focus on peer assistance for the dental team member with opioid dependency.

Objective 3.1: Pursue programs that members value and are "Best in class."

Initiative/Program: State Dentist Well-Being Program Director Conference

Success Measure: Present the biennial conference in 2017 with 85% of attendees surveyed responding satisfied or very satisfied with the education program.

Target: 85 conference attendees

Range: 50–85 attendees

Outcome: This Conference will be held September 7–8, 2017. Speakers, sponsors and exhibitors have been secured. Registration opened on April 13, 2017; 50 attendees were registered as of July 10, 2017.

The ADA recognizes the single most valuable asset in any dental practice is the dentist and their dental team. Optimal health and work-life balance are essential to the maintenance of the person(s) without whom the practice would cease to exist. The purpose of the Conference is to bring together state dentist well-being program staff to connect them with national experts who can discuss and provide key information on professional impairment.

The Conference objectives are:

- to provide information that enhances state dentist well-being programs efforts to prevent or help those dealing with substance use disorders;
- to provide those involved in outreach and advocacy for drug/alcohol addiction efforts for dentists the opportunity to network and share their information; and
- to provide well-being volunteers and staff who value the specialized continuing education and sense of community that has been provided by this Conference.

Objective 3.1: Pursue programs that members value and are "Best in class."

Initiative/Program: ADA® Center for Professional Success™ (CPS)

Success Measure: Increase user engagement by targeting user interests. This can be accomplished by fully utilizing all improved features of 2016 CPS redesign.

Target: Reduce bounce rate to average of 61%.

Range: Average of 59-63%

Outcome: 63% as of June 2017

The ADA® Center for Professional Success™ launched a refreshed, fully mobile-enabled design in October 2016. As part of the new capabilities, staff has been able to utilize technology to much more aggressively serve up content to the site users. This involves a comprehensive strategy that involves a magazine style delivery, increased cross-linking, and targeted topical areas of material based on user selection, easier site navigation and stronger key wording. As of June 2017, the average bounce rate is 63%, which represents a 1% decrease over 2016's year-end average of 64%.

Objective 3.1: Pursue programs that members value and are "Best in class."

Initiative/Program: Development of Practice Management Resources

Success Measure: A comprehensive resource on navigating the regulatory environment will be developed and published as a member benefit via CPS. The content will also be submitted to Product Development and Sales to develop a print format.

Target: Increase traffic to Council-produced content on CPS by 5% compared to 2016 data.

Range: Increase traffic 3–7%

Outcome: For the period January 1 to June 30, 2017, traffic to Council-produced content on CPS increased 19.87% compared to the same period last year.

A group of dental consultants recognized as authorities on a variety of federal regulatory topics, and selected members of the Council, collaborated to provide members with guidance regarding best management practices for regulatory compliance. The resource discusses federal regulations issued by the Centers for Disease Control and Prevention; Center for Medicare & Medicaid Services; Drug Enforcement Agency; Environmental Protection Agency; Occupational Safety and Health Administration; and the Office for Civil Rights. The Regulatory Module was posted on CPS in the second quarter; and the print edition is expected to be available in July 2017.

Objective 3.1: Pursue programs that members value and are "Best in class."

Initiative/Program: ADA Standards Program

Success Measure: Increase member awareness and utilization of standards by:

- providing members with Executive Summaries for all ADA new standards deliverables and 25% of existing Standards Committee on Dental Informatics (SCDI) standards by beginning of fourth quarter 2017;
- providing ADA news media with standards articles six times per year; and
- completing strategy, in collaboration with Membership Marketing and Research, to assess member needs and awareness of standards deliverables by fourth quarter 2017.

Target: 15% increase in member downloads and free previews of ADA Technical Reports and provide executive summaries of 25% of SCDI standards and 15% of Standards Committee on Dental Products (SCDP) standards by October 2017.

Range: N/A

Outcome: Downloadable statistics will be available by year-end 2017. The department is on track to meet the goal by October 2017. In the second quarter of 2017, Standards staff began working with Information Technology and Publishing on a new document distribution system that will offer a better method of providing free, read-only viewing of standards to members. Seven news articles have been published as of July 2017. Meetings with Membership Marketing and Research will be held to develop a member assessment strategy which will be completed by fourth quarter 2017.

Emerging Issues and Trends

Federal Regulation

The volume and complexity of federal regulations requires constant vigilance by dental practices and the ADA. This is especially true now, as the new presidential administration has expressed interest in revising the regulatory landscape. Compliance with the Health Insurance Portability and Accountability Act (HIPAA), the Americans with Disabilities Act and the Affordable Care Act continue to challenge dental practices. The Environmental Protection Agency recently reinstated the amalgam separator rule. The Council plans to monitor federal regulations and update resources when activity at the federal level results in significant changes.

Consumerism

There has been an upward trend in dental patients viewing themselves as active consumers who are educated, informed, and committed to advocating on their own behalf. This shift in mindset has had, and will continue to have, a significant impact within dentistry. Patients may be more inclined to "shop" for health care providers and may be more willing to engage in "do-it-yourself" activities that are purported to improve one's smile or overall oral health status. Consumerism as it relates to dentistry continues to evolve and dentists will increasingly need to be mindful of the complete "customer experience," rather than focus primarily on the quality of care provided.

Integration of Dentistry and Medicine

Oral health impacts an individual's overall health. Dentists have the ability to observe manifestations of certain medical conditions within the oral cavity and to refer patients to a medical doctor for evaluation and appropriate treatment. Some dentists have expressed interest in offering patients certain services, such as immunizations, screenings or testing for diabetes, high cholesterol, etc. Similarly, some medical practices, most often pediatric offices, now provide patients with fluoride varnishes and other preventive services. Greater interprofessional collaboration benefits patients' overall health and has the potential to result in an expansion of a dentist's role as a prevention specialist.

New Standards Addressing Emerging Issues

The following new standards released over the past year were the first to address these emerging issues:

- ANSI/ADA Standard No. 35 Dental Headpieces and Motors
- ANSI/ADA Standard No. 117 Fluoride Varnishes
- ANSI/ADA Technical Report No. 146 CAD/CAM Abutments in Dentistry
- ADA Technical Report No. 1088 Identification of Human Remains by Dental Means
- ADA Technical Report No. 1030 Dental Provider's Guide to the Electronic Health Record
- ADA Technical Report No. 1087 Essential Characteristics of Digital Oral Health Risk Assessment
- ADA Technical Report No.1094 Quality Assurance for Digital Intra-Oral Radiographic Systems.

New Work Projects Addressing Emerging Issues

Technical reports now under development include:

- No. 1093 Essential Characteristics of an Electronic Dental Record System
- No.1095 Clinical Electronic Resources and Evidence Based Dentistry
- No.1096 Patient Data Risk Assessment for Privacy and Security

Standards under development include:

- No.1097 Digital Caries Risk Assessment Resources
- No. 158 Coupling Dimensions for Headpiece Connectors
- No. 159 Coiled Springs for Use in Orthodontics
- No. 161 Guidance on Color Measurement in Dentistry
- No. 163 Dental Furnace - Test Method for Temperature Measurement with Separate Thermocouple
- No. 164 Dental Furnace - Part 2: Test Method for Evaluation of Furnace Program via Firing Glaze

Cleanliness in Reprocessing
The ADA Standards Committee on Dental Products (SCDP) recently formed a Working Group on Cleanliness in Reprocessing to tackle the issue of developing standards that address how to determine whether mineralized soils that are compacted into rotary instruments such as burs, diamonds and files, have been removed in compliance with a verifiable cleaning method. Working Group members are reviewing existing standards to determine what information already exists and how it can be used to develop a cleaning method specifically for dental products including finding the relevant soils to be tested.

Security and Privacy of Electronic Data and Images
The ADA Standards Committee on Dental Informatics (SCDI) continues to provide new resources to assist members in ensuring that storage and transmission of their electronic patient data and images are HIPAA-compliant. Proposed ADA Technical Report No.1096 Patient Data Risk Assessment for Privacy and Security will provide members with guidelines for conducting an office risk assessment and the development and implementation of a HIPAA privacy compliance program.

Issues from Other Standards Organizations
ADA liaisons to the Association for the Advancement of Medical Instrumentation (AAMI), a nonprofit organization that is the primary source of consensus standards for the medical device industry, provided the dental profession's input into the revision of AAMI ST/WG 40, Hospital Steam Sterilization Practices. The revision was adopted by the ADA SCDP as suitable for use in dentistry, is advancing to the Public Review stage and will be considered for the ADA standard.

ADA liaisons to the American Society of Heating, Refrigeration, and Air-conditioning Engineers (ASHRAE), an international professional group accredited by ANSI to develop standards in areas such as ventilation and indoor air quality, including institutional dental facilities, participated in the revision of Guidance 12-2000, Minimizing the Risk of Legionellosis Associated with Building Water Systems. A proposal was submitted by the ADA for consideration that would encourage the use of a risk assessment tool in order to decide if the standard applies to an outpatient healthcare facility.

SNODENT®
SNODENT was approved by the American National Standards Institute (ANSI) as ANSIADA Standard No. 2000 in November 2016. A SNODENT Maintenance Committee to develop revisions to the Standard met in February 2017 to discuss the next proposed changes with the intent of an annual revision through the SNODENT Canvass Committee process. Approval of the next version of ADA Standard No. 2000 SNODENT is expected by December 2017.

Responses to House of Delegates Resolutions

Resolution Objective: Resolution 96H-2015 (*Trans.*2015:262) Development of ADA Policy on Dentistry's Role in Sleep-Related Breathing Disorders (SRBD).

> **96H-2015. Resolved,** that the American Dental Association develop policy as to dentistry's role in Sleep Related Breathing Disorders (SRBD), and be it further
>
> **Resolved,** that the American Dental Association Council on Scientific Affairs in collaboration with other appropriate ADA agencies ~~designate the appropriate agency to~~ develop said policy ~~suggested guidelines~~ as to the dentist's role in ~~airway management~~ SRBD, and be it further
>
> **Resolved,** that the ~~designated agency~~ CSA report its progress and time line for completion to the 2016 ADA House of Delegates. ~~at the 2016 Annual Session with recommendations for dentists' involvement in SRBD~~

Initiative/Program: Develop proposed policy as to the dentist's role in SRBD.

Success Measure: A new policy on SRBD will be submitted for consideration to the 2017 House of Delegates (HOD).

Target: 50 comments received from all interested parties (AIP) in response to a call for comment on the proposed policy.

Range: 40–60 comments.

Outcome: 134 comments were received on the draft policy from all interested party reviews.

Resolution 96H-2015 (*Trans.*2015:262) was assigned to the Council on Scientific Affairs (CSA) and directed CSA to collaborate with appropriate ADA agencies to develop policy as the dentist's role in SRBD. CSA completed a state-of-the-science Evidence Brief on Oral Appliances for SRBD in 2016 and the Council has developed draft policy. The proposed policy will be submitted to the 2017 HOD.

Resolution Objective: Resolution 87H-2016 (*Trans*.2016:287) Recommendations for Cone Beam Computed Tomography Inspections

> **87H-2016. Resolved,** that the appropriate ADA agencies review the recommendations for the quality assurance inspection of dental radiographic equipment, including but not limited to, intra-oral, panoramic, cephalometric and cone beam computed tomography devices and recommend inspection protocols that would include the appropriate method and interval for inspection.

Initiative/Program: Review recommendations for quality assurance inspection of dental radiographic equipment related to the interval and appropriate methods of inspection.

Success Measure: A report will be submitted to the 2017 HOD

Target: N/A

Range: N/A

Outcome: A detailed report will be submitted to the 2017 HOD.

Resolution 87H-2016 was assigned to the Council with CSA as a supporting agency. The Council convened a working group of subject matter consultants, council members including representatives from CSA and the Council, and representatives of specialty groups.

Resolution Objective: Resolution 91-2016 (*Trans*.2016:287) Development of Sample Clinical Chart Entries to Increase Quality in Documentation. The 2016 House of Delegates referred Resolution 91 to the appropriate ADA agency for further study and report back to the 2017 House of Delegates.

> **91H-2016. Resolved,** that the appropriate ADA agencies develop a resource guide which contains sample chart entries for the 30 most common procedure codes and additional guidance on best practices which relates to documentation which supports Medicaid Compliance for use by dentist members, and be it further
>
> **Resolved,** that this benefit be maintained within the Members Only section of ADA.org, and be it further
>
> **Resolved,** that this resource be shared with auditing units of state Medicaid programs so as to inform auditors of the best practices of clinical documentation.

Initiative/Program: To further study the appropriateness of the development of clinical chart entries and make recommendations on this issue.

Success Measure: A report will be submitted to the 2017 HOD.

Target: N/A

Range: N/A

Outcome: A report will be submitted to the 2017 HOD with a proposed recommendation to develop a comprehensive online practice management resource that addresses a variety of risk management topics, including guidance on properly charting clinical entries.

The Council determined that no template could sufficiently address all of the state-specific and patient-specific information needed in order to ensure that examinations, procedures and conversations were appropriately documented in the patient's record. It was determined the best course of action would be to offer members a comprehensive resource that provides information and guidance on appropriate patient charting and other risk management topics.

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 definitions of active and inactive patients of record, cosmetic dentistry, oral diagnosis, primary dental care and primary dental care providers, professional dental care, and treatment plan; dentists' well-being; substance use and abuse; victim identification; and the illegal/unlicensed practice of dentistry and/or dental hygiene.

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

Active and Inactive Dental Patients of Record (*Trans*.1991:621; 2012:441)
Cosmetic Dentistry (*Trans*.1976:850)
Oral Diagnosis (*Trans*.1978:499)
Primary Dental Care (*Trans*.1994:668; 2010:562; 2012:441; 2014:506)
Primary Dental Care Provider (*Trans*.1994:668; 2010:548)
Professional Dental Care (*Trans*.1996:689)
Treatment Plan (*Trans*.1978:499)
Guiding Principles for Dentist Well-Being Activities at the State Level (*Trans*.2005:330; 2012:442)
Statement on Substance Use Among Dental Students (*Trans*.2005:329)
Statement on Substance Abuse Among Dentists (*Trans*.2005:328)
Dental Identification Efforts (*Trans*.1985:588)
Dental Identification Teams (*Trans*.1994:654; 2012:441)
Dental Radiographs for Victim Identification (*Trans*.2003:364; 2012:442)
Uniform Procedure for Permanent Marking of Dental Prostheses (*Trans*.1979:637; 2012:448)
Status of General Practice (*Trans*.1973:725)
"Denturist" and "Denturism" (*Trans*.1976:868; 2001:436)
Activity to Stop Unlicensed Dental or Dental Hygiene Practice (*Trans*.1999:949)
Dental Society Activities Against Illegal Dentistry (*Trans*.1977:934; 2001:435)
Opposition to "Denturist Movement" (*Trans*.2001:436)
Insurance Coverage for Chemical Dependency Treatment (*Trans*.1986:519; 2012:442)
Statement on Alcohol and Other Substance Use by Pregnant and Postpartum Patients (*Trans*.2005:330)
Statement on Alcoholism and Other Substance Use Disorders (*Trans*.2005:328)

Council Minutes

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

Council on Ethics, Bylaws and Judicial Affairs

Halasz, Michael H., 2017, Ohio, chair
Herman, Gary N., 2018, California, vice chair
Browder, Larry F., 2020, Alabama
Cohen, Donald F., 2020, Texas
Edwards, Adam A., 2017, New York
Griffin, Seth W., 2020, Michigan
Howley, Thomas A., Jr., 2019, Pennsylvania
Ilkka, Don J., 2018, Florida
Kochhar, Puneet, 2018, New Hampshire
Kurkowski, Michael, 2020, Minnesota
Merritt, Kennedy W., 2017, New Mexico
Moss, J. David, 2018, South Carolina
Patel, Vishruti M., 2019, Illinois
Rice, M. Elwood, 2019, Missouri
Shekitka, Robert A., 2017, New Jersey
Smith, James A., 2019, Oregon
Soileau, Kristi M., 2020, Louisiana
Stuefen, Sara E., Iowa, 2017*

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

The Council's 2016–17 liaisons include: Dr. Robert N. Bitter (Board of Trustees, Eighth District), and Mr. Alex Mitchell (American Student Dental Association). The ADA president appointed Dr. Vishruti M. Patel to complete the term of Dr. Petra von Heimburg, who resigned in early 2017.

Bylaws **Areas of Responsibility**

As listed in current Chapter X, Section 130F of the ADA *Bylaws*, the areas of 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 on 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 3.1: Pursue programs that members value and are "Best in class."

Initiative/Program: Support member success by providing varied ethics programming accessible to membership through multiple venues.

Success Measure: Membership access to excellent ethics continuing education programming.

Target: Highly favorable participant evaluation of continuing education ethics programming**.**

Range: Favorable to highly favorable participant evaluation of continuing education ethics programming

Outcome: On target at time of submission (August 2017).

Objective 3.1: Pursue programs that members value and are "Best in class."

Initiative/Program: Support member success by providing communications vehicle allowing members to obtain advice on ethical questions in a very timely manner.

Success Measure: Membership access to timely advice concerning ethics questions that arise in members' practices.

Target: Highly favorable participant evaluation of ethics advice program.

Range: Favorable to highly favorable participant evaluation of ethics advice program.

Outcome: On target at time of submission (August 2017).

Continuing Education Programming in Ethics: During the 2016 annual meeting, the Council presented a two-hour continuing education course entitled "The ADA Code: 150 Years of Putting the Patient First," covering topics including: treating patients with special needs (both adults and children); managing patients with memory impairment and patient and practice issues related to the legalization of marijuana use.

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 ADA 2017 – America's Dental Meeting, entitled "Ethical Considerations in Patient Selection: Guidance from the ADA *Code*" which will cover topics including: treating patients with different political views, religious perspectives or other lifestyle choices that conflict with the dentist's own views; 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 2017, a live webinar was presented to the Virginia Dental Association (VDA). A copy of the webinar was archived for viewing by members who were unable to participate in the live VDA session.

Sesquicentennial Anniversary of the ADA *Code*: 2016 marked the 150th anniversary of the adoption of the ADA *Code*. The Council commemorated that milestone with 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 at the annual meeting of the American Society for Bioethics and the Humanities). During the 2016 annual meeting, a full text copy of the ADA *Code* and information concerning the Ethics Hotline were printed and distributed at the exhibition hall, as were lapel pins commemorating the 150th anniversary of the ADA *Code.* A visual of the principles of the ADA *Code* was also developed and displayed in the exhibition hall. Throughout 2016, the 150th anniversary of the ADA *Code* was promoted 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 2016 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 predoctoral dental students of ethical situations that are encountered during the everyday practice of dentistry and provides a creative forum for students to consider how those situations should be addressed using the ADA *Code*. The Council awarded the contest grand prize to a team of students from the University of Missouri–Kansas City School of Dentistry, while the grand prize in the contest focusing on patient safety that was underwritten by CNA was awarded to the School of Dentistry at the University of Texas Health Science Center at Houston.

The entry period for the 2017 contest has opened and will close at the end of July 2017. Videos received will be assessed and the winning videos displayed at ADA 2017 America's Dental Meeting®.

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. Other indicia for measuring the success and value of the program are being investigated. Currently the Hotline receives an average of two calls per month. Ethics inquiries have also been presented to Council members through other channels including communications with colleagues and inquiries made to other departments.

ADA Success Program: Since the last annual report of the Council, it has assisted the New Dentist Committee in the development of a module on Leadership and Ethics in Dentistry for the newly revamped ADA Success Program. The module is one hour in length and is available to be presented at dental schools throughout the country at no cost to the schools.

Emerging Issues and Trends

Fairness in Patient Selection: Through an Ethics Hotline call, the Council was made aware that the existing language of 4.A. of the ADA *Code* is considered, by some, not to be sufficiently inclusive of sexual orientation and gender identity.

Considering the changing social climate as well as the responses of other professional societies, the amendment of the relevant portion of the ADA *Code* is the correct course of action and comports with the ADA *Code* statement that "Qualities of honesty, compassion, kindness, integrity, fairness and charity are part of the ethical education of a dentist and practice of dentistry and help to define the true professional."

A proposed resolution to amend Section 4.A. of the ADA *Code* is presented as Resolution 6.

Adding a Sixth Principle to the ADA *Code*: A commentary was published in the December 2016 issue of *The Journal of the American Dental Association* calling for the addition of a sixth ethical principle to the ADA *Code*. The article asserted that the principle of "Respect for Human Dignity," should be added to address developments in genetic science. Upon a review of the request, the Council determined that to add an additional section of the ADA *Code* to address the concerns raised in the article would run counter to the philosophy that the ADA *Code* should be structured to be capable of broad application in a myriad of situations that confront dentistry now and will arise in the future. The Council further determined to monitor advances in genetics and, if it is believed that a more specific statement on the ethical implications of genetic research is warranted, the Council will address that need at that time.

Revision to Advisory Opinion 5.B.6 of the ADA *Code*: At the request of a Council member, the Council undertook an examination of Advisory Opinion 5.B.6 of the ADA *Code* which states that recommending

and performing unnecessary treatment is unethical. The examination culminated in the Council reasoning that the diagnosis of unnecessary treatment is unethical in its own right. Consequently, the Council unanimously agreed to revise Advisory Opinion 5.B.6 to state that "…recommending or performing" unnecessary treatment is unethical.

Search Engine Optimization: Members of the Council have collaborated with a professor and graduate student in the Department of Biomedical and Health Information Sciences in the College of Applied Health Sciences at the University of Illinois at Chicago to author a manuscript that addresses ethical issues relating to the use of optimization techniques to boost a website's visibility in response to queries using Internet search engines such as Yahoo, Bing and Google. As of the writing of this report, a draft manuscript has been completed and is being submitted for publication to suitable professional journals, including *JADA*.

Responses to House of Delegates Resolutions

Resolution Objective: 118H-2014. Review of ADA *Constitution and Bylaws.* (*Trans.*2014:446)

> **118H-2014. Resolved,** that the Council on Ethics, Bylaws and Judicial Affairs, in consultation with other appropriate ADA agencies, ~~develop a plan and timetable for performing~~ perform a complete review and rewrite of the ADA *Constitution and Bylaws,* ~~including an estimate of the financial implications for performing that review,~~ and be it further
> **Resolved,** that the Council on Ethics, Bylaws and Judicial Affairs provide a report on its ~~proposed plan and timetable~~ progress to the 2015 House of Delegates.

Initiative/Program: *Constitution and Bylaws* review.

Success Measure: Complete review and revision of the ADA *Constitution and Bylaws.*

Target: Completion of draft proposals by December 2016.

Range: Draft proposals completed February 2017; distributed for comment April–May 2017.

Outcome: Final presentation to the 2017 House of Delegates. See Resolution 7.

The amendments to the ADA *Bylaws* resulting from its work responsive to Resolution 118H-2014 by the House of Delegates are presented in a worksheet that will be transmitted to the 2017 House of Delegates for consideration.

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 relating to ethics and governance.

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

Guidelines Governing the Conduct of Campaigns for all ADA Offices (*Trans.*2012:417; 2014:478; 2016:336, 337);
Guidelines for Dentist Advertising (*Trans.*1979:647);
Criteria for Restructure of Trustee Districts (*Trans.*1986:498);
ADA Member Conduct Policy (*Trans.*2011:539); and
Definition of Freedom of Choice (*Trans.*1994:668).

Council Minutes

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

Council on Government Affairs

Bronson, Mark E., 2017, Ohio, chair
Graham, Frank J., 2018, New Jersey, vice chair
Andolina, Richard F., 2017, New York**
Armstrong, Craig S., 2019, Texas
Beauchamp, K. Jean, 2018, Tennessee
Bishop, Deborah S., 2020, Alabama
Cheek, Daniel K., 2019, North Carolina
Desrosiers, Mark B., 2020, Connecticut
Fijal, Philip J., 2020, Illinois
Garrett, Marty B., 2018, Louisiana
Hennessy, Rhonda M., 2020, Michigan
Incalcaterra, Charles J., 2017, Pennsylvania
Kalarickal, Zacharias J., 2020, Florida
Medrano-Saldana, Lauro, 2019, New York
Minahan, David M., 2018, Washington
Morrison, Scott L., 2017, Nebraska
Nguyen, Robin, 2017, Florida*
Terlet, Ariane R., 2019, California
White, David M., 2017, Nevada

Spangler, Thomas J., director

The Council's 2016–17 liaisons include: Dr. Gary E. Jeffers (Board of Trustees, Ninth District), Dr. Andrew Soderstrom (Council on Advocacy for Access and Prevention), Ms. Janette Sonnenberg (Alliance of the American Dental Association), and Mr. Eddie Lee (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 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.

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

Objective: Assessment of Member Value.

Initiative/Program: Advocacy for Science, Education, Appropriations, Wellness Issues.

Success Measure: Increase appropriations in dental programs.

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

Target: 4% increase over the same period in 2016.

Range: 3%–5% over the same period in 2016.

Outcome: At the time of this report (July 17), the federal funding levels for dental programs in fiscal year (FY) 2018 have not been established. An across-the-board cut of about 3% is being proposed for discretionary domestic programs, which could affect dental programs. However, early feedback from Congress suggests a bipartisan support for additional funding of the National Institutes of Health. If the separate appropriations legislation fails to pass and the dental programs are funded through a continuing resolution, the favorable FY 2017 funding levels for the National Institute of Dental and Craniofacial Research (3% increase above the FY 2016 level) and the funding for pediatric and general residencies ($10 million each) will remain in place for FY 2018.

Objective: Assessment of Member Value.

Initiative/Program: Advocacy for Dental Practice, Federal Dental Services Issues.

Success Measure: Prevail on ADA's position.

Target: 4% increase over the same period in 2016.

Range: 3%–5% over the same period in 2016.

Outcome: As a percentage of bills supported by the ADA, the ADA's progress toward passage increased by about 3% over the same period in 2016. Some examples include the following bills.

- McCarran-Ferguson Reform: The U.S. House of Representatives passed the Competitive Health Insurance Reform Act of 2017, H.R. 372, by a vote of 416-7 on March 22. H.R. 372 would amend the McCarran-Ferguson Act to authorize the Federal Trade Commission and the Justice Department to enforce federal antitrust laws against health insurance companies. This bill was one of the key issues lobbied at the ADA Dentist and Student Lobby Day with the goal of ensuring the legislation will now be taken up by the Senate.

- Non-Covered Services Bill: The Dental and Optometric Care Access Act or the "DOC Access Act" (H.R. 1606) was introduced in the 115th Congress by Rep. Earl "Buddy" Carter of Georgia. This *non-covered services* bill 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.

- Student Loan Debt Relief: Rep. Mark Pocan of Wisconsin introduced the Student Loan Refinance Act (H.R. 1614), which allows individuals to refinance federal direct student loans. This bill was lobbied at the ADA Dentist and Student Lobby Day.

- Amalgam Separators: On June 9, the Environmental Protection Agency (EPA) issued a final rule that requires most dental offices nationwide to install amalgam separators. The ADA, which worked with the EPA for several years on the final rule, commended the agency for what it considers "a fair and reasonable approach to the management of dental amalgam waste." In a statement, ADA President, Dr. Gary L. Roberts, said:

  > The ADA shares the EPA's goal of ensuring that dental amalgam waste is captured so that it may be recycled… We believe this new rule—which is a federal standard—is preferable to a patchwork of rules and regulations across various states and localities.

  The new rule meets the nine principles established by the ADA House of Delegates as a condition for ADA support for a national rule. Additional highlights of the rule include:

  - Dentists who practice in oral pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics, periodontics, and prosthodontics are exempt from the rule.

- Dentists who do not place amalgam and only remove amalgam in unplanned or emergency situations (estimated at less than 5 percent of removals) are also exempt.
- Mobile dental units are exempt.
- Dentists who already have separators are grandfathered for ten years.

Objective: Assessment of Member Value.

Initiative/Program: Advocacy for Access, Dental Coverage Issues.

Success Measure: Passing Dental Health Access bills.

Target: One bill passed.

Range: One bill passed.

Outcome: As of July 17, one bill was passed out of the House's Energy and Commerce's Subcommittee on Health, none have passed Congress.

- Action for Dental Health Act: On June 29, the House's Energy and Commerce's Subcommittee on Health unanimously passed the Action for Dental Health Act of 2017. The bill, H.R. 2422, was introduced by Rep. Robin Kelly, D-Ill., and Rep. Mike Simpson, R-Id., and calls for Congress to authorize additional oral health promotion and disease prevention programs. In addition, the Association was invited to testify at the House's Energy and Commerce's Subcommittee on Health hearing, titled "Examining Initiatives to Advance Public Health," to talk about H.R. 2422. Dr. Cheryl D. Watson-Lowry, a Chicago general dentist, testified on behalf of the ADA at the May 17 hearing. Dr. Watson-Lowry's testimony focused on two of the program's initiatives: emergency room referral programs and the ADA's Community Dental Health Coordinator program. The dental initiative drew bipartisan interest from members of the subcommittee. (See *ADA News* article.)

- ADA Testified for IHS Centralized Credentialing System: On June 13, ADA President-elect, Dr. Joseph Crowley, testified before the Senate Indian Affairs Committee in support of the "medical credentialing system" provision of S. 1250— the "Restoring Accountability in the Indian Health Service Act of 2017" bill. That provision calls for the Indian Health Service (IHS) to implement a centralized system to credential licensed health care professionals who seek to provide health care services at any IHS facility. The current credentialing process makes it more difficult for the Service to timely fill dental vacancies. And it serves as a disincentive to those who want to contract with IHS or volunteer their services. Dr. Crowley also pointed out that the ADA is currently supporting implementation of a Ten Year Health and Wellness Plan, which is designed to reduce oral disease by 50% among the Navajo tribal communities. On June 21, the ADA submitted a statement for the record to the House Subcommittee on Indian, Insular and Alaska Native Affairs, Committee on Natural Resources, in support of H.R. 2662, the companion bill for S. 1250.

Objective: Assessment of Member Value.

Initiative/Program: ADPAC Administration.

Success Measure: Growth in ADPAC membership over same period in 2016.

Target: 2% growth.

Range: 1%–3% growth.

Outcome: The targeted growth rate has not been met at this time. ADPAC giving is consistently higher in election years. At the end of April 2016, ADPAC basic membership was 18,194 compared to 15,016 at the end of April 2017. 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. ADPAC is currently engaging in an educational campaign and will launch a solicitation campaign prior to ADA 2107.

Emerging Issues and Trends

Federal Issues

As of July 17, it is still very early in the Trump administration and the 115th Congress. The two areas of greatest potential impact on oral health care delivery and the profession are regulatory reform and health care reform.

Regulatory Reform: The ADA was one of several health organizations with a seat at the table during a June 22 stakeholder meeting with the U.S. Department of Health and Human Services (HHS). The meeting, led by Tom Price, M.D., HHS secretary, was designed to give the agency input on the impact government has on the doctor-patient relationship and to discuss barriers that unnecessarily interfere with providers and their patients. During the meeting, ADA President-elect Dr. Joseph Crowley shared four regulatory burdens that affect ADA members and which the Association believes adversely impact patients' access to oral health care: the Medicare Ordering and Referring rule, the Medicare Part D rule, a Medicare Part C rule, and a portion of the Section 1557 Nondiscrimination rule. The HHS listening session included participants from groups that included the American Academy of Dermatology, American Academy of Family Physicians, American College of Cardiology, American Society of Clinical Oncology, American College of Radiology and American Psychiatric Association.

Health Care Reform Legislation: The U.S. House of Representatives on May 4 voted 217-213 in favor of H.R. 1628, an amended version of the American Health Care Act. The legislation contains some provisions the ADA supports such as expanding the use of health savings and flexible spending accounts and extending the "Cadillac Tax" to an implementation date of 2026. The bill also contains provisions that cause the ADA concern, chiefly the provision that changes the Medicaid program to a per capita cap allotment system and not offering the use of tax credits for the purchase of stand-alone dental plans. (See *ADA News* article.)

The Senate bill, called the Better Care Reconciliation Act, is not terribly different than the House-passed bill. It is not clear that the Senate leadership has the necessary votes (at a minimum, 50 Senators and the Vice-President) to pass the bill. **Biggest impact on access to dental services**: Loosens restrictions on the essential health benefits requirements to provide more flexibility to states, which include pediatric oral health care and changing the federal funding mechanism of Medicaid to a per capita allotment**.**

Some of the details of the Senate bill:

Medicaid

- Repeals the Medicaid expansion option for states.
- Changes Medicaid funding from the current matching formula to a per capita allotment beginning in FY2020.
- Provides for a block grant option for states instead of a per capita allotment for non-elderly, nondisabled, non-expansion adults. States would be required to receive the block grant for a five-year period.
- Allows states to impose work requirements for enrollees, with excepted categories (e.g., pregnant women up to 60 days post-partum; elderly; disabled).

While the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides dental services to enrolled children, is not specifically mentioned, states will be granted additional flexibility in order to operate under the new per capita cap funding. Concern remains over the ability to fulfill the EPSDT requirement under a reduced funding scenario. The ability of states with adult dental

services to continue to provide such services may be impacted with less funding available from the federal government.

Commercial Coverage in Individual Market

- Repeals the individual mandate penalty.
- Repeals the employer mandate (51 FTE) penalty.
- Expands Health Savings Accounts (HSAs) and repeals the annual limits on contributions to Flexible Spending Accounts (FSAs)—an ADA priority.
- Allows insurers offering coverage in the individual market to impose a six-month waiting period for individuals with a gap in coverage in the preceding 12-month period of more than 63 days.
- Reduces the eligibility for tax credits available to help cover the cost of insurance to 100–350% of the federal poverty level (FPL) from the current level of 100–400% FPL.
- The age band increases to 5:1 (from the current 3:1). This means that an insurer could charge five times as much for the highest age bracket v. the lowest.
- Creates a state stability and innovation program for states to apply for funding to address market conditions. Examples include assistance for high-risk individuals, assistance for health insurance issuers to remain viable in the market, payments for health care providers as deemed necessary by the Administrator of the Centers for Medicare and Medicaid Services, assistance for out of pocket costs for individuals with individual market coverage. Requires an application and funds will phase out. The goal is to provide relief to states to help stabilize the markets and create competition.
- Allows for association health plans under the small business health plans provisions.
- Allows states to expand the use of waivers if a state can demonstrate the intent is to increase access. Provides for an expedited approval process by the Secretary of HHS for the waivers. This provision could impact the offering of essential health benefits in the individual/small group market.
- Sunsets the Affordable Care Act's (ACA) medical loss ratio requirements for plans beginning in 2019.
- The bill also eliminated the Prevention and Public Health Fund beginning with FY 2018. This fund provides about 12% of funding for Centers for Disease Control and Prevention programs.

Taxes

- Repeals the medical device tax—an ADA priority.
- Repeals tax on over the counter medicines. Current law requires that medicine or a drug must be a prescribed or insulin to be deemed a qualified expense for expenses under a tax advantaged account.
- Repeals the 0.9% Medicare excise tax applicable to higher income earners (200,000 individual/ 250,000 joint filers) by 2023.
- Repeals the 3.8% investment tax beginning for tax year 2017.
- Delays the excise tax on higher cost health plans (Cadillac tax) until January 1, 2026.
- Repeals the annual tax on health insurers, beginning in calendar year 2017.

State Issues

Medicaid: Proposed changes currently being discussed at the federal level may fundamentally alter the Medicaid program. State Medicaid officials are understandably reluctant to pursue major systemic improvements until they know whether Medicaid will transform from an open-ended entitlement to a limited grant approach like block-grants. That said, some trends are worth noting.

States continue to experiment with financial incentives to improve participation and utilization. If California's Dental Transformation Initiative that rewards care delivery and utilization proves successful,

other states may wish to replicate aspects of the initiative. Colorado's financial incentive law that offered one-time payment to dentists for taking a certain number of Medicaid patients is still being evaluated.

Administrative uniformity has gained momentum. For instance, a bill in Minnesota would have required uniform and clear processes for prior authorizations in dental Medicaid along with a single/uniform credentialing process. Bills in Washington and North Carolina also called for administrative improvements including prior authorizations. A Texas measure would have provided a method for certain dentists to provide Medicaid services while their applications were being processed. Of note, prior authorization improvements are proposed for commercial dental plans as well this year.
A few states have enacted laws to study dental coverage in Medicaid, among them Georgia, Maryland, Texas and Utah. Study outcomes and any resulting policy changes could be used to improve dental coverage in Medicaid.

A steady stream of bills regulating Medicaid audits in recent years should continue as a few states have enacted laws in recent years, Montana and Washington providing new laws in this area in 2017.

Lastly, as reform proposals simmer at the federal level, state Medicaid officials continue to pursue cost saving options, with a particular focus on contracting dental Medicaid administrative services to commercial carriers. State dental societies want to ensure that if a commercial carrier is selected to administer dental Medicaid, it functions effectively in providing reimbursement, credentialing and other administrative components of the program.

Dental Benefits/Third Party Reimbursements: Legislation designed to improve patients' experience with their dental benefit coverage continues, with a focus on convenience and transparency. Assignment of benefit (AoB) laws require insurers to follow patients' directives to pay benefits for covered services directly to the rendering dentist. These laws provide conveniences for patients that own their dental policies and improve processes for the dental practice. This year saw one more state added to the twenty-two other states with AoB laws. Six states pursued this in 2017.

Patients expect to have clear information on the value of the products they purchase. This is true in dental benefits, and public policy trends are seeking to support this movement. In conversations with state dental associations, it is clear there is interest in requiring dental plans to report the percentage of premium revenue spent on dental care as compared to administrative costs. Known as Medical Loss Ratio (MLR), these measures allow stakeholders to understand the proportion of dental plan premiums truly spent on care. Measures that make rental networks and silent PPO more transparent to dentists is a trend sure to continue. Dentists are often frustrated to learn they are participating providers in plans for which they did not sign an agreement. Proposed legislation would require notification to dentists when such transfers occur. Legislation requiring such notification will continue to be pursued in 2018 as will requirements to notify participating dentists when substantive contract changes are planned.

Midlevel Legislation: Efforts to enact dental therapy or other midlevel models in states across the nation were unsuccessful in the first half of 2017. A bill is still pending in Massachusetts, while Pew and Kellogg are poised to launch serious mid-level campaigns in Florida and Maryland this summer. Despite this new activity, pro-dental therapy advocates continue to struggle convincing legislatures of the long-term viability of the program. Dental therapy programs have struggled to even get started in the few states, besides Minnesota, where legislation authorizing dental therapists has become law (e.g., Vermont and Maine).

Responses to House of Delegates Resolutions

There are no assignments for the Council from the 2016 House of Delegates.

Self-Assessment

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

Policy Review

In accordance with Resolution 170H-2012, Reaffirming Existing ADA Policy, the Council concluded a comprehensive review of its policies in 2016 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.

Council on Members Insurance and Retirement Programs

McLean, David E., 2017, Vermont, chair
Hehli, Peter D., 2018, Wisconsin, vice chair
Coleman, J. Preston, 2017, Texas
Ellison, Naomi L., 2019, California
Hokanson, Brian N., 2017, Wyoming
Johnston, Jon J., 2020, Pennsylvania
Jolly, Robert L., Sr., 2019, Arkansas
Kido, Scott H., 2020, Idaho
Kilcollin, Katie L., 2019, West Virginia
Lipton, James M., 2018, Indiana
Mann, Marshall H., 2018, Georgia
Olenyn, Paul T., 2017, Virginia
Pirmann, Peter J., 2019, Illinois
Sterritt, Frederic C., 2020, New Jersey
Tota, Christopher M., 2020, New York
White, Cecil, Jr., 2020, Florida
Wieting, Scott, 2018, Nebraska
Yates, Lindsey J., 2017, Illinois*

Tiernan, Rita, senior manager

The Council's 2016–17 liaisons include: Dr. Judith M. Fisch (Board of Trustees, First District), and Ms. Eileen Shah (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 for the Council are:

a) insurance and retirement plan products and resources; and
b) risk management education programs and resources.

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

Objective: The ADA member's insurance and retirement savings plans are uniquely designed to enhance the value of ADA membership across all segments in support of member recruitment and retention and non-dues revenue goals. Through its oversight of the ADA Plans, the Council aligns with and contributes to the advancement of the ADA Strategic Plan 2020 goals of fiscal responsibility and the safeguarding of membership assets.

Initiative/Programs: ADA Members Group Insurance Plans, underwritten and administered by Great-West Financial; ADA Members Retirement Programs, administered by AXA Equitable; American Health Insurance Exchange.com (AHIX) web portal, powered by JLBG Health, Inc., and development of insurance and financial risk management educational resources to help members succeed in managing exposure to risk.

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

Success Measure: Increase member engagement and utilization of the ADA member's insurance and retirement programs and risk management resources as defined by growth in plan participation, total assets under management, non-dues revenue and royalties paid for ADA's endorsement and use of intellectual property. In addition, audits and benchmarking studies help validate the competitive value and financial sustainability of the ADA Plans to protect the future interests of members.

Target: Growth in plan participation is stagnant due in part, to aging ADA membership trends. The Plans remain strongly competitive as benchmarked and financially sustainable with increased assets under management. The Council's 2017 revenue budget will generate an estimated $6.5 million in non-dues revenue and royalties in support of ADA's financial goals.

Range: $5 million to $7 million in non-dues revenue and royalty income budgeted in 2017.

Outcome: As of June 30, 2017, approximately $6.5 million in ADA royalties from the ADA Members Insurance Plans have been received to meet this goal. In addition, AXA Equitable and Great-West Financial are on target with planned marketing initiatives and promotional efforts in support of program growth.

ADA Members Insurance Plans: The ADA Members Insurance Plans ("ADA Plans") portfolio consists of seven group plans underwritten by Great-West Financial including the 1) Members Term Life (annually renewable), 2) Level Term Life, 3) Universal Life, 4) Disability Income Protection, 5) Office Overhead Expense, 6) Hospital Indemnity with an optional Extended Care Rider and 7) Critical Illness. In addition, ADA sponsors the guaranteed issue Student Life and Disability Plans at no cost to student members while completing their dental education and residency programs.

As a tangible benefit of membership, the ADA Plans directly support membership recruitment of new members and retention of existing members. A new member "six-month no cost term life insurance offer" provides added incentive for eligible dentists to join the ADA. Last year nearly 1,500 members purchased one or more of the insurance products for the first time from conversions, new member offer promotions and organic sales.

Table 1. ADA Members Insurance Group Plans Aggregate Participation 2015–June 30, 2017

ADA MEMBERS INSURANCE PLANS	2015	2016	2017 June 30
Members Term Life	50,604	48,053	48,174
Spouse Term Life	17,705	17,056	16,486
Child Term Life[1]	6,960	6,664	6,402
Student Members Term Life	15,603	14,525	13,469
Members Universal Life	1,302	1,244	1,210
Members Level Term	336	729	901
Spouse Level Term	80	164	201
Child Level Term[1]	31	73	90
Members Disability Income Protection	15,793	15,462	15,936
Student Members Disability Income	14,964	13,816	12,463
Members Office Overhead Expense	8,065	7,782	7,829
MedCASH *(Members & Deps)*	6,457	6,131	5,655
Hospital Care *(Members & Deps)*	N/A	82	167
Critical Illness *(Members & Deps)*	N/A	76	150
Total Participation	**137,900**	**131,857**	**129,133**

[1] Number of members insuring dependent children.

As shown in Table 1, June 30, 2017 mid-year results indicate a decline in the total aggregate participation (ADA members, spouse and children) as measured across all of the ADA Plans which largely represents a decrease in the number of insured spouses and children in the Term Life Plan, and timing issues in the mid-year reporting of auto-enrolled incoming freshmen in the Fall when ADA membership is activated and graduates are reclassified. Other factors influencing participation growth are 1) the aging population of insured members, 2) ADA membership trends and tepid growth of new active members, 3) higher voluntary coverage lapses by dentists choosing to non-renew their ADA membership and 4) lower conversion rates among new graduates at the expiration of the no-cost student coverage.

Despite these trends, the ADA Plans continue to underscore the value of membership and help to protect nearly 54,840 members, 24,550 spouses and dependent children, and over 12,000 dental students. Marginal increases in new coverage sales of the level term life, disability and office overhead expense products is a positive sign moving into 2018. In addition, higher coverage limits for insuring spouses and children under the term life plan were introduced in May 2017 to help boost sales and offset the decline in this category.

This year a major strategic initiative was implemented to foster engagement across dental schools and promote automatic enrollment of students in the guaranteed issue, no-cost ADA Student Members Life and Disability Plans, which provides the foundation for future growth of active members (i.e., “fill the pipeline”) and the opportunity to maximize student conversions into the ADA Members Plans following graduation. Moreover, this initiative will help heighten awareness of ADA member value and the Great-West Financial product brand on dental campuses and increase student member engagement.

The ADA Plans are significantly competitive as benchmarked against market competitors. Specifically, Great-West Financial actuarial findings confirmed that the ADA experience-rated group insurance model, which has low expense ratios and no agent or broker commissions, continues to deliver tremendous price advantage to ADA members. A key metric which signifies the financial stability of the ADA Plans portfolio

is the annual increase in total gross premiums due to continued growth in cross-sell product sales and coverage upgrades. New 2017 direct mail campaigns include illustrations of the ADA Plans competitive cost savings and personalized messaging targeted to attract new dentists, female dentists and ethnically diverse groups.

In addition, 317 direct mail sales of the new suite of supplemental medical insurance products introduced in late 2016 indicates a strong potential for future growth. The new ADA Hospital Indemnity with an optional Extended Care Rider and Critical Illness Plans provide expanded and more liberalized benefits (than the former MedCASH Plan) in an unbundled design which allows members to select the coverage that best meets their personal needs. More specifically, Great-West Financial took an innovative approach to develop the Extended Care Rider option which provides long term care-type benefits for home health care, skilled nursing facility and nursing home care. These member benefit plans are offered at a substantial price advantage for ADA members and their families looking to purchase supplemental coverage against the rising personal cost of healthcare and related confinements. The former MedCASH Plan continues for those insured who opted to maintain their existing coverage.

The ADA Members Insurance Plans remain robustly strong financially and helped contribute to the ADA financial goals through payment of approximately $6.5 million in royalties in 2017.

ADA-endorsed Members Retirement Programs: The ADA Members Retirement Programs are administered by the AXA Equitable Insurance Company and include a full range of recordkeeping and plan services. The programs offer tax-qualified retirement savings plan options including three types of 401(k) plans: simple, safe harbor and traditional; new comparability plans; and defined contribution pension and profit-sharing plans. In addition, ADA endorses AXA's Individual Retirement Account (IRA) which can be adopted as a traditional IRA, Roth IRA, Rollover IRA or Self-Employed IRA (SEP-IRA). Plan participation is reported below in Tables 2 and 3.

The ADA Members Retirement Programs are annually reviewed by an outside consulting firm to ensure the AXA brand product offerings and investment management services provided by AXA Funds Management Group are market competitive.

Table 2. ADA Members Retirement Program Participation

	2015	2016	June 30 2017
Number of Sponsored Plans	3,178	2,929	2,830
Number of Dentists and Employee Participants	14,251	12,342	12,685

Table 3. Individual Retirement Accounts Participation

	2015	2016	June 30 2017
Number of Participants	1,504	1,443	1,696

The ADA Members Retirement Program was first introduced in 1968 as a "start-up" plan for new dentist practice owners. As reported in Table 2, the declining participation trends in this flagship program are in large part, a reflection of the aging population of ADA plan participants. More specifically, in recent years AXA reports a significant increase in the number of dentist employers and employees who have maximized their contributions and/or are transitioning into retirement. To meet the distribution plan needs of these members and preserve existing accounts, the ADA-endorsed AXA portfolio includes fixed indexed and customizable variable annuity products (i.e., Retirement Gateway Association, Structured Capital Strategies and Investment Edge.) The broader portfolio design allows AXA to market retirement

product solutions to members who are not practice owners, but still looking to plan for their future financial needs.

Faced with the changing participant demographics, current ADA membership trends and the need to attract new dentists, AXA's primary goal in 2017 shifted from product development to aggressive new marketing strategies to build brand recognition and increase awareness of the ADA member value proposition. One of the biggest challenges in today's fiercely competitive marketplace, which tends to favor local insurance and financial advisors, is attempting to grow sales through direct mail marketing. While inherently more cost effective for the benefit of ADA members, it is a time consuming process that is impacting overall program growth. To address this, AXA is devoting resources to have a greater presence in 2017–18 at local conferences, state and regional meetings and foster engagement with members and new graduates. Additionally, AXA has increased its use of digital media, web advertising and electronic communication channels. These initiatives and focused marketing strategies are structured to boost sales and improve plan retention in 2018.

From a financial perspective, the ADA Members Retirement Programs remain strong with over $1.6 billion in assets under management as of June 30, 2017 and have generated approximately $275,000 in service income and ADA royalties' year-to-date.

American Health Insurance Exchange.com Web Resource: The ADA-endorsed American Health Insurance Exchange.com (AHIX.com) web portal continues to provide member value in being a national resource for ADA members and employees to navigate the health insurance exchange markets and plan options, including plans endorsed by the state and local dental societies. ADA royalty revenue for its endorsement of the web portal has been minimal since the launch in 2014. More specifically, the 2016–17 open enrollment of the insurance marketplace generated $2,300 in ADA royalties as of March 30, 2017.

Emerging Issues and Trends

The Council is not aware of any new, significant trends or emerging issues not already being addressed by the Council.

Responses to House of Delegates Resolutions

There were no assignments from the 2016 ADA House of Delegates.

Self-Assessment

In accordance with Resolution 1H-2013, the Council conducted its self-assessment in August 2016 and subsequently formed a work group to further explore all possible options before making recommendations on how to increase governance effectiveness. Following deliberations at its March 2017 meeting on the proposed recommendations by the governance workgroup, the Council adopted the following recommendations: 1) that the Council be reconstituted as a skills-based council comprised of nine ADA members at large; 2) that the term of service on the council would be three years with a tenure of up to two terms; and 3) that there be a transition period beginning at the close of the 2018 House of Delegates to allow current council members to complete their existing terms of service. The Council's recommendations are being transmitted to the 2017 House of Delegates for consideration.

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

Maranga, Maria C., 2017, New York, chair
Romano, Rodrigo, 2018, Florida, vice chair
Chatterjee Kirk, Pia, 2020, Mississippi
Czerniak, Lauren, 2019, Ohio*
Durbin, Michael G., 2017, Illinois
Ellinwood, Steven P., 2018, Indiana
Freedman, Isaac Jay, 2020, Pennsylvania
Hanlon, Mary Jane, 2020, Maine
Irani, Karin, 2019, California
Jones, Gary O., 2017, Arizona
Kampfe, Mark I., 2020, Arkansas
Muncy, Marc, 2018, Arkansas
Riordan, Danielle M., 2020, Missouri
Sherwin, Ted, 2019, Virginia
Smith, Carmen P., 2017, Texas
Tigani, Stephen P., 2019, District of Columbia
Vitek-Hitchcock, Alexa M., 2019, Michigan
Willis, Heather A., 2018, Alaska

Reynolds, Andrew S., senior manager

The Council's 2016–17 liaisons include: Dr. Jeffrey M. Cole (Board of Trustees, Fourth District), and Dr. Sohaib Soliman (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. 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 2: Achieve a net increase of 4,000 active licensed members by the end of 2019.

Initiative/Program: New/Reinstated Member Acquisition Campaigns.

Success Measure: Increased membership among dentists who were not members in the prior year.

Target: 2,700 new or reinstated members at the end of June 2017; 6,000 new or reinstated members at the end of 2017.

Range: 2,500–3,000 at the end of June 2017; 5,750-6,250 at the end of 2017.

Outcome: As of June 2017, 2,754 new or reinstated members (exceeding target by 1.9%).

Objective 2: Achieve a net increase of 4,000 active licensed members by the end of 2019.

Initiative/Program: Targeted communications to new dentists progressing through the reduced dues program.

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

Success Measure: Increase retention rate among 2012–2015 dental school graduates.

Target: 76% retention of 2013–2016 grads by end of June; 85.8% at the end of 2017.

Range: 73%–80% through the end of June; 83% to 87% at the end of 2017.

Outcome: As of June 30, 2017: 74.6% retention (1.4% behind target).

Objective 2: Achieve a net increase of 4,000 active licensed members by the end of 2019.

Initiative/Program: Increase the number of graduate student members.

Success Measure: Larger number of graduate student members.

Target: 2,000 graduate student members at the end of June 2017; 3,100 graduate student members at the end of 2017.

Range: 1,900–2,200 at the end of June; 2,900–3,300 at the end of 2017.

Outcome: As of June 30, 2017: 1,910 graduate student members (4.5% behind target).

A continued dedication across the tripartite in reducing process hurdles, combined with focused messaging and communication, is continuing to yield positive results.

Emerging Issues and Trends

The Council is monitoring a number of trends that are accelerating the rate of change in dentistry, including the rise of alternative practice models, a changing regulatory environment, and generational shifts in what dentists expect from the organization that supports their profession.

Responses to House of Delegates Resolutions

Resolution Objective: Resolution 47H-2015 (*Trans.*2015:297)

Initiative/Program: Implementation of a Uniform Dues Transaction.

Success Measure: n/a

Target: n/a

Range: n/a

Outcome: A Council report will be presented to the 2017 House of Delegates proposing a uniform dues transaction.

Resolution Objective: Resolution 80H-2016 (*Trans.*2016:280)

> **80H-2016. Resolved,** that $250,000 be appropriated in the 2017 Budget to fund a program overseen by the Council on Membership to financially assist constituent and component societies to support member engagement for outreach to dental students, dentists in an advanced dental education or residency program, and new dentists 1-10 years out of dental school, and be it further
>
> **Resolved,** that the Council on Membership require participants to demonstrate the membership-related nature of the engagement activity to ensure that funding does not support purely social events.

Initiative/Program: In 2017 the Council launched the ADA Engagement Program. This program is intended to convert dentists to membership, or to add mobile phone numbers and permanent email addresses to student records in order to make it easier to recruit them into membership when eligible. Unlike previous programs, the ADA Engagement Program is not intended to support retention of existing dentist members.

Success Measure: Increased member conversion over prior year results. Updated student database records to facilitate future recruitment.

Target: 80% completion of database updates for attendees.

Range: 70–90% completion of database updates for attendees.

Resolution Objective: Resolution 92H-2009 (*Trans.*2009:415)

> **92H-2009. Resolved,** that the appropriate ADA agency report yearly to the House of Delegates the five-year anticipated (projected) dues revenues impact from members transition to life membership.

Initiative/Program: Yearly report to House of Delegates showing five-year anticipated (projected) dues revenues impact from members' transition to life membership.

Success Measure: Report completed (see narrative below).

Target: n/a

Range: n/a

Outcome: Report completed (see narrative below).

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 to 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	2017	2018	2019	2020	2021
Dues Revenue Reduction From Members Transitioning to Life Membership	($379,688)	($424,994)	($376,240)	($362,502)	($368,556)

Note: Assumes no dues increase and no assessment in years 2017–2021 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 from 2017 to 2021. The number of members who begin paying Life membership dues over the next five years is estimated to fluctuate beginning with an increase from 2,704 in 2017 to 3,023 in 2018 and then decrease to 2,620 by 2021. 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 2017–2021

Year Paying Life Dues for First Time	**2017**	**2018**	**2019**	**2020**	**2021**
Expected Active Life	2,181	2,297	2,032	2,067	1,991
Expected Retired Life	523	726	642	653	629
Total Projected to Become Life Members	2,704	3,023	2,674	2,720	2,620

Note: 24% are expected to become retired life based on membership as of 4-24-17. 24% was then used to project the number expected to become Retired Life members for each year for those becoming eligible for life membership through 2021.

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 2016, there were 15,101 active life members and 26,832 retired life members. The non-renew percentage for active life members at the end of 2016 was 3.4%, just 0.1 percentage point higher than full dues paying members (3.3%).

Self-Assessment

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

Licari, Frank W., 2017, Utah, chair, American Dental Education Association
Heinrich-Null, Lisa, 2018, Texas, vice chair, American Dental Association
Chamberlain, Dale R., 2018, Montana, American Association of Dental Boards
Efurd, Melissa G., 2018, Arkansas, American Dental Hygienists' Association
Fujimoto, Luis J., 2017, New York, American Association of Dental Boards
Haley, Cheryl D., 2019, Missouri, American Dental Association
Leone, Cataldo, 2020, Massachusetts, 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
Shelton-Jenkins, Issie L., 2018, Maryland, Public Member
Telin, Jordan J., 2017, New York, American Student Dental Association
Weiss, Leonard P., 2019, Ohio, American Association of Dental Boards

Waldschmidt, David M., secretary and director
Hinshaw, Kathleen J., senior manager
Hussong, Nicholas B., manager
Katznelson, Alix D., manager
Ryske, Ellen, manager
Svendby, Bryan, manager
Yang, Chien-Lin, manager

The Council's 2016–17 liaisons include: Dr. Chad P. Gehani (Board of Trustees, Second District), and Mr. Aaron Henderson (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 1: The public will recognize the ADA and its members as leaders and advocates in oral health.

Initiative/Program: Joint Commission on National Dental Examinations

Success Measure: All state boards use information from Joint Commission examinations for dental and dental hygiene licensure decisions.

Target: 100% utilization

Range: 90–100% utilization

Outcome: 100% utilization

Supporting Activities: In support of state board utilization of Joint Commission examinations, at its June 2017 meeting the Joint Commission accomplished the following:

1. *Budget Proposal and Fees.* Approved the 2017 and 2018 budget proposal, proposed research and development activities for 2017 and 2018, and 2018 candidate fees. The total examination fees charged in 2018 to candidates will be $435 for the National Board Dental Examination (NBDE) Part I, $480 for the NBDE Part II, and $430 for the National Board Dental Hygiene Examination (NBDHE). Candidates from non-accredited institutions will be assessed an additional $200 processing fee at the time of application. Score report request fees will be $37. These fees were approved by the Joint Commission, subject to final approval by the ADA House of Delegates.

2. *Integrated National Board Dental Examination (INBDE)*. Approved Joint Commission actions and reviewed progress in support of the INBDE and its implementation, including the following:
    A. Approved the annual report of the Committee for an Integrated Examination (CIE), and directed staff to communicate the findings of the 2016 INBDE Short Form Field Test to stakeholders and communities of interest.
    B. Approved the test specifications for the INBDE. Test specifications indicate the number of questions allocated to specific content areas.
    C. Approved the 2017 INBDE Field Test as a Mid-Length Form comprised of 300 questions. Administration of the 2017 Field Test will occur November 1, 2017 to January 31, 2018, and will require a total of eight hours.
    D. Approved the proposed methodology for the 2017 INBDE Field Test, including a performance-based incentive for participants as follows:
        i. $500 to candidates whose test performance falls within the Fourth Quartile
        ii. $400 to candidates whose test performance falls within the Third Quartile
        iii. $350 to candidates whose test performance falls within the Second Quartile
        iv. $300 to candidates whose test performance falls within the First Quartile
    E. Approved posting 30 INBDE Field Test questions to the INBDE website, as practice test questions for use by communities of interest.
    F. Requested the Committee for an Integrated Examination (CIE) develop a clear and concise list of selection criteria to facilitate the selection of INBDE Test Constructors.

3. *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, and the NBDHE). This includes the following approvals:
    A. Updates to the test specifications for the NBDHE, including slight increases in the number of questions appearing in the following two areas: pharmacology and periodontal procedures.

B. Updates to the test specifications for the NBDE Part II, including slight increases in the number of questions appearing in the following three areas: endodontics, oral and maxillofacial surgery/pain control, and patient management.
C. Pursuit of a multiyear plan to update the Joint Commission's practice analysis methodology, to further improve examination validity and the content basis for Joint Commission examination programs.
D. Reappointment of current NBDE and NBDHE test constructors, and selection of new primary and alternate NBDE and NBDHE test constructors for committees meeting in 2018.
E. Revisions to selection criteria for Dental Hygiene Test Constructors.
F. Acceptance of the following reports used to monitor and report on the quality and performance of National Board Examinations:
    - National Board Dental Examinations Technical Report
    - National Board Dental Hygiene Examination Technical Report
    - Trends in Candidate Performance
    - Quality of Recent Examinations
G. The Joint Commission will seek approval from the ADA to investigate the relationship between National Board Examination performance and performance on examinations of the ADA, in accordance with agreements appearing in corresponding Examination Candidate Guides, for internal research purposes only. This would provide supplemental validity evidence in support of the National Board Examinations.

4. *Strategic Planning*. Pursued efforts in support of the strategic direction of the Joint Commission. This includes the following approvals and discussions:
    A. Submission of a self-assessment report to the 2017 ADA House of Delegates, in compliance with ADA House of Delegates policy. This introspective report was developed over a two-year period.
    B. Authorization of funding in support of a facilitated planning process to develop a comprehensive strategic plan that identifies and prioritizes short and long terms goals and corresponding action plans, with consideration given to factors such as the Joint Commission's needs, values, scope, mission, governance, operating environment, stakeholders, communities of interest, projects, resources, and deliverables, as well as the Joint Commission's strengths, weaknesses, opportunities, and threats.
    C. Changes to Joint Commission *Bylaws*, contingent upon approval by the ADA House of Delegates, which would permit the Joint Commission to develop written examinations, exclusive of clinical demonstrations, for the purpose of assisting state boards in determining qualifications of other oral health care professionals who seek licensure to practice in any state, district or dependency of the United States, which recognizes the National Board Examinations. In short, this change would expand the Joint Commission's current scope to include other oral health care professionals (i.e., beyond dentists and dental hygienists).
    D. The Joint Commission will be distributing a communication to the American Association of Dental Boards (AADB), ADA and the American Dental Education Association (ADEA), soliciting feedback concerning the Joint Commission's interest in serving as a provider of licensure examinations for oral health care professions. An informational copy of this communication will also be provided to the American Dental Hygienists' Association (ADHA).

5. *Communities of Interest.* Considered requests made to the Joint Commission involving communities of interest.
    A. Approved the development of a contractual agreement with the ADEA to report NBDE results to ADEA, for use in the following advanced dental education program and advanced standing program application systems: ADEA Postdoctoral Application Support Service (ADEA PASS) and the ADEA Centralized Application for Advanced Placement for International Dentists (ADEA CAAPID). ADEA will use Applicant Information for reporting applicant scores to dental schools and programs as designated by the applicant

and participating in the ADEA Associated American Dental Schools Application Service (ADEA AADSAS), ADEA PASS and ADEA CAAPID (the "Purpose"), and for no other purpose other than for those purposes for which ADEA is authorized directly by the applicant.

B. Approved extending through 2022 the Joint Commission's contractual agreement with the American Student Dental Association (ASDA) concerning NBDE released questions. This extension permits dissemination of NBDE released questions to individual students and others in print format for individual study for a modest fee.

C. Reviewed a request by the NBDE Part II Patient Management Test Construction Committee (TCC), to consider providing detailed examination performance information to dental programs, beyond the performance information that is already currently provided to these programs. The Joint Commission expresses its heartfelt thanks to these Test Constructors for their commitment and contribution in providing item development support for the NBDE Part II. However, the TCC's request falls outside the scope and mission of the Joint Commission.

6. *Mission of the Joint Commission.* Approved efforts in support of the Joint Commission's mission, and the reduction of potential conflicts of interest for Commissioners.
   A. A member of the Joint Commission cannot simultaneously serve as a principal officer of a clinical testing agency. This change—made to the Joint Commission's Standing Rules—requires approval by the ADA House of Delegates.
   B. Accepted the process and criteria for electing the Joint Commission public member.

7. *Joint Commission Examination Regulations.* Approved modifications to the Joint Commission's Examination Regulations, including changes to reflect the Joint Commission's transition to electronic reporting mechanisms, clarify the concept of certification, and incorporate the processing fee associated with candidates from non-accredited institutions.

8. *Joint Commission Elections.* Reaffirmed Dr. Lisa Heinrich-Null as chair and elected Dr. William F. Robinson as vice chair of the Joint Commission. Their terms will begin in October of 2017.

9. *Meeting Dates.* Approved proposed 2018 and 2019 meeting dates, pending meeting and hotel room availability. June 20, 2018 is the scheduled meeting date for 2018. To facilitate greater participation by dental board members in the National Dental Examiners' Advisory Forum (NDEAF), in 2018 NDEAF will directly precede the full Joint Commission meeting.

Emerging Issues and Trends

The following presents trends in administration volume and examinee performance on the NBDE and NBDHE over a ten-year period beginning in 2007. These trends are presented with respect to candidates' status as first-time or repeat test takers, and their enrollment in accredited or non-accredited programs.

NBDE Part I: Table 1 presents performance trends for NBDE Part I over the past ten years, while Figure 1 provides a graphic depiction of administration volume. Table 1 shows steady growth in the number of first-time candidates from accredited programs taking NBDE Part I across the ten-year period indicated. The total number of first time candidates from non-accredited programs also increased during this ten-year timeframe, with 2010 representing the low at 1,218 candidates and 2016 representing the peak at 2,351 candidates. The total number of administrations (i.e., first-time candidates and repeating candidates from accredited and non-accredited programs) increased from 6,479 in 2007 to 9,973 in 2016. This represents an overall increase of 3,494 candidates (i.e., 53.9%).

Across the ten-year period indicated, failure rates for first-time candidates from accredited programs ranged from 3.4% (2015) to 7.4% (2008). Failure rates for first-time candidates from non-accredited programs were relatively higher, ranging from 31.9% (2014) to 39.5% (2008).

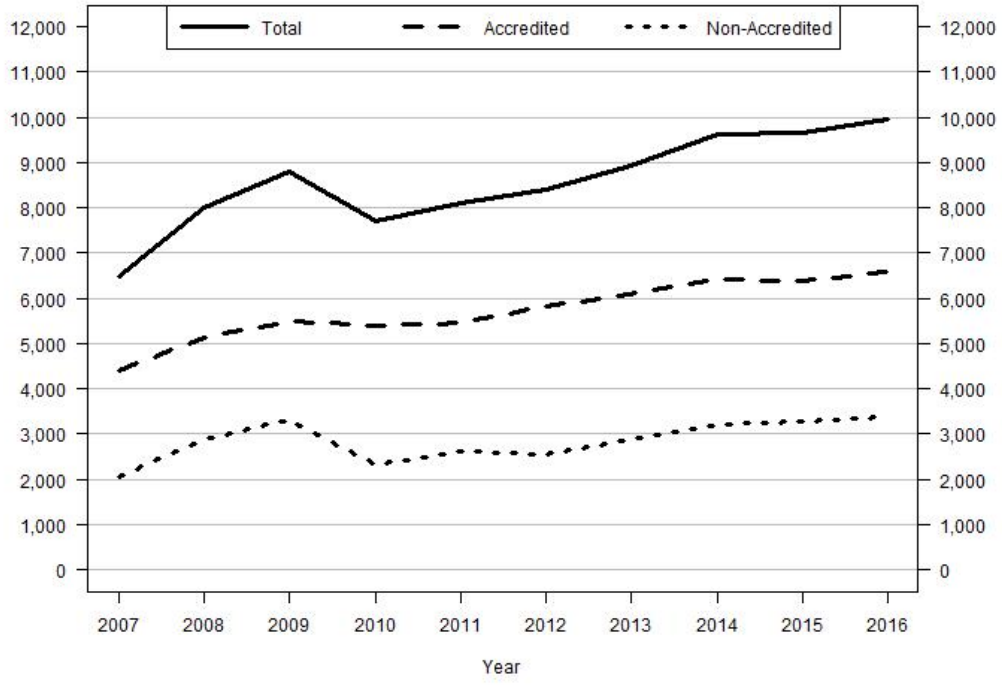
In interpreting this table, please note that effective 2007, NBDE Part I became a comprehensive examination that was no longer administered in four sections based on subject matter. Prior to 2007, candidates had to pass all four sections in order to pass the examination. Additionally, please note that effective 2010, candidates who have passed NBDE Part I may not retake the examination unless required by a state board or relevant regulatory agency. It should also be noted that a new NBDE Part I standard was introduced in November 2016. The new standard resulted in an increase in failure rates in the fourth quarter. This increase will become more apparent in the 2017 reporting cycle, when all data is based on the new standard.

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
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
2016**	6,260	5.2	340	33.5	2,351	33.0	1,022	59.1	9,973	18.2

* 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.

Figure 1. NBDE Part I Administrations (2007–2016)



NBDE Part II: Table 2 presents performance trends for National Board Dental Examination Part II (NBDE Part II) over the past ten 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 showed continued growth from 2007 through 2011. Volume decreased from 2011 to 2012, and then increased in 2016 to a ten-year high (N=6,034). There has been quite a bit of variability since 2007, ranging from a low of 4,464 candidates in 2007 to a high of 6,034 in 2016 (i.e., a 35% increase). The total number of first-time and repeating candidates from non-accredited programs increased from 1,092 in 2007 to 2,774 in 2016. Comparing the number of total administrations occurring in 2007 (N=5,961) with 2016 (N=9,490) shows a 59% increase in overall administration volume, with gains occurring in both accredited and non-accredited candidates.

Across the ten-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 8.7% in 2016, representing a slight increase from 2015. Failure rates for first-time candidates from non-accredited programs were relatively higher, ranging from 23.4% (2008) to 43.4% (2009).

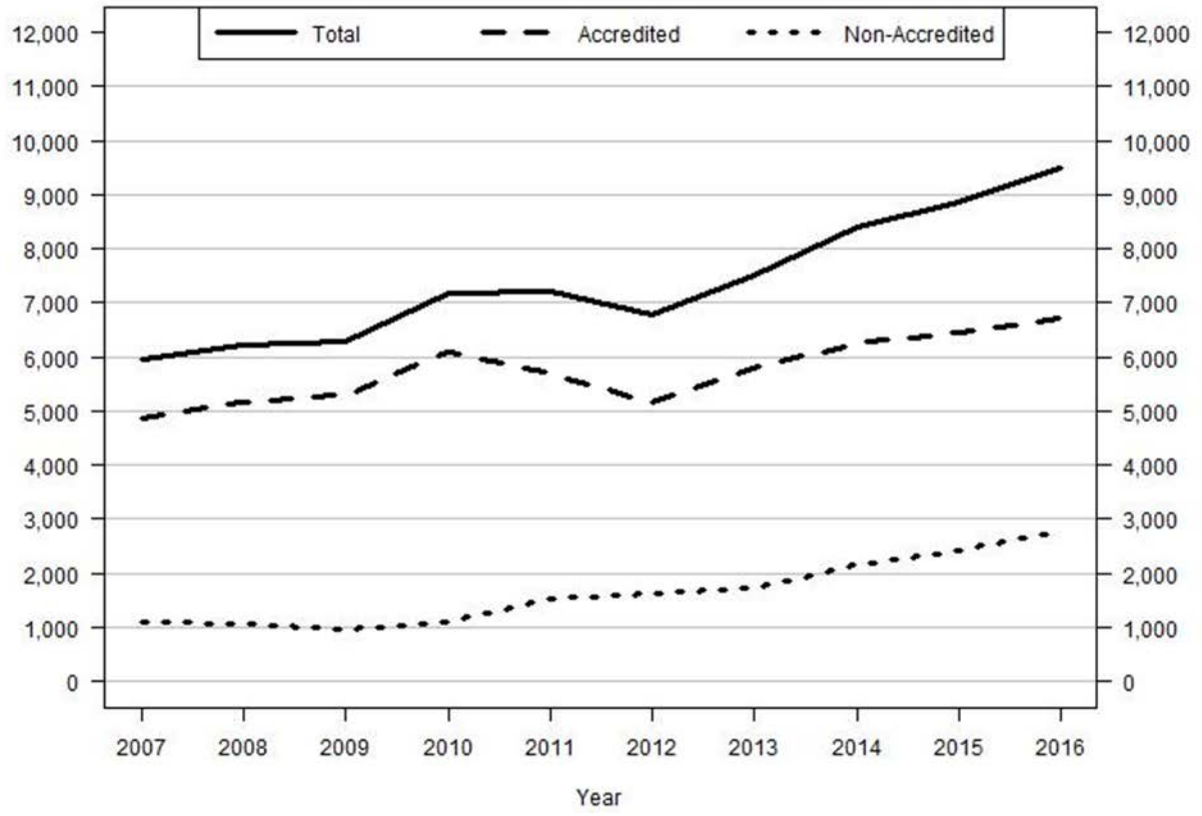
Concerning NBDE Part II failure rates, the Joint Commission recognized an increase in the failure rate from 2008 to 2009. The Joint Commission reviewed procedures and protocols associated with the development of Part II examination forms, standard-setting activities conducted in 2008, and scoring. The 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
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
2016	6,034	8.7	682	24.1	1,861	34.2	913	45.0	9,490	18.3

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

Figure 2. NBDE Part II Administrations (2007–2016)



NBDHE: Table 3 presents performance trends for the National Board Dental Hygiene Examination (NBDHE) over the past 10 years, while Figure 3 provides a graphic depiction of administration volume. As shown in Table 3, the number of first-time candidates from accredited programs increased from 6,680 in 2007 to 7,397 in 2016 (i.e., an 11% increase). The total number of candidates from non-accredited programs was relatively small compared to the total number of candidates from accredited programs, representing approximately 6% of administrations occurring in 2007 and approximately 3% of administrations occurring in 2016. Comparing the number of total administrations occurring in 2007 with 2016 shows an overall increase of 422 first-time and repeating candidates from accredited and non-accredited programs (i.e., a 5% increase). Generally speaking, NBDHE total administration volume has been quite stable over the ten-year period indicated.

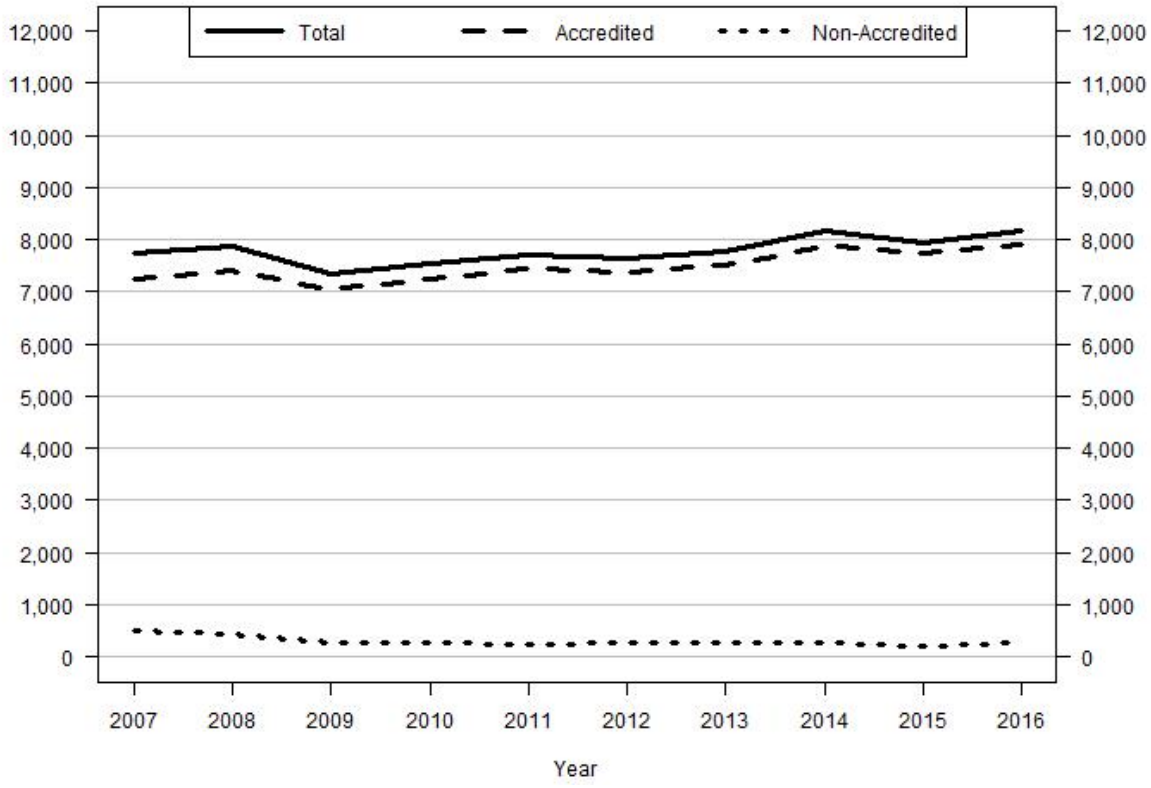
Failure rates were below 7% for all ten years for first-time candidates from accredited programs. Failure rates for first-time candidates from non-accredited programs were higher during the earlier years, and lower in more recent years, with the lowest rate occurring in 2013 (17.3%). The general trend shows a substantial decrease in failure rates for first-time candidates from non-accredited programs, decreasing from 50.4% in 2007 to 27.6% in 2016.

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
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
2016	7,397	5.1	506	41.7	214	27.6	45	35.6	8,162	8.1

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

Figure 3. NBDHE Administrations (2007–2016)



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 National Board Dental or Dental Hygiene Examinations with accommodations over the past five 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 2016, accommodated examination attempts

made up 1.5% of the total attempts for the NBDE Part I, 1.3% of the total attempts for the NBDE Part II, and 0.8% of the total attempts for the NBDHE. Across the five-year period indicated, failure rates were less for first-time candidates than for repeating candidates across the three exam programs.

Table 4. Numbers and Failure Rates for Accredited Candidate 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
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
2016	114	12.3	32	50.0	100	17.0	25	40.0	53	11.3	14	35.7

*The number of candidates from non-accredited institutions receiving accommodations was too small to provide meaningful trend information in this report.
Note. A new standard was introduced for NBDE Part I in 2016, based on updated standard setting activities.

Responses to House of Delegates Resolutions

There were no House of Delegates resolutions directed at the Joint Commission in 2016.

Self-Assessment

The Joint Commission has conducted a self-assessment in accordance with ADA House of Delegates (HOD) Resolution 1H-2013 (*Trans.*2013:339) and using the topical outline developed by the ADA Board of Trustees. This self-assessment took place over a two-year period involving discussions occurring by the full JCNDE, three JCNDE standing committees (Committee on Administration, Committee on Dental Hygiene, and Committee on Examination Development) and two separate ad hoc committees, the latter of which focused on self-assessment and the JCNDE's scope of activity as determined by the ADA *Bylaws*.

The Joint Commission concluded that it continues to play a critical and unique public service role in helping state dental boards to assess the qualifications of licensure candidates for dentistry and dental hygiene. The structure and responsibilities defined within the ADA *Bylaws* remain appropriate and are being carried out effectively. The Joint Commission includes appropriate representation from stakeholders and communities of interest, and the Joint Commission's examinations continue to be accepted by all U.S. state boards. Over 27,000 examinations were administered by the Joint Commission in 2016. It is vital that the Joint Commission continue to maintain its independence in decision making and its semi-autonomous status. From an operational perspective, the Joint Commission believes that its decision-making process is efficient and that volunteer time has been optimized. Detailed discussion and projects are referred to the Joint Commission's four standing committees, and test construction activities are delegated to Test Construction Committees. Ad hoc committees are appointed as needed. Day-to-day operations are appropriately delegated to staff. The Joint Commission monitors its need for resources and takes action accordingly. The Joint Commission recognizes that quality and innovation are essential to the validity and clinical relevance of the Joint Commission's examination programs, which have tremendous impact on public health.

In conducting this self-assessment and providing its findings to the ADA HOD, the Joint Commission identified a recommended *Bylaws* change, which will be considered separately by the ADA HOD. *Bylaws*

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 *Joint Commission Standing Rules*, 2) the *Joint Commission Examination Regulations*, and 3) the *Joint Commission 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

Platt, Jeffrey A., 2017, Indiana, chair
Eleazer, Paul D., 2018, Alabama, vice chair
Aminoshariae, Anita, 2018, Ohio
Braun, Thomas W., 2019, Pennsylvania
Dmytryk, John J., 2017, Oklahoma
Fallon, Andrea C., 2017, Connecticut*
Fontana, Margherita R., 2020, Michigan
Geisinger, Maria L., 2020, Alabama
Jefferies, Steven R., 2020, Pennsylvania
Keels, Martha A., 2020, North Carolina
Mariotti, Angelo J., 2019, Ohio
Moore, Paul A., 2018, Pennsylvania
Offenbacher, Steven, 2018, North Carolina
Parker, William B., 2019, Florida
Roberts, Howard W., 2018, Mississippi
Slayton, Rebecca L., 2017, Washington
Tinanoff, Norman, 2019, Maryland
Weyant, Robert J., 2017, Pennsylvania

Lyznicki, James M., senior manager

The Council's 2016–17 liaisons include: Dr. Daniel Klemmedson (Board of Trustees, Fourteenth District) and Mr. Stephen Rogers (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 presents outcomes of Council programs from January to July 2017 and tracks 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 1: Leaders and Advocates

Initiative/Program: Publish and/or present scientific data

Success Measure: Three documents per quarter; 12 per year

Target: 12 per year

Range: 10 to 14 documents per year

Outcome: 32 documents developed through July 2017, including: one systematic review and one clinical practice guideline on the evaluation of potentially malignant disorders in the oral cavity (both scheduled for publication in October 2017 *JADA*); the Council's "Proposed ADA Oral Hygiene Recommendations" and an accompanying evidence report (both completed for the "Project Clean" initiative); and 16 new or updated Oral Health Topic pages on ADA.org addressing such topics as genetics and oral health, dental erosion, antibiotic stewardship, amalgam separators, mouthwash, toothpastes, and aging and dental health. Six critical summaries of systematic reviews were published, including this summary in the January 2017 issue of *JADA*; four American National Standards Institute (ANSI)/ADA standards were also published. Objective completed/exceeded.**

Objective 1: Leaders and Advocates

Initiative/Program: Develop scientific content for continuing education (CE) courses and offer opportunities for members to earn ADA CE credit based on work of the Council and other Science Institute programs.

Success Measure: 80 hours per year; 20 per quarter

Target: 80 hours per year

Range: 60 to 100 hours per year

Outcome: 52 CE credit hours offered through June 2017 (45 CE hours from the ADA Center for Evidence-Based Dentistry [EBD] training/workshops; two CE hours from webinars on prophylactic antibiotic use in dental patients with prosthetic joints; one CE hour from a June 2017 webinar on "Translating Research into Effective Care"; one CE hour offered in the March 2017 *JADA* issue; and three CE hours from a clinical-guidelines workshop and research abstracts presented at the 2017 American Association for Dental Research [AADR] annual meeting). The Council is sponsoring 11 CE courses at the ADA 2017 meeting, and the Science Institute is sponsoring an Oropharyngeal Cancer Symposium at ADA 2017 that will offer 4.5 CE hours. The EBD Center plans to offer an additional 29 CE credit hours through December 2017. Objective is on schedule.**

Objective 3: Member Value

Initiative/Program: Deliver increased non-dues revenue

Success Measure: $1.205 million for 2017

Target: $1.205 million

Range: $0.7–1.3 million

Outcome: $580,607 through June 2017. Objective is on schedule.**

Evidence-based Clinical Practice Guidelines. Between 2016 and 2017, the EBD Center led two evidence-based clinical practice guideline projects, which are summarized below.

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

- **Evaluation of Potentially Malignant Disorders in the Oral Cavity**: In the first half of 2017, the EBD Center completed a systematic review and an evidence-based clinical practice guideline on the evaluation of potentially malignant disorders in the oral cavity (the latter is an update of the Council's 2010 guideline on this topic). In July 2017, the Council approved the final manuscripts for the systematic review and clinical practice guideline for publication; both articles are scheduled for publication in the October 2017 issue of *JADA*. A Chairside Guide to assist clinicians with this updated guideline is under development, and will be posted on the EBD Center website in fall 2017.

  At ADA 2017 – America's Dental Meeting, the Council is sponsoring a continuing education session on this updated clinical practice guideline (course number 6809), which will presented by Dr. Mark Lingen, chair of the expert panel that developed the guideline. Also at the ADA annual meeting, Dr. Lingen and other researchers will present at a new joint Oropharyngeal Cancer Symposium sponsored by the ADA and MD Anderson Cancer Center, which will address the latest science on oropharyngeal cancer and how dental professionals can be part of prevention and treatment solutions pertaining to oral HPV infection and oropharyngeal cancer. This symposium is open to all ADA annual meeting attendees, who will receive 4.5 CE hours for attending the full session.

- **Development of New Systematic Review and Clinical Practice Guideline on Non-surgical Approaches to Managing Dental Caries:** This year, the EBD Center is also conducting a systematic review and meta-analysis that will help experts to formulate an evidence-based clinical practice guideline during a three-day meeting at the ADA Headquarters in October 2017. Based on projected timelines for this evidence-based process, the Council plans to approve final manuscripts of the systematic review and clinical practice guideline for submission to *JADA* in early 2018 for publication.

Evidence-based Guideline Dissemination. Developed under the auspices of the Council, the EBD Center's clinical practice guidelines offer clear member value by providing clinicians with point-of-care recommendations based on best current evidence. As of June 2017, the clinical practice guidelines on prophylactic antibiotics and pit-and-fissure sealants are among the top-five, most-read articles on *JADA*'s website. The prophylactic antibiotics guideline is *JADA*'s most-read article over the past two years, with nearly 183,000 downloads since publication in the January 2015 *JADA*; the pit-and-fissure sealant guideline is *JADA*'s fifth most-read article, with over 13,600 downloads since publication in August 2016.

In 2017, the EBD Center also hosted two "Facebook Live" events: the first was a February 2017 interview with the Council's Dr. Margherita Fontana to promote the 2016 clinical practice guideline on dental sealants; and another in April 2017 to promote the 2013 guideline on topical fluoride. Combined, the two "Facebook Live" events generated over 55,200 views.

EBD Educational Programs. In 2017, the EBD Center continued to provide leadership in providing EBD-related educational workshops and programs. In April 2017, the EBD Center hosted a five-day Intensive EBD Workshop in Phoenix, Arizona, which drew 20 participants who received in-depth training on appraising and implementing evidence-based treatment and diagnostic options in clinical practice, educational curricula and research. In a post-workshop survey, all participants indicated that they would recommend the Intensive EBD Workshop to colleagues, and 95% of the participants rated the lectures, hands-on activities and small-group interactions as good or excellent.

Also in 2017, the EBD Center hosted external workshops in collaboration with the following dental schools or organizations: a full-day EBD workshop at the New Mexico Dental Association (January 2017); a March 2017 presentation on "The Production and Presentation of Clinical Guidelines," which was delivered, in collaboration with the Cochrane Oral Health Group, as part of an EBD workshop at the 2017 AADR annual meeting; and an April 2017 presentation on "Evidence-Based Clinical Practice Guidelines" at the Sixth Annual Grand Rounds Program (Marquette University School of Dentistry). In summer 2017 and later this year, the EBD Center has confirmed that it will provide custom EBD workshops at the

following schools: University of Alabama at Birmingham, University of Maryland and the University of California-San Francisco.

At the ADA annual meeting, the EBD Center will offer a half-day continuing-education workshop titled "Identify Truth vs. Fiction to Navigate Uncertainty" (course number 7326), which will focus on helping dentists with integrating their clinical expertise with existing evidence in order to make sound clinical decisions.

Scientific Information. The Center for Scientific Information's primary project in 2017 has been the development of updated, evidence-based oral hygiene recommendations, as part of an ADA-wide initiative known as "Project Clean." The Council has approved the primary and secondary recommendations developed as part of "Project Clean." These recommendations will be presented to ADA members and the general public in fall 2017 as part of an ADA-wide marketing campaign to promote evidence-based oral hygiene to reduce risk of oral disease.

In response to a request from the Council on Dental Practice (CDP) to address opioid-prescribing practices in dental settings, the Council developed and approved a new report on acute pain management following third molar extraction. This Council report was developed as a rapid evidence review for transmittal to CDP as a resource for content development and dissemination to ADA members, as appropriate. Additionally, following up on a 2016 Council report on the risks and benefits of using capnography in dental patients undergoing moderate sedation, the Council's Dr. William Parker developed a draft manuscript that has been submitted to *JADA* for publication consideration.

In spring 2017, the Council sponsored a new on-demand webinar on "Prophylactic Antibiotic Use in Dental Patients with Prosthetic Joints: What is the Evidence?," which is available on ADA.org to members and nonmembers. This course was also featured in a "live CE," question-and-answer session with Dr. Thomas Sollecito, Council consultant and primary webinar presenter, and in collaboration with the ADA New Dentist Committee. The live CE session was free to ADA members and drew over 300 registrants, providing a national forum for the Council's scientific and educational outreach.

In June 2017, the Council's Dr. Robert Weyant hosted a live webinar titled "Translating Research into Effective Care," which was presented on the ADA's live CE platform. This webinar focused on the importance of evidence-based clinical research for dental professionals, the value of research from both academia and industry and disseminating high-quality evidence in support of improved patient outcomes. A live Q&A session followed the presentation, which provided participants with one hour of CE credit.

In early 2017, the Council approved a new biennial ADA Research Agenda, which was shared with research organizations, dental school deans and other stakeholders to promote dental research advocacy and funding of key priorities for the advancement of oral health care. The Council also submitted the 2017–2018 ADA Research Agenda to the National Institute for Dental and Craniofacial Research (NIDCR) directly through the "NIDCR 2030" website, an online forum for sharing oral health research ideas and envisioning dentistry's future.

Also in 2017, the Center for Scientific Information collaborated with Research and Standards staff to finalize a draft manuscript titled "Clinician Perceptions of Four Hearing Protection Devices." This manuscript has been accepted for publication in *JDR Clinical and Translational Research*, where it will be published later this year.

ADA Seal of Acceptance Program. In accordance with the ADA *Bylaws*, the Council has subject matter responsibility for the ADA Seal of Acceptance Program, which provides the profession and the public with reliable information on safe and effective over-the-counter (OTC) oral health products. To support the ADA Seal of Acceptance Program, the Council provides review and analysis of program requirements and the evaluation of product submissions to be considered for the ADA Seal of Acceptance. The Council also provides suggestions for strengthening and promoting the ADA Seal of Acceptance Program to help ensure the safety and efficacy of OTC dental products for consumers.

In spring 2017, the Council approved five product submissions to be awarded the ADA Seal of Acceptance, including the first home-use tooth bleaching and powered interdental cleaning products to earn the ADA Seal. The Council also approved new ADA Seal of Acceptance Program category requirements for "Products to Help Prevent or Reduce Enamel Erosion," which were shared with Seal Program participants. In July 2017, the Council recommended development of category-specific ADA Seal of Acceptance Program requirements for products intended to relieve dry mouth, such as artificial saliva, rinses, lozenges and sprays. These ADA Seal of Acceptance Program requirements will be developed in the second half of 2017, shared with manufacturers and interested parties for editorial review, and submitted to the Council for approval.

In 2017, the ADA Science Institute, *ADA News* and the Division of Integrated Marketing and Communications are working in close collaboration to promote the ADA Seal of Acceptance Program to member dentists and consumers. Examples include an *ADA News* article featuring the new ADA Seal for product packaging and an ADA satellite media tour that facilitated discussions on choosing ADA-Accepted products to help manage oral malodor. The media tour resulted in 51 airings on 40 television stations, with an audience reach of over two million people.

Between February and April 2017, the ADA Seal of Acceptance Program was promoted through various websites in an extension of a paid advertising campaign targeting dental professionals and consumers. Display ads promoting the ADA Seal on websites with dental-related content generated approximately 24 million impressions, and promotions on social-networking sites (e.g., LinkedIn) and paid-search ads resulted in click-through rates well above target. In spring 2017, the ADA commissioned a media company to develop a video to educate manufacturers on the ADA Seal of Acceptance Program's product submission and evaluation procedures, including recent programmatic changes and consumer survey findings. The video will serve as a useful marketing resource that emphasizes the ADA Seal of Acceptance Program as the gold standard for evaluating safe and effective OTC oral health products.

The Council built upon its 2016 initiative to review and revise all existing Acceptance Program Requirements to market the updated programmatic requirements to manufacturers across the U.S. Feedback from product manufacturers to the ADA Seal of Acceptance Program has been quite positive, and the Seal Program's marketing and revitalization efforts are generating favorable results. The Council awarded the Seal to two first-in-category product submissions, and at least two more first-in-category product submissions are anticipated before year's end.

ADA Product Evaluation. Through the ADA *Bylaws*, the Council has subject matter responsibility for the "evaluation of professional products" used in dental practice. The Council fulfills this responsibility through development and publication of the ADA Professional Product Review (PPR).

The April 2017 PPR featured an overview of clinical uses of ceramic CAD/CAM materials, which provided clinicians with an increased understanding of key properties, processing considerations, delivery modes, shade options and recommended surface treatments for these materials. Ceramic CAD/CAM materials have become increasingly popular among dentists whose patients are looking for a metal-free or more natural-looking option for indirect restorations. Significant advances in digital fabrication techniques and the development of newer, stronger ceramic materials give practitioners the ability to combine esthetics with durability. Ceramic CAD/CAM materials differ in composition, material properties, processing methods and clinical indications, all of which work together when determining a material's best use.

The August 2017 PPR will feature research from the ADA research laboratory with measurements of fluoride release from fluoride varnishes and silver diamine fluoride. Using a method developed by the University of Michigan Cariology Research Laboratory, ADA Product Evaluation staff investigated the release pattern of fluoride from these products over a four-hour span, and the findings will be highlighted in this PPR newsletter.

Since October 2016, 65 member dentists have joined the ADA Clinical Evaluators (ACE) panel, a group of over 570 clinicians that is used to gather product-evaluation feedback for the PPR newsletter. The expanded ACE Panel will be utilized more extensively and proactively over the near-term future, allowing the Council to conduct research studies on professional products used in day-to-day clinical practice. At

the ADA annual meeting, the Council will host an ACE Panel reception to recognize ACE panelists for their contributions to the program, welcome new members who joined over the past year, and recruit new members from the dental community. The ACE Panel reception will also feature an award ceremony honoring recipients of the ADA/AADR Evidence-Based Dentistry Faculty Award.

Product Evaluation staff are developing a new, user-friendly dental drug book in a concise, clinically relevant format that can be easily and effectively used in clinical practice. The concept for this publication, proposed initially by the ADA New Dentist Committee, is to develop a go-to resource for dental therapeutic information in a format that any dentist can use at the point of care. The Council is pursuing this as a priority initiative in 2017, and ADA Product Evaluation staff are preparing this publication in collaboration with the Council members and consultants. Based on current timelines, final publication of this resource is anticipated by the ADA 2018 annual meeting.

ADA Research and Standards. ADA Research and Standards staff conduct research on dental materials, instruments, and equipment, including general and applied research to address questions and emerging issues pertaining to dental materials or products. ADA Research and Standards staff presented or were collaborators on the following research presentations at the 2017 AADR annual meeting: beam-homogeneity characterization of light-emitting diode (LED) curing units; the influence of light-curing unit irradiance on resin-matrix composite cross-link density; and two presentations addressing long-term effects of different cleaning methods on clear retainer materials.

The Research and Standards Department performs laboratory testing of dental materials and products using standard and novel test methods, including research to support the development and verification of novel test methods and equipment. Research and Standards staff also provide subject-matter expertise and laboratory support to the ADA in its role as the ANSI-recognized standards development organization for dentistry. This includes Research and Standards participation in inter-laboratory studies and serving as conveners, chairpersons, and content experts for national and international working groups on dental materials and products. To provide further member value, Research and Standards staff also investigate emerging issues that could impact the environment, occupational health and safety, and patient care.

Research and Standards staff are conducting the following research evaluations:

- ability of protective filtering devices and shields to block transmission of “blue” light from dental curing units;
- updated evaluation of newer LED curing lights, including high-power units;
- a user survey on waterline-monitoring devices and the dental team; and
- evaluation of zirconia specimens of varying compositions and translucency measures.

Also, the Research and Standards Department provided direct input to the Council in its review of the FDA’s growing emphasis on instructions for cleaning devices before sterilization, if the device is considered reusable, and that if no cleaning process is specified, the item must be considered to be single use and disposable. Research and Standards staff are currently drafting a technical report on the steps to validate cleanliness instructions for dental instruments. The Council will continue to monitor and support standards-development activities pertaining to cleaning, processing and sterilization of devices in health care settings, in collaboration with various standards groups and organizations.

Research and Standards staff worked with the Center for Scientific Information to finalize a draft manuscript titled “Clinician Perceptions of Four Hearing Protection Devices.” This manuscript has been accepted for publication in *JDR Clinical and Translational Research*, where it will be published later this year.

Emerging Issues and Trends

The Council’s scientific programs help facilitate continuous review of the research literature and proactive monitoring of emerging issues affecting clinical practice. This past year, the Council continued to address continuing concerns about chronic opioid use and misuse by developing resources to help dentists with safe, appropriate opioid prescribing. In July, the Council adopted a report that presents a rapid evidence

review of the relative safety and efficacy of oral opioid and non-opioid analgesics for the management of acute postoperative dental pain following extractions. The Council will also propose a state-of-the science CE session addressing safe and responsible prescribing of opioid analgesics, for presentation at the ADA 2018 annual meeting.

The Council issued its first online resources addressing genetics and oral health, which noted that genetic testing holds potential for future clinical application, but clinical measurements (e.g., radiographic evaluation, periodontal probing) remain the best approach to assessment of caries and periodontal disease at present. Additionally, the Council's programs and standards-development activities continue to evolve in response to the growing digitization of dentistry, and continued improvements in three-dimensional imaging (e.g., cone-beam computed tomography), nanotechnology-based restorative materials, CAD/CAM systems and digital scanning technologies.

Responses to House of Delegates Resolutions

Resolution Objective: Resolution 86H-2016: Proposal to Convene Three Expert Panels to Address Optimizing Dental Health Prior to Surgical/Medical Procedures and Treatment (*Trans.*2016:307)

> **86H-2016. Resolved,** that the Council on Scientific Affairs work with other appropriate ADA agencies and external stakeholders to develop proposed policy and evidence-based resources to optimize oral health prior to the performance of complex medical and surgical procedures, and be it further
>
> **Resolved,** that the Council on Scientific Affairs submit a progress report to the 2017 House of Delegates.

Initiative/Program: Convene three expert panels to work with appropriate ADA agencies and external stakeholders to develop evidence-based clinical resources to optimize dental health prior to the performance of the following complex medical and surgical procedures:

- Cardiac patients who are scheduled for cardiac valve repair/replacement or left ventricular assist device placement as a bridge to transplantation;
- Cancer patients, prior to head and neck radiation and chemotherapy; and
- Solid organ transplant patients prior to surgery.

Success Measure: Establish implementation plan to convene three expert panels to address this House resolution.

Target: Develop and obtain Council approval of an implementation plan to convene three expert panels addressing optimal dental health prior to the surgical/medical procedures indicated above.

Outcome: The Council approved the members of an Oversight Core Committee to provide guidance and continuity for the three expert-panel reviews. The Oversight Core Committee will begin discussions on the formation and structure of the three expert panels in August 2017, with formation of the first panel (cardiac) to be formed shortly thereafter. The remaining two panels will be formed in late 2017 and early 2018.

Resolution Objective: Resolution 87H-2016: Review of Recommendations for Cone Beam Computed Tomography Inspections (*Trans.*2016:287)

> **87H-2016. Resolved,** that the appropriate ADA agencies review the recommendations for the quality assurance inspection of dental radiographic equipment, including but not limited to, intra-oral, panoramic, cephalometric and cone beam computed tomography devices and recommend inspection protocols that would include the appropriate method and interval for inspection.

Initiative/Program: Provide subject matter expertise to the Council on Dental Practice (CDP) to assist in the development of recommendations for the quality assurance inspection of dental radiographic equipment.

Success Measure: Complete provision of scientific input to the CDP to support the review of recommendations for the quality assurance inspection of dental radiographic equipment, and provide scientific feedback and review on CDP's draft response that addresses this House resolution.

Target: Provision of the Council member and staff support to assist CDP's efforts to address this House resolution.

Outcome: Dr. Paul Eleazer, Council vice chair, attended a March 2017 meeting organized by CDP to address periodic quality assurance inspection of dental radiographic equipment. Dr. Eleazer and Council staff also reviewed CDP's draft report addressing quality assurance testing of digital radiographic equipment, which is being developed in response to Resolution 87H-2016.

Policy Review

In accordance with Resolution 170H-2012, Reaffirming Existing ADA Policy, the Council reviewed several Association policies related to dental science, oral health research and evidence-based dentistry. The Council reviewed the following policies and determined they should be maintained:

Study of Human Remains for Forensic and Other Scientific Purposes (*Trans.*2002:421)
Use of Amalgam as Restorative Material (*Trans* 1986:536)
Precapsulated Amalgam Alloy (*Trans.*1994:676)
Scientific Assessment of Dental Restorative Materials (*Trans.*2003:387)
Bone Marrow Matching Programs (*Trans.*2012:458)

Additional policy-related recommendations from the Council will be presented in future reports to the 2017 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, 2020, Ohio
Maher, John, 2017, Wisconsin

Doherty, Deborah, managing director

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

ADA Business Enterprises, Inc. (ADABEI) leads in the development of revenue generation by providing best-in-class products, services and opportunities that create value.

In 2016, ADABEI Goals Included:

- Financial Sustainability
  - Increase Non-Dues Revenue for the ADA
  - Key Provider Renewals (U.S. Bank and CareCredit)
- Increase Member Value
  - Increase Member Engagement and Data Centric Focus
  - Increase Database Efforts Internally and with Partners
  - Improve Marketing Tactics Based on Data
- New Product Development and Existing Product Enhancements
  - Based on Research
- Develop Organization with Capacity to Meet Stakeholder Needs
  - Increase Collaboration with the ADA
  - Increase Collaboration with State Dental Societies

Throughout 2016, ADABEI staff achieved each of the goals. Examples, among other efforts, included:

- Exceeded Financial Goals (Tables 1 and 2)
- Completed Seven Year Contract Renewals
  - U.S. Bank ($2,400,000 per year)
  - CareCredit ($1,700,000 per year)
- Added Two New Providers
  - AHI (Small Group Tours & Cruises)
  - Lenovo (Computers)
- Increased State Royalty Sharing and Co-Endorsements
  - Three New State Co-Endorsements (48 total)
  - 489 Product Co-Endorsements (23.5% Increase)
  - $1,094,000 State Royalty Sharing (11.5% Increase)
- Built Five-Year Strategic Plan with ADABEI Board
  - Long-Term Vision Tied to ADA's Strategic Plan (Members First 2020)
- Member Value and Engagement
  - 90% Member Engagement
  - 114,120 Single Buyer ADABEI Product Buyers
  - 26,911 Multi-Product Buyers
  - 10,407 New Dentist Buyers

* *ADA Trustee*

ADABEI Financials

In 2016, ADABEI earned $2,361,000 in gross revenue as a result of service fees to ADABEI from the program and finished 2016 with net income (pre-tax) of $322,000, driven in large part by strong product performance and managing expenses below budget.

Table 1. 2016 ADABEI Financials

	2016 Actuals	2016 Budget	Variance ($)	Variance (%)
ADABEI Revenue	$2,361,000	$2,317,000	$44,000	1.9%
Expenses	$2,039,000	$2,076,000	$37,000	1.8%
Net (Pre-Tax)	**$322,000**	**$241,000**	**$81,000**	**33.6%**

ADA Royalties

In 2016, the ADA earned royalties of $4,672,000 from endorsed providers in the program, exceeding the budget by $568,000 or 13.8%. 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 2016, the ADA paid $1,094,000 (first time over $1 million) in royalties to states and exceeded the budget due to additional states joining the program and co-endorsements.

Table 2. 2016 ADA Financials

	2016 Actuals	2016 Budget	Variance ($)	Variance (%)
ADA Royalties	$4,672,000	$4,104,000	$568,000	13.8%
State Royalty Share	$1,094,000	$1,014,000	($80)	(7.9%)
Net (Pre-Tax)	**$3,578,000**	**$3,090,000**	**$488**	**15.8%**

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 2016, the program included 19 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
- Marketing and Secure Email—PBHS, Inc.
- Tours & Cruises—AHI Travel
- Amalgam Separators and Sharps—HealthFirst
- Payroll Services—SurePayroll, Inc.

- Message on Hold—InTouch Practice Communications
- Staff Apparel—Lands' End Business Outfitters, Inc.
- Online Backup and Digital Records—The Digital Dental Record
- Shipping—UPS and Meridian One Corporation
- Appliances—Whirlpool VIP Program and Meridian One Corporation
- Computers—Lenovo and Meridian One Corporation

Renewed and New Business

ADABEI completed a seven-year renewal with two key providers, U.S. Bank and CareCredit. These two products are utilized by more than 100,000 ADA members and generate more than $4,000,000 in total program revenue, per year. Product development continued to be a key focus for ADABEI. Eighty-five inquiries were received in 2016 from prospective providers. Each prospective provider is required to complete thorough company and product information and undergo extensive due diligence, if considered further by senior staff and the ADABEI Board of Directors. Two products were added in 2016, Tours & Cruises (AHI Travel) and Computers (Lenovo).

ADA Foundation

Green, Edward J., vice president, grants, 2017, Georgia
Jeffers, Gary E., vice president, scientific research, 2017, Michigan
Kiesling, Roger, vice president, finance, 2019, Montana
Maggio, Frank A., vice president, development, 2018, Illinois

Members at Large
Asai, Rickland G., 2018 Oregon*
Bruck, Ann, 2020, Minnesota
Dolan, Teresa A., 2019, Pennsylvania
Fujimoto, Patsy K., 2019, Hawaii
Gallant, Marshall L., 2019, Florida
Hayes, Mary J., 2017, Illinois
Himmelberger, Linda K., 2018, Pennsylvania
Icyda, Teri-Ross, 2018, Florida
Klemmedson, Daniel J. 2019, Arizona*
Lieb, Howard I.A., 2020, New York
Lynch, Michael C., 2019, New Jersey
McDermott, Bernard, 2017, District of Columbia
Morell, Maritza, 2020, Massachusetts
Panagakos, Fotinos S., 2017, New Jersey
Penrose, Michele, 2020, Michigan
Thompson, Roy, 2020, Tennessee*

Calnon, William R., Interim Executive Director and President, 2018, New York

Dr. Calnon became the ADAF interim executive director in December 2016 upon the retirement of the previous executive director. Currently, the ADAF is working with an executive search firm to fill the executive director role. An active search is in progress with final candidate interviews getting underway.

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

The ADA Foundation's (ADAF) programs and initiatives are poised to reach the current and next generation of dentists and continue to improve the oral health of the public. The ADAF provides social responsibility engagement through its grants, scholarships and awards that appeals to a diverse audience, particularly millennials who have a much more global view than previous generations and want to be associated with organizations that are giving back to those in need. Research has shown that younger generation dentists seek out organizations which offer "passion projects." Two priorities of the ADAF, Give Kids A Smile® (GKAS); providing free oral health services to underserved children and international programs; supporting the improvement of global oral health, provide opportunities to connect and collaborate with millennials. The ADA Foundation Volpe Research Center (VRC) provides a physical presence in a "national" venue that can influence policy and funding decisions that enhance member practices through science. In addition, ADAF research outcomes from GKAS and other initiatives can be leveraged in ADA advocacy efforts.

As the philanthropic arm of the ADA, the ADAF has programs and initiatives, as further described below, that drive positive oral health outcomes in the United States and internationally, as well as support the needs of the dental profession:

- Research at the VRC;
- GKAS;

** ADA Trustee*

- Grants, scholarships, and awards for education, research, access to care, and leadership;
- Financial assistance and disaster relief grants for dentists and their dependents; and
- International charitable programs.

Volpe Research Center

The VRC develops and provides world-class, basic and applied material and biochemical science expertise and capabilities to support the development of improved dental materials and treatment strategies. Through research, the VRC contributes to the improvement of dental practice and patient care and, ultimately, advances the oral health of the public.

Achievements:

- Work was completed on the fourth year of the U01 project (novel dental resin composites with extended service life; DE23752) and the first year of the R01 project (antimicrobial and remineralizing composites for Class V restorations; DE 26122) and the anticipated annual milestones were reached. These two federally-funded National Institute of Dental and Craniofacial Research (NIDCR) research grants bring collectively $803,888 in annual funding. Both projects are well-aligned with the Polymer-based Additive Manufacturing initiative considered to be of high priority for National Institute of Standards and Technology (NIST).
- Ongoing material and bioscience projects include the following:
  - Hydroxyapatite Standard Reference Material SRM 2910.
  - Reference material for human tooth enamel.
  - Novel bioactive calcium phosphate cements with anti-inflammatory, anti-microbial and osteoinductive properties.
  - Synthesis of carbonated hydroxyapatite SRM.
  - Biosensors in oral cavities for real-time disease diagnosis.
  - Carbonate-incorporated hydroxyapatites (CHC) for bio-dosimetry.
  - Tooth remineralization and/or de-sensitization materials.
  - Nano forms of bio-relevant compounds.
  - Effects of e-cigarette on oral health.
  - Multi-targeted treatment strategies for dental pulp tissues.
  - Lab-on-a-chip: Advancing cell culture evaluation to resemble oral environment.
  - Occupational hazard and standards in dental offices biosensors for oral health.
  - Bone turnover in calcium phosphate cements.
  - Visualization of osteoclasts using engineered magnetic microbeads.

All projects support both VRC/ADAF and NIST missions and are aligned with the latest research/innovation/manufacturing initiatives such as the Advanced Regenerative Manufacturing Institute (AMRI), the National Institute for Innovation in Manufacturing Biopharmaceuticals (NIIMBL), and the National Network for Manufacturing Innovation (NNMI).

Other achievements:

- Twenty-one publications in peer-reviewed journals which is a 62% increase from 2016.
- Seventeen presentations at scientific meetings which is a 13% increase from 2016.
- Two intellectual property protection provisional applications submitted and four new patents issued by the U.S. Patent and Trademark Office.
- VRC scientists continue to collaborate with industry and academia on a variety of projects.
- An R01 grant application (E-cigarettes and Perturbations in Oral Microbial-mucosal Homeostasis) with the Principal Investigator Dr. P. Kumar from The Ohio State University and VRC's Dr. J. Kim as Co-Investigator was submitted to NIDCR.
- Collaborative research with Catholic University of America on novel microfluidic co-culture of cells that resembles human gingival tissue resulted in a joint grant proposal has been submitted to the National Science Foundation.
- FDA pre-submission 510(k) premarketing document covering five dental devices (degradation-

resistant resin, degradation-resistant composite, antimicrobial resin, antimicrobial composite and self-healing composite) has been submitted to the Food and Drug Administration (FDA).

Future Priorities and Impact:

- Continued strong presence at the scientific conferences and publication record.
- Continued applications/grant submissions for external funding.
- Further engagement with industry and the academic partners.
- Cultivation and growth of partnerships and alignment with NIST.

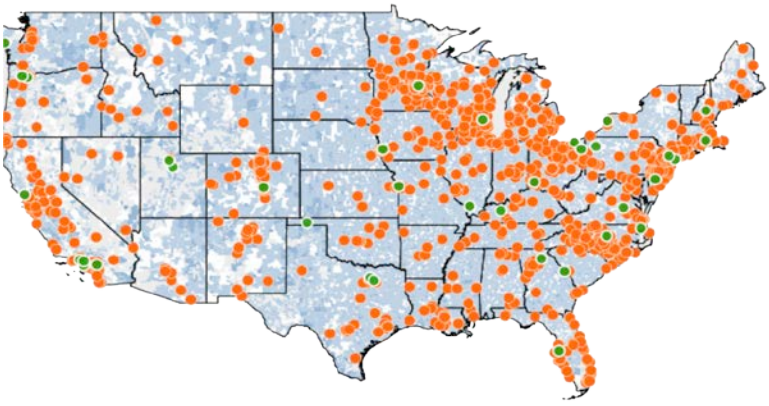
Give Kids A Smile®

The GKAS program celebrates its 15th anniversary this year. Through GKAS, the ADAF provides oversight, technical assistance and resources to hundreds of thousands of dental team members each year who volunteer their time to provide free oral health services to underserved children.

Achievements:

- GKAS has grown to be the largest children's oral health charitable program in the U.S.
- Since 2003, 5.5 million underserved children have received free oral health education, screenings and treatment.
- More than half a million volunteers in all 50 states—including 137,000 dentists and 420,000 other volunteers—have participated over the program's history.
- Introductory sealant kits were distributed to local GKAS programs to help dental volunteers place more than 400,000 sealants on the teeth of underserved kids in 2017.
- GKAS presented a webinar entitled "Increasing Continuity of Care" that reached 60 participants.
- Over 1,500 GKAS events took place across the U.S. in 2016 (see Figure 1).
- GKAS launched a newly acquired toll-free phone number (1-844-490-GKAS). This number provides caregivers and/or volunteers a means to call and find out if there is a GKAS program taking place near them.
- Over 50 GKAS ambassadors have been trained to serve as regional resources for other program coordinators who wish to initiate, expand or enhance their own GKAS programs.

Figure 1. GKAS Events in 2016



Future Priorities and Impact:

- Develop a multi-year GKAS strategic plan to ensure sustainable growth for the program, particularly in the areas of data collection, continuity of care, event attendance, communications, and external partnerships.
- Collaborate with ADA Government Affairs to leverage data collected for advocacy purposes.
- Continue stewarding current sponsor relationships while cultivating new mutually beneficial relationships within and outside of the dental arena.
- Expand collaboration with dental students to engage millennials, new dentists and the American Student Dental Association (ASDA).

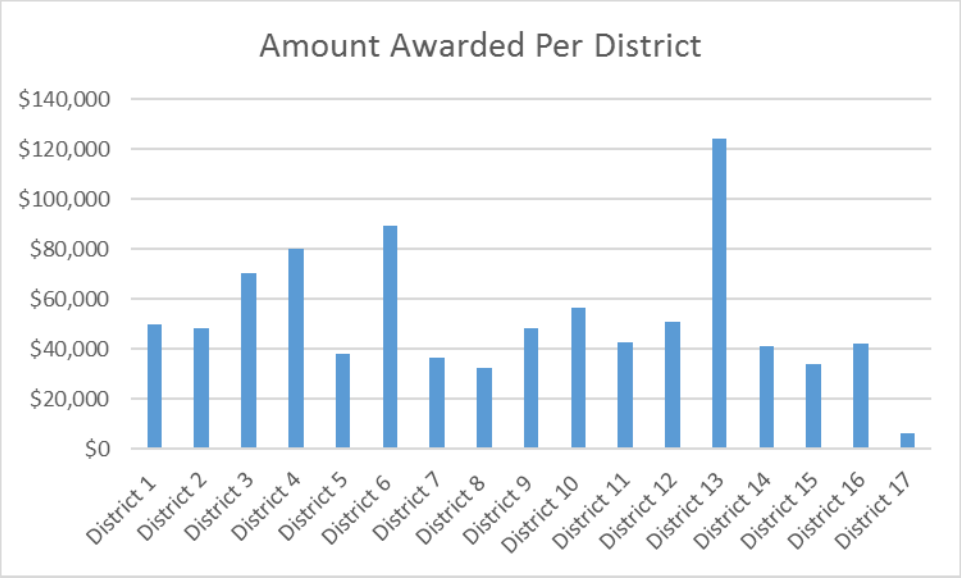
Grants, Awards and Scholarships

Through its philanthropic programs, the ADAF provides charitable assistance to the dental community and works to improve oral health by supporting access to care, research, and education programs.

Achievements:

- A total of $892,147.54 in grants, awards and scholarships awarded in 2016 (see Graph 1).
- Partnered with 187 organizations and individuals to provide charitable assistance, oral health access to care, research or education.
- Awards positively impacted all 17 ADA districts, and promoted ADAF priorities in 38 states and the District of Columbia.
- Awarded more than $55,000 GKAS Continuity of Care Grants to fund follow-up care and emphasize the importance of a dental home following the initial GKAS event.

Graph 1. Amount Awarded Per District



Future Priorities and Impact:

- Explore the feasibility of offering grant opportunities to provide oral health care to elders.

- Seek out ways to assist the military to assess and address oral health issues of service men and women.
- Determine opportunities to support and collaborate with special needs dentistry communities.
- Evaluate all grant, award and scholarship programs in terms of impact and programmatic priorities.
- Increase the dollar amount and reduce the number of awards; thus increasing the impact of dollars and further advancing the mission and priorities of the ADAF.
- Continue to organize grantee site visits to connect ADA and ADAF Board members and donors to local grantees to foster relationship building amongst all parties and develop long term relationships.

International Programs

The ADAF, through its international programs, works to improve global oral health and oral health care infrastructure through professional education, oral health infrastructure development, community dental public health, and humanitarian outreach programs.

Achievements:

- In October 2016, two courses on international volunteerism were offered during the annual meeting which attracted more than 200 attendees each, the highest attendance at a course on this topic to date.
- Sponsorship of Health Volunteers Overseas' (HVO) 30th anniversary.
- In honor of FDI World Oral Health Day, distributed 9,600 Arm & Hammer Tooth Tunes™ toothbrushes, donated by Church and Dwight, to 28 U.S.-based volunteer organizations that provide oral health care services in 73 countries.
- Presented a webinar on international volunteerism attracting 66 participants.
- Surveyed 23,233 U.S. dental students to learn about their attitudes toward international volunteer programs, which will define future initiatives.
- The international volunteer website attracted 20,105 users who visited 80,081 pages, with an average session duration of two minutes and 28 seconds.
- In partnership with Health Volunteers Overseas, 13 volunteer dentists completed oral health assignments in Cambodia, Laos, Nepal, St. Lucia, Nicaragua and Tanzania which resulted in 226 providers of dental service and education being trained.

Future Priorities and Impact:

- Offer grants and awards to support international volunteering.
- Develop a series of webinars on topics related to international volunteerism (ethics, infections control, etc.) to provide an ongoing resource to dental professionals.
- In collaboration with HVO and other organizations, identify and implement programs to train dentists and promote the importance of oral health with the ultimate goal of improving access to care in communities of need.

Communications

The ADAF communicates the impact of programs and its credibility as an organization to create relationships that will result in collaboration, awareness and resources to fulfill the Foundation's mission.

Achievements:

- Developed and executed a communications plan around GKAS's 15th anniversary that included a GKAS 15th anniversary video and a new GKAS tag line: "A healthy smile for every child. Volunteer. Participate. Donate."

- Launched a Thunderclap social media outreach campaign which had a reach of 171,823, to encourage GKAS program sign-up.
- Reaching more than 157,000 individuals, A GKAS poster was polybagged with the January 2017 *ADA News*, providing dental practices across the U.S. with the opportunity to promote their involvement and/or support of GKAS.
- Developed a new GKAS 15th anniversary "Gratitude Report" brochure.
- As part of the GKAS campaign, the ADAF distributed a mat release in English and Spanish to online news outlets across the country on February 6. See a sample English mat release pickup and a sample Spanish mat release pickup. See Table 1 for the outcomes.

Table 1. Outcomes of Mat Releases

Item description	Online placements	Ad value
English-language mat release	1,162	$321,687.00
Spanish-language mat release	1,160	$218,913.00
Infographic	590	$245,007.00

- Created a paid blog post that was distributed to "mommy bloggers" through Influence Central, with the goal of educating parents and caregivers about the importance of kids' oral health. A total of more than 45 blog posts were published, generating 34.7 million total campaign impressions from 2,711 total social posts. One hundred percent of blog posts included at least one key oral health education message, 92% of blog posts included two messages, and 89% of blog posts included all three key messages provided to the bloggers.
- The VRC area of the ADAF's website was significantly expanded to include in-depth information such as primary investigator profiles, information about current research projects, lists of selected publications, and links to the NIH Public Access Listing.

Future Priorities and Impact:

- Actively develop next-generation ADAF messaging to communicate the positive impact of ADAF charitable programs and research, to engage current and future donors.
- Connect and collaborate with state dental executive directors, component dental societies, ADPAC and State PAC members to engage, educate and influence legislators and policymakers.
- Increase engagement and communication with the ADA DC office and build on mutual areas of impact.
- Expand the profile at ADA 2017 – America's Dental Meeting in Atlanta beyond traditional exhibit floor presence, to include representation at both the House of Delegates and the headquarters hotel.
- Continue the GKAS 15th Anniversary celebrations through annual meeting.
- Collaborate with ADA staff to increase the ADAF's video presence throughout the next year.

AMERICAN DENTAL ASSOCIATION AND SUBSIDIARIES

Consolidated Financial Statements and Supplemental Schedules

December 31, 2016 and 2015

(With Independent Auditors' Report Thereon)

KPMG LLP
Aon Center
Suite 5500
200 E. Randolph Street
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, which comprise the consolidated statements of financial position as of December 31, 2016 and 2015, 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, 2016 and 2015, 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 is presented for purposes of additional analysis and is 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 13, 2017

AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES

Consolidated Statements of Financial Position

December 31, 2016 and 2015

Assets		**2016**	**2015**
Cash and cash equivalents	$	9,707,799	8,643,807
Receivables, net		7,720,912	8,829,830
Deferred taxes		58,266	59,106
Income taxes receivable		173,735	185,262
Prepaid expenses and other assets		4,180,207	2,243,136
Inventories, net		650,451	588,304
Marketable securities and alternative investments		160,950,809	150,125,357
Property and equipment, net		34,883,496	35,846,362
Funds held for deferred compensation		6,935,006	6,375,829
Total assets	$	225,260,681	212,896,993
Liabilities and Net Assets			
Accounts payable and accrued liabilities	$	14,765,443	13,500,381
Due to constituent societies		—	35,155
Deferred revenue		13,414,062	12,281,009
Income taxes payable		500	352,667
Charitable gift annuities		—	64,540
Liability for deferred compensation		6,935,006	6,375,829
Postretirement benefit obligation		11,378,082	11,093,105
Pension liability		56,388,326	54,146,067
Total liabilities		102,881,419	97,848,753
Net assets:			
Unrestricted		106,690,579	99,968,506
Temporarily restricted		13,549,841	12,940,892
Permanently restricted		2,138,842	2,138,842
Total net assets		122,379,262	115,048,240
Total liabilities and net assets	$	225,260,681	212,896,993

See accompanying notes to consolidated financial statements.

AMERICAN DENTAL ASSOCIATION AND SUBSIDIARIES

Consolidated Statements of Activities

Years ended December 31, 2016 and 2015

	2016				2015			
	Unrestricted	Temporarily restricted	Permanently restricted	Total	Unrestricted	Temporarily restricted	Permanently restricted	Total
Revenue:								
Membership dues	$ 54,476,016	—	—	54,476,016	55,626,857	—	—	55,626,857
Advertising	6,093,544	—	—	6,093,544	6,168,587	—	—	6,168,587
Rental income	3,920,757	—	—	3,920,757	3,544,193	—	—	3,544,193
Publication and product sales	6,422,985	—	—	6,422,985	6,186,714	—	—	6,186,714
Testing and accreditation fees	25,109,693	—	—	25,109,693	23,553,912	—	—	23,553,912
Meeting and seminar income	8,071,495	16,800	—	8,088,295	8,445,640	—	—	8,445,640
Grants, contributions, and sponsorships	2,147,294	4,028,321	—	6,175,615	1,942,292	3,836,517	—	5,778,809
Royalties and service fees	19,396,551	—	—	19,396,551	18,406,511	—	—	18,406,511
Investment income (loss)	7,170,676	752,208	—	7,922,884	(2,835,023)	(446,839)	—	(3,281,862)
Other income	2,993,748	—	—	2,993,748	3,763,524	480	—	3,764,004
Net assets released from restrictions	4,188,380	(4,188,380)	—	—	4,118,018	(4,118,018)	—	—
Total revenue	139,991,139	608,949	—	140,600,088	128,921,225	(727,860)	—	128,193,365
Expenses:								
Staff compensation, taxes, and benefits	62,940,063	—	—	62,940,063	59,497,296	—	—	59,497,296
Printing, publication, and marketing	9,288,362	—	—	9,288,362	8,654,877	—	—	8,654,877
Meeting expenses	2,565,711	—	—	2,565,711	2,761,620	—	—	2,761,620
Travel expenses	6,852,562	—	—	6,852,562	7,337,132	—	—	7,337,132
Consulting fees and outside services	10,237,532	—	—	10,237,532	10,545,120	—	—	10,545,120
Professional services	9,606,293	—	—	9,606,293	9,085,613	—	—	9,085,613
Office expenses	4,837,614	—	—	4,837,614	5,509,828	—	—	5,509,828
Facility and utility expenses	5,840,052	—	—	5,840,052	5,630,942	—	—	5,630,942
Grants and awards	6,220,560	—	—	6,220,560	5,856,170	—	—	5,856,170
Endorsement expenses	1,391,376	—	—	1,391,376	1,246,417	—	—	1,246,417
Depreciation and amortization	6,413,520	—	—	6,413,520	6,481,142	—	—	6,481,142
Bank and credit card fees	1,438,627	—	—	1,438,627	1,311,636	—	—	1,311,636
Other expenses	1,502,205	—	—	1,502,205	1,326,230	—	—	1,326,230
Total expenses	129,134,477	—	—	129,134,477	125,244,023	—	—	125,244,023
Net income (loss) from operations before income tax expense	10,856,662	608,949	—	11,465,611	3,677,202	(727,860)	—	2,949,342
Income tax expense	1,351,200	—	—	1,351,200	1,732,110	—	—	1,732,110
Net income (loss)	9,505,462	608,949	—	10,114,411	1,945,092	(727,860)	—	1,217,232
Pension—and postretirement health plan—related changes other than net periodic pension cost	(2,783,389)	—	—	(2,783,389)	(4,603,432)	—	—	(4,603,432)
Change in net assets	6,722,073	608,949	—	7,331,022	(2,658,340)	(727,860)	—	(3,386,200)
Net assets at beginning 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
Net assets at end of year	$ 106,690,579	13,549,841	2,138,842	122,379,262	99,968,506	12,940,892	2,138,842	115,048,240

See accompanying notes to consolidated financial statements.

AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended December 31, 2016 and 2015

	2016	2015
Cash flows from operating activities:		
Change in net assets	$ 7,331,022	(3,386,200)
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	2,783,389	4,603,432
Depreciation and amortization	6,413,520	6,481,142
Deferred income tax expense	840	1,451
Net change in unrealized (appreciation) depreciation in fair value of marketable securities and alternative investments	(5,424,449)	10,587,080
Net realized gain on sale of marketable securities and alternative investments	(7,565)	(5,181,325)
Net assets released from restrictions and used for operations	4,188,380	4,118,018
Change in actuarial value of gift annuity obligations	(49,538)	15,655
Provision for uncollectible accounts	85,007	33,469
Changes in assets and liabilities:		
Receivables, net	1,023,911	(45,540)
Income taxes payable (receivable), net	(340,640)	13,516
Prepaid expenses and other assets	(1,937,071)	(247,742)
Inventories, net	(62,147)	(25,798)
Accounts payable, accrued liabilities, and other liabilities	1,229,907	(132,606)
Deferred revenue	1,133,053	(1,166,143)
Postretirement benefit obligation	284,977	(401,707)
Pension liability	(541,130)	(843,926)
Net cash provided by operating activities	16,111,466	14,422,776
Cash flows from investing activities:		
Purchase of marketable securities and alternative investments	(47,152,071)	(68,592,834)
Sale and maturity of marketable securities and alternative investments	41,758,633	55,260,340
Acquisitions of property and equipment	(5,450,654)	(6,794,084)
Net cash used in investing activities	(10,844,092)	(20,126,578)
Cash flows from financing activities:		
Net assets released from restrictions and used for operations	(4,188,380)	(4,118,018)
Payments to charitable gift annuitant	(15,002)	(20,004)
Net cash used in financing activities	(4,203,382)	(4,138,022)
Net increase (decrease) in cash and cash equivalents	1,063,992	(9,841,824)
Cash and equivalents at beginning of year	8,643,807	18,485,631
Cash and cash equivalents at end of year	$ 9,707,799	8,643,807
Supplemental disclosure of cash flow information:		
Cash paid for income taxes	$ 1,690,000	1,748,513

See accompanying notes to consolidated financial statements.

(1) Summary of Significant Accounting Policies

(a) Organization and Purpose

The American Dental Association (the 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, 2016 and 2015 consist primarily of interest-bearing deposits under overnight repurchase agreements. The Association, ADPAC, ADAF, and ADABEI each maintains its 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 $128,933 and $120,214 in 2016 and 2015, 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 350, *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 $4,829,263 and $3,507,157 at December 31, 2016 and 2015, respectively.

Periodical subscriptions are recognized as revenue over the terms of the subscriptions. Subscriptions paid in advance are recorded as deferred revenue. Advertising revenue and direct publication costs are recognized in the period the related publication is issued. Rental income from the Association’s headquarters building and Washington, DC office building is recorded as revenue when earned. Testing fees are recognized as 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. 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 into 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 in 2016 or 2015.

In May 2015, the Financial Accounting Standards Board 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. ASU 2015-07 is to be applied retrospectively. The Association has elected to early adopt ASU 2015-07 in 2015.

(r) New Accounting Pronouncements

In May 2014, FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*. This ASU establishes principles for reporting useful information to users of financial statements about the nature, amount, timing, and uncertainty of revenue and cash flows arising from the entity's contracts with customers, particularly, that an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The requirements of this statement are effective for the Association for the year ending December 31, 2019. The ASU permits the new revenue recognition guidance to be applied using one of two retrospective application methods. The Association has not yet determined which application method it will use or the potential effects on the consolidated financial statements, if any.

In November 2016, FASB issued ASU 2016-18, *Restricted Cash, a consensus of the FASB Emerging Issues Task Force*. ASU 2016-18 requires an entity to include amounts generally described as restricted cash and restricted cash equivalents, along with cash and cash equivalents when reconciling beginning and ending balances on the statement of cash flows. ASU 2016-18 is effective for nonpublic business entities for annual reporting periods beginning after December 15, 2018, with retrospective application and disclosure. Early adoption of ASU 2016-18 is permitted. The requirements of this standard are effective for the Association for the year ending December 31, 2019. The Association has not evaluated the impact of this statement.

In August 2016, FASB issued ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities*. ASU 2016-14 represents phase 1 of FASB's Not-for-Profit financial reporting project and results in reducing the number of net asset classes, requires expense presentation by functional and natural classification, requires quantitative and qualitative information in liquidity, retains the option to present the cash flow statement on a direct or indirect method, as well as includes various other additional disclosure requirements. ASU 2016-14 is effective for annual reporting periods beginning after December 15, 2017, with retrospective application. Early adoption of ASU 2016-14 is permitted. The requirements of this statement are effective for the Association for the year ending December 31, 2018. The Association has not evaluated the impact of this statement.

In February 2016, FASB issued ASU 2016-02, *Leases*. ASU 2016-02 requires entities to recognize all leased assets as assets on the balance sheet with a corresponding liability resulting in a gross up of the balance sheet. Entities will also be required to present additional disclosures as the nature and extent of leasing activities. ASU 2016-02 is effective for nonpublic business entities for the annual reporting period beginning after December 15, 2019. The requirements of this statement are effective

for the Association for the year ending December 31, 2020. The Association has not evaluated the impact of this statement.

(2) Receivables

Receivables at December 31, 2016 and 2015 consist of the following:

		2016	2015
Trade receivables	$	3,971,299	5,292,561
Royalties receivable		2,326,268	2,516,757
Grants and contracts receivable		276,199	71,036
Tenant receivables		1,634,652	1,624,597
Pledges receivable		435,510	410,887
Other		76,317	27,666
Total		8,720,245	9,943,504
Less allowance for doubtful receivables		(999,333)	(1,113,674)
Net receivables	$	7,720,912	8,829,830

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, 2016 and 2015:

		2016	2015
Unconditional promises to give	$	442,330	430,526
Less unamortized discount		(6,820)	(19,639)
		435,510	410,887
Less allowance for uncollectible pledges		(800)	—
Net pledges receivable	$	434,710	410,887
Amounts due in:			
Less than one year	$	432,185	224,676
One to five years		2,525	186,211
Total	$	434,710	410,887

(3) Marketable Securities and Alternative Investments

Marketable securities at December 31, 2016 and 2015 consisted of the following:

	2016	
	Cost	Market
Money market funds	$ 15,902	15,902
Bonds and bond funds	50,665,134	49,692,737
Equities and equity funds	94,343,204	94,854,366
Alternative investment funds	14,542,396	16,387,804
	$ 159,566,636	160,950,809

	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

The fair value of marketable securities and alternative investments held in the Reserve Division amounted to $121,017,646 and $111,362,855 at December 31, 2016 and 2015, respectively.

Investment income is included in the accompanying consolidated statements of activities for the years ended December 31, 2016 and 2015 as follows:

	2016	2015
Interest and dividends	$ 2,490,870	2,123,893
Change in net unrealized appreciation (depreciation) in fair value of marketable securities and alternative investments	5,424,449	(10,587,080)
Net realized gain on sale of marketable securities and alternative investments	7,565	5,181,325
Total investment income (loss)	$ 7,922,884	(3,281,862)

(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, 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. Alternative investments funds are measured at the net asset value as a practical expedient to determine fair value.

(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 tables set forth by level, within the fair value hierarchy, the Association's assets at fair value as of December 31, 2016 and 2015:

	2016				Redemption or liquidation	Days' notice
	Level 1	Level 2	Level 3	Total		
Cash and cash equivalents	$ 9,707,800	—	—	9,707,800	Daily	One
Marketable securities and alternative investment funds:						
Money market funds	15,902	—	—	15,902	Daily	One
Fixed income mutual funds	49,597,557	—	—	49,597,557	Daily	One
Equity mutual funds	94,854,366	—	—	94,854,366	Daily	One
Corporate bonds	—	95,180	—	95,180	Daily	One
Alternative investment funds:						
Blackstone Partners Offshore Fund (1)	—	—	—	8,564,356	Semiannual	95
Wellington Archipelago Fund (1)	—	—	—	7,823,448	Quarterly	45
Total alternative investment funds	—	—	—	16,387,804		
Total marketable securities and alternative investment funds	144,467,825	95,180	—	160,950,809		
Funds held for deferred compensation:						
Money market funds	1,120,546	—	—	1,120,546	Daily	One
Equity mutual funds	4,489,496	—	—	4,489,496	Daily	One
Fixed income mutual funds	476,449	—	—	476,449	Daily	One
Corporate bonds	—	848,515	—	848,515	Daily	One
Total funds held for deferred compensation	6,086,491	848,515	—	6,935,006		
Total assets at fair value	$ 160,262,116	943,695	—	177,593,615		

(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.

	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 and alternative investment funds:						
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 and alternative investments funds	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.

There were no transfers between levels during the years ended December 31, 2016 and 2015.

The Association is invested in alternative investment funds at December 31, 2016 and 2015 for which the net asset value is used as a practical expedient to determine fair value in accordance with ASC Subtopic 820-10. The Association has no contractual commitments to fund the alternative investment funds. The balances in these funds were $16,387,804 and $16,556,041 at December 31, 2016 and 2015, respectively. The Association fully redeemed its investment in the Barlow Partners Offshore Fund in 2016.

(5) Property and Equipment

Property and equipment at December 31, 2016 and 2015 consisted of the following:

	2016		
	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	74,560,150	4,018,956	78,579,106
Furniture and equipment	51,821,887	1,287,039	53,108,926
Tenant leasehold improvements	2,980,523	3,057,311	6,037,834
	142,455,842	22,965,615	165,421,457
Less accumulated depreciation and amortization	116,406,077	14,131,884	130,537,961
	$ 26,049,765	8,833,731	34,883,496

	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

The Association leases portions of both the headquarters building in Chicago, Illinois, and the Washington, DC office building to unrelated parties under operating leases with varying terms. These amounts may be adjusted upon renewal of the leases. Minimum future rentals to be earned from leases currently in effect as of December 31, 2016 are as follows:

2017	$ 3,737,053
2018	5,712,878
2019	5,770,771
2020	4,351,329
2021	4,124,852
Thereafter	34,955,727
	$ 58,652,610

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 $58,266 and $59,106 as of December 31, 2016 and 2015, 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 $4,578 and $92,037 at December 31, 2016 and 2015, respectively.

Income tax expense differs from the amount computed by applying the statutory federal income tax rate of 34% to income before income tax expense primarily because a significant portion of consolidated income is exempt from income tax. 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, 2016 and 2015. Income tax expense for the years ended December 31, 2016 and 2015 is as follows:

	2016	2015
Current:		
Federal	$ 1,022,291	1,351,830
State	328,909	380,280
Current income tax expense	1,351,200	1,732,110
Deferred:		
Federal	76,753	60,594
State	11,547	9,116
Change in valuation allowance	(88,300)	(69,710)
Deferred income tax expense	—	—
Income tax expense	$ 1,351,200	1,732,110

Net deferred tax assets at December 31, 2016 and 2015 consisted of the following:

	2016	2015
Deferred tax assets resulting from:		
Postretirement health benefits	$ 58,266	59,106
Capital loss carryforward	4,578	92,037
Total deferred tax assets, net	62,844	151,143
Valuation allowance	(4,578)	(92,037)
Total deferred tax assets, net of valuation allowance	$ 58,266	59,106

(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 2016 and 2015.

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 tables set forth the Plan's funded status and amounts recognized in the Association's consolidated financial statements:

	2016		
	Employees' retirement trust	Employees' supplemental trust	Total
Change in projected benefit obligation:			
Projected benefit obligation, beginning of year	$ 196,431,054	1,429,755	197,860,809
Service cost	2,034,533	—	2,034,533
Interest cost	9,421,999	67,460	9,489,459
Actuarial loss	6,815,811	37,541	6,853,352
Benefits paid	(9,247,313)	(92,796)	(9,340,109)
Projected benefit obligation, end of year	$ 205,456,084	1,441,960	206,898,044
Change in plan assets:			
Fair value of plan assets, beginning of year	$ 143,714,742	—	143,714,742
Actual return on plan assets	10,542,289	—	10,542,289
Employer contributions	5,500,000	92,796	5,592,796
Benefits paid	(9,247,313)	(92,796)	(9,340,109)
Fair value of plan assets, end of year	$ 150,509,718	—	150,509,718
Funded status, end of year:			
Fair value of plan assets	$ 150,509,718	—	150,509,718
Benefit obligation	205,456,084	1,441,960	206,898,044
Funded status	$ (54,946,366)	(1,441,960)	(56,388,326)
Amounts recognized in the accompanying consolidated statements of financial position:			
Pension liability	$ 54,946,366	1,441,960	56,388,326
Accumulated benefit obligation in net periodic benefit expense and included as accumulated charges to unrestricted net assets:	205,456,084	1,441,960	206,898,044
Prior service cost	$ (5,445,376)	—	(5,445,376)
Net actuarial loss	81,868,670	—	81,868,670
Net amounts included as an accumulated charge to unrestricted net assets	$ 76,423,294	—	76,423,294

	2016		
	Employees' retirement trust	Employees' supplemental trust	Total
Components of net periodic benefit cost:			
Service cost	$ 2,034,533	—	2,034,533
Interest cost	9,421,999	67,460	9,489,459
Expected return on plan assets	(11,460,055)	—	(11,460,055)
Prior service cost	(1,491,883)	—	(1,491,883)
Recognized net loss	7,290,827	—	7,290,827
Net periodic benefit cost	$ 5,795,421	67,460	5,862,881
Calculation of change in unrestricted net assets:			
Accumulated unrestricted net assets, end of year	$ 76,423,294	—	76,423,294
Reversal of accumulated unrestricted net assets,	(74,451,120)	—	(74,451,120)
Change in unrestricted net assets	$ 1,972,174	—	1,972,174
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:			
Net loss experienced during the year	$ 7,771,118	—	7,771,118
Amortization of prior service cost due to plan amendments	1,491,883	—	1,491,883
Amortization of unrecognized net loss	(7,290,827)	—	(7,290,827)
Net amounts recognized in unrestricted net assets	$ 1,972,174	—	1,972,174
Estimate of amounts that will be amortized out of unrestricted net assets into net pension expense in 2017:			
Net loss	$ 7,040,146	—	7,040,146
Prior service cost	(1,491,883)	—	(1,491,883)
Weighted average assumptions as of December 31:			
Discount rate	4.68 %	4.68 %	
Expected return on plan assets	8.00	8.00	
Rate of compensation increase	3.00	3.00	

	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)
Amounts recognized in the accompanying consolidated statements of financial position:			
Pension liability	$ 52,716,312	1,429,755	54,146,067
Accumulated benefit obligation in net periodic benefit expense and included as accumulated charges to unrestricted net assets:	196,431,054	1,429,755	197,860,809
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

	2015		
	Employees' retirement trust	Employees' supplemental trust	Total
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,	(69,782,190)	—	(69,782,190)
Change in unrestricted net assets	$ 4,668,930	—	4,668,930
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 2017:			
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	

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 2016 and 2015 were $5,424,172 and $1,657,338, 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:

2017	$ 9,705,621
2018	9,946,410
2019	10,328,875
2020	10,830,906
2021	11,544,774
Thereafter	64,559,837
	$ 116,916,423

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, 2016 and 2015, and target allocations by asset category, are as follows:

	2016	
Asset category	Actual allocation	Target allocation
Fixed income	38 %	40 %
Equity:		
Domestic small cap	11	11
Domestic large cap value	11	10
Domestic large cap growth	19	18
International	21	21
	100 %	100 %

	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 %

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, 2016 and 2015.

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, 2016 and 2015.

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2016 and 2015:

	2016				Redemption or liquidation	Days' notice
	Total	Level 1	Level 2	Level 3		
Guaranteed investment contract (1)	$ 1,451,690	—	—	—	Daily	One
Equity mutual funds:						
Dodge & Cox Stock Fund	15,929,283	15,929,283	—	—	Daily	One
Vaughan Nelson Opportunity Fund	8,577,402	8,577,402	—	—	Daily	One
Vanguard Institutional Index Fund	13,157,073	13,157,073	—	—	Daily	One
LKCM Institutional Fund	8,021,154	8,021,154	—	—	Daily	One
T. Rowe Price Growth Fund	15,679,899	15,679,899	—	—	Daily	One
Templeton Institutional Funds, Inc. International Equity series	15,803,824	15,803,824	—	—	Daily	One
GMO International equity fund	15,749,391	15,749,391	—	—	Daily	One
Total equity mutual funds	92,918,026	92,918,026	—	—		
Fixed income mutual funds:						
Vanguard Intermediate-Term Index Bond Fund	10,025,301	10,025,301	—	—	Daily	One
Vanguard Long-Term Bond Index Fund	14,114,017	14,114,017	—	—	Daily	One
Vanguard Long-Term Corporate Bond Fund	32,027,211	32,027,211	—	—	Daily	One
Total fixed income mutual funds	56,166,529	56,166,529	—	—		
Accrued fees	(26,527)	(26,527)	—	—		
Total	$ 150,509,718	149,058,028	—	—		

(1) Certain investments that are measured at fair value using the net asset value (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in note 8.

	2015				Redemption or liquidation	Days' notice
	Total	Level 1	Level 2	Level 3		
Guaranteed investment contract (1)	$ 1,451,690	—	—	—	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	$ 140,751,852	139,330,532	—	—		

(1) Certain investments that are measured at fair value using the net asset value (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in note 8.

(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 2016 and 2015, the Association contributed 4% per year of each eligible employee's base salary. The Association's contributions under the plan were $1,641,844 and $1,567,870 in 2016 and 2015, 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 $18,096 were made to participants in 2016. Payments totaling $75,501 were made to participants in 2015. In 2013, the Association decided to terminate the plan, and accordingly, no awards were earned in 2016 or 2015. 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. For 2016 and 2015, the medical plan annual reimbursement limit for retirees at retirement and for ages 65-74 is $1,500 and increases to $1,800 from age 75 for life. For 2016 and 2015, each eligible dental plan participant is reimbursed 100% of qualified dental expenses to an annual limit of $1,300.

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

		2016	2015
Change in benefit obligation:			
Benefit obligation, beginning of year	$	11,093,105	11,494,812
Service cost		359,269	392,118
Interest cost		510,886	491,087
Actuarial gain		(273,594)	(999,147)
Benefits paid		(311,584)	(285,765)
Benefit obligation, end of year	$	11,378,082	11,093,105
Change in plan assets:			
Employer contributions	$	311,583	285,766
Benefits paid		(311,583)	(285,766)
Plan assets, end of year	$	—	—
Funded status, end of year:			
Benefit obligation	$	11,378,082	11,093,105
Accumulated benefit obligation		11,378,082	11,093,105

		2016	2015
Components of net periodic benefit cost:			
Service cost	$	359,269	392,118
Interest cost		510,886	491,087
Amortization of prior service cost		(1,459,910)	(1,459,910)
Recognized net loss		375,101	511,189
Net periodic benefit cost	$	(214,654)	(65,516)
Amounts recognized in the accompanying consolidated statements of financial position:			
Postretirement benefit obligation	$	11,378,082	11,093,105
Amounts not yet reflected in net periodic benefit expense and included as accumulated charges to unrestricted net assets:			
Net actuarial loss	$	4,545,378	5,194,073
Prior service cost		(6,219,213)	(7,679,123)
Net amounts included as an accumulated charge to unrestricted net assets	$	(1,673,835)	(2,485,050)
Calculation of change in unrestricted net assets:			
Accumulated unrestricted net assets, end of year	$	(1,673,835)	(2,485,050)
Reversal of accumulated unrestricted net assets, prior year		2,485,050	2,434,624
Change in unrestricted net assets	$	811,215	(50,426)
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:			
Net gain experienced during the year	$	(273,594)	(999,147)
Amortization of net loss		(375,101)	(511,189)
Amortization of prior service cost		1,459,910	1,459,910
Net amounts recognized in unrestricted net assets	$	811,215	(50,426)
Estimate of amounts that will be amortized out of unrestricted net assets into net postretirement benefit expense in 2016 and 2015:			
Net gain	$	(204,040)	(131,778)
Prior service cost		(1,459,910)	(1,459,910)

	2016	2015
Weighted average assumptions used to determine obligations at December 31:		
Discount rate	4.68 %	4.86 %
Weighted average assumptions used to determine net periodic benefit cost for the years ended December 31:		
Discount rate	4.86 %	4.55 %
Dental care trend rate	4.00	4.00

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
2017	$ 447,983
2018	480,702
2019	527,562
2020	573,862
2021	598,566
2022–2025	3,442,949

(9) Net Assets

Temporarily restricted net assets at December 31, 2016 and 2015 were available for the following purposes:

	2016	2015
Campaign for innovation in dental education	$ 74,961	133,103
Trusts	1,138,301	1,112,841
Extramural programs	113,520	113,520
Research	1,468,739	1,331,597
Awards	154,960	162,076
Education	460,805	405,095
Access	2,562,986	2,324,911
Political and legislative	589,638	627,419
Relief program	6,985,931	6,730,330
	$ 13,549,841	12,940,892

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 2016 and 2015 by incurring expenses satisfying the restricted purposes as follows:

	2016	2015
Campaign for innovation in dental education	$ 59,623	166,681
Trusts	535	471
Research	468	27,059
Awards	35,062	37,186
Education	21,579	103,754
Access	1,991,327	2,051,430
Political and legislative	1,893,047	1,650,389
Relief program	186,739	81,048
	$ 4,188,380	4,118,018

Permanently restricted net assets at December 31, 2016 and 2015 totaled $2,138,842, in each 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 2016 and 2015, the ADAF had the following activities related to endowment net assets:

	2016			
	Unrestricted	Temporarily restricted	Permanently restricted	Total
Endowment net assets, beginning of year	$ —	719,477	2,138,842	2,858,319
Investment returns:				
Interest and dividends	—	57,654	—	57,654
Realized gain on sale of investments	—	47,212	—	47,212
Net unrealized appreciation on investments	—	88,993	—	88,993
Total investment returns	—	193,859	—	193,859
Investment management fee	—	(2,662)	—	(2,662)
Appropriation of endowment assets for expenditures	—	(119,931)	—	(119,931)
Total change in endowment net assets	—	71,266	—	71,266
Endowment net assets, end of year	$ —	790,743	2,138,842	2,929,585

	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 appreciation 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

(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, 2016 and 2015:

	2016	2015
General fund:		
Administrative services	$ 6,829,860	7,186,652
Human resources	2,146,093	1,916,179
Legal affairs	4,033,052	3,887,031
Government affairs	9,064,568	8,656,103
Communications	6,630,280	5,672,108
Membership and dental society services	7,659,951	8,672,027
Conference and meeting services	9,093,441	8,759,893
Finance and operations	11,302,085	10,426,951

	2016	2015
Salable materials	$ 4,050,307	4,056,884
Central administration	8,040,385	8,762,545
Information technology and standards	13,083,831	13,841,298
Dental practice	5,361,974	5,404,438
Health policy resources center	2,696,758	2,827,559
Education	15,565,268	14,328,556
Science	4,941,358	4,414,488
Publishing	7,583,952	7,789,662
Business relations	641,679	805,256
Activities funded from reserves	327,468	353,983
Grant from ADA to ADAF	2,361,000	2,320,153
	121,413,310	120,081,766
Reserve division investment account	(232,566)	(1,151,753)
Eliminations of intercompany activities:		
Grant from ADA to ADAF	(2,361,000)	(2,320,153)
Headquarters building management office rent expense	(31,392)	(31,392)
Total expenses of general fund including income tax expense	118,788,352	116,578,468
ADPAC total expenses including income tax expense	2,898,260	2,589,599
ADAF total expenses	8,907,908	8,221,978
ADABEI total expenses including income tax expense	2,185,783	2,054,303
Eliminations of intercompany activities:		
ADABEI rental charges	(102,650)	(100,376)
Staffing, compensation, and benefits	(767,984)	(776,794)
Professional services	(40,488)	(28,237)
Printing, publication, and marketing	(176,069)	(249,851)
Research expenses	(80,000)	(269,090)
Overhead recovery	(112,724)	(104,655)
In-kind administrative expenses	(1,014,711)	(939,212)
Total expenses including income tax expense	$ 130,485,677	126,976,133

(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.

(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, 2016 through June 13, 2017, 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, 2016

	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	$ 7,167,221	—	—	—	—	7,167,221	593,495	1,490,171	456,912	—	9,707,799
Receivables, net	6,439,578	—	—	—	—	6,439,578	10,000	707,969	563,365	—	7,720,912
Due from affiliates	3,319,705	—	—	—	(3,546,480)	(226,775)	—	273,809	(47,034)	—	—
Deferred taxes	—	—	—	—	—	—	—	—	58,266	—	58,266
Income taxes receivable	10,404	—	—	—	—	10,404	—	—	163,331	—	173,735
Prepaid expenses and other assets	4,160,900	—	—	—	—	4,160,900	4,086	15,221	—	—	4,180,207
Inventories, net	650,451	—	—	—	—	650,451	—	—	—	—	650,451
Marketable securities and alternative investments	14,186,607	—	5,862,794	26,681,936	88,472,916	135,204,253	—	23,900,280	1,846,276	—	160,950,809
Investment in subsidiaries	—	2,843,364	—	—	—	2,843,364	—	—	—	(2,843,364)	—
Property and equipment, net	34,546,023	—	—	—	—	34,546,023	—	337,473	—	—	34,883,496
Funds held for deferred compensation	6,935,006	—	—	—	—	6,935,006	—	—	—	—	6,935,006
Total assets	$ 77,415,895	2,843,364	5,862,794	26,681,936	84,926,436	197,730,425	607,581	26,724,923	3,041,116	(2,843,364)	225,260,681
Liabilities and Net Assets											
Accounts payable and accrued liabilities	$ 13,626,746	—	—	—	—	13,626,746	17,443	923,502	197,752	—	14,765,443
Due to constituent societies	—	—	—	—	—	—	—	—	—	—	—
Deferred revenue	13,414,062	—	—	—	—	13,414,062	—	—	—	—	13,414,062
Income taxes payable, net	—	—	—	—	—	—	500	—	—	—	500
Charitable gift annuities	—	—	—	—	—	—	—	—	—	—	—
Liability for deferred compensation	6,935,006	—	—	—	—	6,935,006	—	—	—	—	6,935,006
Postretirement benefit obligation	—	—	—	—	11,378,082	11,378,082	—	—	—	—	11,378,082
Pension liability	56,388,326	—	—	—	—	56,388,326	—	—	—	—	56,388,326
Total liabilities	90,364,140	—	—	—	11,378,082	101,742,222	17,943	923,502	197,752	—	102,881,419
Net assets:											
Common stock	—	—	—	—	—	—	—	—	100,100	(100,100)	—
Additional paid-in capital	—	—	—	—	—	—	—	—	500,000	(500,000)	—
Unrestricted	(12,948,245)	2,843,364	5,862,794	26,681,936	73,548,354	95,988,203	—	10,702,376	2,243,264	(2,243,264)	106,690,579
Temporarily restricted	—	—	—	—	—	—	589,638	12,960,203	—	—	13,549,841
Permanently restricted	—	—	—	—	—	—	—	2,138,842	—	—	2,138,842
Total net assets	(12,948,245)	2,843,364	5,862,794	26,681,936	73,548,354	95,988,203	589,638	25,801,421	2,843,364	(2,843,364)	122,379,262
Total liabilities and net assets	$ 77,415,895	2,843,364	5,862,794	26,681,936	84,926,436	197,730,425	607,581	26,724,923	3,041,116	(2,843,364)	225,260,681

See accompanying independent auditors' report.

Schedule 2

AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES

Consolidated Statement of Activities with Supplementary Consolidating Information

Year ended December 31, 2016

	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	$ 54,476,016	—	—	—	—	54,476,016	—	—	—	—	54,476,016
Advertising	6,223,467	—	—	—	—	6,223,467	—	—	—	(129,923)	6,093,544
Rental income	4,054,799	—	—	—	—	4,054,799	—	—	—	(134,042)	3,920,757
Publication and product sales	6,449,131	—	—	—	—	6,449,131	—	—	—	(26,146)	6,422,985
Testing and accreditation fees	25,109,693	—	—	—	—	25,109,693	—	—	—	—	25,109,693
Meeting and seminar income	8,049,195	—	—	—	—	8,049,195	—	39,100	—	—	8,088,295
Grants, contributions, and sponsorships	1,395,135	—	—	—	—	1,395,135	1,845,427	3,035,053	—	(100,000)	6,175,615
Grant from ADA	—	—	—	—	—	—	—	2,361,000	—	(2,361,000)	—
Royalties and service fees	17,032,776	—	—	—	—	17,032,776	—	35,682	2,328,093	—	19,396,551
Investment income	2,057,503	173,102	—	1,898,700	2,684,445	6,813,750	341	1,251,156	30,739	(173,102)	7,922,884
Other income	3,146,700	—	—	—	—	3,146,700	—	207	53	(153,212)	2,993,748
In-kind services	—	—	—	—	—	—	1,014,711	767,984	—	(1,782,695)	—
Total revenue	127,994,415	173,102	—	1,898,700	2,684,445	132,750,662	2,860,479	7,490,182	2,358,885	(4,860,120)	140,600,088
Expenses:											
Staff compensation, taxes, and benefits	58,349,760	—	—	—	(236,703)	58,113,057	—	4,873,346	721,644	(767,984)	62,940,063
Printing, publication, and marketing	8,501,673	—	—	—	—	8,501,673	51,732	83,926	827,100	(176,069)	9,288,362
Meeting expenses	2,449,768	—	—	—	—	2,449,768	13,768	66,137	36,038	—	2,565,711
Travel expenses	6,429,740	—	—	—	—	6,429,740	405	352,885	69,532	—	6,852,562
Consulting fees and outside services	9,665,727	—	—	—	—	9,665,727	323,217	229,873	18,715	—	10,237,532
Professional services	9,036,955	—	—	—	4,137	9,041,092	33,986	426,515	145,188	(40,488)	9,606,293
Office expenses	4,496,340	—	—	—	—	4,496,340	10,739	313,517	17,018	—	4,837,614
Facility and utility expenses	5,869,374	—	—	—	—	5,869,374	—	—	104,720	(134,042)	5,840,052
Grants and awards	2,515,871	—	—	—	—	2,515,871	1,419,864	2,339,825	25,000	(80,000)	6,220,560
Grant to ADA Foundation	2,361,000	—	—	—	—	2,361,000	—	—	—	(2,361,000)	—
Endorsement expenses	1,391,376	—	—	—	—	1,391,376	—	—	—	—	1,391,376
Depreciation and amortization	6,325,146	—	—	—	—	6,325,146	—	88,374	—	—	6,413,520
Bank and credit card fees	1,409,289	—	—	—	—	1,409,289	29,338	—	—	—	1,438,627
Other expenses	1,360,362	—	—	—	—	1,360,362	—	133,510	121,057	(112,724)	1,502,205
In-kind administrative expenses	—	—	—	—	—	—	1,014,711	—	—	(1,014,711)	—
Total expenses	120,162,381	—	—	—	(232,566)	119,929,815	2,897,760	8,907,908	2,086,012	(4,687,018)	129,134,477
Net income (loss) from operations before income tax expense	7,832,034	173,102	—	1,898,700	2,917,011	12,820,847	(37,281)	(1,417,726)	272,873	(173,102)	11,465,611
Income tax expense	1,250,929	—	—	—	—	1,250,929	500	—	99,771	—	1,351,200
Net income (loss)	6,581,105	173,102	—	1,898,700	2,917,011	11,569,918	(37,781)	(1,417,726)	173,102	(173,102)	10,114,411
Pension—and postretirement health plan— related changes other than net periodic pension cost	(1,972,174)	—	—	—	(811,215)	(2,783,389)	—	—	—	—	(2,783,389)
Change in net assets	4,608,931	173,102	—	1,898,700	2,105,796	8,786,529	(37,781)	(1,417,726)	173,102	(173,102)	7,331,022
Net assets (deficit) at beginning 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
Equity transfers	(4,462,719)	—	(1,536,845)	6,520,161	(520,597)	—	—	—	—	—	—
Net assets (deficit) at end of year	$ (12,948,245)	2,843,364	5,862,794	26,681,936	73,548,354	95,988,203	589,638	25,801,421	2,243,264	(2,243,264)	122,379,262

See accompanying independent auditors' report.

Schedule 3

AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES

Consolidated Statement of Cash Flows with Supplementary Consolidating Information

Year ended December 31, 2016

	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:											
Change in net assets	$ 4,608,931	173,102	—	1,898,700	2,105,796	8,786,529	(37,781)	(1,417,726)	173,102	(173,102)	7,331,022
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	1,972,174	—	—	—	811,215	2,783,389	—	—	—	—	2,783,389
Depreciation and amortization	6,325,146	—	—	—	—	6,325,146	—	88,374	—	—	6,413,520
Deferred income tax expense	—	—	—	—	—	—	—	—	840	—	840
Net unrealized appreciation in fair value of marketable securities and alternative investments	(14,083)	—	—	(1,056,135)	(3,932,779)	(5,002,997)	—	(420,678)	(774)	—	(5,424,449)
Net realized loss (gain) on sale of marketable securities and alternative investments	(13,773)	—	—	(394,090)	799,860	391,997	—	(386,639)	(12,923)	—	(7,565)
Net assets released from restrictions and used for operations	—	—	—	—	—	—	1,893,047	2,295,333	—	—	4,188,380
Change in actuarial value of gift annuity obligations	—	—	—	—	—	—	—	(49,538)	—	—	(49,538)
Provision for uncollectible accounts	—	—	—	—	—	—	—	85,007	—	—	85,007
Equity in net income of other investments	—	(173,102)	—	—	—	(173,102)	—	—	—	173,102	—
Changes in assets and liabilities:											
Receivables, net	1,169,198	—	—	—	—	1,169,198	(10,000)	(170,999)	35,712	—	1,023,911
Income taxes payable (receivable), net	(362,071)	—	—	—	—	(362,071)	(500)	—	21,931	—	(340,640)
Prepaid expenses and other assets	(1,969,782)	—	—	—	—	(1,969,782)	45,932	(15,221)	2,000	—	(1,937,071)
Inventories, net	(62,147)	—	—	—	—	(62,147)	—	—	—	—	(62,147)
Accounts payable, accrued liabilities, and other liabilities	977,127	—	—	—	(18,096)	959,031	(40,253)	326,464	(15,335)	—	1,229,907
Due from/to affiliated organizations	(876,231)	—	—	—	920,694	44,463	—	8,677	(53,140)	—	—
Deferred revenue	1,138,053	—	—	—	—	1,138,053	—	(5,000)	—	—	1,133,053
Postretirement benefit obligation	811,214	—	—	—	(526,237)	284,977	—	—	—	—	284,977
Pension liability	(541,130)	—	—	—	—	(541,130)	—	—	—	—	(541,130)
Net cash provided by operating activities	13,162,626	—	—	448,475	160,453	13,771,554	1,850,445	338,054	151,413	—	16,111,466
Cash flows from investing activities:											
Purchase of marketable securities and alternative investments	(17,204,354)	—	(2,118,000)	(6,968,636)	(16,681,414)	(42,972,404)	—	(1,824,679)	(2,354,988)	—	(47,152,071)
Sale and maturity of marketable securities and alternative investments	14,555,229	—	3,654,845	—	17,041,558	35,251,632	—	4,669,056	1,837,945	—	41,758,633
Acquisitions of property and equipment	(5,344,839)	—	—	—	—	(5,344,839)	—	(105,815)	—	—	(5,450,654)
Net cash provided by (used in) investing activities	(7,993,964)	—	1,536,845	(6,968,636)	360,144	(13,065,611)	—	2,738,562	(517,043)	—	(10,844,092)
Cash flows from financing activities:											
Net assets released from restrictions and used for operations	—	—	—	—	—	—	(1,893,047)	(2,295,333)	—	—	(4,188,380)
Payments to charitable gift annuitant	—	—	—	—	—	—	—	(15,002)	—	—	(15,002)
Equity transfers funded with cash	(4,462,719)	—	(1,536,845)	6,520,161	(520,597)	—	—	—	—	—	—
Net cash provided by (used in) financing activities	(4,462,719)	—	(1,536,845)	6,520,161	(520,597)	—	(1,893,047)	(2,310,335)	—	—	(4,203,382)
Net increase (decrease) in cash and cash equivalents	705,943	—	—	—	—	705,943	(42,602)	766,281	(365,630)	—	1,063,992
Cash and equivalents at beginning of year	6,461,278	—	—	—	—	6,461,278	636,097	723,890	822,542	—	8,643,807
Cash and cash equivalents at end of year	$ 7,167,221	—	—	—	—	7,167,221	593,495	1,490,171	456,912	—	9,707,799

See accompanying independent auditors' report.