

2018

Annual Reports and Resolutions

159th Annual Session
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James L. Willey, senior director, Practice Institute
Anthony J. Ziebert, senior vice president, Education/Professional Affairs

Council on Advocacy for Access and Prevention

Fagan, Timothy R., 2018, Oklahoma, chair
 Herman, Richard P., 2019, New York, 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 C., 2018, Wisconsin*
 Hilton, Irene V., 2021, California
 Humenik, Mark J., 2020, Illinois
 Koday, Mark, 2019, Washington
 LoMonaco, Carmine J., 2020, New Jersey
 Meeske, Jessica A., 2021, Nebraska
 Morrow, Carol M., 2021, Colorado
 Neighbors, Bonita D., 2021, Michigan
 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 2018–19 liaisons include: Dr. Daniel Klemmedson, Board of Trustees, Fourteenth District; Mr. Jonathan C. Vogel, American Student Dental Association; Dr. Frank J. Graham, chair, Council on Government Affairs; and Dr. Craig S. Armstrong, vice chair, Council on Government Affairs.

Areas of Responsibility as Set Forth in the *Bylaws or Governance and Organizational Manual of the American Dental Association*

As listed in Chapter VIII Section K1 of the ADA *Governance and Organizational Manual*, the areas of subject matter responsibility of the Council shall be:

- a. Oral Health Literacy
- b. Oral Disease Prevention and Intervention
- c. Access to Oral Healthcare
- d. Community Oral Health Advocacy

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

Action for Dental Health: In keeping with the Strategic Plan Objective 1, the public will recognize the ADA and its members as leaders and advocates in oral health, 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 of increasing member value, Objective 3 of achieving an increase in the value from membership and Objective 6.1 of acting in

* *New Dentist member*

the best interest of the member, rather than the organization when designing processes, programs and services).

The Action for Dental Health Bill, passed by the U.S. House of Representatives in March and introduced in the Senate in June, describes support for the Council directed activities listed below, which involve members across the country.

The new vision statement, “Empowering All Members to Achieve Optimal Health for All” further supports the relevance of these activities.

Objective 3.1: Pursue programs that members value and are “Best in class”

Initiative/Program: ADH Community Water Fluoridation

Success Measure: Technical Assistance for States / Publication–Sales of Fluoridation Facts

Target: 30 states

Range: 25–40 states

Outcome: 32 states

Fluoridation Facts 2018 edition was released in February with sales approaching \$21,000 within 90 days. This highly regarded reference guide is valued by members to assist with local water fluoridation challenges.

Objective 6.1: Act in the best interest of the member, rather than the organization when designing processes, programs and services when designing programs

Initiative/Program: Medicaid provider education addressing program integrity and protection from audits through proper documentation of medical necessity, thus reducing administrative burdens often associated with Medicaid participation.

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

Target: 5 Boot Camps per year

Range: 5–7 Boot Camps per year with over 1,100 Dentists completing the online CE Course

Outcome: 7 Boot Camps done in 2018 with over 1,500 dentists participating. Over 4,000 dentists have taken this CE course (either online or live) since the 2014 offering began

Objective 1: Leaders and Advocates

Initiative/Program: Emergency Department (ED) Referral Initiative

Success Measure: ED Referral programs now exist in all 50 states.

The 2018 progress in this area now includes the American College of Emergency Physicians (ACEP) Practice Committee approving the ED Referral Development Guide, identifying eight “priority cities” for ED Referral model development and the inclusion of new ACEP Manager who serves as advisor for the Council’s ED Referral Workgroup.

Target: To begin an ED Referral program in two of the eight identified priority cities by January 1, 2019

Range: 2–3 priority cities

Outcome: Ongoing—key stakeholder groups to begin models in two identified priority cities

Objective 1: Leaders and Advocates

Initiative/Program: Community Dental Health Coordinator (CDHC)

Success Measure: CDHC presence (a graduate, trainee or school) in at least 25 states

Target: 35 states

Range: 32–40 states

Outcome: 42 states now have CDHC presence, with additional research goal set to study the program impact in a variety of settings

Through State Government Affairs, a white paper regarding the impact of the CDHC program will be completed this year, ready for a 2019 publication. Additional case studies are ongoing with CDHC outcomes to be examined within a private dental practice, hospital ED department, community clinic and primary care medical office.

Access and Advocacy Subcommittee Highlights:

- 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](#) with over 100 enrollees in the first half of 2018 and numerous “live” presentations to national, regional and state audiences, while educating providers to avoid audit angst through proper documentation of medical necessity, including presentations in Alaska, Oregon, Florida, Michigan, Louisiana, Hawaii and New York. 2019 sessions are tentatively scheduled for Maine, Missouri and California.
- In collaboration with the American Association of Pediatric Dentistry, MPAC has published a [Medicaid Provider Reference Guide](#) in support of the ADH Health campaign. With over 900 hits since its opening in late November 2017, the guide provides information on various topics, including Early Prevention Screening Diagnosis and Treatment (EPSDT), adult dental Medicaid benefits, cultural competency, compliance, documenting medical necessity, and the benefits of utilizing silver diamine fluoride. On this same site, an advocacy toolkit for promoting various legislative and regulatory aspects of Medicaid practice will be online by August.
- Access and Advocacy staff have 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 to ten states in 2018.
- In collaboration with the Arizona and New Mexico state dental associations, Access and Advocacy continues to support the inclusion of Navajo Community Health Representatives and community health workers into the new online CDHC non-credit certificate program at Central New Mexico Community College, in Albuquerque, NM. This effort supports the ADA’s stance of promoting community-based prevention as the catalyst for improving the oral health of underserved populations, including Native Americans.
- Coordinated six continuing education sessions for ADA 2018 – America’s Dental Meeting, with nine more in contention for 2019—all of which address an aspect of the ADH campaign.

Prevention Subcommittee Highlights:

- Health Literacy in Dentistry webpage has been launched on ADA.org and provides hyperlinks to online resources to educate members about health literacy principles. Since January 2018 through June 2018, there have been 1,981 visits to the webpage. This exceeds the Council's goal of 500 visits per quarter.
- Students from seventeen dental schools participated in the 2018 Health Literacy contest sponsored by the National Advisory Committee on Health Literacy in Dentistry (NACHLD), which promotes increased use of health literacy principles. The winning essay is posted on ADA.org, and published in the state dental association journal of the winner.
- For National Children's Dental Health Month (NCDHM), approximately 81,000 posters were distributed upon request to dental societies, preschools, elementary and middle schools, and other health agencies. In February, the NCDHM webpage was ranked sixth for most visits on all of ADA.org (28,500 visits). From December 6, 2017 to February 28, 2018, (the timeframe for the campaign), there were 35,591 visits, making the page the tenth most popular page during the months of the campaign. Traffic to the MouthHealthy Tooth Team NCDHM [poster](#) was 2,751 visits total, which was on par with the 2017 campaign.
- The Council has collaborated with CDC to promote the *Tips from Former Smokers* website and provide webinars on tobacco cessation strategies. These activities enhance the ability of members to improve patient health while providing the most current information from the CDC on this topic.
- The National Fluoridation Advisory Committee completed its work on *Fluoridation Facts* which became available through the ADA Catalog in March 2018. In addition to including ten new Q&As, the ninth edition included more than 400 references with links to abstracts and was available in both print and eBook format. As of mid-July, sales of *Fluoridation Facts* have generated \$27,143 in non-dues revenue.
- Over the past several years paid Google Ads developed and funded through the Division of Integrated Marketing and Communications ensured that the fluoridation pages were in the top ten pages visited on ADA.org. When funding for the ads ended in mid-2018, the effect was immediate as visits to the fluoridation pages plummeted reducing ADA's ability to advocate for community water fluoridation.

Emerging Issues and Trends

The Council is aware of several trends, which include:

- Potential dental benefit within the Medicare program. The Council has been one of the councils involved in the ongoing discussion, brought about by several national agencies such as the Santa Fe Group, Oral Health America and the DentaQuest Foundation. The Council's leadership worked closely with the Council on Dental Benefit Programs (CDBP), the Council on Dental Practice (CDP) and the Council on Government Affairs (CGA) in this area.
- Expansion of state Medicaid programs, which draw upon the technical assistance of Council members and the Council's Medicaid Provider Advisory Committee for participation guidance and education on avoidance of unintentional noncompliance.
- Opportunity for dentists to promote prevention of oropharyngeal cancer by appropriate education and referral of patients for HPV vaccinations from their primary care provider. The Council collaborated in a workgroup with the Council on Scientific Affairs (CSA) and CDP addressing this issue.
- Growing scale of school-based oral health programs and the opportunity to work with the National School-Based Health Alliance to incorporate tobacco cessation strategies within a prevention framework.
- Increasing opportunity to work with Society of American Indian Dentists (SAID) regarding tribal oral health issues including the Navajo Nation CDHC cohorts and the renewed commitment from the Chickasaw Nation in Oklahoma.

- Dental Quality Alliance involvement with the Council as the number of quality indicators expands for public dental treatment issues.
- Safety issues within dental offices is an emerging issue, which prompts coordinated efforts to articulate measures to assure public safety. Deaths of young patients (frequently from underserved populations) while undergoing dental treatment are robustly reported in the media and provides an opportunity to promote a culture of safety within the dental profession.

Responses to House of Delegates Resolutions

Resolution Objective: 33H-2017 Peer to Peer State Dental Medicaid Audits

33H-2017. Resolved, that the American Dental Association encourages all state dental associations to work with their respective state Medicaid agency to ensure that Medicaid dental audits be conducted by dentists who have similar educational backgrounds and credentials as the dentists being audited, as well as being licensed within the state in which the audit is being conducted.

The Council continues to work with state dental associations to partner with their respective state Medicaid agencies to reduce the administrative burdens associated with Medicaid participation. The encouragement that Medicaid audits should be conducted by dentists with similar educational training and licensed in the same state in which the audit is transpiring has borne good fruit. Reference to this ADA policy was significant in reducing a Medicaid audit proposed penalty within a Federally Qualified Health Center (FQHC) from \$7 million to about \$100,000, when the arbitrators learned that the auditor was a dental specialist, who was not licensed in the state where the FQHC was situated, did not accept Medicaid himself, and never visited the FQHC during the audit.

The Council cites its [Medicaid Provider Reference Guide and Advocacy Toolkit](#) as a significant step in raising the awareness of both providers and state dental associations about participating in Medicaid.

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2020 since the Visioning Session priorities established in January 2016 were affirmed by the Council in January 2018.

Policy Review

In accordance with House Resolution 170H-2012, Regular Comprehensive Policy Review, which calls for the review of Association policies every five years, the following policy was reviewed by the Council in collaboration with the Council on Membership:

March of Dimes Prematurity Campaign (*Trans.*2003:356)

In consultation with the Speaker, this resolution has been identified as a House directive that has been fulfilled and will no longer be listed in *Current Policies*.

Council Minutes

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

Council on Communications

Reich, Robin S., 2018, Georgia, chair
 Meinecke, Gigi, 2019, Maryland, vice chair
 Bean, Canise Y., 2018, Ohio
 Carney, Kerry K., 2020, California
 Fallon, Andrea, 2018, Massachusetts*
 Guthrie, Frederick V., 2021, Tennessee
 Hall, Jeannette Peña, 2020, Florida
 Hanley, Yvonne S., 2018, Minnesota
 Iuorno, Frank P., 2020, Virginia
 Karp, William H., 2019, New York
 Kenyon, David J., 2019, Wisconsin
 Lindemann, Kurt S., 2018, Montana
 Mansour, Sam, 2021, Pennsylvania
 Manzanares, David J., 2020, New Mexico
 Pitmon, Stephen M., 2021, Vermont
 Poteet, Sarah Tevis, 2020, Texas
 Schefke, Philip L., 2019, Illinois
 Weaver, Stephanie B., 2021, Louisiana

MacLachlan, Janine, director

The Council's 2017–18 liaisons include: Dr. Judith M. Fisch (Board of Trustees, First District), and Mr. Ryan McCormick (American Student Dental Association).

Areas of Responsibility as Set Forth in the *Bylaws or Governance and Organizational Manual of the American Dental Association*

As listed in Chapter VIII, Section K2 of the ADA *Governance and Organizational Manual*, the subject matter responsibility for the Council shall be:

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

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

Integrated Marketing and Communications has continued to recast resources to better meet the changing communications landscape and align with ADA's priorities to put the member at the center of our efforts in crafting strategic marketing programs that increase: the net number of new members, non-dues revenue and state/local capacity. The result is that the ADA is able to better inform, educate, and engage with members, future members, stakeholders/influencers, media and the public.

To guide the entire ADA in its quest to deliver member value, the Council collaborated with staff to create a new master brand and vision to serve as a guiding star and strategic filter for ADA initiatives.

* *New Dentist member*

A key part of the vision and master brand is to help the public understand the importance of seeing their ADA dentist regularly. The ADA® Find-a-Dentist™ campaign is in its second year—results will be reported in September to allow collection of more real-time data. And this year the ADA announced a new collaboration with CVS Pharmacy to showcase ADA Seal of Acceptance products and deliver oral health education to consumers. As the Council continues to adapt to the changing communications ecosystem, members will always remain central to the Council's work.

Objective 1: Grow Active, Full Dues Paying Membership by a net increase of 600 over 2017

Initiative: Integrated Marketing Campaigns

To achieve the ADA's 2020 Strategic Plan membership goal, the ADA is increasing its focus on recruitment campaigns in 2018–2019. For the first two quarters of 2018, the ADA continued implementation of the three member campaigns that were initiated in 2017: Be Your Best, Make Life Easier, and ADA Pride. Beginning in June, the ADA transitioned to a Choose ADA recruitment campaign. Following are results from the member campaigns for the first half of 2018:

Success Measure: All met or exceeded expectations (see itemization below)

Target: N/A

Range: N/A

Outcome: See below

Be Your Best: Supports clinical excellence with prioritized content from the Science Institute, Center for Evidence-Based Dentistry (EBD), JADA, ADA Library and Continuing Education.

- **Oral Cancer Awareness Month in April** – Exceeded Expectations
 - How to Check Patients for Oral Cancer video exceeded 17,000 views
 - Website traffic to the EBD Oral Cancer guidelines increased 129% over the previous month
- **Project Clean** (a campaign to help patients build better oral care routines) – Exceeded Goal
 - 45 influencers created blog, Instagram, and Facebook posts, which achieved 39.1 million impressions (exceeded goal by 9 million impressions)
- **Paid search** campaigns were launched for key clinical topics to ensure ADA was at the top of the results, positioning the ADA as clinical experts. All search terms achieved click through rates well above average:
 - Antibiotic Prophylaxis (10.2% CLR)
 - Oral Cancer (6.2% CTR)
 - Fluoride (2.7% CTR)

Make Life Easier: Supports practice management, financial and career decision-making with prioritized content from the Practice Institute, ADA Business Resources, Finance, Membership and CE. All initiatives exceeded expectations.

- **New grad activation** – 4,933 signing day applications. 858 more than in 2017
 - 64 out of 65 eligible schools participated
- **Laurel Road** (discounted student loan consolidation)
 - more than 2,207 ADA members have refinanced with Laurel Road, totaling more than \$485 million in loan volume since program inception
- **Decoding Dental Benefits**
 - Nearly 22,000 visits to the dental benefits content on ADA.org, a 411% increase over visits in 2017
 - Over 1,100 downloads of dental benefits resources
 - Over 1,500 registrants to the Coordination of Benefits webinar
- **Credentialing**
 - Over 29,000 dental providers have completed the full attestation process

ADA Pride: Helps elevate the value of membership for new dentists from transactional to motivational. Discovers and celebrates inspiring stories about ADA dentists who make a difference. All initiatives exceeded expectations.

- **10 Under 10 Awards:** a new program recognizing 10 amazing dentists who graduated from dental school less than 10 years ago and are already inspiring their colleagues by making a difference in dentistry
 - 200+ submissions and over 5,400 visits to the award content on ADA.org (top performing page on ADA at the time)
 - Over 78,000 impressions on LinkedIn and Facebook
- **2017 ADA Highlights video**
 - Nearly 4,100 views

Following are highlights of the new member recruitment campaign that launched in June and will continue through 2019.

Choose ADA: Primary target: nonmembers, with an emphasis on new dentists in practice up to ten years and women dentists. Demonstrate the value of ADA membership through three priority areas of support: clinical excellence, career center, third-party payer concierge.

- New paid digital ads, and sponsored content and/or ads on LinkedIn, Dental Economics, Dr. Bicuspid, Dentistry IQ, Dental Entrepreneur Woman (first time on many of these sites)
- Early results are positive:
 - 43 more new dentist members in June 2018 over June 2017
 - 180 more established dentist members in June 2018 over June 2017

Initiative: New ADA Master Brand and Vision

Why does the ADA need a master brand and vision? To address the ADA's declining market share of new dentists, and declining member engagement and revenue, the goal is to be unified in our positioning and messaging for stronger impact to reach the ADA's strategic goals.

- **Master Brand:** (adopted by the ADA Board of Trustees in February 2018)
The ADA powers the profession of dentistry to advance the overall oral health of the public.
- **Vision:** (adopted by the ADA Board of Trustees in April 2018)
Empowering dental professionals to achieve optimal health for all.

How the master brand and vision will be brought to life:

- **As a strategic filter:** questions we'll ask when applying it to designs on projects, acquisitions, programs, products, services, etc.
- **In messaging:** include focus on profession and public in major programs
- **In ADA channels:** show connections between profession and public intersection through storytelling and imagery
- **In large programs:** CVS partnership, ADA Seal of Acceptance, State/Local societies, recruitment and retention campaigns, annual meeting, upcoming 160th ADA Anniversary (in 2019)

Initiative: Collaboration with CVS Pharmacy

In January 2018, the ADA announced a collaboration with CVS Pharmacy to help put millions of Americans on the path to better overall health. This three-year initiative will include visibility for ADA Seal of Acceptance products in CVS circulars, as well as in-store signage with oral health messages such as "teeth so clean you'll have to smile." Results to date include:

- 40 million circular of full-page ad with the introduction of "from the dental chair to daily care"
- 15.1 earned media impressions
- 16 million impressions from *PR Newswire* release

- Signage in many CVS retail stores nationwide through March 2019
- News shared across ADA channels, including *ADA News*

Objective 2: Improve awareness and positive perception among ADA key stakeholders of Action for Dental Health (ADH) and other priority programs.

Success Measure: All met or exceeded expectations (see itemization below)

Target: N/A

Range: N/A

Outcome: See below

Initiative: ADA Interim Policy on Opioid Prescribing – Exceeded Expectations

- **250 news stories and 519.2 million impressions** through earned media
 - An Associated Press story garnered the most coverage; picked up by hundreds of news outlets including *The New York Times* and the *Washington Post*
 - The news also reached Washington influencer and legislator audiences through *The Hill*, *WTOP*, and *Modern Healthcare*
- **2,500+ visits on ADA.org/Opioids**
- An ADA tweet reached more than 27,000 users and was retweeted by the assistant White House press secretary
- An ADA Facebook post reached more than 28,000 users, far exceeding average social media performance on ADA accounts.

Initiative: Policymaker Campaign – Positive Results

To support the Council on Advocacy for Access and Prevention (CAAP) and the Council on Government Affairs (CGA) on ADH.

- **More than 443,000 views of Community Dental Health Coordinator patient videos:** Two-week paid Twitter campaign to drive views from the dental professional and Capitol Hill audiences.
- **375,000 impressions of paid Lobby Day tweets:** Paid campaign to drive awareness of the Action for Dental Health Act during Lobby Day targeting lawmakers and Hill staffers and driving clicks back to updated ADA website and views of CDHC videos.
- **1.5 million+ impressions of sponsored content**
 - Three paid sponsored content pieces in *Vox* and *Modern Healthcare* that highlight both the CDHC and Emergency Department Referral programs, and Virginia op-ed with Virginia Dental Association Executive Director Terry Dickinson in *The Roanoke Times*. These pieces served a dual purpose to both raise awareness of ADH programs and to serve as thought leadership for the ADA.

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 2019.

Policy Review

In accordance with Resolution 170H-2012, Regular Comprehensive Policy Review, the Council reviewed the following Association policies and determined that they should be maintained:

- Dental Access Barriers (*Trans.*2010:566)
- Guidelines for State Board of Dental Examiners on the Definition of Routine Dental Services for Purposes of Dentist's Advertisements (*Trans.*1977:616, 945)
- Guidelines for an Advertising Code (*Trans.*1971:108, 563; 1997:659)
- Use of Name of American Dental Association (*Trans.*1962:210, 284; 1999:974)
- Standards for Dental Society Publications (*Trans.*1997:303,660; 2010:602)
- ADA Positions, Policies and Definitions in ADA Publications (*Trans.*1996:732)
- Preferred Professional Terminology (*Trans.*1977:914; 1997:661)
- Mechanism for Complaints and Referrals (*Trans.*1972:669)
- Clarification of Dental Professional Credentials (*Trans.*2003:354)
- Official Emblem for Dentistry (*Trans.*1965:228, 364)
- Policy Governing Use of American Dental Association Dental Health Education Statement (*Trans.*1969:193, 322)
- Institutional Advertising (*Trans.*1979:598)

Council Minutes

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

Commission for Continuing Education Provider Recognition

Fiorellini, Joseph P., 2018, Pennsylvania, chair
 Rosenthal, Nancy R., 2019, Pennsylvania, vice chair
 Bennett, Jeffrey D., 2019, Indiana
 Bilodeau, Elizabeth Ann, 2021, Pennsylvania
 Cipes, Monica H., 2021, Connecticut
 DeWood, Gary M., 2021, Arizona
 Dixon, Debra, 2018, Illinois
 Hammond, Barry, 2019, Georgia
 Hughes, Bertram J., 2020, Florida
 Hutten, Mark C., 2018, Illinois
 Keiser, Karl, 2021, Texas
 Lipp, Mitchell J., 2019, New York
 McNulty, Conor, 2018, Oregon
 Parker, Steven E., 2021, Ohio
 Reed, Susan G., 2020, South Carolina
 Speicher, Jr., Joseph J., 2019, New York

Borysewicz, Mary A., director

The Commission's 2017–18 liaison to the Board of Trustees is Dr. Linda K. Himmelberger (Board of Trustees, Third District).

Areas of Responsibility as Set Forth in the *Bylaws or Governance and Organizational Manual of the American Dental Association*

As stated in Chapter IX, Section 30C of the ADA *Bylaws*, the duties of the Commission shall be to:

- a. Formulate and adopt requirements, guidelines and procedures for the recognition of continuing dental education providers.
- b. Approve providers of continuing dental education programs and activities.
- c. Provide a means for continuing dental education providers to appeal adverse recognition decisions.
- d. Submit an annual report to the House of Delegates of this Association and interim reports, on request, and the Commission's annual budget to the Board of Trustees of the Association.
- e. Submit the Commission's rules and amendments thereto to this Association's House of Delegates for approval by majority vote either through or in cooperation with the Council on Dental Education and Licensure.

In addition, the *Governance and Organizational Manual of the American Dental Association*, Chapter IX, Section L, gives the Commission the power to make editorial corrections to its Rules "which do not alter context or meaning without the need to submit such editorial corrections to the House of Delegates."

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

The Commission is an ADA agency with independent authority to administer the ADA Continuing Education Recognition Program (CERP). The Commission determines its own strategic goals and objectives. For 2017–2018, the Commission goals and objectives are as follows:

Objective: CERP 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 October 2018 meeting.

Target: Draft revisions of six standards reviewed by Commission in October 2018.

Range: Draft revisions of six standards completed by December 2018.

Outcome: The Commission has drafted three of six revised CERP Standards, and is on target to draft revisions of three Standards at its October meeting. The communities of interest were invited to submit comments on the first three drafts, and will be invited to submit comments on the drafts planned for release in October. All comments will be reviewed by the Commission and further revisions considered as needed.

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: This objective was initially planned for 2017 but was deferred pending approval of funding for a CERP instance of Aptify. Funding has been requested in the 2019 budget. To improve program operations and reporting capabilities, and in anticipation of transitioning data and application functions to the Aptify platform, an interim Access database was developed and implemented in 2017. The interim database has introduced some efficiencies in administration of the CERP application and recognition process by expanding query capabilities and automating some record keeping functions. Development of a web-based CERP application form on the Aptify platform is now tentatively planned for 2019. At the time this report was prepared, a development timeline was not available.

Objective: Conduct a financial assessment with the goal of becoming financially self-sustaining.

Initiative/Program: ADA CERP

Success Measure: Conduct a financial analysis of the CERP fee structure by March 2018. Work with the ADA to define by October 2018 the Commission's long-term goals for a self-sustainable, financial position.

Outcome: After conducting a review of current CERP provider fees, past and projected program revenues and expenses, and a market analysis of the fee structures of other accrediting agencies, the Commission approved a new fee structure for ADA CERP beginning in 2019. The revised fee structure will eliminate the reapplication fee, and will assess participating providers an annual fee based on the size of their CE programs as determined by the number of participants in all activities offered in a year. The revised fee structure is projected to maintain or exceed current revenue levels. For a comprehensive accounting of program expenses in the future, the Commission anticipates that indirect expenses for shared services will be formally defined and incorporated into Commission budgets.

Emerging Issues and Trends

The Commission oversees ADA CERP, 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 relicensure. At the time this report was prepared in June 2018, there were 467 ADA CERP recognized providers, including twenty-four based outside the United States or Canada. Another 103 providers were approved by state dental societies and national specialty societies through the CERP Extended Approval Process (EAP).

CERP recognized providers reported offering a total of over 31,000 CE activities in 2016, the most recent year for which data is available, including more than 221,000 hours of continuing education. Information on the size and scope of ADA CERP providers' activities is published in the Commission's [2017 Annual Report](#) to communities of interest.

Review and Revision of CERP Standards. The ADA CERP Recognition Standards form the basis for the Commission's evaluation and approval of continuing dental education providers. The Commission continues its comprehensive revision of the Standards with the goal of emphasizing criteria essential to effective continuing education that supports dental practitioners' continuing professional development and continuous quality improvement. The Commission released for comment drafts of three of six revised standards. Two of these focus on the important function CE providers perform in assessing learning outcomes.

In 2017, with input from the communities of interest, the Commission revised the CERP criteria establishing minimum duration for CE activities. The required minimum length for CE activities was reduced from one hour to 15 minutes, and CERP recognized providers may now award CE credits in increments of 0.25 hours. The shorter minimum accommodates new methods of delivering education in shorter, focused segments, in keeping with the evolving principles of effective adult learning. All CE activities offered by CERP recognized providers, including short format activities, must continue to meet the [CERP Recognition Standards](#).

Interprofessional Education and Trends in Continuing Professional Development. The Commission is communicating with representatives of accrediting agencies in other health care professions regarding opportunities to support interprofessional continuing education and for potential opportunities for alignment. Many accreditors of continuing education in the health care professions believe that as health care professionals grapple with increasing time demands and institutional requirements, to remain relevant and meet the needs of professionals, continuing education must evolve from basic fulfillment of regulatory requirements to a system of learning that supports professional development and promotes improvements in health care.

Responses to House of Delegates Resolutions

There were no House of Delegates resolutions directed at the Commission in 2017.

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, Regular Comprehensive Policy Review.

The Commission approved editorial changes to the [Commission Rules](#). The approved changes were editorial in nature and limited to updating references to the revised ADA *Bylaws* and the *Governance and Organizational Manual of the American Dental Association*.

Commission Minutes

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

Commission on Dental Accreditation

Leffler, William G., 2018, Ohio, chair, American Association of Dental Boards
 Feldner, Loren J., 2019, Illinois, vice-chair, American Dental Association
 Agar, John R., 2021, Connecticut, American College of Prosthodontics
 Attanasi, Ralph C., 2018, Florida, American Dental Association
 Callahan Barnard, Susan, 2019, New Jersey, American Dental Hygienists' Association
 Cushing, David P., 2019, New Jersey, Public Member
 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
 Hasty, Christopher M., 2021, Georgia, American Dental Association
 Hebl, Monica, 2018, Wisconsin, *ad interim* American Dental Association*
 Hershey, H. Garland, Jr., 2019, North Carolina, American Association of Orthodontists
 Hicks, Jeffery L., 2021, Texas, Special Care Dentistry Association/American Dental Education Association
 Jackson, Adolphus M., 2021, Alabama, American Association of Dental Boards
 Javed, Tariq, 2019, South Carolina, American Dental Education Association
 Jee, Arthur C., 2020, Maryland, American Association of Dental Board
 Johnson, Bradford R., 2020, Illinois, American Association of Endodontists
 Kinney, Bruce P., 2019, Washington, American Association of Dental Boards
 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
 McClemens, Charles E., 2021, Wisconsin, National Association of Dental Laboratories
 Mills, Michael P., 2018, Texas, American Academy of Periodontology
 Mo, Nancy, 2021 New York, American Student Dental Association/American Dental Education Association
 Nelson, William J., 2021, Wisconsin, American Association of Oral and Maxillofacial Surgeons
 Stentiford, Deanna N., 2020, Florida, American Dental Assistants Association
 Stergar, Cindy J., 2018, Montana, Public Member
 Unser, Glenn J., 2019, California, Public Member
 Wheeler, Matthew B., 2018, Illinois, Public Member
 Wolinsky, Lawrence E., 2021, Texas, American Dental Education Association

Tooks, Sherin, director
 Johnson, Doreen, manager, Allied Dental Education
 Marquardt, Gregg, manager, Communication and Technology Strategies
 Smith, Michelle, manager, Allied Dental Education
 Snow, Jennifer, manager, Advanced Specialty Education
 Soeldner, Peggy, manager, Postdoctoral General Dentistry Education

The Commission's 2017–18 liaison is Dr. Robert Bitter (Board of Trustees, Eighth District).

Areas of Responsibility as Set Forth in the *Bylaws or Governance and Organizational Manual of the American Dental Association*

As listed in Chapter IX Commissions, Section 30 Duties of the ADA *Bylaws*, the duties of the Commission on Dental Accreditation (The Commission) shall be to:

*Replaced Hagenbruch, Joseph F., 2020, Illinois, American Dental Association

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

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

The Commission is an ADA agency with independent authority to administer the accreditation program, and with recognition by the United States Department of Education (USDE). The Commission determines its own strategic goals and objectives. For 2017–2018, the Commission goals and objectives are as follows:

Goal: The Commission continues to be USDE recognized accrediting agency for dental and dental-related education programs.

Success Measure: Maintain current USDE recognition and monitor reauthorization of the Higher Education Act (HEA).

Outcome: Since the prior annual report, the Commission has received re-recognition by the USDE, following completion of the re-recognition review process. The Commission continues to hold recognition by the Department of Education and is monitoring reauthorization of the HEA.

Goal: The Commission will modify its documents and website to remove references to "dental specialties" within its lexicon.

Success Measure: Identify documents to be modified; develop a plan for document revision and a communication plan; report on progress through the Standing Committee on Documentation and Policy Review at the Commission's summer 2018 meeting; communicate the plan and revise all documents by December 1, 2018, as directed by the Commission in summer 2018.

Outcome: In progress, with a report to the Commission in summer 2018.

Goal: The Commission will make progress on financial and governance changes in accordance with strategic plan.

Success Measure: Develop ADA-CODA Relationship Workgroup agenda and identify governance and finance issues to be addressed; prepare the Workgroup report with possible submission of resolutions to the ADA House of Delegates; follow-up from 2018 House of Delegates as needed.

Outcome: In progress, with an ADA-CODA Relationship Workgroup report to be considered at the August 2018 Board of Trustees meeting. Additionally, the Commission's Standing Committee on Documentation and Policy Review will submit proposed revisions to the Commission's Rules for consideration by the Commission in summer 2018, with a potential resolution to the 2018 House of Delegates.

Goal: The Commission will enhance technology usage through development of an electronic accreditation management system for programs and volunteers.

Success Measure: Work with ADA Technology department to build the accreditation management system and test the system; identify and develop training resources for staff, programs, and volunteers.

Outcome: In progress, with development of the database replacement identified as being on-track for completion by year end 2018. The electronic accreditation platform will continue to be developed in 2019.

Goal: The Commission will enhance training of volunteers and/or its community of interest through enhanced annual training mechanisms for site visitors and through development of one to two webinars to various audiences.

Success Measure: Develop a mandatory annual site visitor training plan, working with the Standing Committee on Quality Assurance and Strategic Planning, with a report to the Commission in summer 2018. Pending Commission approval, begin development of the mandatory training program through fall 2018 and deploy the training in 2019. Additionally, publish one to two webinars to various audiences in 2018.

Outcome: In progress, with a draft mandatory training plan to be considered by the Commission at its summer 2018 meeting.

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 791 accreditation actions at its August 2017 and February 2018 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 1,439. This represents a decrease of 11 programs from the previous reporting period.

Sixty-one programs hold the status of "Approval with Reporting Requirements" and have been given a specified time period to demonstrate compliance with all accreditation standards. Failure to do so will result in accreditation being withdrawn. One (1) pediatric dentistry program and one (1) dental laboratory technology education program had accreditation withdrawn during this reporting period.

During this timeframe, nine (9) programs were granted accreditation; these include one (1) advanced education in general dentistry, one (1) general practice residency, two (2) advanced general dentistry education program in orofacial pain, two (2) dental hygiene, and three (3) pediatric dentistry 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 2018

	Dental	Specialty	Advanced General Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Initial Accreditation	1	15	5	1	2	0	24
Approval <u>Without</u> Reporting Requirements	62	447	288	232	313	12	1354
Approval <u>With</u> Reporting Requirements	3	14	6	21	15	2	61
Total Number of Accredited Programs	66	476	299	254	330	14	1439

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.

ADA/CODA Relationship Workgroup

The ADA/CODA Relationship Workgroup has met annually since 2014 at the ADA Headquarters. Members of the 2017–2018 Workgroup include: Dr. Robert Bitter (Eighth District Trustee, co-chair), Dr. William Leffler (CODA, co-chair), Dr. Raymond Cohlmiia (Twelfth District Trustee), Dr. Loren Feldner (CODA), Dr. Steven Friedrichsen (CODA), Dr. Chad Gehani (Second District Trustee), Dr. Jeffery Hicks (CODA), Dr. Billie Sue Kyger (Seventh District Trustee), and Dr. Roy Thompson (Sixth District Trustee). Dr. Joseph Hagenbruch (CODA) resigned his position on the Commission just prior to the Workgroup's meeting.

The Workgroup continues to focus on two general areas, finance and governance oversight of the Commission. The Workgroup's 2018 report was provided to the Board of Trustees at its August meeting. The next meeting of the ADA/CODA Relationship Workgroup is scheduled for May 2019.

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 2018 Standing Committee included Dr. George Shepley, chair (ADA); Dr. Gary Herman (ADA), Dr. Tariq Javed (CODA), Dr. Steven Tonelli (ADA), and Dr. Lawrence Wolinsky (CODA). Dr. Michael Reed served as a consultant to the Standing Committee. During their terms, ADA

president, Dr. Joseph Crowley, and Commission chair, Dr. William Leffler, served as non-voting members of this committee. Staff support was provided by Dr. Sherin Took, 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. Sixteen (16) 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, seven (7) 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. One (1) additional program (Jerusalem, Israel) provided sufficient documentation and will receive a comprehensive PACV site visit in 2019. 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. The Commission conducted an accreditation site visit to León, Mexico in fall 2017 and will conduct an accreditation site visit to Jeddah, Saudi Arabia in fall 2018. 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 March 7, 2018 and May 2, 2018 meetings of the Standing Committee on International Accreditation.

- The Standing Committee considered the PACV Survey submitted by the Seoul National University, Seoul, South Korea, 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 Self-Study submitted by the Hebrew University Hadassah, Jerusalem, Israel, and directed that the program proceed to the next step of the PACV process whereby a committee of the Commission will conduct a Preliminary Accreditation Consultative Site Visit to the dental education program at a time that is convenient to the program, Commission representatives, and Commission staff.
- The Standing Committee considered the letter of intent submitted by the King's College London, London, England. The Standing Committee directed that a formal letter be sent to the King's College London informing the program of the next steps in the PACV consultative process and deadline for submission on the PACV Self-Study to not exceed three (3) years.

Responses to House of Delegates Resolutions

There were no House of Delegates resolutions directed at the Commission in 2017.

Self-Assessment

The Commission conducted a self-assessment in accordance with Resolution 1H-2013. Since the Commission's last ADA self-assessment in 2014, the Commission has undertaken a number of ongoing measures to self-assess, including but not limited to: 1) ongoing meetings of the ADA-CODA Relationship Workgroup (annual meetings since 2014), 2) a comprehensive strategic planning process in 2016 and establishment of the Commission's 2017-2021 Strategic Plan which is continuously reviewed by the Commission, 3) development of an Operational Effectiveness Plan, which is continuously reviewed by the Commission; 4) ongoing consideration of feedback from programs and volunteers related to the accreditation process and accreditation standards; 5) ongoing review of trends in dentistry, dental education, accreditation, and higher education both nationally and internationally to ensure the Commission remains the gold standard for dental accreditation; and 6) successful re-recognition in 2017 for the full scope of five (5) years with no reporting requirements by the USDE.

In consideration of the ADA Self-Assessment, the Commission determined that it effectively carries out its *Bylaws* duties and continues to serve a critical role in dental education and the profession of dentistry as the only nationally recognized accreditation agency for dental and dental related education programs. Specifically, 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. The Commission receives its authority as a programmatic accreditor by the USDE, and through its acceptance by the dental community. The Commission found that its structural levels of site visitors, review committees, standing committees, and the Board of Commissioners, along with the separate Appeal Board ensure that the Commission can accomplish its mission with an optimal number of members who conduct business in an efficient and effective manner. The Commission's staff resources are currently adequate; however, the Commission should monitor trends in the Commission's workload that may influence future decisions on additional human resource needs. The Commission anticipates the development and implementation of an electronic accreditation platform that will further streamline the accreditation program and reduce some costs for education programs related to printing and distribution of accreditation documents to the Commission and Commission volunteers.

The Commission continues to believe that it should assume greater financial and governance oversight of the Commission's accreditation program. In 2014, following a presentation by the Commission Chair to the ADA Board of Trustees, the ADA Board directed formation of the ADA-CODA Relationship Workgroup whose membership consists of equal numbers of ADA Board of Trustees members appointed by the ADA president and CODA Commissioners appointed by the Commission chair. The ADA-CODA relationship workgroup and the Commission believe that the Commission and the ADA should establish a shared services agreement whereby the Commission reimburses the ADA for indirect expenses. The Workgroup and the Commission have agreed that the Commission should have the ability to retain its revenue after expenses in a reserve fund, to support other Commission projects and activities without the need to seek financial assistance from the ADA. Both of these issues have been brought to the attention of the Board of Trustees and are under review. Finally, the Workgroup and the Commission believe that the Commission should have sole authority to revise its *Rules*. The ADA-CODA Workgroup has encouraged the Commission to draft revisions to the Commission's *Rules* and submit these revisions to the ADA, following review by the Council on Ethics, Bylaws, and Judicial Affairs.

Policy Review

There were no ADA policy reviews by the Commission in accord with Resolution 170H-2012, Regular Comprehensive Policy Review.

Commission Minutes

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

Council on Dental Benefit Programs

Snyder, Steven I., 2018, New York, chair
 Bulnes, Christopher M., 2019, Florida, vice chair
 a'Becket, Thomas R., 2020, Maryland
 Calitri, Paul F., 2020, Rhode Island
 Chung, Kenneth L., 2020, Oregon
 Davenport, Carson S., 2018, North Carolina
 Hamel, David L., 2018, Kansas
 Hollingsworth, James W., 2020, Mississippi
 Kessler, Brett H., 2019, Colorado
 Makowski, Martin J., 2019, Michigan
 Maldonado, Yvonne E., 2021, Texas
 Markarian, Randall C., 2021, Illinois
 Mihalo, Mark J., 2019, Indiana
 Olenwine, Cynthia H., 2020, Pennsylvania
 Stuefen, Sara E., 2018, Iowa*
 Vaillant, Matthew J., 2018, Minnesota
 Watson, Hope E., 2021, Tennessee
 Weber, Walter G., 2021, California

Aravamudhan, Krishna, senior director
 McHugh, Dennis, manager
 Ojha, Diptee, senior manager
 Pokorny, Frank, senior manager
 Sanders, Marissa, manager
 Tilleman, Sarah, senior manager

The Council's 2017–18 liaisons include: Dr. Roy Thompson (Board of Trustees, Sixth District) and Mr. John Luke Andrew (American Student Dental Association).

Areas of Responsibility as Set Forth in the *Bylaws or Governance and Organizational Manual of the American Dental Association*

As listed in Chapter VIII, Section K3 of the ADA *Governance and Organizational Manual*, the areas of subject matter responsibility of the Council shall be:

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

* *New Dentist member*

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 & Credentialing

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

Target: At least 80% of members whose call was closed by Tier 2 and 3 are satisfied with the service.

Range: Level of satisfaction of Tier 2–3 closures is between 75% and 85%.

Outcome: This program area supports individual member assistance through phone and email. Over 6,000 member issues are addressed annually. As of June 30, 2018, 3,613 member requests have been addressed and the level of satisfaction of Tier 2–3 closures is 79.5%. The timeliness of call closure is 98.39%. Staff often reach out to third-party payers with individual member concerns to assist with claim payments and other payer issues. A number of inappropriate explanation of benefits language have been corrected through these interactions.

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)/Third-Party Payer Advocacy & Credentialing

Success Measure: Ensure that information on dental benefits and CDT Code is disseminated to members through well-attended webinars.

Target: At least 3,000 individuals will participate in workshops or webinars by November 1, 2018. 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, 2018, a total of 2,248 individuals have participated in three webinars; 98.08% expressed satisfaction with the education programs. A total of 2,009 CE credits have been offered through these webinars. As of June 30, 2018, three webinars have been conducted and one is planned for mid-July. Topics addressed include:

- Audits and Utilization Management
- Coordination of Benefits
- Preferred Provider Organizations (PPO) Leasing
- In-office dental plans

In addition to [Webinars](#) this program area has facilitated creation of several toolkits to assist members with third-party payer issues. Notable toolkits include a checklist on establishing [Electronic Funds Transfer](#) (EFT) and [In-office Dental Plans](#). A new series in the ADA News Decoding Dental Benefits was launched to share member experiences on various dental benefit issues and highlight relevant solutions.

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

Initiative/Program: CDT Code

Success Measure: Ensure on-time delivery of CDT products for publication and dissemination.

Target: Delivery of CDT 2018 ASCII file by May, 2018. Delivery of CDT 2019 and CDT Companion by July, 2018.

Range: N/A

Outcome: As of July 2018, all deliverables have been submitted. The CDT Code is the recognized standard procedure code set for documenting dental procedures on claim forms. In 2018, 97.8% 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. Apart from providing individual member support on CDT Coding issues, a number of targeted [Coding guides](#) to educate dentists on proper use of the CDT Code have been developed.

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: Ensure that the Dental Quality Alliance (DQA) continues 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: Twenty-five 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. Thirty-four organizations are members of the DQA. Several federal agencies are continuing their participation as technical advisors. The DQA has developed 16 quality measures for both the pediatric and adult populations to assess performance of programs and dental plans. These measures are geared towards achieving improvements in population health through increased use of preventive services. The DQA is currently developing practice-level measures and educating users of measures to ensure appropriate implementation of quality measurement in dentistry.

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

Initiative/Program: Third-Party Payer Advocacy & Credentialing

Success Measure: Reduce paperwork burden for dentists by streamlining third-party payer credentialing.

Target: At least an additional 1,000 dentists per month have a current attested profile in ADA's Credentialing Service powered by CAQH ProView.

Range: Between 600 and 1,400 new profiles are added as complete current profiles in CAQH ProView each month.

Outcome: As a response to concerns regarding delays in credentialing, the ADA and CAQH have formed a strategic alliance to help streamline the credentialing process for dentists and participating organizations, such as payers, hospitals and employers. Currently, dentists submit credentialing applications and other related information to numerous dental health plans, employers of dentists, and other healthcare organizations for credentialing, directories and other data requirements multiple times each year. Participation in CAQH ProView improves the process of data collection for credentialing and reduces the number of times that a dentist has to complete and submit the same information. To date, 29,056 dentists have complete and current profiles. Another 16,228 dentists have completed applications and now only need to login to re-attest. ADA outreach is focused on enabling dentists and practice managers to engage with the ADA credentialing service. Outreach to dental payers has culminated in 22 participating dental organization to date. To date, the program has generated \$17,233 as non-dues revenue.

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

Initiative/Program: Dental Informatics

Success Measure: Update SNODENT® and derivative Refsets by December 31, 2018.

Target: Complete a comprehensive update of SNODENT and derivative Refsets by December 1, 2018.

Range: N/A

Outcome: The SNODENT Maintenance Committee approved change requests that have been submitted to the SNOMED Dentistry Clinical Reference Group (CRG) for possible inclusion in SNOMED CT. Approved changes will appear in the newest release of SNODENT.

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 \$124 billion in 2016. Per capita dental spending in 2016 was \$384.
- In 2015, Medicaid/CHIP accounted for 38.5% of the children's dental benefits market up from 21% in 2000. Private dental benefits accounted for 51.3% of the market and 10.3% were uninsured in 2015.

Enrollment [Source: National Association of Dental Plans]

- 248.1 million people (77% of the U.S. population) had a dental benefit in 2016—up from 211.4 million (66%) in 2015.
- In 2016, PPOs accounted for 81% of the dental plans in the market—down from 82% in 2015.
- In 2016, the commercial market had 81.6 million people (52%) with fully insured dental benefits versus 74.4 million (48%) with self-funded plans.

Network Statistics [Source: National Association of Dental Plans]

- In 2017, among those who participate in PPO networks, on average, each dentist participates with approximately 14 carriers.

Overall, the dental benefits market appears to be continuing to expand. PPOs continue to dominate. More dentists are participating as network providers in more plans. The market remains split between self-insured and fully-insured products. Employers are transferring more of the premium costs to the employees. Downward pressure on reimbursement rates continues. Efforts to steer patients to use in-network dentists remains strong. On average, patients are receiving more procedures and per patient charges are on the rise. Over 80% of the submitted procedures are for diagnostic, preventive & restorative services.

Third-Party Payer Advocacy

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 its ongoing efforts to address payer disallow policies which interfere with the dentist-patient relationship, the Council:

- has requested member dentists to submit to ADA staff, redacted copies of explanation of benefits statements where a disallowed clause has been applied;
- has posted the [Principles for Model Legislation](#) prohibiting disallow clauses on the Center for Professional Success website;
- is working closely with state dental societies to propose legislation that would ban the use of disallow clauses in dental benefit plans.

Staff have also presented on this issue at various forums to raise awareness of this issue.

Medicare

As reported in the Council's 2017 annual report, the Council continues to monitor the initiatives of various coalitions advocating for a dental benefit in Medicare. A separate report on this issue will be submitted to the 2018 House of Delegates.

Emerging Payment Models

On the medical side, the emphasis on achieving "value" through various payment model reforms continues. Both the public and private payers are engaged in transitioning to new payment models. Results on achieving improved quality at lower cost remains mixed. There is emerging concern that new types of incentives increase health disparities. More payers including the Centers for Medicare & Medicaid Services (CMS) are publicly reporting quality scores for healthcare providers. The Council is monitoring these trends.

On the dental side, Medicaid programs are beginning to look into value-based purchasing models and imposing requirement for managed care programs to pay dentists for performance and value. The Texas Medicaid Program is the first in the nation to move in this direction. The Council anticipates that more programs will try to follow this model.

[Direct primary care arrangements](#) (model that offers all primary care services for a monthly fee) are gaining popularity among physicians. The American Academy of Family Physicians is actively promoting this model.

Insurance Market Consolidation

Mergers among insurance carriers and between insurance carriers and other industry partners continues. One significant development this year is a new non-for-profit health insurance company established by Amazon, JP Morgan and Berkshire to offer health insurance to their employees in a manner that doesn't aim to garner profits for the insurer. It remains to be seen whether dental benefits are addressed in this new endeavor.

Responses to House of Delegates Resolutions

Resolution Objective: 35H-2017. Third Party Payer Patient Treatment History

Resolved, that the Council on Dental Benefit Programs formulate and pursue an action plan to encourage third-party payers to provide to the patient and treating dentist, documentation of current treatment history and patient benefits along with plan limitations based on frequency or time, and be it further

Resolved, that progress on this issue be reported to the 2018 House of Delegates.

Initiative/Program: Third-Party Payer Advocacy

Success Measure: Progress communicated to the 2018 House of Delegates.

Target: N/A

Range: N/A

Outcome: The Council developed the following action plan to encourage third-party payers to provide to the patient and treating dentist, documentation of current treatment history and patient benefits along with plan limitations based on frequency or time. The action plan entails three major activities. The narrative below provides an update on each of these activities.

Investigate current state of information available to dental offices. Many carriers appear to have proprietary means of providing information on current treatment history, patient benefits and plan limitations to network dentists. To verify, a brief survey was sent to several major payers with the following two questions.

- 1) Do your provider and patient online portals (or paper equivalent, if any) include documentation of the patient's: a) current treatment history, b) available benefits, and c) benefit plan limitations based on frequency or time?
- 2) If not currently available, might this information be made available in the future?

Eleven payers responded, in varying levels of detail, that this information is found in their provider and patient portals. Details of the individual responses are in the following table.

Aetna	<p>Providers have access to patient history or benefits by connecting to Dental Xchange (Real Time Eligibility vendor) via Aetna dental.com. Here, providers can access a member's plan information including eligibility dates, plan benefits, plan limitations, deductibles and frequencies. A provider can also obtain this information via voice or fax through the Aetna Voice Advantage (AVA) system.</p> <p>Individual plan members, via Aetna's secure Navigator site, can view their personal health record and claim history. The member also has access to benefits which includes plan limitations, deductibles and frequencies. Explanation of Benefits statements (EOBs) also provide the plan deductibles and maximums with how much has been met.</p>
Ameritas	<p>The online web portals for both provider and plan member includes policy limitations and frequency for most common procedures. Information on remaining benefits and/or deductible amounts met is also available. Both provider and patient are able to view claim history for three years online. Providers are only able to see the claims submitted from their office.</p> <p>Ameritas has stated that it is always looking to the future and for ways to improve the web experience for its customers and has asked the ADA to let Ameritas know if there is other specific information ADA would like to see posted. No promises were made that the information would be made available, but Ameritas welcomes input on what its customers think. Bottom line is Ameritas wants to reduce customer effort.</p>
Anthem	<p>Current treatment history, benefits and limitations are not yet available online. It is estimated that it may take up to three years to accomplish this.</p>
Delta Dental of California	<p>An online portal accessible at www.deltadentalins.com allows providers to access this information. Providers also have the ability for real-time claims processing through this portal.</p> <p>One feature of Delta Dental of California's Provider Tools, National Search, makes it easier for dentists to verify eligibility and benefits without having to visit multiple sites. There are 39 different Delta Dental companies plus the Delta Dental Plans Association, and each company has the ability to offer their own version of a provider portal.</p> <p>All Delta Dental companies do not utilize the same solution, but do attempt to align similar features while retaining each company's own style and design. The various portals are only available via the world-wide web and can be accessed from devices that have internet access.</p>
Delta Dental of Massachusetts	<p>Delta Dental of Massachusetts hosts a portal that includes service history, remaining maximum and some basic benefit plan time limitations.</p>

Delta Dental of Michigan, Indiana and Ohio	The information is available on the Dental Office Toolkit (DOT) which can be found on the payer's provider portal.
Humana	The provider portal allows the providers to see a plan member's summary for treatment rendered. There is also an area to view benefits by plan. The member health summary for clinicians includes medical, dental and vision data.
Liberty	Liberty provider and patient portals include documentation of the patient's treatment history, available benefits and benefit plan limitations.
MetLife	Dentists can log in to their MetDental account to view patient eligibility, plan details and claims.
United Concordia Companies, Inc.	"My Patients' Benefits" offers dental offices online access to instantly check member eligibility, benefits, claim status, procedure codes and fee information. In addition, dentists can review procedure history and determine deductible and maximum accumulations using this secure tool. Dentists can also add a date of service to an existing predetermination online.
United Healthcare	The provider portal provides information on the patient's current treatment history, benefits and limitations.

The existence of payer proprietary portals provides access to information in a method and manner determined by the individual payer. Dental practice staff must therefore be cognizant of, and accommodate, different modes of information access, as well as differences in the breadth and depth of information available. To date there are no known automated interfaces between these proprietary portals and a dentist's practice management system. Less efficient manual transcription by practice staff is required to document needed information.

Encourage payers to enhance existing solutions for real time access to requested information. The Council has brought this issue to the attention of the Board of the National Association of Dental Plans. However to engage in meaningful progress the Council is planning to convene an Administrative Efficiencies Summit on August 17, 2018, with knowledge experts and thought leaders from the ADA, third-party payers, clearing houses, practice management system vendors and other sectors of the dental community involved in health information exchange. The purpose of the Summit is to determine technology solutions between payers and practice management vendors to address information exchange between dental offices and third-party payers. The increasing amount of time spent by office managers on the telephone to access eligibility information is the primary basis for this Summit. The Council hopes to identify viable solutions following this Summit.

Long-term standards solutions. The Council approached the ADA Standards Committee on Dental Informatics (SCDI) to determine what role, if any, SCDI could have in addressing Resolution 35H-2017. The SCDI Oversight Committee determined that the committee does not have an immediate solution at this time. Given this situation the likely long-term remedy to streamline availability of the data identified through Resolution 35 would require legislative effort.

Resolution Objective: 56H-2017. Establishment of a Comprehensive Dental Disease Clinical Registry

56H-2017. Resolved, that the American Dental Association establish a comprehensive clinical data warehouse/registry to support development of health policy, treatment guidelines, medical necessity rules, and to define population health and quality of care.

Outcome: A separate report was provided to the Board of Trustees at the August 2018 meeting as Resolution 25.

Resolution Objective: 53H-2017. Genetic Testing for Risk Assessment

53H-2017. Resolved, that for the health and well-being of the public, the American Dental Association believes that any payer organization using a genetic test to determine eligibility for benefit coverage for specific oral healthcare services and any manufacturer of a test(s) used in such an effort must publish specific information on:

- Confirmation from an independent third party agency of test validity and reliability for the intended purpose
- Analysis on how this specific plan design will impact health outcomes and plan costs
- Disclosure of financial relationships between the manufacturer and payer
- Disclosure of bias and conflict of interest between the test manufacturer, investigators providing evidence and literature used to promote the test and plan design and with the payer organization

and be it further

Resolved, that the American Dental Association should work with the American National Standards Institute (ANSI) to develop industry standards for these tests.

Initiative/Program: Standards Committee on Dental Products (SCDP)

Success Measure: SCDP approves a new work proposal and begins development of an informational white paper that focuses on the current state of technology for genetic testing of risk assessment.

Target: N/A

Range: N/A

Outcome: The ADA SCDP is currently looking into the feasibility of developing an informational white paper.

Self-Assessment

The Council conducted its self-assessment through an open discussion. Council members advocated for skill-based Council appointments, citing the benefits of a Council having some experience working with insurance companies, public health and general business practice. The Council emphasized the need for diversity among Council members. Regarding ADA representation on the DQA, the Council noted that longer term appointments from CDBP might better serve the ADA interests as quality based payment programs evolve. Overall, the Council was satisfied with Council processes that allow for more productive and efficient face-to-face meetings.

The Council agreed that the current duties and responsibilities as described in the current *Governance and Organizational Manual* are relevant.

Policy Review

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

Statement on Dental Benefit Plans (*Trans.*1988:481; 2013:316)
 Standards for Dental Benefit Plans (*Trans.*1988:478; 1989:547; 1993:696; 2000:458; 2001:428; 2008:453; 2010:546) (*Trans.*1988:478; 1989:547; 1993:696; 2000:458; 2001:428; 2008:453; 2010:546)
 Limitations in Benefits by Dental Insurance Companies (*Trans.*1997:680; 2011:453)
 Guidelines for Components of Dental Health Maintenance Organizations (*Trans.*1988:476; 1993:689; 1995:610; 2013:304)
 Statement on Capitation Dental Benefit Programs (*Trans.*1985:582; 1993:689; 2013:303)
 Statement on Managed Care and Utilization Management (*Trans.*1995:624)
 Position Statement on the Appropriate Use of Data From Quality Measurement (*Trans.*1998:701; 2013:311)
 Use of Healthcare Effectiveness Data and Information Set (HEDIS) for Utilization Measures (*Trans.*2013:344)
 Statement on Quality Health Care (*Trans.*1995:609; 2013:311)
 Principle for the Application of Risk Assessment in Dental Benefit Plans (*Trans.* 2009:424; 2013:321)
 Principles for Pay-for-Performance or Other Third-Party Financial Incentive Programs (*Trans.*2006:328; 2013:310)

In addition, the Council adopted a resolution to forward policy change recommendations to the 2018 House of Delegates. These policy change recommendations will be submitted on a separate worksheet.

Statement on Preventive Coverage in Dental Benefits Plans (*Trans.*1992:602; 1994:656; 2013:306)

Council Minutes

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

Council on Dental Education and Licensure

Glickman, Gerald N., 2018, Texas, chair, American Dental Education Association
 Gehani, Rekha C., 2020, New York, vice chair, American Dental Association
 Boden, David F., 2020, Florida, American Dental Association
 Cassella, Edmund A., 2019, Hawaii, American Dental Association
 DiFranco, GeriAnn, 2020, Illinois, American Association of Dental Boards
 Donoff, Bruce R., 2020, Massachusetts, American Dental Education Association
 Edgar, Bryan C., 2018, Washington, American Association of Dental Boards
 Halpern, David F., 2018, Maryland, American Dental Association
 Hangorsky, Uri, 2022, Pennsylvania, American Dental Education Association
 Hebert, Edward J., 2018, Louisiana, American Dental Association
 Korzeb, Jennifer, 2019, Massachusetts, American Dental Association
 Miles, Maurice, 2019, Maryland, American Association of Dental Boards
 Niessen, Linda C., 2021, Florida, American Dental Education Association
 Pascarella, Jonathan R., 2018, Connecticut, New Dentist Committee
 Plemons, Jacqueline M., 2021, Texas, American Dental Association
 Scarbrough, A. Roddy, 2021, Mississippi, American Association of Dental Boards
 Strotman, Meaghan D., 2021, Illinois, American Dental Association

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

The Council's 2017–18 liaisons include: Dr. Kirk M. Norbo (Board of Trustees, Sixteenth District), and Dr. Tanya Sue Maestas (American Student Dental Association). Upon the recommendation from the American Dental Education Association, the ADA President appointed Dr. Uri Hangorsky to complete the third-year of the unexpired four-year term of Dr. Mert Aksu, who resigned in early 2018.

Areas of Responsibility as Set Forth in the *Bylaws or Governance and Organizational Manual of the American Dental Association*

As listed in Chapter VIII, Section K4, of the ADA *Governance and Organizational Manual*, the areas of subject matter responsibility for the Council shall be:

- 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: 3 states

Range: 2–5 states

Outcome: At the time this report was prepared, assistance had been provided to Vermont and Massachusetts. In addition, representatives of the ADA were invited to provide information on PGY1 as a licensure pathway to the Indiana State Board of Dentistry. Information regarding development of the Dental Licensure Objective Structured Clinical Exam (DLOSCE) was provided to the Ohio Dental Association's Dental Education and Licensure Committee. Preliminary inquiries about the DLOSCE also have been received from additional states.

The following states expanded licensure portability regulations during 2017–18:

Table 1. 2017–18 Expanded Licensure Portability Regulations

State	Regulatory change
Connecticut	Enacted June 2018, HB 5163 allows the Department of Public Health to issue a license without examination to a dentist licensed in another state who has worked as such for the past five years, even if the other state does not require a practical examination for licensure.
Iowa	Effective January 2018, the California portfolio examination is accepted for licensure by examination for University of Iowa graduates. Graduates of other schools may petition the board for a rule waiver.
Washington	Effective November 2017, the Washington Dental Quality Assurance Commission will accept the complete National Dental Examining Board (NDEB) of Canada clinical examination as meeting its standards if the applicant is a graduate of an approved dental school.

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

Initiative/Program: Monitor and support the DLOSCE Steering Committee and the ADA Department of Testing Services as appropriate in support of the execution of the DLOSCE Business Plan

Success Measure: Implementation of plan

Target: Full Implementation of plan

Range: Initiation of task analysis, identification of key technology and administration vendors, establishment of test construction teams, and determination of examination content and test specifications

Outcome: On plan to pilot DLOSCE administration in late 2019

As recommended by the Council, the ADA Board of Trustees approved the DLOSCE Business Plan in 2017; implementation of the plan is well underway in 2018. The development of the DLOSCE supports current ADA policy calling for the elimination of patients from the dental licensure examination process. The development of the DLOSCE is anticipated to ultimately help support licensure portability for practicing dentists.

The composition of the DLOSCE Steering Committee is noted below. This Steering Committee provides oversight and guidance to the DTS experts; the Council is represented on the Committee.

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 (current) Dr. Prabu Raman, MO (former)
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

The test specifications for the DLOSCE have been identified and approved by the Steering Committee, based on the recommendation of an expert panel. The test specifications were informed by the results of a 2016 practice analysis involving more than 2,500 entry-level general dentists. Still under consideration is the most appropriate administration structure for the DLOSCE, including the optimal number of test items and stations.

A pilot administration of the DLOSCE is expected to occur in late 2019. The Steering Committee will plan for this pilot, including identifying appropriate target populations and encouraging participation by dental schools, examination candidates and state dental boards. Deployment of the DLOSCE is planned for 2020. For more information about the DLOSCE, review [DLOSCE Frequently Asked Questions](#) and [presentations](#) posted on ADA.org.

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

Initiative/Program: Review and propose revisions to ADA licensure and specialty policies for consideration by the 2018 ADA House of Delegates.

Success Measure: Submission of proposed new policy, rescissions and amendments to 2018 House of Delegates

Target: Council review by June 2018; Reports to House of Delegates by August 2018

Range: May–September

Outcome: On plan for submission of resolutions to 2018 House of Delegates

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. At its winter 2018 meeting, the Commission took action to remove the word *specialty* from all CODA documentation, as well as its website, concluding that its current terminology for advanced education programs (i.e., “advanced” and “advanced specialty”) may unintentionally imply which dental disciplines are “specialties.” An Action Plan for revision of all documents is to be considered by the Commission at its summer 2018 meeting with changes most likely taking effect in fall 2018.

In regard to monitoring accreditation standards, the Council supported proposed changes to Standard 6. Research of the Accreditation Standards for Dental Education Programs. The proposed language urges dental schools to strengthen their research strategies, assess research outcomes and recruit research faculty. The Council also supported changes proposed by the Council on Advocacy for Access and Prevention (CAAP) to the CODA Accreditation Standards for Dental Education Programs. These proposed changes focused on the addition of a definition of health literacy and proposed requirements to ensure that dental students complete their education with an understanding of health literacy principles and effective communication skills. The proposed revisions are out for circulation to the communities of interest for review and comment and will be reviewed by CODA at its winter 2019 meeting.

The Council also considered proposed changes to the Accreditation Standards for Dental Hygiene Education Programs as submitted by the American Dental Hygienists' Association (ADHA) to CODA. The proposed revisions focused on the use of the term "dental hygiene diagnosis," the degree awarded to graduates of the programs, and the required qualifications of dental hygiene program directors and faculty members. The Council reviewed the proposed changes and concluded again that the term "dental hygiene diagnosis" can be misleading to the public and should be replaced with the term "assessment." CODA will review all comments from the communities of interest, including the Council's, at its summer 2018 meeting.

All other actions taken by the Council regarding accreditation matters are reflected in the Council's meeting minutes.

The Council sponsored three 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. Carol L. Aiken (MA), Dr. Matthew Mara (MA), and Dr. Vincent C. Mayher, Jr. (NJ).

Recognition of Dental Specialties and Interest Areas in General Dentistry: With the establishment of the National Commission on Recognition of Dental Specialties and Certifying Boards (National Commission or NCRDSCB) in 2017, the Council and the National Commission have collaborated this year on transitioning dental specialty recognition responsibilities, as appropriate, from the Council to the National Commission.

For example, the National Commission adopted verbatim the ADA statements recognizing each of the nine ADA-recognized dental specialties, their sponsoring organizations and certifying boards as well as the ADA policy related to the periodic review of the dental specialties. Because of the National Commission's actions and in accord with the policy, Regular Comprehensive Policy Review (*Trans.*2012:370), the Council recommends that the Association's statements recognizing the dental specialties, their sponsoring organizations and certifying boards be rescinded because such recognition is now the purview of the National Commission and to avoid confusion and redundancy. Further, the Council recommends rescission of the policy, Periodic Review of Dental Specialty Education and Practice because this activity is now managed by the National Commission as reflected in its own policy statement. Accordingly, the Council has submitted Resolution 9 to the 2018 House of Delegates.

The chairs of the Council and NCRDSCB sent notifications to the executive directors of the nine (9) dental specialty certifying boards requesting completion of the *Annual Survey of the Recognized Dental Specialty Certifying Boards* to ensure continuity in the collection and analysis of this important data. Beginning in January 2019, The *Annual Survey of the Recognized Dental Specialty Certifying Boards* will be conducted solely by the NCRDSCB.

This year the Council also reviewed the ADA's Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists. The Council believes that housekeeping revisions to the *Requirements for Recognition* are necessary due to the establishment of the National Commission. Additionally, revisions related to Requirements 3, 4 and 6 are recommended to provide further

clarification on the intent of the Requirements for Recognition. Accordingly, the Council has submitted Resolution 13 to the 2018 House of Delegates.

The Council also reviewed the policies, Certification in Unrecognized Practice Areas and Use of the Term “Specialty” and concluded that the policies are outdated and contrary to the Principles of Ethics and Code of Professional Conduct. The Council supports rescission of both; see Resolutions 15 and 21.

The Council also reviewed the Number of Specialty Areas of Dental Practice policy and the Criteria for Recognition of Interest Areas in General Dentistry and believes housekeeping amendments should be made to both. Accordingly, the Council has submitted Resolutions 17 and 11, respectively, to the 2018 House of Delegates. The Council reviewed the Requirements for Board Certification and believes the first resolve is redundant with the Requirements for Recognition and the second resolve is outdated. The Council has submitted Resolution 12 to the 2018 House of Delegates.

In addition, the Council recommends that the ADA have policy in support of the National Commission on Recognition of Dental Specialties and Certifying Boards, and urging state dental boards to recognize the National Commission. The ADA has similar policy statements urging state dental boards to recognize the Commission on Dental Accreditation, the Joint Commission on National Dental Examinations and the Commission for Continuing Education Provider Recognition. The Council has submitted Resolution 8 to the 2018 House of Delegates.

Dental Anesthesiology and Sedation: The Council monitors national anesthesia guidelines that may impact the ADA’s policies on sedation and anesthesia. In late 2017, the ADA was a cosponsor of the American Society of Anesthesiologists (ASA) [Practice Guidelines for Moderate Procedural Sedation](#). This year, the Council considered two new statements on administering moderate and deep sedation to children published by the ASA 2017 House of Delegates. The ASA documents include a “Statement on Sedation & Anesthesia Administration in Dental Office-Based Settings” as well as the “Statement on Granting Privileges to Non-Anesthesiologist Physicians for Personally Administering or Supervising Deep Sedation.” The Council concluded that the ASA pediatric-related guidelines are comparable to the *Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016*, published by the American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry (AAPD). The ADA cites AAP/AAPD Guidelines for pediatric sedation within the *ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists* and the *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*.

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.

DAT Trends in 2017–18:

- Average scores for first-time examinees in 2017 on all tests in the DAT battery were slightly higher than those from 2016.
- During 2017, 12,499 DATs were administered, slightly down from 12,811 in 2016.
- 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 2017 were as follows: White (61%), Asian (28.2%), Hispanic (11.8%), Black (8.4%), American Indian/Alaska Native (1.5%), and Native Hawaiian/Pacific Islander (0.9%).

ADAT Trends in 2017–18:

- During 2017, 481 candidates took the ADAT, 56.5% were female and 43.5% were male.
- From highest to lowest, the percentage of administrations based on examinee self-report ethnicity in 2017 were as follows: White (56.2%), Asian (40.4%), Black or African American (1.8%), American Indian or Alaska Native (0.4%), and Native Hawaiian or Other Pacific Islander (0.2%).
- As of the end of June 2017, 483 candidates had registered to take the ADAT. The test window for 2018 is March 1–August 31.

Dental Licensure: This year the Council completed a two-year comprehensive review of the Association's policies related to dental licensure. The Council identified redundancies, outmoded language and lengthy explanations within these policy statements and concluded that new succinct policy related to: (1) general principles for dental licensure, (2) initial licensure, (3) the curriculum integrated format clinical examination (4) graduates of non-CODA accredited dental education programs, (5) licensure by credentials, and (6) licensure by credentials for dentists who are not graduates of CODA-accredited dental schools, should be established to replace many of the current policies. In doing so, the Council paid careful attention to the important points stated in current policies, ensuring that key positions are reflected in the proposed policy submitted via Resolution 26 to the 2018 House of Delegates.

Further, the Council has submitted Resolution 22 to the 2018 House of Delegates recommending rescission of an outdated policy on dual-degree dentists. Finally, the Council recommends revision of two licensure-related policies: Promotion of Freedom of Movement for Dental Hygienists (*Trans.*1990:550) and Examinations for Allied Dental (Non-Dentist) Personnel (*Trans.*2010:595) and has submitted Resolutions 5 and 6 to the 2018 House of Delegates.

In addition to participating on the DLOSCE Steering Committee, current and former Council members also serve on the ADA/ADEA Task Force on the Assessment of Readiness for Practice. The Council received and discussed Task Force reports at both of its 2018 meetings as noted in the Council's minutes.

The Council maintains testing and licensure 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.

Per a directive of the 2013 House of Delegates (*Trans.*2013:327), the Council monitors the Dental Board of California's (DBC) implementation of its portfolio-style examination and reports information annually to the House of Delegates. Information received from the DBC in June 2018 noted that during the timeframe of June 2017 through May 2018, the DBC issued 21 licenses via the portfolio pathway. The following dental schools participated in the portfolio licensure pathway June 2017–May 2018; the number of licensees is noted in parentheses: University of California, Los Angeles (0); University of California, San Francisco (9); University of the Pacific Dugoni Dental School (7); University of Southern California (1); Western University of Health Sciences (0); and Loma Linda University (4). It has been reported that the DBC has a number of pending portfolio applications and more are expected later in 2018.

State Licensure Legislation: In collaboration with the department of State Government Affairs, the Council monitors proposed and enacted state dentist licensure legislation. The following table summarizes 2018 legislation enacted by states.

Table 3. Recent Enacted State Licensure Legislation

State	Bill Number and Date Enacted	Action
Alabama	HB 388. Enacted 4/6/2018.	Eases licensure procedures for military spouses but expressly excludes dentists/dental licensure.
Alabama	SB 123. Enacted 3/21/18.	Multi-purpose bill to: (a) define and include patient abandonment as grounds for disciplinary action against a dentist; (b) expand the time during which an applicant may take the licensure examination to within 18 months after completion of an accredited or approved post-doctoral residency program; (c) require each dentist and dental

		hygienist to display his or her license certificate in a visible location; (d) remove all references to the American Dental Association as the body designating what constitutes specialty status in advertising and instead make it the dental board the body responsible for recognizing and approving specialty status in advertising by dentists.
Connecticut	HB 5163. Enacted 6/13/18.	Allows the department of health to issue a license without examination to a dentist licensed and practicing in another state if the dentist holds a current license in good standing in another state and: (A) was licensed by taking an exam in another state that maintains licensing standards which, except for the practical examination, are commensurate with the Connecticut's standards; and (B) has worked continuously as a licensed dentist in an academic or clinical setting in another state or territory for at least five years immediately preceding.
Missouri	HB 1719. Enacted 6/1/18.	Removes the requirement that an applicant for dental licensure be at least 21 years old.
Idaho	SB 1321. Enacted 3/20/18.	Changes the clinical hour requirement of the licensure by credential statute from requiring a dentist (who has been in clinical practice for the preceding five years), to have accumulated of a minimum of 1,000 hours each year to having accumulated 3,500 hours total in that time period.
Maryland	HB 800. Enacted 5/15/18.	Provides a new licensure pathway for board certified dental specialists who are faculty members at the University of Maryland School of Dentistry and who were trained at a foreign dental school. Candidates must meet special criteria. Candidates are then certified by the dental school to take the American Board of Dental Examiners exam and then apply for Maryland licensure.
Maine	LD 1825. Enacted 4/15/18.	Eliminates the charitable dentist and clinical dentist educator license categories and updates other language.

Oklahoma	HB 2759. Enacted 5/1/18.	Reestablishes the temporary license to an “emergency temporary license.” Changes the requirements for dentist continuing education from 60 hours of CE every three years, to (beginning in 2020) 40 hours of CE every two years.
Texas	Dental Board Proposed Rule Adopted 5/10/18.	Effective January 1, 2019, requires all applicants for dental licensure by examination to successfully pass the periodontics and prosthodontics sections of the regional board exam that the applicant takes.
Utah	HB 200 Enacted 3/15/18	Allows dentist licensure candidates to take any regional dental clinical examination. (i.e., added Council of Interstate Testing Agencies)
Vermont	VT HB 684. Enacted 5/21/18.	Allows applicants seeking dental licensure by examination who have graduated from “a program of foreign dental training” to have completed a postgraduate program accredited by the Commission on Dental Accreditation that is acceptable to the Board. This is in lieu of graduation from a CODA-accredited dental college and passing an exam given by a clinical testing agency.

ADA-Recognized Allied Dental Certifying Boards: The Council accepted the 2017 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.

The following updates on Certified Dental Technician (CDT) Program Changes have gone into full effect as of January 1, 2017: New Examination References; Revised Job Task Outlines; Modified Practical Exams & Updated Written Exams; and a New Pathway to Certification. NBC has begun the process of incorporating digital technologies into the CDT Practical Examinations. In doing so, candidates are now able to use digital or analog fabrication techniques in their preliminary work and have more flexibility with choice of materials. As a means to reduce barriers to testing and make CDT and Recognized Graduates (RG) written examinations more accessible, the NBC Trust is exploring transitioning from paper/pencil based testing to computer based testing. NBC hopes to have a decision and structure in place to offer computer based testing by the end of the first quarter in 2018. NBC’s Annual Report indicated that as of September 30, 2017, there are 4,753 active CDTs and 234 active retired CDTs.

The Annual Report submitted by the Dental Assisting National Board, Inc. (DANB) was reviewed in light of the ADA’s Criteria for Recognition of a Certification Board for Dental Assistants. DANB’s Annual Report indicated that between September, 1, 2016 and August 31, 2017, 1,812 examinees took the entire Certified Dental Assistant (CDA) Examination with a pass rate of 73%. The General Chairside portion of the CDA exam was taken by an additional 2,155 examinees with an 80% pass rate. As of October 3, 2017, DANB has 36,869 CDA Certificants.

Continuing Dental Education: The total 2018 year-to-date revenue of online CE (\$101,350) is approximately 194% of the same time frame in 2017. Total number of CE hours awarded is up 475% from

the same time period in 2017, and unique registrants have more than quadrupled. These gains are due in part to the addition of *JADA* CE online monthly quizzes as well as a more cohesive and collaborative marketing strategy. A subscription pricing model for the CE Online catalog has been approved and will be strategically implemented in the future.

Table 4. ADA CE Online 2018 YTD

	January – June 2018 Totals
Current Course Count	186
Courses Ordered	12,102
Number of Orders	6,595
Unique Registrants	3,324
Total CE Hours Awarded	12,670
YTD Online CE Revenue	\$101,350

Proposed Amendment to the Governance Manual: The Council has identified that the former ADA *Bylaws* and current ADA *Governance and Organizational Manual* do not clearly address the process for outside organizations, i.e., the American Association of Dental Boards (AADB) and the American Dental Education Association (ADEA), to make direct appointments to the Council. Further, managing a vacancy occurring when an AADB or ADEA appointee's term concludes early is not clearly stated. Therefore, the Council recommends that the Composition and Vacancy provisions in Chapter VIII Councils of the *Governance Manual* be amended and urges the House of Delegates to adopt Resolution 7.

Responses to House of Delegates Resolutions

Resolution Objective: Resolution 11H-2017—Policy on State Dental Board Recognition of the Commission for Continuing Education Provider Recognition

11H-2017. Resolved, that the American Dental Association urges all state dental boards to recognize the Commission for Continuing Education Provider Recognition as a national agency responsible for the approval of continuing dental education providers, and to accept for licensure renewal purposes dentists' participation in continuing education courses offered by providers approved by the Commission for Continuing Education Provider Recognition through the Continuing Education Recognition Program (CERP).

Initiative/Program: Urge state dental boards to recognize the Commission for Continuing Education Provider Recognition

Success Measure: Notices disseminated

Target: State dental boards and state dental associations

Range: January–March 2018

Outcome: Electronic notices sent via ADA Leadership Update, *ADA News*, state dental boards and the AADB

Self-Assessment

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

Policy Review

In accordance with the policy, Regular Comprehensive Policy Review (*Trans.*2012:370), this year the Council on Dental Education and Licensure reviewed Association policies related to recognition of dental specialties and specialty certifying boards and licensure matters.

The Council determined that the following licensure policies should be retained as written:

Dentistry as an Independent Profession (*Trans.*1995:640)
 State Board Support for CODA as Responsible to Accredite Dental Education Programs
 (*Trans.*2003:367; 2012:463)
 Policy on Licensure of Dental Assistants (*Trans.*2000:474)

As noted previously in this report, the Council recommends adoption of a new policy and rescission of several others related to licensure (See Resolutions 26 and 22). Proposed revisions to two licensure policies are presented in Resolutions 5 and 6. In regard to policies related to dental specialties and interest areas in general dentistry, the Council recommends amendment to four (Resolutions 13, 17, 11, 12), rescission of several (Resolutions 9, 15, and 21) and adoption of one new policy (Resolution 8).

The Council determined that the following policies should be rescinded:

Policy on One Standard of Competency (*Trans.*2003:369; 2012:463)
 Acceptance of Results of Regional Boards (*Trans.*1992:630; 2001:468; 2012:468)
 Position Statement on Federal Intervention in Licensure (*Trans.*1975:187, 718; 2012:468)
 Dental Practice by Unqualified Persons (*Trans.*1959:207)
 Eliminating Use of Patients in Board Examinations (*Trans.*2005:336; 2013:351)
 Policy on Dental Licensure (*Trans.*1998:720; 2003:341)
 Guidelines for Licensure (*Trans.*1976:919; 1977:923; 1989:529; 1992:632; 1999:938; 2000:401; 2003:340; 2012:464)
 Monitoring Clinical Dental Licensure Examinations (*Trans.*2005:333; 2012:462)
 Definition of Curriculum Integrated Format (*Trans.*2007:389)
 Clinical Licensure Examinations in Dental Schools (*Trans.*2003:368; 2012:462)
 Policy on Licensure of Graduates of Nonaccredited Dental Programs (*Trans.*1984:539; 2012:477)
 Endorsement of Recommendations of the ADA Guidelines for Licensure by Credentials
 (*Trans.*1992:628; 2009:447; 2012:464)
 Policy on Dual Degreed Dentists (*Trans.*2003:367; 2012:464)
 Certifying Board in Oral and Maxillofacial Pathology (*Trans.*1950:29; 2015:255)
 Recognition of Oral and Maxillofacial Pathology as a Dental Specialty (*Trans.*1987:510; 2015:255)
 Certifying Board in Oral and Maxillofacial Radiology (*Trans.*2015:256)
 Recognition of Oral and Maxillofacial Radiology as a Dental Specialty (*Trans.*1999:898; 2015:256)
 Certifying Board in Oral and Maxillofacial Surgery (*Trans.*2015:256)
 Recognition of Oral and Maxillofacial Surgery as a Dental Specialty (*Trans.*1990:554; 2015:256)
 Specialty of Oral and Maxillofacial Surgery (*Trans.*1990:549)
 Certifying Board in Pediatric Dentistry (*Trans.*2015:257)
 Recognition of Pediatric Dentistry as a Dental Specialty (*Trans.*1990:549; 2015:257)
 Certifying Board in Periodontics (*Trans.*2015:258)
 Recognition of Periodontics as a Dental Specialty (*Trans.*1988:490; 2015:257)
 Certifying Board in Prosthodontics (*Trans.*2015:258)
 Recognition of Prosthodontics as a Dental Specialty (*Trans.*1987:510; 2015:258)
 Certifying Board in Orthodontics and Dentofacial Orthopedics (*Trans.*1950:189; 2015:257)
 Recognition of Orthodontics and Dentofacial Orthopedics as a Dental Specialty (*Trans.*1989:519; 2015:257)
 Certifying Board in Endodontics (*Trans.*1964:251; 2015:255)
 Recognition of Endodontics as a Dental Specialty (*Trans.*1963:244; 2015:254)
 Certifying Board in Dental Public Health (*Trans.*1951:180; 2015:254)
 Recognition of Dental Public Health as a Dental Specialty (*Trans.*1986:512; 2015:254)

Periodic Review of Dental Specialty Education and Practice (*Trans.*2001:468; 2011:465)
Certification in Unrecognized Practice Areas (*Trans.*1957:360)
Use of the Term “Specialty” (*Trans.*1957:360)

Council Minutes

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

Council on Dental Practice

Ratner, Craig S., 2018, New York, chair
 Van Scoyoc, Stacey K., 2019, Illinois, vice chair
 Aflatooni, Nima, 2020, California
 Berkley, Jeffrey S., 2021, Connecticut
 Connell, Christopher M., 2019, Ohio
 Edgar, Linda J., 2020, Washington
 Hale, Hal E., 2019, Kansas
 Ho, Duc M., 2021, Texas
 Kent, Leigh W., 2018, Alabama
 Liang, Christopher G., 2021, Maryland
 Liddell, Rudolph T., III, 2020, Florida
 Limberakis, Cary J., 2021, Pennsylvania
 Medovic, Michael D., 2020, West Virginia
 Mikell, Julia K., 2019, South Carolina
 Saba, Michael, A., 2018, New Jersey*
 Theurer, Scott L., 2018, Utah
 Wojcik, Scott 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

The Council's 2017–18 liaisons include: Dr. Richard C. Black (Board of Trustees, Fifteenth District) and Dr. Sara Perrone (American Student Dental Association).

Areas of Responsibility as Set Forth in the *Bylaws or Governance and Organizational Manual of the American Dental Association*

As listed in Chapter VIII, Section K5 of the *ADA Governance and Organizational Manual*, the areas of subject matter responsibility of the Council shall be:

- 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: Guidelines for Practice Success™ (GPS) webinars

*New Dentist member

Success Measure: Deliver three Guidelines for Practice Success™ webinars by the fourth quarter in 2018.

Target: 200 registrants per seminar

Range: 200–250 registrants

Outcome: The project met its goals. Four GPS webinars were produced during the program year; continuing education (CE) credits were available to attendees who completed a brief survey after participating in at least 45 minutes of the program. GPS webinar topics included: Managing Patients: “Is Your Practice Exceeding Patient Expectations? How to Manage Patients for Success,” presented by William A. van Dyk, D.D.S.; Managing Finances: “How to Collect What You Produce” presented by Cathy Jameson, PhD.; Managing Marketing: “Demystifying Marketing” presented by Wendy O'Donovan Phillips; and Managing the Dental Team: “Attracting and Retaining All-Star Dental Teams” by Debra Engelhardt-Nash. The four webinars based on content from different GPS modules that were offered in the program year had a total of 1,080 registrants, or an average of 270 registrants per program. Across all programs, an average of 99% participants reported being very satisfied or satisfied that the program content and materials were useful and relevant to their needs; 99% reported being very satisfied or satisfied that the programs' presenters were knowledgeable and engaging; and 99% reported being very satisfied or satisfied with the overall presentation.

Additional webinars based on GPS content will be offered in 2018–2019. All webinars are available for on-demand viewing on the ADA® Center for Professional Success™ (CPS); CE credit is available for those attending the live program only.

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

Initiative/Program: BIG Idea 2018: Discovering Group Practice Conference

Success Measure: Present the Conference in conjunction with the American Academy of Dental Group Practice (AADGP) with 75–100 attendees providing a satisfaction rating of 3.0–4.0 with 4.0 being excellent and at least 500 hours of continuing education hours delivered.

Target: 100 conference attendees

Range: 75–100 attendees

Outcome: The project met its goals. The Discovering Group Practice Conference was held in conjunction with the AADGP on January 31, 2018, with 111 attendees. Presentations by nine speakers resulted in a satisfaction rating of 3.4 with 4.0 being excellent among all attendees. The Conference topics included: “Growth Strategies” by Allen Schiff, CPA, CFE; “How to Use Key Performance Indicators” by Roger Levin, DDS; “Integrating Systems” by Teresa Duncan, M.S.; “Think Like a Lawyer” by Jeffrey Fraum, Esq. and Cathryn Albrecht, Esq.; and a Panel Discussion: “Personal Journeys to Discovering Group Practice.” Each participant received 5.5 hours of continuing education, and a total of 555 hours of continuing education were granted. The Conference netted a profit of \$2,278.

Objective 1.3: Promote oral health through advocacy and science.

Initiative/Program: National Elder Care Advisory Committee (NECAC): Elder Oral Health Care Awareness Webinar

Success Measure: Deliver a one-hour elder oral health care webinar that educates our members on the importance of elder oral health care issues and how they can get involved to help those in need.

Target: 75 webinar participants by the fourth quarter in 2018; 85% of attendees surveyed respond satisfied or very satisfied with education program; at least 50 hours of continuing education delivered

Range: 50–75 attendees

Outcome: The project is on track to meet its goal. The NECAC met on April 6, 2018, to discuss ongoing education, research and advocacy activities and plan future activities. These included the continuation and funding of the Manuscript Project for dental public health residents and development of interprofessional elder care webinars and formal CE programs. Planning for the NECAC's first elder care webinar is underway. The NECAC selected treatment planning for elder oral health care as the topic for the webinar, to be presented by Dr. Greg Folse, during a conference call held in July and will host the webinar in the third quarter of 2018.

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

Initiative/Program: ADA Opioid Campaign

Success Measure: Form an interagency Opioid Team to support the ADA Dentist and Student Lobby Day event held April 2018 in Washington, DC. Introduce Opioid Team to Agile principles and hold an initial facilitation to address opioid issues affecting dentists in the second quarter of 2018.

Target: N/A

Range: N/A

Outcome: The Opioid Agile Team completed its first quarter mission by providing support to the ADA Dentist and Student Lobby Day event held in Washington, DC in April 2018. During the lobby event, the ADA was cited in more than 300 news stories with 500 million audience impressions when the new ADA interim opioid policy was announced. In addition, the ADA received praise from individual Congressional representatives and the National Institute on Drug Abuse (NIDA). The ADA Opioid Agile Team completed an idea generating facilitation on June 8, 2018, to determine future areas of focus for the team. During the facilitation, the team saw opportunities for the ADA to develop safe use and disposal resources for patients as well as tool kits for state dental associations; share data and collaborate with dental specialties; and develop guidelines for the treatment of acute dental pain. The team intends to prioritize and pursue the opportunities discovered during its 2018 facilitation into 2019.

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

Success Measure: Deliver four webinars on opioid prevention topics.

Target: 2,500 webinar participants by the fourth quarter in 2018; 80% of webinar participants respond *satisfied* or *very satisfied* with the webinar; 80% of participants are *confident* or *very confident* in prescribing opioids safely and *likely* or *very likely* to continue to learn about pain management; 85% of webinar participants became aware of the ADA opioid webinar offering by viewing promotions in *ADA News*, the Morning Huddle, all member emails and the Leadership Update.

Range: 2,000–2,500 webinar participants

Outcome: The project is on track to meet its goals. Three PCSS-O Webinars, “Improving Opioid Prescribing: The CDC Guidelines for Prescribing Opioids for Chronic Pain and Considerations for Dentistry,” “Federal Law, Regulations and the Dispensing of Controlled Substances” and “Adolescent Pain Management and NSAID Considerations” were presented by the second quarter in 2018, with a total

of 1,376 participants. An average of 94% participants reported being very satisfied with the webinar content, 95% reported being very confident in prescribing safely, 92% were likely to continue to learn about acute pain management and 92% became aware of the webinar through *ADA News*, the Morning Huddle, all member emails and the Leadership Update.

The fourth webinar, “Opioids: Current Status of the Crisis, Response, and Future Directions” co-sponsored by the Federal Drug Administration, has been scheduled for July 19, 2018.

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

Initiative/Program: ADA Career Center

Success Measure: Form a Career Center Agile Team that will evaluate vendors and select features to incorporate into a refreshed, improved and dynamic revision of the ADA Career Center and complete all design decisions and business negotiations with a select vendor by the fourth quarter of 2018 with a firm commitment to launch the project in the first quarter of 2019.

Target: To evaluate and launch an improved ADA Career Center by the first quarter of 2019.

Range: Full launch range in the first or second quarter of 2019.

Outcome: The project is on track to meet its goal. A Request for Information (RFI) was circulated to gather feedback from several vendors. Following an analysis of the vendor responses, two entities were selected as finalists. Both finalists gave in-person demonstrations to the ADA Career Center team in June 2018. The two finalists will be given an opportunity to respond a second time to a more formal Request for Proposal (RFP) process. On the basis of those responses, one vendor will be selected as the preferred vendor of choice. The targeted date for final vendor selection is the fourth quarter of 2018, with the implementation of a new Career Center product occurring during the first quarter of 2019.

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

Initiative/Program: “Beginning Career” CPS Series: Resource identification, development, packaging and delivery for year-long series.

Success Measure: To identify gaps in content related to the “Beginning Career” segment of our members’ lives and produce, deliver and market these materials to our pipeline members.

Target: Survey CPS Community User’s Group a minimum of six times in 2018 on related content interests; development of content in every sprint on related topic completed; and publish a minimum of six content promotional articles in *ADA News*.

Range: Survey five to seven times in 2018; development of related content in at least five of the seven sprints in the 2018 calendar year and five to seven articles in the *ADA News*.

Outcome: The project is on track to meet its goals. At the time this is written, the CPS Community User’s Group has been surveyed three times, and staff were also able to utilize the larger ADA Advisory Circle survey vehicle for two additional surveys. Three more user’s group’s surveys are planned for this year. Content has been developed in the identified areas throughout each of the four sprints thus far, with plans to continue in this vein throughout the year. Eight articles have appeared in *ADA News* to date, with plans for at least four more in the remainder of the 2018 issues.

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

Initiative/Program: ADA Standards Program**Success Measure:** Increase member engagement through the following actions:

- reviewing draft executive summaries and format in ADA style form;
- working with ADA and Practice Institute (PI) staff, to determine which executive summaries would be suitable for posting on CPS and ADA.org; and
- publishing a minimum of six new articles outlining/promoting standards activities.

Target:

- development of executive summaries with all new ADA Standards deliverables;
- development of executive summaries in existing ADA Standards deliverables in Standards Committee on Dental Informatics (SCDI) and ADA Standards Committee on Dental Products (SCDP);
- 15% increase in ADA downloads and free preview of standards deliverables through tracking matrix from 2017-2018; and
- publication of at least six new articles outlining/promoting standards activities to news media.

Range: N/A

Outcome: The project met its goals. The Department of Standards increased member engagement by developing executive summaries of all new and a percentage of existing ADA standards and technical report, which will continue throughout 2018. Twenty-three executive summaries have been written from 2017 to date, representing all new standards, 15% of existing dental products standards and 25% of existing dental informatics standards.

The Department of Standards began working with PI staff to develop an area in CPS where members will be directed for free access to the executive summaries. Twelve articles were published over 2017 to date and additional articles are scheduled for the remainder of 2018. There were a total of 300 free technical reports downloaded by members in 2017 and 140 in the first half of 2018, indicating the rate of free downloads is continuing to remain strong. The number of free previews by members has remained even with a total of 70 in 2017 and 25 in the first half of 2018. Future availability of executive summaries will greatly improve distribution of information about standards to members.

Success Measure: Ensure that ADA continues to be the leader in the development of dental standards by:

- successfully implement the accredited American National Standards Institute (ANSI) procedures leading to ANSI approval of ADA standards and technical reports that impact dentistry; and
- using the accredited US TAG and International Organization for Standardization (ISO) programs, successfully identify international standards that are appropriate for adoption as U.S.-based ADA standards and initiation of adoptions through the accredited ANSI procedures.

Target: ANSI will approve new ADA standards that were developed using accredited standards committees procedures.

Range: N/A

Outcome: The project met its goals. Using accredited standards committee's procedures, thirteen new standards approved by ANSI and four new technical reports were approved by ADA standards committees from 2017 to date.

Success Measure: Provide ADA members with an updated diagnostic coding standard.

Target: 2018 maintenance process successfully completed and SNODENT® updated incorporating approved change requests; and the ANSI/ADA SNODENT standard processed according to the approved Canvass Committee procedures and approved by ANSI.

Range: N/A

Outcome: The SNODENT maintenance process and approval by ANSI was successfully completed in 2017. The 2018 maintenance process has been completed and procedures will lead to ANSI approval of the annual revision of ADA SNODENT standard by December 2018.

Success Measure: Ensure that ADA continues to be a leader in the development of international dental standards through hosting of the 2020 International Standards Organization (ISO) TC106 meeting by:

- obtaining approval to host the meeting by ADA leadership;
- developing a project plan to set goals and deadlines for meeting requirements;
- working with conference services, determine possible meeting venue and hotels; and
- developing a funding plan for hosting of meeting through sponsorships and donations.

Target: Approval of the ADA/U.S. hosting of the ISO/TC106 meeting in 2020 and project management plan completed.

Range: N/A

Outcome: The project is on track to meet its goal. The leadership of the ADA has approved the proposal to host the ISO/TC106 meeting in 2020 and a project management plan has been completed. The Department of Standards has begun working with staff from the Department of Conference Services and Meeting Planning as well as sponsorship sales staff to implement the project plan.

Emerging Issues and Trends

Pulmonary Fibrosis

In March 2018, the Centers for Disease Control and Prevention (CDC) published findings in the Morbidity and Mortality Weekly Report (MMWR) showing a case cluster of a progressive lung disease among dentists and other dental workers treated at one Virginia tertiary care center. At this time, the CDC does not know what caused this cluster of idiopathic pulmonary fibrosis cases in dental personnel; however, the CDC noted that, for years, dentists have been exposed to plaster and dust from a variety of occupational activities, in addition to other toxic substances. There was agreement that dental students, dental laboratory personnel, and dental assistants may be at increased exposure to dentally related aerosolized materials.

The Council on Scientific Affairs (CSA) is the lead on this issue and will work with staff from the Council and the Council on Member Insurance and Retirement Plans (CMIRP) to learn more from the CDC, the National Institute for Occupational Safety and Health (NIOSH) and the Pulmonary Fibrosis Foundation (PFF) to gather additional data that will indicate whether this is an occupational hazard.

Pediatric Airway Disorders

Obstructive Sleep Apnea Syndrome (OSAS) in children is emerging as a condition that can have long-term implications into adulthood, if left untreated. Early diagnosis and management of OSAS in pediatric populations can help avoid the serious comorbidities associated with sleep related breathing disorders in adults.

The 2017 House of Delegates adopted an ADA policy statement addressing dentistry's role in sleep related breathing disorders. Recognizing this public health issue, the ADA is hosting a two-day Children's Airway Health Conference on August 24–25, 2018, at the ADA Headquarters Building in Chicago.

Oral Health Care for the Elderly

Issues relating to the health and well-being of America's senior population are likely to be at the forefront of future healthcare discussions at the state and federal levels for years to come as the baby boomer generation ages. The Council participated in discussions on including a dental benefit in Medicare and will be the lead agency for addressing oral health needs of this population group.

Pregnancy Resources for Dentists

In February, the Board of Trustees adopted B-8-2018, which directed the Council, in consultation with the Council on Communications, to investigate possible solutions that address the needs of pregnant dentists and report back to the September 2018 Board of Trustees. The Council is assessing the value and resource implications of developing such solutions and will report their recommendations to the September Board.

New Standards Addressing Emerging Issues

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

- ADA Technical Report No. 1091, Cloud Computing: Implications and Recommendations for Dental Practice
- ADA Technical Report No. 1094, Quality Assurance for Intra-Oral Digital Radiographic Systems
- ADA Technical Report No. 1095, Electronic Resources for Access and Appraisal of Clinical Information
- ADA Technical Report No. 1088, Human Identification by Comparative Dental Analysis

New Work Projects Addressing Emerging Issues

- Proposed ADA Technical Report No. 168, Guidance on Method Development and Validation of Cleaning Processes
- Proposed ADA Standard No. 144, Alloy for Dental Amalgam
- Proposed ADA Technical Report No. 166, Accuracy of CAD/CAM Digital Dentures and Data Captures
- Proposed ADA Standard No. 117, Fluoride Varnishes
- Proposed ADA Technical Report No. 1096 for Electronic Protected Health Information Health Information Portability and Accountability Act of 1996 (HIPAA) Security Risk Analysis
- Proposed ADA Technical Report No. 1098 for Quality Assurance for Cone Beam Computed Tomography
- Proposed ADA Technical Report No. 1099 for Quality Assurance for Digital Panoramic/Cephalometric Radiography
- Proposed ADA Technical Report No. 1077, Human Age Assessment by Dental Analysis

Cleanliness in Reprocessing

The ADA Standards Committee on Dental Products (SCDP) Working Group on Cleanliness in Reprocessing is working on the development of Proposed ADA Technical Report No. 168 Dentistry - Guidance on Method Development and Validation of Cleaning Processes for Dental Instruments. This technical report describes method development and validation of cleaning processes, the first step in the multi-step procedure of reprocessing. This project is intended 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.

Security and Privacy of Electronic Data and Images

The ADA provides a variety of educational resources to assist members in learning best practices in ensuring their electronic patient data and images are secure and protected; and that their systems are HIPAA compliant. The ADA Standards Committee on Dental Informatics (SCDI) is providing both technical reports and CE courses to meet this need. Proposed ADA Technical Report No. 1096 Patient Data Risk Assessment for Privacy and Security, to be published in 2018, will provide members with guidelines for conducting a patient data security risk analysis. "Solving the Nightmare of HIPAA Liability in Digital Communications," is an interactive CE course that was presented in 2017 and will be repeated in 2018 and demonstrates methods of HIPAA compliant digital communication. "Avoid the Million Dollar Mistake!

HIPAA Security Compliance: Protecting Your Patients, Your Practice, And Yourself," was a ADA 2017 CE course that provided practical guidance on protecting patients' electronic protected health information and complying with the HIPAA security regulations.

Forensic Odontology Informatics

The ISO is developing a uniform nomenclature for the description of forensic dental data and the ADA SCDI Subcommittee on Forensic Odontology Informatics is assisting ISO on this project using ANSI/ADA Standard No.1058-Forensic Dental Data Set as one of the reference documents. The Subcommittee also collaborates with the National Institute of Justice (NIJ), the National Institute of Standards and Technology (NIST) and the newly created Organization of Scientific Area Committees (OSAC). NIST has approved ADA Technical Report 1088 for the Identification of Human Remains by Dental Means, for entry into the Federal Forensic Repository, a registry of NIST-accepted forensics standards. The SCDI Subcommittee on Forensic Odontology Informatics delivered a successful CE course at ADA 2017 in Atlanta, "Identifying Disaster Victims: Standards for Electronic Dental Patient Data."

Guidelines for Researching Online Evidence Based Clinical Data

ADA Technical Report No. 1095, for Electronic Resources for Access and Appraisal of Clinical Information, published in 2018, presents online sources for clinical data and provides dentists with the tools needed to acquire "information skills": the identification, appraisal and application of up-to-date clinical evidence. This report provides a basic outline of information skills, followed by definition of various types of clinical evidence, with electronic resources to access and contains information about how each can be applied in practice.

Issues from Other Standards Organizations

Association for the Advancement of Medical Instrumentation (AAMI)

The Department of Standards maintains the ADA liaison to the Association for the Advancement of Medical Instrumentation (AAMI), an ANSI accredited standards developer that is the primary source of standards for the medical device industry. There are AAMI working groups that address reprocessing instructions and validation methods of medical devices through standards and technical reports. For example, TIR 30 "a compendium of processes, materials, test methods, and acceptance criteria for cleaning reusable medical devices" is in the process of being transformed into a formal standard. An important subject that is being addressed in the transformation is manual cleaning validation of instruments. The ADA plans to contribute to this standard by incorporating information about reprocessing of dental instruments, as appropriate.

American Society of Heating, Refrigeration and Air-Conditioning Engineers (ASHRAE)

The Department of Standards maintains the ADA liaison to the American Society of Heating, Refrigeration, and Air-conditioning Engineers (ASHRAE). ASHRAE is an international group accredited by ANSI to develop standards in areas such as ventilation, indoor air quality and water treatment, and infection control and diseases, including in healthcare and dental facilities. Recent meetings covered standards for building air and water safety; and prevention of Legionnaire's and other infectious diseases.

Responses to House of Delegates Resolutions

Resolution Objective: Resolution 16H-2017 Amendment of Policy, Statement on Dentist Health and Wellness

16H-2017. Resolved, that the ADA policy "Statement on Dentist Health and Wellness" (*Trans.*2005:321), be amended by deletion of the third paragraph (deletion ~~stricken~~).

Statement on Dentist Health and Wellness (*Trans.*2005:321)

To preserve the quality of their performance and advance the welfare of patients, dentists are encouraged to maintain their health and wellness, construed broadly as preventing or treating acute or chronic diseases, including mental illness, addictive disorders, disabilities and occupational stress. When health or wellness is compromised, so may be the safety and effectiveness of the dental care provided. When failing physical or mental health reaches the point of interfering with a dentist's ability to engage safely in professional activities, the dentist is said to be impaired.

In addition to maintaining healthy lifestyle habits, every dentist is encouraged to have a personal physician whose objectivity is not compromised. Impaired dentists whose health or wellness is compromised are urged to take measures to mitigate the problem, seek appropriate help as necessary and engage in an honest self-assessment of their ability to continue practicing.

~~Dentists are encouraged to participate in the ADA's Health Screening Program when they attend annual session, both to assist them in monitoring key indicators of personal health and to contribute to the body of knowledge about dentist health and well-being.~~

Dentists are strongly encouraged to have adequate disability and overhead protection insurance coverage which they review on a regular basis.

The ADA and/or its constituent and component societies, as appropriate, are encouraged to assist their members in being able to provide safe and effective care by:

- promoting health and wellness among dentists
- supporting peers in identifying dentists in need of help
- intervening promptly when the health or wellness of a colleague appears to have become compromised; including the offer of encouragement, coverage or referral to a dentist well-being program
- encouraging the development of mutual aid agreements among dentists, for practice coverage in the event of serious illness
- establishing or cooperating with dentist (or multidisciplinary) well-being programs that provide a supportive environment to maintain and restore health and wellness
- reporting impaired dentists who continue to practice, despite reasonable offers of assistance, to appropriate bodies as required by law and/or ethical obligations
- supporting recovered colleagues when they resume patient care

Outcome: The policy was added to the [2017 Current Policies](#).

Resolution Objective: Resolution 17H-2017 Response to Resolution 96H-2015: Development of ADA Policy on Dentistry's Role in Sleep Related Breathing Disorders

17H-2017. Resolved, that the following policy on Sleep Related Breathing Disorders be Adopted.

Proposed Policy Statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders

Initiative/Program: Update the Sleep Related Breathing Disorders (SRBD) policy webpage and develop a communication plan. The communication dissemination plan for SRBD includes emailing a press release to the following news outlets: the dental trades, state and local societies and specialties, health journalists, PR individuals from various health outlets including physician/specialty groups.

Success Measure: Update the SRBD webpage and create a communication dissemination plan by May 2018.

Target: 19% open rate of press release email

Range: 15–25% open rate of press release email

Outcome: The Proposed Policy Statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders was adopted by the 2017 House of Delegates and added to the [2017 Current Policies](#).

- The webpage was updated to include the adopted policy statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders. The press release open rate was 26%.
- The Policy was featured in *ADA News*, the Morning Huddle and is posted to ADA.org outside the firewall.
- The Department of Product Development and Sales is developing a SRBD patient education brochure.
- ADA CE Live will present the “Children’s Airway Health Conference” on August 24-25, 2018.

Resolution Objective: Resolution 44H-2017 Response to Resolution 91-2016: Development of Sample Clinical Chart Entries to Increase Quality in Documentation

44H-2017. Resolved, that the 2017 ADA House of Delegates approve the development of a practice management resource that will provide guidance on a variety of risk management topics, including properly charting clinical entries and documenting medical necessity, to be completed in 2018.

Initiative/Program: Develop new module on Managing Professional Liability Risks for the Guidelines for Practice Success™

Success Measure: Complete new content before the 2018 House of Delegates and submit the module to Publishing and the CPS in the fourth quarter in 2018.

Target: Submit the GPS™ module on Managing Professional Liability Risks by October 18, 2018.

Range: The module will include 20–40 original articles and resources.

Outcome: The GPS module on Managing Professional Liability Risks includes 46 articles and 12 original resources.

Council staff had provided the draft of the module to the first community of reviewers at the time this report was written. Review and comment by relevant communities of interest will continue through the summer and early fall of 2018.

Resolution Objective: Resolution 50H-2017 Do-it-Yourself Teeth Straightening

50H-2017. Resolved, that for the health and well-being of the public, the American Dental Association believes that supervision by a licensed dentist is necessary for all phases of orthodontic treatment including:

- oral examination
- periodontal examination
- radiographic examination
- study models or scans of the mouth
- treatment planning and prescriptions
- periodic progress assessments and
- final assessment with stabilizing measures

and be it further

Resolved, that the ADA strongly discourages the practice of do-it-yourself orthodontics because of the potential for harm to patients.

Initiative/Program: Develop proposed policy on Direct to Consumer Dental Laboratory Services and propose an amendment to that the policy *Statement on Prosthetic Care and Dental Laboratories* (*Trans.*1990:543; 1995:623; 2000:454; 2003:365; 2005:327; 2007:430) to state dentists should order laboratory prosthetics or appliances and submit to the 2018 House of Delegates.

Success Measure: A report with a proposed policy to discourage direct to consumer dental laboratory services and report with a proposed amendment to the policy *Statement on Prosthetic Care and Dental Laboratories* (*Trans.*1990:543; 1995:623; 2000:454; 2003:365; 2005:327; 2007:430) will be submitted to the 2018 House of Delegates.

Target: N/A

Range: N/A

Outcome: The Direct to Consumer Laboratory Services report will be submitted to the 2018 House of Delegates with a proposed policy. This report extends ADA's opposition to DIY procedures to all laboratory services beyond orthodontics. The report with the proposed amendment to the policy *Statement on Prosthetic Care and Dental Laboratories* (*Trans.*1990:543; 1995:623; 2000:454; 2003:365; 2005:327; 2007:430) will be submitted separately. The amended resolution will be submitted by CDP to maintain consistency between this policy and its proposed policy for Direct to Consumer Dental Laboratory Services. The ADA Statement on Prosthetic Care and Dental Laboratories currently limits diagnosis and treatment by a licensed dentist to complete and partial denture patients.

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), Regular Comprehensive Policy Review, the Council reviewed the following Association policies and determined they should be maintained.

Recommendations of Future of Dentistry Report (*Trans.*1983:552; 2013:313)
 Opposition to Corporate Mandated Requirements for Patient Treatment (*Trans.*2009:420)
 Best Dentists Lists (*Trans.*2005:339)
 Statement Supporting the Dental Team Concept (*Trans.*2013:313)
 ADA's Position on Dentist Mid-Level Provider (*Trans.*2008:439)
 Comprehensive Policy Statement on Allied Dental Personnel (*Trans.*1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307; 2010:505)
 New Clinical Responsibilities for Dental Assistants (*Trans.*1996:701)
 Maintenance of Multi-Pathway for Options for Dental Assistants (*Trans.*1996:696)
 Delegation of Radiographic Film Exposure (*Trans.*1982:534)
 Fee-For-Service Private Practice (*Trans.*1979:620)
 Dentistry's Role in Emergency Preparedness and Disaster Response (*Trans.*2007:431)
 Liability Protection for Bioterrorism Responders (*Trans.*2002:398)
 State Mass Disaster Plan (*Trans.*2002:387)
 Dental Practice Management Software (*Trans.*200:428)
 Seamless Electronic Patient Record (*Trans.*1996:694)
 Electronic Technology Activities (*Trans.*1993:695; 2013:313)
 Electronic Technology in Dentistry (*Trans.*1992:608)
 ADA Involvement in Electronic Data Interchange Activities (*Trans.*1992:598)
 Development of Electronic Dental Patient Records (*Trans.*1992:598)

Bone Marrow Matching Programs (*Trans.*2012:458)
 Hospital Medical Staff Membership (*Trans.*1999:923)
 Economic Credentialing (*Trans.*1993:692)
 Registration of Dental Laboratories (*Trans.*2013:323)
 Statement to Encourage U.S. Dental Schools to Interact with U.S. Dental Laboratories
 (*Trans.*2010:547)
 Support of the Dental Laboratory Technician Certification Program and Continuing Education
 Activities (*Trans.*1997:682, 2010:547)
 Recognition Program for Meritorious Service by Certified Dental Technologists
 (*Trans.*1987:496; 1999:922)
 Availability of Survey Results (*Trans.*2008:474)
 Use of Environmentally Conscientious Measures in the Production, Packaging and Shipping
 of Dental Products (*Trans.*2013:314)
 Ownership of Dental Practices (*Trans.*2000:462)
 Guidelines Related to Alcohol, Nicotine, and/or Drug Use by Child or Adolescent Patients
 (*Trans.*2005:330)
 ADA's Position on New Members of the Dental Team (*Trans.*2009:419)
 Collaboration with Specialty Organizations on Workforce (*Trans.*2009:420)
 Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform
 Irreversible Procedures (*Trans.*2005:343; 2010:521)
 Diagnosis or Performance of Irreversible Dental Procedures by Nondentists (*Trans.*2004:328;
 2010:494)
 Measuring the Demand for Dental Services (*Trans.*1995:623)
 Support for Programs that Forecast Public Demand for Dental Services (*Trans.*1995:609)
 Dental Needs Survey (*Trans.*1985:588)

Council Minutes

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

Council on Ethics, Bylaws and Judicial Affairs

Herman, Gary N., 2018, California, chair
 Smith, James A., 2019, Oregon, vice chair
 Browder, Larry F., 2020, Alabama
 Burns, Jill M., 2021, Indiana
 Cohen, Donald F., 2020, Texas
 Compton, Lindsey M., 2018, Colorado*
 Griffin, Seth W., 2020, Michigan
 Howley, Thomas A., Jr., 2019, Pennsylvania
 Ilkka, Don J., 2018, Florida
 Jonke, Guenter J., 2021, New York
 Kochhar, Puneet, 2018, New Hampshire
 Kurkowski, Michael, 2020, Minnesota
 Moss, J. David, 2018, South Carolina
 Patel, Onika, 2021, Arizona
 Patel, Vishruti, 2019, Illinois
 Rice, Marvin E., 2019, Missouri
 Soileau, Kristi M., 2020, Louisiana
 Wilson, Robert J., 2021, Maryland

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

The Council's 2017–18 liaisons include: Dr. Billy Sue Kyger (Board of Trustees, Seventh District) and Ms. Danielle Marciniak-Brambilia (American Student Dental Association).

Areas of Responsibility as Set Forth in the *Bylaws or Governance and Organizational Manual of the American Dental Association*

As listed in Chapter VIII, Section K.6. of the *Governance and Organizational Manual of the American Dental Association*, the areas of responsibility of the Council shall be:

- a. Ethics and professionalism, including disciplinary matters relating thereto;
- b. The *Constitution* and *Bylaws* of this Association, including:
 - i. Review of the constitutions and bylaws of constituents and components to ensure consistency with the Association's *Bylaws*; and
 - ii. 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 *Governance Manual* upon the unanimous vote of the Council members present and voting; and
- c. Hold hearings and render decisions in disputes arising between constituents or between a constituent and component.

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

Objective: Increase member value and engagement.

Initiative/Program: Support member success by providing varied ethics programming.

*New Dentist member

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

Target: Highly favorable participant evaluation of continuing education ethics programming and attendance at continuing education program(s).

Range: Favorable to highly favorable participant evaluation of continuing education ethics programming; registration between 50 and 100 for the Council continuing education course at the annual meeting.

Outcome: On target. 89 individuals registered for the 2017 course and 58–59 provided evaluations. A substantial majority of evaluations received indicated that all aspects of the presentation (content, presenters, topic) were “excellent” or “above average.”

During the 2017 annual meeting, the Council presented a two-hour continuing education course entitled “Ethical Considerations in Patient Selection: Guidance from the ADA Code” which addressed topics including treating patients with political views, religious perspectives or other lifestyle choices that conflict with the dentist’s own views. Other continuing education programming provided included presenting at the Michigan Dental Association annual meeting and for the Seattle Study Club of Pittsburgh. At the 2018 annual meeting the Council will present a two-hour continuing education course entitled “Primary Care: Ethical Considerations in Dentistry.” Additionally, an abstract was submitted for consideration for the 2019 annual meeting entitled: “Friend or Foe? Ethical Issues of Social Media and other Electronic Communications in Dentistry.”

Objective: Increase member value and engagement.

Initiative/Program: Support member success by providing communications vehicle allowing members to obtain advice on ethical questions in a timely manner and support initiatives of other ADA agencies by providing responses to requests for content and comment concerning the ADA *Principles of Ethics and Code of Professional Conduct* (ADA Code) and the ADA *Bylaws and Constitution* (ADA Bylaws).

Success Measure: Membership access to timely and topical advice concerning ethics questions that arise in members’ practices and responsiveness to questions, comments and requests for advice concerning amendments to the ADA *Bylaws*.

Target: Frequent use and favorable response and evaluation of ethics advice program and ethics column appearing in *The Journal of the American Dental Association* (JADA), timely response to questions on the interpretation of and requests for advice on amending the ADA Code and ADA Bylaws.

Range: Positive responses and feedback regarding ethics advice program and JADA ethics column and responses questions on the interpretation of and requests for advice on amending the ADA Code and ADA Bylaws prior to the House of Delegates annual meeting.

Outcome: On target. Anecdotal feedback from those who have utilized the ethics hotline has been positive. Positive correspondence received concerning JADA ethics column. All requests for advice and proposals for amendments to the ADA Code and the ADA Bylaws have been addressed by the Council, with several resolutions proposing amendments to the ADA Code, ADA Bylaws and the *Governance Manual* being submitted to the House of Delegates.

Specific ADA Code and ADA Bylaws activity undertaken by the Council since the 2017 House of Delegates include:

The maintenance of a service by which members can contact the Council call to discuss specific ethical issues. A member of the Council directly contacts the member and discusses the ethical issue in question. Responses are made within two to three business days and sooner if requested by the member. Although members using the service indicate they find it valuable, low uptake among the

membership has prompted the Council to examine if a different vehicle for imparting advice in response to ethics inquiries may be of greater member value.

The Council continues to collaborate with and assist the New Dentist Committee by providing ethics-related material for inclusion in the ADA Success Program which is presented at dental schools throughout the country.

As it has for several years, the Council sponsors an ethics video contest for dental students. 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 by providing a creative forum for students to consider how ethical decisions should be addressed using the ADA *Code*. Entries that have been received since the inception of the Contest are available to view at <https://www.youtube.com/user/AmericanDentalAssoc/videos>.

The entry period for the 2018 ethics video contest has opened and will close at the end of August 2018. Videos received will be considered by the Council and monetary awards will be presented for the winning and honorable entry submissions.

In addition to amendments to the ADA *Code* discussed elsewhere in this report, the Council has received a number of requests to amend the ADA *Code*, the ADA *Bylaws* and the *Governance Manual* since the submission of its last annual report. These requests arose from both ADA agencies (the Councils on Dental Education and Licensure and Dental Benefit Programs and the DLOSCE Steering Committee) and external organizations (the American Academy of Pediatric Dentistry).

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

Initiative/Program: Reengineering of the Council's District Reports.

Success Measure: Submission of completed reports from constituent societies concerning ethics and bylaws activities in their jurisdictions.

Target: Increase in number of reports on ethics and bylaws activities submitted in advance of the Council's meeting.

Range: 10 to 20 constituent reports submitted.

Outcome: On target. In 2017 only six reports concerning ethics and bylaws were submitted by Council members. In July 2018, with the deployment of an automated survey tool, 17 constituent reports were submitted.

Emerging Issues and Trends

Treatment Discrimination Based on Sexual Orientation or Identity: In response to a member inquiry and suggestion through the Ethics Hotline, the Council proposed amending Section 4.A. of the ADA *Code* to specifically recite that it is unethical to deny treatment to patients because of the patient's gender or sexual orientation or identity. The House of Delegates adopted that amendment at the 2017 annual meeting.

Treatment Discrimination Based on Disability: In early 2018, the Council received a request from the National Council on Disability (NCD) to amend Section 4.A. of the ADA *Code* to specifically recite that it is unethical to refuse treatment because a patient is intellectually and developmentally disabled. Following discussions and collaboration with the NCD, the Council approved a proposal to amend Section 4.A. and also approved a restatement of Advisory Opinion 4.A.1. to further emphasize that refusals to treat patients because of a patient disability is unethical. The proposal to amend Section 4.A. of the ADA *Code* is being submitted to the 2018 House of Delegates; the restatement of Advisory Opinion 4.A.1. is approved by the Council is as follows:

ADVISORY OPINION 4.A.1: PATIENTS WITH DISABILITIES OR BLOODBORNE PATHOGENS.

As is the case with all patients, when considering the treatment of patients with a physical, intellectual, or developmental disability or disabilities, including patients infected with Human Immunodeficiency Virus, Hepatitis B, Hepatitis C Virus or another bloodborne pathogen, or who are otherwise medically compromised, the individual dentist should determine if he or she has the need of another's skills, knowledge, equipment or expertise, and if so, consultation or referral pursuant to Section 2.B. hereof is indicated. Decisions regarding the type of dental treatment provided, or referrals made or suggested, should be made on the same basis as they are made with other patients. The dentist should also determine, after consultation with the patient's physician, if appropriate, if the patient's health status would be significantly compromised by the provision of dental treatment.

Integrating Ethics Education into Dental School Curriculum: Recognizing the importance of ethics in practice and as integral to professionalism, the Council considered dental school education in dental schools and found that a considerable variance in content exists among schools. Consequently, the Council agreed to engage in dialogue with other appropriate ADA agencies and third-party stakeholders concerning the state of ethics education in dental schools with the goal of developing a more robust and integrated ethics curriculum.

Responses to House of Delegates Resolutions

Resolution Objective: 62H-2017—Study of the Effects of States Requiring Licensure as a Prerequisite for Active Membership

62H-2017. Resolved, that the Council on Ethics, Bylaws and Judicial Affairs is directed to study the proposal for allowing a constituent's bylaws to require licensure as one prerequisite for active membership and the effects, if any, that such an amendment would have on other portions of the ADA *Bylaws*, and to report back to the 2018 House of Delegates with proposed amendments to the ADA *Bylaws* that would allow states to require licensure as a condition of membership in the constituent.

The 2017 House of Delegates adopted Resolution 62H-2017, proposed by Reference Committee D, directing the Council to study the proposal for allowing a constituent's bylaws to require licensure as one prerequisite for active membership and the effects, if any, that such an amendment would have on other portions of the ADA *Bylaws*. As requested by the Resolution, the Council studied the proposal and the effects that the Council believes that the proposal would have if adopted. A report entitled "Report of the Council on Ethics, Bylaws and Judicial Affairs in Response to Resolution 62H-2017" will be submitted to the 2018 House of Delegates in response to the referral.

Self-Assessment

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

Policy Review

In accordance with Resolution 170H-2012, Regular Comprehensive Policy Review, the Council reviewed Association policies relating to ethics and governance.

The Council reviewed the following policies and determined in each case that revisions to the policy should be made. The revisions proposed by the Council are separately submitted.

Definition of Committees (*Trans.*2001:421; 2013:340)
Statement Regarding Employment of a Dentist (*Trans.*2013:315)

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

Council Minutes

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

Council on Government Affairs

Graham, Frank J., 2018, New Jersey, chair
 Armstrong, Craig S., 2019, Texas, vice chair
 Beauchamp, K. Jean, 2018, Tennessee
 Bird, Gerald W., 2018, Florida**
 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
 Kalarickal, Zacharias J., 2020, Florida
 Medrano-Saldana, Lauro, 2019, New York
 Messina, Matthew J., 2021, Ohio
 Minahan, David M., 2018, Washington
 Nguyen, Robin M., 2020, Florida*
 Reitz, John V., 2021, Pennsylvania
 Terlet, Ariane R., 2019, California
 White, David M., 2021, Nevada
 Willett, Emily S., 2021, Nebraska

Kupiec, Janice E., director
 Kyle, Frank A., manager
 Burns, Robert J., manager

The Council's 2017–18 liaisons include: Dr. Rickland G. Asai (Board of Trustees, Eleventh District), Dr. Timothy R. Fagan (Council on Advocacy for Access and Prevention), Ms. Janette P. Sonnenberg (Alliance of the American Dental Association), and Mr. Kyle T. Lantz (American Student Dental Association).

Areas of Responsibility as Set Forth in the *Bylaws or Governance and Organizational Manual of the American Dental Association*

As listed in Chapter VIII. Section K7 of the ADA *Governance and Organizational Manual*, the areas of subject matter responsibility of the Council shall be:

- 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 policies which are designed to advance the professional status of federally employed dentists; and
- d. Disseminate information which will assist the constituents and components involving legislation and regulation affecting the dental health of the public.

** ADPAC chair without the power to vote.

* New Dentist member.

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

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

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

Success Measure: Increase appropriations in dental programs and prevail on ADA's non-appropriations positions.

Target: 4% increase over the same period in 2017.

Range: 3%—5% over the same period in 2018.

Outcome: Federal fiscal year 2018 funding levels were increased across the board for oral health programs by approximately 7.5% (\$52 million) over the same period in 2017.

- Centers for Disease Control and Prevention oral health: \$19 million (\$1 million increase from FY17).
- Oral health training: \$40 million (\$4 million increase from FY17).
- Area Health Education Centers: \$38 million (\$8 million increase from FY18).
- National Institutes of Dental and Craniofacial Research: \$447 million (\$22 million increase from FY17).
- Indian Health Service Dental: \$195 million (\$13 million increase from FY17).
- Military Dental Research: \$10 million (\$4 million increase from FY17).

ADA Testified for Oral Health Funding: On April 26, Dr. Tim Fagan, chair, Council on Advocacy for Access and Prevention, testified before the House Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies to request oral health funding for FY19. The ADA's FY19 requests include: \$20 million for the Centers for Disease Control and Prevention's Division of Oral Health; \$24 million for the Health Resources and Services Administration's (HRSA) general and pediatric dental residency programs; \$10 million for military dental research; and \$199 million for Indian Health Service oral health funds. Dr. Fagan's testimony highlighted the importance of dental residency programs, funding for community water fluoridation and the role of prevention. (See [ADA News](#) article).

At the time of this report (July 16), federal funding levels for FY19 have not been established. The Senate Appropriations Committee approved the Senate Labor, Health and Human Services spending bill on June 28. The Senate bill includes report language urging the Centers for Medicare and Medicaid Services (CMS) to fill the vacant chief dental officer position and includes \$1 million for HRSA to develop and implement an agency wide oral health awareness and education campaign. Both the House and Senate Appropriations Committees must agree on a final spending package for FY19.

Student Loan Debt: The ADA has been lobbying Congress to abandon proposals to eliminate the federal Public Service Loan Forgiveness program, consolidate all graduate and undergraduate federal student loan programs into a single student loan program, and cap the borrowing limit at \$235,000. These provisions are currently in the House bill to reauthorize the Higher Education Act, which provides the statutory authority for most federal student loan programs to operate. The House version is in limbo due to significant opposition from numerous stakeholder groups. The Senate has not introduced an official bill and negotiations have been mired in partisan differences. The ADA continues to advocate for the following:

- H.R. 1614, the Student Loan Refinancing Act, which would allow individuals to refinance their federal direct student loans more than once. This bill was a key issue for the ADA Dentist and Student Lobby Day.
- H.R. 4001, the Student Loan Refinancing and Recalculation Act, which would allow borrowers to refinance their student loans at lower rates, delay accrual of student loan interest, allow dental

residents to defer payments until their residency is completed, and eliminate certain borrowing fees. This bill was a key issue for the ADA Dentist and Student Lobby Day.

- H.R. 5734, the Resident Education Deferred Interest Act, which would provide interest-free deferment on student loans for borrowers serving in a dental or medical internship or residency program.

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

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 2017.

Range: 3%–5% over the same period in 2018.

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 2017. Some examples include the following bills:

- McCarran-Ferguson Reform: In 2017, the U.S. House of Representatives passed the Competitive Health Insurance Reform Act of 2017, H.R. 372, by a vote of 416-7. 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 in 2018 with the goal of ensuring the legislation will 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. The bill was one of the key issues lobbied at the ADA Dentist and Student Lobby Day. At the time of this report (July 16) the bill had 100 cosponsors, 23 additional cosponsors were added after the ADA Dentist and Student Lobby Day meeting, April 8–10.
- Tax Reform: Comprehensive tax reform legislation was enacted in December 2017. (See [ADA News](#) article). The final bill included the following changes:
 - Expands Section 179 expensing to allow for the immediate expensing of up to \$1 million of qualifying property for small businesses.
 - Cash Accounting: Allows corporations and partnerships with average gross receipts up to \$25 million to use cash accounting.
 - Student Loan Interest Deduction: Final law retained the student loan interest deduction at existing levels.
 - Pass-Through Deduction: Provides for a pass-through deduction for certain professional services businesses. The final law allows the deduction to be available to eligible dental practices as a result of ADA advocacy.
 - The Internal Revenue Service will issue further guidance on the tax law changes. At the time of this report (July 16), guidance has not been issued to address the tax deductibility for association member dues.

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

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

Success Measure: Passing Dental Health Access bills and prevail on ADA's positions.

Target: One bill passed.

Range: One bill passed.

Outcome: As of July 16, one bill was passed in the House of Representatives and the companion bill was introduced in the Senate. One bill passed out of the House Natural Resources Committee and its companion passed out of the Senate Indian Affairs Committee. The Children's Health Insurance Program was reauthorized for 10 years.

- Children's Health Insurance Program (CHIP): On February 9, Congress passed a stop-gap spending bill that included a 10-year extension of CHIP. CHIP expired on September 30, 2017, and Congress delayed action to extend its authorization. The ADA joined with stakeholders in efforts prior to this deadline through the February 9 action to advocate for reauthorization. CHIP provides a critical safety net for children who do not qualify for Medicaid and provides dental services to enrolled children.
- Action for Dental Health Act: On February 26, the House of Representatives passed H.R. 2422, the Action for Dental Health Act, with a vote of 387-13. The bill, introduced by Rep. Robin Kelly, D-IL, and Rep. Mike Simpson, R-ID in 2017, and calls for Congress to authorize additional oral health promotion and disease prevention programs. On June 6, Sens. Cory Booker, D-NJ., Bill Cassidy, R-LA., Mazie Hirono, D-HI., and Tim Scott, R-SC., introduced S. 3106, the Action for Dental Health Act in the Senate.
- Indian Health Service Credentialing: On April 11, the Senate Indian Affairs Committee passed S. 1250 – the “Restoring Accountability in the Indian Health Service Act of 2017”. The bill contains a provision that would create 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 IHS to fill dental vacancies in a timely manner and serves as a disincentive to those who want to contract with IHS or volunteer their services. The House companion bill, H.R. 5874, was passed by the House Natural Resources Committee on June 13. As of the timing of this report (July 16) both bills await floor action in the House of Representatives and the Senate.
- ADA Testified for Indian Health Service Funding: On May 9, ADA President, Dr. Joseph Crowley, testified before the House Appropriations Subcommittee on Interior, Environment, and Related Agencies to request \$199 million in funding for the Indian Health Service Division of Oral Health to aggressively reduce oral disease for American Indians and Alaska Natives. Dr. Crowley stated the ADA's support for a centralized credentialing system in the Indian Health Service (IHS) to credential licensed health care professionals who seek to provide health care services at any IHS facility. (See [ADA News](#) story).
- Opioid Crisis: On June 22, the House of Representatives passed H.R. 6, the SUPPORT for Patients and Communities Act, which contained a number of ADA-supported provisions to help prevent first-time exposure to opioids following one-time dental procedures. The ADA's position was enhanced by the March 14 adoption of an interim Board of Trustees policy, requested by the Council. The interim policy provides a position on mandatory continuing education for opioid prescribers, limits on the number of pills that can be prescribed for initial acute pain, and use of prescription drug monitoring programs. The interim policy was a key issue shared during the ADA Dentist and Student Lobby Day by attendees to paint a positive image of dentistry during their Capitol Hill visits. (See [ADA News](#) story).

Concurrently, ADA leaders met with senior officials at four federal agencies to share the policy and explore opportunities to collaborate, submitted comments to two federal pain management task forces, and weighed-in on a series of other House and Senate bills to address the opioid crisis. As of the date of this report (July 16) there is no indication of when the Senate will take action.

- Monograph Reform: The House and Senate are advancing ADA-supported legislation that would streamline the way the Food and Drug Administration (FDA) reviews and approves new over-the-counter drugs based on drug monographs, which are essentially predetermined checklists covering acceptable forms of testing, ingredients, doses, formulations and product labeling. Both

bills, S. 2315 and H.R. 5333, would empower the FDA Commissioner to approve monograph drug submissions by sponsors via administrative order in lieu of following a laborious rulemaking process. If enacted, FDA would be able to swiftly and promptly address safety issues and remove barriers to innovation (eligibility is largely limited to active ingredients that were marketed before 1972). ([See ADA News story](#)).

Objective: Increase member value and engagement.

Initiative/Program: ADPAC Administration.

Success Measure: Growth in ADPAC membership over same period in 2017.

Target: 2% growth.

Range: 1%–3% growth.

Outcome: ADPAC giving is consistently higher in election years, and ADPAC is on-target to reach its growth goal in 2018. ADAPC will not have solid data until the end of the fourth quarter. ADPAC is engaging in a lapsed donor campaign, educational campaign, and a solicitation campaign before ADA 2018 – America’s Dental Meeting. ADPAC will also be engaging in a campaign to increase contributions to the Political Education Fund. There are currently four ADA member dentists serving in Congress: Reps. Mike Simpson, D.M.D. (ID-02); Paul Gosar, D.D.S. (AZ-04), Brian Babin, D.D.S. (TX-36), and Drew Ferguson, D.M.D. (GA-03). New Jersey State Senator Jeff Van Drew, D.M.D., is running for the House seat (NJ-02).

Emerging Issues and Trends

Federal Issues: As of July 16, Congress is in the second year of the 115th Congress and there is a focus on the mid-term elections. Two areas of greatest potential impact on oral health care delivery and the profession are regulatory reform and health care reform.

- **Regulatory Reform:** CMS issued a final rule on April 16, 2018, rescinding enrollment requirements associated with Medicare Part D and C. The rule, effective June 15, 2018, removes the Medicare Part D enrollment requirement that would have become effective January 1, 2019. The rule also rescinded changes to Medicare Part C that would have required dentists to be enrolled in Medicare in order to provide supplemental services to patients enrolled in Part C, also known as Medicare Advantage plans. Eliminating these enrollment requirements has been a key priority for the ADA for over three years.
- **Health Care Reform:** During the first half of the 115th Congress, the House passed legislation to repeal the Affordable Care Act (ACA) while the Senate failed to take similar action. Efforts in 2018 to address health care reform have been made through the regulatory process. The Administration finalized the 2019 Notice of Benefit and Payment Parameters, an annual notice issued to address any requirements and changes under the ACA. The 2019 notice provides additional flexibility to states to alter existing requirements for the essential health benefits package, which includes a pediatric oral health benefit. There remains question as to the legality of the pre-existing condition exclusion requirement in the ACA, and a legal challenge is ongoing.
- **Medicare:** The Council devoted time during its 2018 meetings to the issue of a dental benefit in Medicare. The Council continues to monitor coalition activities focused on advocating for a dental benefit in Medicare.

State Issues:

- **Medicaid:** Inclusion of dental benefits and funding for dental Medicaid state programs continue to fluctuate. Illinois and Idaho have passed laws to improve adult dental coverage, and Maryland enacted a pilot to test improved adult dental coverage. Starting July 1, payment for Medicaid covered services is capped at \$1,000 annually for adult enrollees in Iowa. While changes occur

for adults, a few states are managing reductions in funding. Delaware not only suffered a reduction in fees, the state is recalling a portion of the fees that were erroneously paid after the reduction was supposed to occur but was delayed due to technical errors. Vermont enacted a law that limits the state to sixty days to credential Medicaid providers. The state will establish a forum to consider providers' suggestions on Medicaid program improvements.

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: States have enacted a number of laws related to the dental benefit/insurance industry. New laws would: limit insurers' refund requests (DE); reduce virtual credit card payment requirements (CT and GA) and ensure payment on claims previously approved in prior authorizations (LA). Dentist credentialing is improved under new laws in Arizona with specified deadlines. Surprise billing continues to invite legislative solutions as seen in New Jersey and Maine that require disclosures and limitations on certain charges. South Dakota now expands the settings where insurers must cover anesthesia and related charges for certain special needs patients. A bill in Washington would have required approval of Explanation of Benefits standardized language, another would have prohibited denial of payment for services to address a missing tooth and a third would have limited insurers' ability to deny payment on previously authorized covered services.
- Opioid/Prescribing Issues: There was significant state legislative activity concerning opioids and prescribing practices in the first half of 2018, with many states enacting laws aimed at curbing addiction and overprescribing. The focus of the enacted legislation has been in four major areas: mandatory continuing education for prescribers (AZ, FL, IN and NE), mandatory prescriber participation with state Prescription Drug Monitoring Programs (PDMPs) (CO, FL, IN, IA, OK, OR, TN, UT and WV), limits on the amount of controlled substances that may be prescribed (AZ, CO, FL, NE, OK, SC, TN and WV), and mandatory electronic prescribing of controlled substances (AZ, IA, OK, TN and RI).
- Fluoridation: New Hampshire enacted a new law which amends requiring a vote before initiating any community water fluoridation programs. The updated law waives this voting requirement if an existing water system receives fluoridated water from another public water system. If a public water system does not fluoridate, but receives fluoridated water from another system, it is required to provide written information to customers.
- Midlevel Legislation: In May, Arizona Governor Doug Ducey signed into law H.B. 2235, which allows dental therapists to practice in tribal settings, Federally Qualified Health Centers (FQHCs), federal look-alike facilities, Community Health Centers and private dental practices that contract with FQHCs. In April, the Massachusetts Dental Society announced a compromise deal with The Pew Charitable Trusts and state legislative leadership on a comprehensive oral health care bill allowing dental therapists to practice in limited settings, primarily targeting underserved populations. The bill, H.B. 4454, is expected to pass the legislature. At the time of this report (July 16) the bill had not passed. In January, the Kansas Dental Association Executive Committee and Board of Delegates voted to approve a compromise bill which, if passed, would allow dental therapists in the state to perform certain procedures under direct and general supervision. The bill cleared the Senate but ultimately failed in the House, due in large part to grassroots opposition from rank-and-file Kansas dentists. Michigan and Wisconsin remain key Pew-targeted battleground states and could see legislative action on the issue before the end of 2018.

Responses to House of Delegates Resolutions

Resolution Objective: 38H-2017. Improper Use of the DEA Registration Number

38H-2017. Resolved, that the appropriate ADA agency seek Federal legislative remedies to stop the inappropriate use of the DEA registration number.

Initiative/Program: Advocacy for Dental Practice

Success Measure: Progress communicated to the 2018 House of Delegates.

Target: N/A

Range: N/A

Outcome: The Council investigated this issue and has been unable to identify the extent of misuse of DEA registration numbers. Quantifying the problem is necessary before seeking legislative remedies. The Colorado Dental Association, the entity initiating the resolution, indicated the problem has not been quantified. Council staff contacted the Council on Dental Benefit Programs (CDBP), and CDBP is unaware of any commercial plans requiring this information for network participation. Further:

- Colorado has updated the state's adopted provider credentialing form since 38H-2017 was adopted and the DEA registration number is not a required field unless the provider prescribes controlled substances.
- DEA numbers may be required by dental benefit plans when dentists prescribe controlled substances for their insureds.
- The ADA has established a joint alliance with the Council for Affordable Quality Healthcare (CAQH) ProView® to offer a centralized credentialing system for dentists. The CAQH ProView® form allows entry of a DEA number when available but does not require the same for every dentist completing an application.
- The Council will continue to monitor this issue and is prepared to develop model legislation when necessary but not at this time.

Self-Assessment

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

Policy Review

In accordance with Resolution 170H-2012, Regular Comprehensive Policy Review, the Council concluded a comprehensive review of Association policies assigned to the Council in 2017 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

Hehli, Peter D., 2018, Wisconsin, chair
 Ellison, Naomi L., 2019, California, vice chair
 Ahern, John P., 2021, New Hampshire
 Johnston, Jon J., 2020, Pennsylvania
 Jolly, Robert L., Sr., 2019, Arkansas
 Kido, Scott H., 2020, Idaho
 Kilcollin, Katherine Leach, 2019, West Virginia
 Lipton, James M., 2018, Indiana
 Luquis-Aponte, Wilma, 2021, Texas
 Mann, Marshall H., 2018, Georgia
 Matin, Britany F., 2019, Alabama*
 Olenyn, Paul T., 2021, Virginia
 Pirmann, Peter J., 2019, Illinois
 Sterritt, Frederic C., 2020, New Jersey
 Thompson, Michael R., 2021, Arizona
 Tota, Christopher, 2020, New York
 White, Cecil, Jr., 2020, Florida
 Wieting, David Scott, 2018, Nebraska

Tiernan, Rita, senior manager

The Council's 2017–18 liaisons include: Dr. George Shepley (Board of Trustees, Fourth District) and Dr. Molly Conlon (American Student Dental Association).

Areas of Responsibility as Set Forth in the *Bylaws or Governance and Organizational Manual of the American Dental Association*

As listed in Chapter VIII. Section K8 of the *ADA Governance and Organizational Manual*, the areas of subject matter responsibility of the Council shall be:

- 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 member*

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: The Council's 2018 revenue forecast is approximately \$7 million in non-dues revenue, service income and royalties in support of the ADA financial goals.

Range: \$6–8 million in total non-dues revenue and royalty income was budgeted for 2018.

Outcome: As of June 30, 2018, approximately \$6.5 million in ADA royalties from the ADA Members Insurance Plans have been received to meet this goal. In addition, approximately \$250,000 has been received year-to-date in service income and royalty from AXA Equitable for ADA's endorsement of the ADA Members Retirement Program.

ADA Members Group Insurance Plans: The ADA Members Group Insurance Plans ("ADA Plans") portfolio consists of seven group plans underwritten by Great-West Financial including the 1) Annually Renewable Term Life, 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 Insurance. These two newly designed supplemental medical plans replace the former MedCASH Plan which is only available to previous certificate holders. In addition, the ADA Student Life and Disability Insurance Plans are provided on a guaranteed issue basis at no-cost to ADA student members while completing their dental education (D1-D4) and post-doc residency programs.

The ADA Plans directly align with the ADA Strategic Plan goals in support of membership recruitment and retention. To help attract new, eligible dentists to join the ADA there is an incentive offer to receive a guaranteed issue, term life benefit at *no-cost* for six months and thereafter, the member can maintain the coverage or apply for higher limits at the low, ADA group rates which are well below most market competitors. Last year, promotion of the new member incentive, student conversion offers and organic sales helped attract 1,850 members to purchase one or more of the ADA Plans. Additionally, the ADA Plans are of financial significance in that they provide competitive cost value to insured members and ADA royalty income which helps protect the future sustainability of the Association.

Table 1. ADA Members Group Insurance Plans Participation as of June 30, 2018

ADA MEMBERS GROUP INSURANCE PLANS	EOY 2016	EOY 2017	June 30 2018
Annually Renewable Term Life (Members)	48,053	45,457	46,114
Spouses	17,056	16,040	15,613
Dependent Children ¹	6,664	6,248	6,085
Student Members No-Cost Term Life	14,525	15,460	13,264 ²
Term Plus/Universal Life	1,244	1,209	1,187
Level Term Life (Members)	729	978	1,054
Spouses	164	209	232
Dependent Children ¹	73	104	108
Disability Income Protection	15,462	15,032	15,416
Student Members No-Cost Disability	13,816	13,229	12,068 ²
Office Overhead Expense	7,782	7,624	7,601

MedCASH (Members & Dependents)	6,131	5,388	5,138
Hospital Indemnity (Members & Dependents)	82	244	283
Critical Illness (Members & Dependents)	76	219	268

Total Participation in All Plans **131,857** **127,441** **124,431**

¹ Number of members insuring dependent children.

² Reflects the mid-year timing of this report, reclassification of graduates and pending enrollment of incoming freshmen.

Table 1 shows a decline in total aggregate participation across all Plans when comparing calendar year 2017 to June 30, 2018 mid-year results. While there are signs of slow growth in a few Plans, it is important to note that mid-year results are a reflection of the timing of billing cycles which vary by Plan. Year-end 2018 figures will be influenced by new business additions, coverage lapses and terminations which on balance may lead to overall participation not showing much improvement. In large part the total variance reflects a decrease in the number of annual student conversions to the Member Plans and the pending enrollment of incoming freshmen which takes place in the fourth quarter. Other factors contributing to the decrease in participation are 1) the stagnant growth in ADA active membership in recent years, 2) a high number of voluntary lapses by dentists opting to non-renew their ADA membership and forfeit their coverage, and 3) the Plan's aging demographic trends (i.e., baby boomer population aging off the Plans).

As evidenced above, the past year has posed many challenges for the Plans as the demographics of the insured population and membership, practice patterns, consumer preferences for Internet buying continue to evolve. Looking ahead to 2019, Great-West is strategically focused on growth and plans to address these issues through innovative new product development, aggressive marketing to heighten brand awareness, competitive value messaging to key market segments, expanded outreach to dental schools, collaborative efforts at the state level, upgraded technology and a service model to enhance the virtual member experience.

From a member perspective, the ADA Plans remain one of the flagship benefits with the broadest reach helping to protect the lives of over 89,000 members and family members. Currently, Great-West Financial insures approximately 52,700 member dentists, 13,000 student members, and 23,340 spouses and dependent children in one or more of the seven member plans. Last year sales of spouse and dependent child life increased by 24% and 41% respectively over the prior year in response to the offering of new higher limits. These are positive signs that will help strengthen member retention in the Life Plans.

Great-West Financial's marketing and presence on dental school campuses helps foster engagement with students and faculty leaders to heighten brand awareness and promote the Dental School Insurance Auto-Enrollment Program designed to ensure that all student members take advantage of the no-cost life and disability benefits of ADA membership. More specifically, the ADA Student Life and Disability Plans help protect student members while completing their dental education and provides the incentive for conversion following graduation. In alignment with the ADA Strategic Plan, the Student Plans create the foundation for the next generation of active members ("fill the pipeline") and potential for future growth of the ADA Plans. Despite the inherent challenges in conversion of student members, Great-West remains committed to new creative marketing and outreach efforts to grow this market segment in 2019.

The ADA Plans remain strongly competitive when benchmarked against competing carriers in the broader market and financially well positioned for the future. Moreover, Great-West Financial actuarial findings have confirmed that the ADA experience-rated group plans model, which has low expense ratios and no third party agent or broker commissions, continues to deliver exceptional cost value to member participants in both the Life and Disability Plans. In an effort to promote the cost advantages of the ADA Plans, Great-West expanded its cost competitive direct mail campaigns in late 2017 and early 2018. The goal of this marketing initiative was to demonstrate the potential cost savings (i.e., per year or practice

career in the case of disability) of the ADA Plans when compared to competitors in the individual retail market. The cost illustration mailings produced 10–20% higher response rates and were successful in raising greater awareness of the value of ADA membership by providing compelling reasons to join and renew. It also helped promote the ADA Plans website and the value of the broader member's portfolio of seven product options available to meet the diverse needs of ADA members at all career stages.

2019 Initiatives to Grow Market Share: The competitive value of the ADA group insurance plan model is contingent upon tripartite membership growth and the future sustainability of the organization. Towards this end, Great-West remains strongly committed and strategically positioned in support of the ADA Strategic Plan goals for 2019 to grow market share and plan royalties. The Company's insurance marketing plans for 2019 are defined to leverage opportunities for growth in key membership segments, including new dentists ("fill the pipeline") and female dentists. Additionally, Great-West is aligning its marketing to focus on ADA priority states which have the greatest potential to improve market share. More specifically, collaborative meetings with state and local societies, increased presence on campus and at local dental meetings, web advertising to increase brand awareness and new digital communications to emphasize the ADA competitive value proposition should help drive results and begin to reverse declining trends.

In addition, the Council's subcommittee on product development is in collaboration with Great-West Financial to evaluate new product concepts and opportunities, including possible enhancements to the existing Plans, in support of strategic growth goals next year.

The ADA Plans as of June 30, 2018, remain strong financially to continue to contribute royalty payments in support of the ADA Strategic Plan goals.

ADA-endorsed Members Retirement Program: The ADA-endorsed Members Retirement Program is underwritten and administered by AXA Equitable Insurance Company (AXA). The Program offers competitive retirement plan design options for dental practice owners including four types of 401(k) plans: Safe Harbor, Traditional, Simple and Owners only, as well as New Comparability Plans and defined contribution pension and profit-sharing plans. 401(k) plans represent 80% of all product sales through mid-year 2018, with Safe Harbor being the most requested.

As shown in Table 2, after recent years of declining participation resulting from the Program's aging demographic trends, 2018 shows improvement with an uptick in the total number of plans, dentist employer and employee participants.

Table 2. ADA Members Retirement Program Participation

	2016	2017	June 30 2018
Number of Sponsored Plans	2,929	2,581	2,669
Number of Dentist Members and Employee Participants	12,342	11,741	12,142

ADA has also endorsed the AXA 300+ Series Individual Retirement Account (IRA) since 1978. The modest decline in participation as of June 30, 2018 reflects the fact that the IRA is now closed to new business. With the evolution of 401(k) plan models, IRA's have become more popular in the consumer retail market and AXA has focused its promotion and sales efforts on growing the ADA-endorsed 401(k) business platform.

Table 3. Individual Retirement Accounts Participation

	2016	2017	June 30 2018
Number of Participants	1,443	1,422	1,411*

As Plan Administrator for the ADA Program, AXA provides all recordkeeping services and plan administration at both the dentist-employer (plan sponsor) and employee participant levels under its “bundled service” platform at a competitive cost to ADA members, as recently validated in 2018. The broad range of service includes transaction processing, maintaining the tax-qualified status of the IRS-approved plans, discrimination testing, trustee services, etc. AXA is also responsible for direct mail marketing and sales promotion to grow plan participation and assets under management which provides a source of royalty income to support the ADA financial goals.

AXA Funds Management Group serves as the investment manager over the Program’s assets under management and fund portfolios. ADA annually retains a consultant to independently review the Program’s investment options structure, investment management fees, program expense charge and overall performance as measured against relative benchmarks. This helps ensure that the ADA endorsement of the AXA brand product portfolio continues to offer competitive value to attract and retain ADA members at all stages of their career in alignment with the ADA Strategic Plan goals.

When first introduced in 1968, the Program was marketed as a “start-up” plan to address the retirement savings needs of new dentist practice owners in the early career stages of accumulating wealth. In 2018, the ADA Members Retirement Program (“Program”) celebrated its 50th anniversary as one of the hallmark benefits of ADA membership and aging demographic trends are becoming more pronounced with annual increases in the number of retirement plan distributions which rose by 12.7% in 2017. In an effort to meet the distribution plan needs of dentist member employers who are at or approaching retirement and have maximized their contributions, preserve existing accounts and grow new business takeovers, the AXA portfolio includes a comprehensive suite of fixed indexed and customizable variable annuities. These options are marketed under ADA’s endorsement as the Structured Capital Strategies, Retirement Cornerstone, Investment Edge and most notably, the Retirement Gateway Association product.

Highlighted for its customizable product advantages and competitive pricing, the Retirement Gateway Association product is designed to attract larger plans with assets over \$500,000. With only limited marketing exposure this past year, RGA total asset values have climbed to nearly \$31 million with 35 plan sales representing approximately 276 participants. The positive sales response to lead generation mailings absent a local sales advisor helps validate the product offering as a valued benefit of membership and the opportunity for continued growth in 2019.

Sales of the individual annuity product which include Structured Capital Strategies, Retirement Cornerstone and Investment Edge products have developed more slowly with total assets building to approximately \$1 million. These investment options are important to the overall sales strategy for future growth and diversification of the ADA-endorsed member’s portfolio.

New product and marketing initiatives in May 2018 included the launch of lower cost Vanguard fixed indexed funds and a new series of target date funds. The goal of adding these new lower cost fund options to the ADA-endorsed portfolio is to increase member value and improve AXA’s competitive position in the retail market space. Early indications this year are that the Vanguard brand has considerable appeal which should help drive new sales and asset retention in 2019.

In alignment with the ADA Strategic Plan goals, the Council’s subcommittee on product development worked collaboratively with AXA to develop a strategic plan and prioritizes opportunities to enhance member value and broaden marketing appeal to attract new members, grow overall participation and assets under management. Some of the challenges impacting future growth include the ADA membership

and dental practice model trends, changes in employee retirement benefit offerings at the employer level, and emerging issues in the financial and retirement plan regulatory markets. In addition, Internet buying habits and digital technology are diminishing the value of the Program's direct mail marketing model in a fiercely competitive and crowded marketplace which tends to favor local (in-person) sales. As 2019 approaches, AXA is committed to innovative and strategic solutions to ensure the Program remains relevant despite market conditions and offers competitive advantages that reinforce the value of ADA membership.

In 2018 the ADA Members Retirement Program remains solid financially with over \$1.6 billion in assets under management and generates annual royalties of approximately \$500,000. As of June 30, 2018, \$275,000 in service income and ADA royalties have been received which contribute to the ADA financial goals.

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. More specifically, JLBG Health, Inc. reports total sales of approximately 617 policies since the 2014 open enrollment launch which has generated less than \$30,000 in ADA royalty income year-to-date.

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: 2H-2017 ADA Sponsored Members Association Health Plan

2H-2017. Resolved, that the American Dental Association investigate the financial and legal possibilities of offering a national association health plan for its members and report to the 2018 ADA House of Delegates.

Pursuant to Resolution 2H, last year ADA retained Milliman consultants to perform a comprehensive feasibility study to investigate the financial and legal possibilities of offering a national association health plan. More specifically, the scope of this study was to identify and assess the federal legislative and state regulatory environments for structuring a national association health plan, competitive market conditions, potential legal risks and financial implications to ADA, including any possible reserve or funding requirements of plan sponsors, and plan design, administrative and marketing related issues and considerations.

The Department of Labor did not issue the final rule on structuring association health plans until June 19, 2018 at which time, Milliman and ADA's DC legislative staff began a thorough review of the very detailed and complex 190 page ruling. Concurrently, the consultants began to conduct preliminary discussions with leading insurance carriers who have national underwriting capabilities to assess their level of interest in writing bona-fide association group health plans and what the parameters and requirements would be. The consultants also assessed the competitive market landscape and ADA membership demographics to better define the potential market for a national plan offering and the potential opportunity for future growth and sustainability.

In July and August, there was considerable disruption in the health insurance marketplace as questions, debate and even legal action ensued over the interpretation and application of the rule by state regulators, insurance carriers and industry groups. On August 20, these concerns prompted the DOL to

issue new guidance on the rule and the market remains fragmented with much uncertainty on the outlook for 2019.

As of this writing there is nothing further to report. The Council is scheduled to meet on August 24 to consider the presentation of Milliman on the feasibility study and deliberate on a recommendation for transmittal to the 2018 House of Delegates in a separate report. The Council's report will be considered by the ADA Board of Trustees at its September 23–25 meeting.

Policy Review

The Council did not have any policies to review in accord with Resolution 170H-2012, Regular Comprehensive Policy Review.

Self-Assessment

In accordance with Resolution 1H-2013, the Council conducted its self-assessment in August 2016 and its recommendations were approved by the 2017 House of Delegates. At the close of the 2018 House, the Council will begin its transition to a skills-based council of ten members, including the new dentist member appointment.

Council Minutes

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

Council on Membership

Romano, Rodrigo, 2018, Florida, chair
 Irani, Karin, 2019, California, vice chair
 Blew, Bryan C., 2021, Illinois
 Chatterjee Kirk, Pia, 2020, Mississippi
 Czerniak, Lauren, Ohio*
 Ellinwood, Steven P., 2018, Indiana
 Freedman, Isaac Jay, 2020, Pennsylvania
 Hanlon, Mary Jane, 2020, Maine
 Kahl, Jeffrey A., 2021, Colorado
 Kampfe, Mark I., 2020, Arkansas
 Ketron, Summer C., 2021, Texas
 Muncy, Marc, 2018, Arkansas
 Riordan, Danielle M., 2020, Missouri
 Sherwin, Ted, 2019, Virginia
 Skolnick, Jay, 2021, New York
 Tigani, Stephen P., 2019, District of Columbia
 Vitek-Hitchcock, Alexa M., 2019, Michigan
 Willis, Heather A., 2018, Alaska

Bronson, Elizabeth, senior manager

The Council's 2017–18 liaisons include: Dr. Cesar R. Sabates (Board of Trustees, Seventeenth District) and Dr. Alex Mitchell (American Student Dental Association).

Areas of Responsibility as Set Forth in the *Bylaws or Governance and Organizational Manual of the American Dental Association*

As listed in Chapter VIII, Section K9 of the *ADA Governance and Organizational Manual*, the areas of subject matter responsibility for the Council shall be:

- 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: 3,000 new or reinstated members at the end of June 2018; 6,000 new or reinstated members at the end of 2018.

Range: 2,700–3,300 at the end of June 2018; 5,750–6,250 at the end of 2018.

Outcome: As of June 2018, 3,016 new or reinstated members (exceeding target by 0.5%).

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

*New Dentist member

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

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

Target: 76% retention of 2014–2017 grads by end of June; 85.8% at the end of 2018.

Range: 73%–80% through the end of June; 83% to 87% at the end of 2018.

Outcome: As of June 30, 2018: 71.3% retention (4.7% 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 2018; 3,100 graduate student members at the end of 2018.

Range: 1,900–2,200 at the end of June 2018; 2,900–3,300 at the end of 2018.

Outcome: As of June 30, 2018: 2,458 graduate student members (22.9% ahead of target).

Emerging Issues and Trends

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

The Council is taking proactive measures to study the point at which a member decides to join or drop out of membership; how the changes in membership requirements for specialty dental organizations may affect the membership of the ADA; how to identify and engage residents/graduate students; and how to simplify the membership dues category structure in order to reduce barriers and create a better membership joining experience across the tripartite.

The Council has embarked on a multi-year, multi-pronged study of the simplification of membership dues categories that will strategically make it easier for dentists to join the ADA and maintain their membership. Areas of study include graduate/residents; faculty; semi-retired; and the dues waiver structure.

Responses to House of Delegates Resolutions

Resolution Objective: Resolution 28H-2017 Implementation of a Uniform Dues Transaction

28H-2017. Resolved, that to simplify the member experience, all constituent societies are urged to use a uniform dues transaction which allows acceptance of dues payments in installments, permits payment of dues with a credit or debit card, and permits auto-renewal of dues, with an opt-out option.

Response to Resolution 28H-2017: The Division of Client Services through the Departments of Client Services and Membership Operations continue to encourage states to adopt a uniform dues transaction where feasible. In addition, at the 2018 ADA Annual Conference on Membership, states were encouraged to share best practices on how to successfully implement a uniform dues transaction. Currently, all states who use the ADA instance of Aptify have access to features that would allow them to use the uniform dues transaction.

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 2016 titled "Number of Practicing Dentists per Capita in the United States Will Grow Steadily." The projection model for the number of dentists expected to retire (outflows) discussed in the research brief were developed for the period 2010–2015.

It was concluded in the brief that future outflow rates of dentists would be the same as the outflow period from 2010–2015. 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 Dues Impact from Members Moving to Life Membership

Year of Impact	2018	2019	2020	2021	2022
Dues Revenue Reduction From Members Transitioning to Life Membership	(\$382,641)	(\$420,014)	(\$370,006)	(\$345,534)	(\$336,091)

Note: Assumes no dues increase and no assessment in years 2018-2022 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 2018 to 2022. The number of members who begin paying Life membership dues rates over the next five years is estimated to fluctuate beginning with an increase from 2,842 in 2018 to 3,111 in 2019 and then decrease to 2,489 by 2022. It should be noted that the further out in the projection, the less accurate the forecast.

Table 2. Forecast for New Active Life and Retired Life Members 2018–2022

Year Paying Life Dues for First Time	2018	2019	2020	2021	2022
Expected Active Life	2,306	2,523	2,223	2,077	2,018
Expected Retired Life	536	588	519	484	471
Total Projected to Become Life Members	2,842	3,111	2,742	2,561	2,489

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 2016 HPI research brief, “Number of Practicing Dentists per Capita in the United States Will Grow Steadily”.

At the end of 2017, there were 15,288 active life members and 27,631 retired life members. The end of year 2017 nonrenew percentage for active life members was 2.8%, 0.7 percentage points lower than full dues paying members (3.5%).

Self-Assessment

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

Policy Review

In accordance with Resolution 170H-2012, Regular Comprehensive Policy Review, the Council on Membership conducted a comprehensive review of ADA policies related to membership. Below are the policies that the Council reviewed and recommended to be maintained.

Recommendations—Policies to Be Maintained

ADA Member Conduct Policy (*Trans.*2011:530)
 Long-Term Dues Waivers (*Trans.*2002:384)
 Administrative Process for Transferring Members (*Trans.*2001:422)
 Compliance With Civil Rights Laws (*Trans.*1997:666)
 Promoting the Value of Tripartite Dentistry (*Trans.*1995:606; 2013:365)
 Application Process for Direct ADA Membership (*Trans.*1989:539)
 Dentists Retired From Federal Service (*Trans.*1963:285; 1996:671)
 Qualifications for Membership (*Trans.*1959:219; 1996:672; 2013:366)
 Registration Fees for Members (*Trans.*1989:537)
 New Dentist Involvement in Volunteer Leadership (*Trans.*2009:487)
 Four-Year Recent Graduate Reduced Dues Program (*Trans.*2008:482)
 Association Support for Members Participating in Various Reimbursement Systems (*Trans.*1996:674)
 Diversity in Association Membership Marketing and Consumer-Related Materials (*Trans.*1995:606)
 Nonmember Utilization of ADA Member Benefits (*Trans.*1990:532)
 Requirement for Membership Maintenance in ADA for Fellows of the American College of Dentists, the USA Section of the International College of Dentists and the Pierre Fauchard Academy (*Trans.*1989:538; 2012:512)
 Dental Organization Membership Contingent on ADA Membership (*Trans.*1985:610; 1996:667)
 Student Membership (*Trans.*1977:957; 1996:673; 2015:291)
 Involvement of Students in Society Activities (*Trans.*1979:649)
 Dues Exemption for Active Duty Members (*Trans.*2004:297, 335; 2015:296)

The Council approved rescission of the following ADA policies to be submitted for consideration by the 2018 House of Delegates. These policy rescission recommendations will be submitted on separate worksheets.

Recommendations—Policies to Rescind

Availability of Survey Results (*Trans.*2008:474)
 Processing of New Member Applications (*Trans.*2000:452; 2002:381; 2003:353)
 ADA Notification of New Tripartite Members by Constituent Societies (*Trans.*2000:446)
 Alternate Methods of Dues Payments (*Trans.*1988:456; 2012:511)

The Council recommends the following policies be amended. These policy amendment recommendations will be submitted on separate worksheets for consideration by the 2018 House of Delegates.

Recommendations—Policies to Amend

Parallel Membership Categories (*Trans.*2008:482)
 Tripartite Membership Application Procedures (*Trans.*1998:685; 2014:524)
 Transfer Nonrenews (*Trans.*1995:605)
 Utilization of Tripartite Resources (*Trans.*1995:604)
 Differential Charges According to Membership Status (*Trans.*1982:506; 2004:294)
 Financial Hardship Dues Waivers (*Trans.*2002:381)
 Streamlining Membership Category Transfers (*Trans.*2001:426)
 Other Organizations' Support for ADA Recruitment and Retention Activities (*Trans.*1989:540; 1997:659)

Finally, the Council noted that the following four resolutions adopted by the House of Delegates were directives rather than policy statements and that these directives had been fulfilled. The Council sought guidance from the Speaker of the House regarding their continued inclusion in the Current Policies document. The Speaker agreed with the Council's assessment. Accordingly, the following statements will not be published in future editions of *Current Policies*.

Policies Removed Administratively Recommendations—Actions to Administratively Remove

ADA Specialty Logo (*Trans.*2009:488)
 Auxiliary Membership (*Trans.*1987:498)
 Establishment of Dental Student Societies Within the Component or Constituent Societies (*Trans.*2001:417)
 State Associations of the Professions (*Trans.*1964:263)

Council Minutes

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

Joint Commission on National Dental Examinations

Heinrich-Null, Lisa, 2018, Texas, chair, American Dental Association
 Robinson, William F., 2020, Florida, vice chair, American Association of Dental Boards
 Chamberlain, Dale R., 2018, Montana, American Association of Dental Boards
 Efurd, Melissa G., 2018, Arkansas, American Dental Hygienists' Association
 Haley, Cheryl D., 2019, Missouri, American Dental Association
 Henderson, Aaron, 2018, Minnesota, American Student Dental Association
 Irons, Roy L., 2021, Mississippi, American Association of Dental Boards
 Leone, Cataldo, 2020, Massachusetts, American Dental Education Association
 Maggio, Frank A., 2021, Illinois, American Association of Dental Boards
 Nadershahi, Nader A., 2019, California, American Dental Education Association
 Ragunathan, K. Ragu, 2021, Ohio, American Dental Association
 Thomas, Wesley D., 2021, District of Columbia, American Association of Dental Boards
 Weiss, Leonard P., 2019, Ohio, American Association of Dental Boards
 Wilson, Douglas C., 2022, Washington, Public Member
 Zambon, Joseph, J., 2021, New York, American Dental Education Association

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

The Joint Commission's 2017–18 liaison and observer are: Dr. Chad P. Gehani (Board of Trustees, Second District) and Mr. Jeffrey Kerst (American Student Dental Association).

Bylaws Areas of Responsibility

As listed in Chapter IX, Section 30B of the ADA *Bylaws*, the duties of the Joint Commission shall be to:

- a. Provide and conduct written examinations, exclusive of clinical demonstrations for the purpose of assisting state boards of dental examiners in determining qualifications of dentists who seek license to practice in any state or other jurisdiction of the United States. Dental licensure is subject to the laws of the state or other jurisdiction of the United States and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.
- b. Provide and conduct written examinations, exclusive of clinical demonstrations for the purpose of assisting state boards of dental examiners in determining qualifications of dental hygienists who seek license to practice in any state or other jurisdiction of the United States. Dental hygiene licensure is subject to the laws of the state or other jurisdiction of the United States and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.
- c. Make rules and regulations for the conduct of examinations and the certification of successful candidates.
- d. Serve as a resource of the dental profession in the development of written examinations.

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

The Joint Commission is an agency of the ADA that maintains independent authority to pursue activities in accordance with the duties assigned to it within the ADA *Bylaws*. As such, the Joint Commission determines its own corresponding goals and objectives. In support of Joint Commission efforts in its *Bylaws* Areas of Responsibility, the Joint Commission accomplished the following since its prior annual report:

1. Approved the 2018 and 2019 budget proposal, research and development activities for 2018 and 2019, and 2019 candidate fees. The total examination fees charged in 2019 to candidates will be \$425 for the National Board Dental Examination (NBDE) Part I, \$475 for the NBDE Part II, and \$440 for the National Board Dental Hygiene Examination (NBDHE). Candidates from non-accredited institutions will be assessed an additional \$210 processing fee at the time of application. Score report request fees will be \$40. These fees are subject to approval by the ADA House of Delegates.
2. Approved actions and reviewed progress in support of the Integrated National Board Dental Examination (INBDE) and its implementation, including the following:
 - A. Approved formal announcement of implementation of the INBDE. The INBDE will be launched on August 1, 2020. The NBDE Parts I and II will be discontinued on July 31, 2020 and July 31, 2022, respectively. A formal communication concerning implementation will be distributed to stakeholders and communities of interest in July 2018.
 - B. Approved a technical report documenting findings from the 2017–2018 INBDE Field Test. These findings provide supporting evidence for use of the INBDE in dental licensure decisions.
 - C. Approved the annual report of the Committee for an Integrated Examination (CIE).
 - D. Approved the recommended time allotment and delivery structure for the INBDE. The INBDE will include 500 items and be administered over one and a half days.
 - E. Approved minor adjustments to the Domain of Dentistry, as follows: two clinical content areas from the Practice and Profession clinical component section were moved to the Diagnosis and Treatment Planning clinical component section. This change also resulted in corresponding minor changes to the INBDE test specifications.
 - F. Directed Department of Testing Services (DTS) staff to provide candidates who fail the INBDE with information concerning their overall performance, and their performance in the three clinical component sections and 10 foundation knowledge areas of the Domain of Dentistry.
 - G. Recognized Dr. Mark Christensen, and all past and current members of CIE, for their hard work, dedication, and significant contributions in developing the INBDE. The CIE has successfully completed its charge. Validation is an ongoing process for all of the Joint Commission's examination programs; future work on the INBDE will be undertaken by Joint Commission standing committees.
3. 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. Modifications to the Five Years/Five Attempts eligibility rule. Under the original policy, candidates who had exhausted the five years or five attempts after January 1, 2012, were

- not permitted to test again. Effective June 20, 2018, subsequent to the fifth year or fifth attempt after January 1, 2012, failing candidates may test once every 12 months after their most recent attempt.
- B. Candidates who fail the NBDE Part II will receive an updated results report that indicates how the candidate performed overall and in each discipline covered by the examination, as compared to the national average. The new report addresses certain challenges present with the prior report.
 - C. Formation of Test Constructor Pools for the National Board Examinations. The term “Test Construction Committee” will also be replaced with the term “Test Construction Team.”¹ Test Constructors will be assigned to Test Construction Teams based on the needs of each National Board Examination program.
 - D. Individuals who currently serve (or are scheduled to serve) as Test Constructors were also approved to serve within their corresponding pool. Individuals currently serving as NBDE Part I Test Constructors were approved to serve as Test Constructors for the INBDE.
 - E. Reappointment of current NBDE and NBDHE test constructors, and selection of new primary and alternate NBDE and NBDHE test constructors for test construction teams meeting in 2019.
 - 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 Report
 - Quality of Recent Examinations Report
 - G. Acceptance of the National Board Examination Guides.
4. Pursued efforts in support of the strategic direction of the Joint Commission. This includes the following:
- A. Approval of a draft strategic plan to serve as a starting point for Joint Commission deliberations. The draft plan was the product of a three-day meeting held in Chicago in May 2018.
 - B. Formation of an ad hoc Governance Committee charged with the task of considering strategic planning findings concerning the Joint Commission’s scope, mission, and governance, and recommending specific changes in accordance with the recommendations emerging from the Joint Commission strategic planning process.
 - C. Formation of an ad hoc Committee on Communications and Stakeholder Engagement, charged with the task of developing a strategic communications plan to guide the Joint Commission’s communications and engagement with key stakeholder groups in accordance with recommendations emerging from the Joint Commission strategic planning process.
 - D. Recommended revisions to the Joint Commission Standing Rules, which modify Test Constructor term limits, thereby affording DTS the flexibility needed to help ensure Test Construction Teams contain individuals with the expertise necessary to develop accurate content and fulfill examination requirements. Implementation of these recommended revisions is contingent upon approval by the ADA House of Delegates.
 - E. Revisions to Joint Commission Examination Regulations, including updates to eligibility requirements, to retest policies described elsewhere in this report, extending the NBDE Part I and NBDHE to two days if taken with testing accommodations, clarifying the regulation to assist the Joint Commission in situations where an examination might be taken for a reason inconsistent with the test purpose, and clarifying how results are sent to state boards.
5. Elected Douglas C. Wilson, B.A., M.A., Ph.D. as the Public Member of the Joint Commission for the 2018–2022 term.

¹ This change in terminology also appears in recommended changes to the Joint Commission *Bylaws*.

6. Dr. William F. Robinson will serve as chair for the 2018–2019 term. The Joint Commission also elected Dr. Cataldo Leone to serve as vice chair during the aforementioned term. Their service in these roles will begin in October of 2018.
7. Successfully convened the National Dental Examiners' Advisory Forum (NDEAF) directly before the meeting of the Joint Commission, including both in-person and remote participants from the dental and dental hygiene communities, with remote participation occurring via webinar.
8. The next annual meetings of the Joint Commission will be held on June 26, 2019 and June 10, 2020. The next annual NDEAF meetings will occur on these same two days, and will directly precede the meeting of the Joint Commission.

Emerging Issues and Trends

The following presents trends in administration volume and examinee performance on the NBDE and NBDHE over a 10-year period. 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.

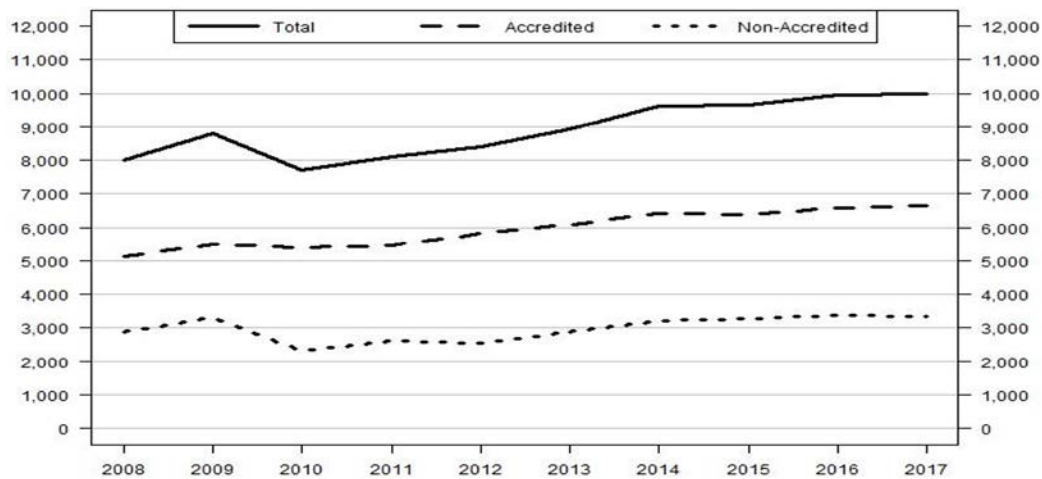
NBDE Part I: Table 1 presents performance trends for National Board Dental Examination Part I (NBDE Part I) over the past 10 years, while Figure 1 provides a graphic depiction of administration volume. Table 1 shows general, steady growth in the number of **first-time** candidates from **accredited** and **non-accredited** programs taking the NBDE Part I from 2008 to 2016, with subsequent decreases in 2017. The total number of **administrations** (i.e., first-time and repeating candidates from accredited and non-accredited programs) rose from 7,994 in 2008 to 9,997 in 2017. This represents an overall increase of 2,003 candidates (i.e., 25%).

A new and more rigorous NBDE Part I standard was introduced in November 2016, resulting in higher failure rates and corresponding increases in the number of candidates needing to retake the NBDE Part I in 2017. This new standard represented an increase in the level of cognitive skills required by entry-level dentists, in order to practice safely. Under this standard, the number of **repeating** candidates from **accredited** programs nearly doubled in 2017 as compared to 2016. Across the 10-year period indicated, failure rates for **first-time** candidates from **accredited** programs ranged from 3.4% (2015) to 10.6% (2017). Failure rates for **first-time** candidates from **non-accredited programs** were relatively higher, ranging from 31.9% (2014) to 39.5% (2008). Appendix A provides additional relevant details. The impact of the new standard on failure rates began in the fourth quarter of 2016.

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
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
2017	5,995	10.6	669	33.5	2,289	37.2	1,044	67.2	9,997	24.1

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

Figure 1. NBDE Part I Administrations (2008–2017)

NBDE Part II: Table 2 presents performance trends for National Board Dental Examination Part II (NBDE Part II) over the past 10 years, while Figure 2 provides a graphic depiction of administration volume. As shown in Table 2, the number of **first-time** candidates from **accredited** programs showed continued growth from 2008 through 2011. Volume decreased from 2011 to 2012, and then increased in 2017 to a 10-year high (N=6,138). There has been quite a bit of variability since 2008, ranging from a low of 4,721 candidates in 2008 to a high of 6,138 in 2017 (i.e., a 30% increase). The total number of **first-time and repeating** candidates from **non-accredited** programs increased from 1,078 in 2008 to 2,577 in 2017. Comparing the number of **total administrations** occurring in 2008 (N=6,237) with 2017 (N=9,427) shows a 51% increase in overall administration volume, with gains occurring with respect to both accredited and non-accredited candidates.

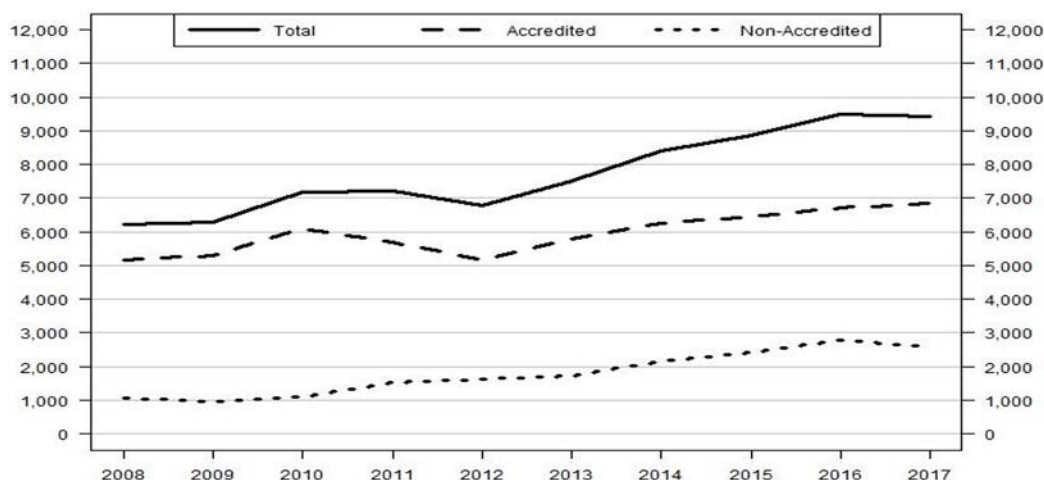
Across the 10-year period indicated, failure rates for **first-time** candidates from **accredited** programs ranged from 5.1% (2011) to 13.7% (2009), and was 8.3% in 2017, a slight decrease relative to 2016. This decrease occurred despite the introduction of a more stringent NBDE Part II standard in March 2017 (see Appendix A for additional details). Failure rates for **first-time** candidates from **non-accredited** programs were higher across the board, 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 NBDE Part II validity evidence, 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
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
2017*	6,138	8.3	712	23.9	1,698	34.4	879	45.3	9,427	17.6

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

Figure 2. NBDE Part II Administrations (2008–2017)

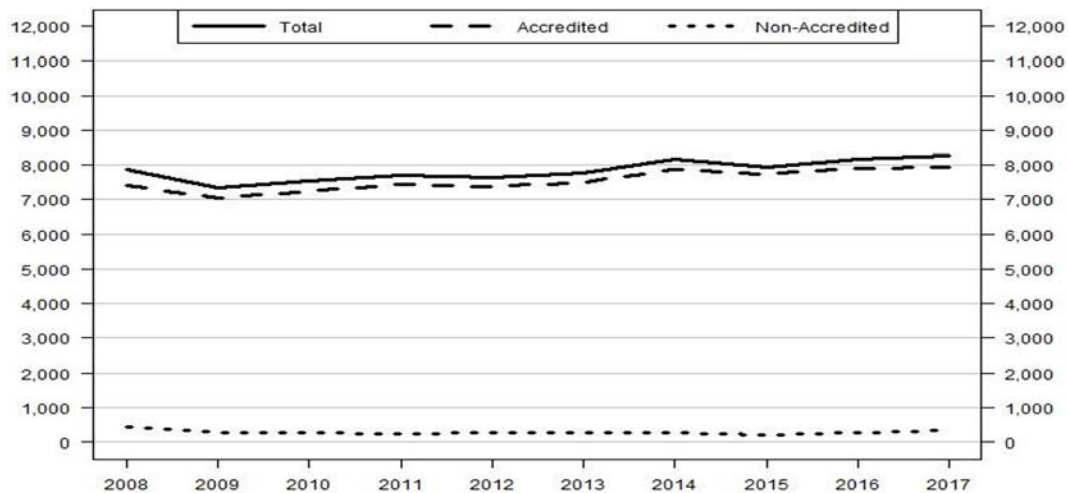
NBDHE: Table 3 presents performance trends for the National Board Dental Hygiene Examination (NBDHE) over the past 10 years, while Figure 3 provides a graphic depiction of administration volume. As shown in Table 3, the number of **first-time** candidates from **accredited** programs increased from 6,770 in 2008 to 7,262 in 2017 (i.e., a 7% 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 2008 and approximately 4% of administrations occurring in 2017. Comparing the number of **total administrations** occurring in 2008 with 2017 shows an overall increase of 414 first-time and repeating candidates from accredited and non-accredited programs (i.e., a 5% increase). Generally speaking, NBDHE total administration volume has been quite stable over the 10-year period indicated.

Failure rates were below 7% for all 10 years for **first-time** candidates from **accredited** programs. A more stringent NBDHE standard was introduced in January 2017 (see Appendix A for additional details), leading to the highest failure rate obtained for this reference group across the 10-year period shown. Failure rates for **first-time** candidates from **non-accredited** programs have varied considerably. These rates were highest in 2008 (57.2%), decreased substantially in the following years with the lowest rate occurring in 2013 (17.3%), and then rose again in 2017 (33.2%).

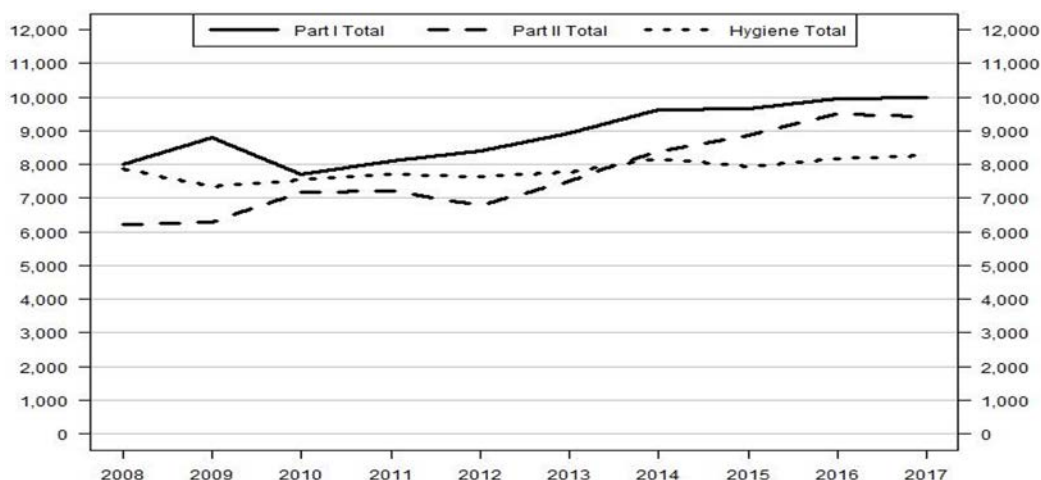
Table 3. Numbers and Failure Rates for First-time and Repeating Candidates: NBDHE

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
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
2017*	7,262	6.2	677	49.8	253	33.2	81	46.9	8,273	11.0

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

Figure 3. NBDHE Administrations (2008–2017)

Overall: Figure 4 provides a graphic depiction of overall test administration volume for the National Board Examinations over the past 10 years. NBDE Part I and Part II total administrations have shown greater variability over time, as compared to Dental Hygiene total administrations which have been fairly consistent. Administration volume for the NBDE Part I has increased every year since 2010. Administration volume for the NBDE Part II increased from 2012 to 2016, and levelled off in 2017.

Figure 4. National Board Examinations: Total Administrations (2008–2017)

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 accommodations 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 2017, accommodated examination attempts made up 1.5% of the total attempts for the NBDE Part I, 1.5% of the total attempts for the NBDE Part II, and 1% of the total attempts for the NBDHE. Across the five year period indicated, failure rates for accommodated candidates were lower for **first-time** candidates than for **repeating** candidates across the three exam programs. The number of candidates receiving accommodations was substantially less for the NBDHE program, as compared to the NBDE programs.

Table 4. Numbers and Failure Rates for Accredited Candidate Attempts Involving Accommodations

Year	Part I				Part II				Dental Hygiene			
	First-time		Repeating		First-time		Repeating		First-time		Repeating	
	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing
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
2017	112	19.6	38	52.7	111	16.2	31	26.2	62	13.0	22	50.0

*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.

Note. A new standard was introduced for NBDE Part II and NBDHE in 2017, based on updated standard setting activities.

Responses to House of Delegates Resolutions

The ADA House of Delegates approved Resolution 21H via consent calendar action in 2017. This action approved changes requested by the Joint Commission, to the Joint Commission Standing Rules. The Joint Commission did not receive any assignments from the ADA House of Delegates in 2017.

Self-Assessment

The Joint Commission continues to develop and refine its strategic plan, and held a professionally facilitated a three-day strategic planning meeting in May 2018 in support of this effort. The Joint Commission has requested a meeting with the ADA Board of Trustees to discuss findings from this meeting and their implications. The Joint Commission is next scheduled to conduct a self-assessment in 2022.

Policy Review

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

Commission Minutes

For more information on recent activities, see the Joint Commission's minutes on [ADA.org](https://ada.org).

Appendix A: Standard Setting and the National Board Examinations

- The purpose of the National Board Examinations (NBEs) is to assist state boards in determining the qualifications of individuals seeking licensure to practice.
- The NBEs are used to determine whether a candidate possesses the minimally acceptable level of knowledge, cognitive skills, and ability that is necessary for safe, entry-level practice:
 - Dentistry (NBDE)
 - Part I: Anatomic sciences, biochemistry-physiology, microbiology-pathology, and dental anatomy and occlusion.
 - Part II: Dental and clinical dental sciences.
 - Dental Hygiene (NBDHE)
 - Scientific basis for dental hygiene practice, provision of dental hygiene services, community health and research principles.
- The NBEs are criterion-referenced examinations; subject matter experts identify performance standards (pass/fail points) following established procedures and criteria that reference specific skill level requirements, not by the process sometimes known as “grading on a curve.”
 - All candidates who demonstrate the necessary skill level through their examination performance will pass the examination (scoring is NOT designed to fail a certain percentage of examinees).
- The standard for each examination is determined through a process called “standard setting.”
- Standard setting activities for all NBE programs were facilitated by Dr. Gregory Cizek, a nationally recognized expert in standard setting who has authored several books on the subject.
- Standard setting panels consisted of ten to 12 subject matter experts, with panelists selected to be broadly representative and aligned with the purpose of the examinations.
- Panelists were extensively trained on procedures, and feedback was collected on five occasions at strategic points within the two-day process.
- An established standard setting method called the “Bookmark” method was used across three rounds of standard setting activities per NBE program.
- At the conclusion of the final round, the three independently conducted standard setting panels provided recommendations to the Joint Commission that increased the performance standard for the corresponding examination each panel had reviewed.
- Application of the new standards to prior samples from 2013 (NBDE) and 2014 (NBDHE) yielded increased failure rates as follows:
 - **NBDE Part I:** Failure rate increased from 6.3% to **10.1%**
 - **NBDE Part II:** Failure rate increased from 6.3% to **8.6%**
 - **NBDHE:** Failure rate increased from 4.8% to **5.6%**
- At the conclusion of all activities, participants’ evaluations of all aspects of the process were uniformly strong and supportive, with each panelist indicating that they supported the final group-recommended performance standard. Panelists were aware of the anticipated failure rates shown above. Panelist feedback on the last item of the final evaluative questionnaire was as follows:

Survey Item Number and Statement	Mean Rating*
15. Overall, I support the final group-recommended cut score as fairly representing the appropriate performance standard for the NBDE Part I .	4.6
15. Overall, I support the final group-recommended cut score as fairly representing the appropriate performance standard for the NBDE Part II .	4.9
15. Overall, I support the final group-recommended cut score as fairly representing the appropriate performance standard for the NBDHE .	5.0

*Key: Values are on a five-point scale, ranging from 1=Strongly Disagree to 5=Strongly Agree; NR = no response. All table entries are based on N=10 (Part I) or N=12 (Part II and NBDHE) responses.

- The new standards for the NBDE Part I, NBDHE, and NBDE Part II were separately reviewed and approved by the Joint Commission, and implemented in November 2016, January, 2017, and March 2017, respectively.

- The Joint Commission has communicated information concerning the new NBE standards through numerous presentations over the past several years, including the following:
 - ADEA Annual Conference (March 2014)
 - National Dental Examiners' Advisory Forum (NDEAF) (April 2014)
 - ADEA Annual Conference (March 2015)
 - NDEAF (April 2015)
 - ADEA Board of Directors (September 2015)
 - ADEA Dean's Conference (October 2015)
 - ADEA Fall Meeting (October 2015)
 - ADEA Annual Conference (March 2016)
 - NDEAF (April 2016)
 - ADEA Annual Conference (March 2017)
 - NDEAF (April 2017)
 - ADEA Annual Conference (March 2018)
 - NDEAF (June 2018)
- Staff monitor failure rates closely. Obtained failure rates subsequent to deployment of the new standards have been quite similar to those projected during the original standard setting exercises, falling within an expected range that accounts for year-to-year variation in the skills of the underlying candidate sample.
- The failure rates for first-time candidates from accredited programs in 2017 were as follows:
 - NBDE Part I: 10.6%
 - NBDE Part II: 8.3%
 - NBDHE: 6.2%
- Staff have also confirmed that the new standards have been implemented correctly.
- Additional information about the standard setting process is available on the Joint Commission website and can be accessed via the link below.
 - http://www.ada.org/~media/JCNDE/pdfs/nbde_standard_setting_ADEA_March%202016.pdf?la=en

National Commission on Recognition of Dental Specialties and Certifying Boards

Norman, Charles, H., III, 2021, North Carolina, chair
 Boyle, James, M., III, 2020, Pennsylvania, vice chair
 Aldredge, Wayne, A., 2021, New Jersey
 Altman, Don, 2020, Arizona
 Battaglia, Joseph, A., 2021, New Jersey
 Benz, James, D., 2021, Illinois
 Cooley, Ralph, A. 2018, Texas
 Delarosa, Robert, 2019, Louisiana
 Friedel, Alan, E., 2018, Florida
 Gohel, Anita, 2021, Ohio
 Henner, Kevin, A., 2019, New York
 Hering, Denise, L., 2020, Ohio
 Johnson, William, T., 2018, Iowa
 Kiesling, Roger, 2020, Montana
 Kwasny, Andrew, J., 2020, Pennsylvania
 Tuminelli, Frank, J. 2018, New York
 Wright, John, M., 2019, Texas
 Zust, Mark, 2019, Missouri

Baumann, Catherine, director

The National Commission's 2017–18 liaison is Dr. Billie Sue Kyger (Board of Trustees, Seventh District).

Areas of Responsibility as Set Forth in the *Bylaws or Governance and Organizational Manual of the American Dental Association*

As stated in Chapter IX, Section 30 of the ADA *Bylaws*, the duties of the National Commission shall be to:

- a. Formulate and adopt procedures for the recognition of specialties and specialty certifying boards in accord with the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialties*.
- b. Grant or deny specialty recognition to specialty organizations and specialty certifying boards seeking recognition in accord with the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialties*.
- c. Provide a means for sponsoring organizations and certifying boards to appeal an adverse recognition decision.
- d. Submit an annual report to the House of Delegates of this Association and interim reports on request.
- e. Submit the National Commission's annual budget to the Board of Trustees of the Association.

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

The National Commission is a commission with independent authority to recognize dental specialties and their respective certifying boards. The Commission determines its own strategic goals and objectives. For 2018, the National Commission goals and objectives are as follows:

Objective 1: To become fully operational and functional with all commission and committee members appointed for the public commissioner, standing review committee, and appeal board.

Initiative/Program: ADA NCRDSCB

Success Measure: The successful solicitation for nominations and appointment of the public commissioner, review committee, and appeal board members.

Target: All appointments completed by July 15, 2018.

Range: All appointments completed by July 15, 2018.

Outcome: National Commission Nomination Committee will meet June 25, 2018; National Commission Chair will make appointments July 2018.

Objective 2: Development of mission, vision, and values statements for the National Commission.

Initiative/Program: ADA NCRDSCB

Success Measure: The National Commission's development of mission, vision and values statements with the goal of approving a draft at the Commission's March 2019 meeting.

Target: Draft version of strategic plan for review by Commission at the March 2019 meeting.

Range: Draft version completed by December 1–30, 2018.

Outcome: National Commission Strategic Planning Committee will meet in August/September 2018 to develop a draft mission, vision and value statements to be present at the March 2019 Commission meeting.

Emerging Issues and Trends

The National Commission currently oversees the recognition of nine (9) dental specialties and their respective certifying boards. The National Commission conducted its inaugural meeting May 9–10, 2018, and adopted formal policies and procedures related to all aspects of the recognition process. At the time of this report, the National Commission is still in an organizational period. Key next steps are the appointment of the public Commissioner, review committee members and having all committees fully operational and meet prior to the end of the year.

Application for Specialty Recognition: The National Commission has acknowledged the receipt of an application for recognition by the American Society of Dentist Anesthesiologists; however, took no action on the application at this time in order to review and revise the specialty application process.

State Dental Boards: The National Commission was briefed by ADA legal Council on the current landscape of specialty recognition by state dental boards. The National Commission is currently monitoring these trends and developing a communication plan with regard to the state dental boards recognizing the National Commission as the appropriate recognizing body of the dental specialties.

Responses to House of Delegates Resolutions

There were no House of Delegates resolutions directed at the National Commission in 2017.

Self-Assessment

The National Commission's self-assessment year has not been determined at this point in time.

Policy Review

There are currently no ADA policies related to the National Commission that the National Commission has been charged with reviewing in accord with Resolution 170H-2012, Regular Comprehensive Policy Review. The National Commission implemented their policies and procedures in 2018. A timeline for periodic review of individual National Commission policies is being developed.

Commission Minutes

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

Council on Scientific Affairs

Eleazer, Paul D., 2018, Alabama, chair
 Mariotti, Angelo J., 2019, Ohio, vice chair
 Alapati, Satish B., 2021, Illinois
 Aminoshariae, Anita, 2018, Ohio
 Bedran-Russo, Anakarina B., 2021, Illinois
 Fontana, Margherita R., 2020, Michigan
 Geisinger, Maria L., 2020, Alabama
 Jefferies, Steven R., 2020, Pennsylvania
 Hargreaves, Kenneth M., 2018, Texas**
 Kademani, Deepak F., 2019, Minnesota, *ad interim*
 Keels, Martha Ann, 2020, North Carolina
 Madurantakam, Parasarathy A., 2021, Virginia
 Moore, Paul A., 2018, Pennsylvania
 Parker, William B., 2019, Florida
 Patton, Lauren L., 2021, North Carolina
 Roberts, Howard W., 2018, Kentucky
 Tinanoff, Norman, 2020, Maryland
 Youel, Benjamin C., 2018, Illinois*

Lyznicki, James M., senior manager

The Council's 2017–18 liaisons include Dr. Raymond Cohlma (Board of Trustees, Twelfth District) and Mr. Andrew Larkin (American Student Dental Association).

Areas of Responsibility as Set Forth in the *Bylaws or Governance and Organizational Manual of the American Dental Association*

As described in Chapter VIII, Section K10 of the ADA *Governance and Organizational Manual*, the areas of subject matter responsibility of the Council shall be:

- a. Science and scientific research, including:
 - i. Evidence-based dentistry;
 - ii. Evaluation of professional products;
 - iii. Promulgation of a biennial research agenda; and
 - iv. 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.

** *Replaced Dr. Steven Offenbacher. The Council expresses sincere gratitude for the scholarship and legacy of Dr. Steven Offenbacher, recipient of the 2015 ADA Gold Medal Award for Excellence in Dental Research, who passed away in August 2018.*

* *New Dentist member*

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

The following presents outcomes of Council programs from January to July 2018 and tracks progress to date in support of the ADA Strategic Plan and the ADA Science Institute's Operating Plan.

Membership Goal: Increase Member Value and Engagement

Initiative/Program: Develop, publish and present science-based content that will add value to clinical practice and help ADA members to become leaders in dentistry.

Success Measure: 6–7 documents per quarter; 25 for full calendar year

Target: 25 per year

Range: 20 to 30 documents per year

Outcome: 28 documents developed through June 2018, including: a rapid-review article on the benefits and harms of capnography during procedures involving moderate sedation (published in the [January 2018 issue of JADA](#)); an April 2018 [overview of systematic reviews on oral analgesics for acute dental pain](#); an Evidence Brief on Oropharyngeal Cancer and Human Papillomavirus (HPV) Infection, Disease and Prevention; posting a new [Oral Health Topic \(OHT\) page](#) on the [oral health effects of cannabis](#) and an updated OHT page on [latex allergy](#); ADA Clinical Evaluator (ACE) Panel Reports on [bioactive materials](#) and [posterior composite resins](#); three “For the Patient” pages in *JADA* addressing [bruxism](#), [dental erosion](#), and [diabetes and oral health](#); an *Angle Orthodontist* article on [long-term effects of cleaning methods on light transmittance, surface roughness, and flexural modulus of polyurethane retainer material](#); and 11 research abstracts presented at the [2018 AADR annual meeting](#). Additional scientific publications are planned and will be available during the second half of the year. Target achieved.

Membership Goal: Increase Member Value and Engagement

Initiative/Program: Add member value through the development of scientific content for continuing education (CE)

Success Measure: Scientific content for 80 hours of CE delivered by December 2018 (equivalent to 20 CE hours per quarter).

Target: 80 hours per year

Range: 60 to 100 hours per year

Outcome: Through June 2018, the Council and ADA Science Institute have offered 64 CE credit hours to ADA members, including: 42.5 CE hours from the ADA Center for Evidence-Based Dentistry's [workshops](#) (e.g., 35 CE hours offered at the May 2018 [“Dentistry for the Modern Age” workshop](#)); 1.5 CE hours from an ADA research symposium titled [“Transforming Oral Health Through Science and Evidence-based Practice”](#), which was presented at the 2018 American Association for Dental Research (AADR) annual meeting (11 research abstracts by Science Institute staff were also presented at that meeting). EBD Center staff delivered an expert-panel training session on evidence-based guideline methodology, which provided 8 CE hours to the panelists. The Department of Scientific Information developed a CE exam for a [capnography article in the January 2018 issue of JADA](#), which provided one hour of CE credit.

The Council is sponsoring six scientific sessions that will offer 9.5 CE hours at the ADA 2018 meeting, and the Science Institute is collaborating on a head-and-neck-cancer course track that will provide 11 CE hours. In November 2018, the EBD Center will present an educational workshop titled [“How to Conduct and Publish to Systematic Reviews and Meta-Analyses”](#), which will offer 18 CE hours to attendees. Three CE webinars are also scheduled for filming and posting on ADA CE Online later this year. Objective is on schedule.**

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

Finance Goal: Be Financially Sustainable

Initiative/Program: Deliver increased non-dues revenue from the ADA Seal of Acceptance, sponsorships and content delivery partnerships.

Success Measures: Total non-dues revenue = \$1.15 million for 2018, including:

- a) Generate \$955,000 on ADA Seal of Acceptance fees by December 2018; and
- b) Sponsorships and Content Delivery = \$195,000

Target: \$1.15 million

Range: \$0.9–1.3 million

Outcome: \$927,120 through June 2018. Objective is on schedule.**

Additional CSA-Related Projects and Results

Evidence-based Dentistry: In June 2018, the ADA Center for Evidence-Based Dentistry (EBD) completed the first clinical practice guideline for this project, which presents evidence-based recommendations on nonrestorative treatments for caries lesions. The guideline is scheduled for publication as an Association report in the October 2018 issue of *JADA*, and it is supported by an accompanying systematic review, which has been submitted for publication in the *Journal of Dental Research*. Two additional commentary articles on the entire caries-management guideline series will also be submitted for publication.

Scientific Information: The Department of Scientific Information supports CSA by developing evidence-based reports and informational resources addressing scientific aspects of the dental practice environment. Key accomplishments for the Department of Scientific Information and CSA in 2018 included:

- development of an Evidence Brief and proposed policy statement to address human papillomavirus (HPV) vaccination for the prevention of infection with HPV types associated with oropharyngeal cancer (this policy proposal will be submitted to the House of Delegates on a separate worksheet); and
- providing scientific support and expertise for an ADA interagency collaboration to address the opioid-use crisis and overdose cases in the United States. At the ADA 2018 meeting, the CSA is sponsoring two CE programs on "[Safe and Responsible Prescribing of Opioid Analgesics](#)," which will be presented by CSA member Dr. Paul Moore.

ADA Seal of Acceptance Program: The Council oversees the ADA Seal of Acceptance Program, and is responsible for reviewing scientific data on over-the-counter (OTC) oral care products to support their safety and effectiveness, in accordance with Acceptance Program requirements.

Through July 2018, the Council has awarded the ADA Seal of Acceptance to 12 product submissions that met Acceptance Program requirements. The Council has also received 23 new product submissions for Acceptance consideration.

Product Evaluation: Another Council area of responsibility is the "evaluation of professional products" used in dental practice, as noted in the *ADA Governance and Organizational Manual*. The Council presents clinical perspectives on professional products through periodic [ACE Panel Reports](#). Through June 2018, the Council's Product Evaluation Subcommittee published two ACE Panel Reports on [posterior composite restorations](#) and [bioactive materials](#), which were promoted to member dentists in various age groups through *ADA News*, the New Dentist blog and other Association media.

In 2016, the New Dentist Committee requested the development of new resources in pharmacology. Three volunteers and Product Evaluation staff from the Science Institute developed a new, user-friendly

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

dental drug product for professional use titled *ADA Dental Drug Handbook: A Quick Reference*, which will make its print debut at the ADA annual and New Dentist Committee meetings in Hawaii.

Research and Standards: The Research and Standards Department conducts research on dental materials, instruments, and equipment, including general and applied research to develop standards and address questions and emerging issues pertaining to dental materials or products.

In 2018, Research and Standards staff worked on a new Technical Report entitled “Dentistry – Guidance on Methods Development and Validation of Cleaning Processes for Dental Instruments,” which presents a set of validated tests and cleaning methods for dental instruments (e.g., multi-use diamond instruments). The technical report will be updated for final approval by fall 2018.

Emerging Issues and Trends

The Council continuously monitors the oral health research literature via its Subcommittees and Workgroups. These entities are responsible for identifying emerging scientific issues and trends that require full Council discussion and possible action. In 2018, this process resulted in CSA actions to address prevention of human papillomavirus (HPV)-associated cancer and dental erosion:

- The Council worked with the Council on Advocacy for Access and Prevention and the Council on Dental Practice (CDP) to develop a joint Council policy proposal to support HPV vaccination to decrease the burden of oral and oropharyngeal HPV infection, which in turn has the potential to decrease the incidence of HPV-associated cancers of the oropharynx and oral cavity. This proposed policy statement will be forwarded to the 2018 House of Delegates on a separate worksheet.
- The Council convened an expert working group to identify opportunities and strategies for addressing the diagnosis, treatment, and management of patients with dental erosion, a multifactorial condition that affects many patients.

Also in 2018, the Council recommended forwarding a proposal to the 2018 House of Delegates to modify one of the Council's areas of responsibility, as defined in the *ADA Governance and Organizational Manual*, to focus on “identification of intramural and extramural priorities for dental research every three years,” rather than “promulgation of a biennial research agenda.” This proposal will be presented to the House of Delegates on a separate worksheet.

Responses to House of Delegates Resolutions

Resolution Objective: Resolution 45-2017 Over-the-Counter Product Labeling of pH

In 2018, the CSA collaborated with the ADA Science Institute to address Resolution 45-2017, Over-the-Counter (OTC) Product Labeling of pH, which was referred (as amended below) to CSA “for further study and report to the 2018 House of Delegates.”

45-2017. Resolved, that the ADA supports and encourages manufacturers to provide product labeling to include information on the pH level for over-the-counter anti-caries and fluoride rinses oral products available to the public for disease prevention and palliation.

Initiative/Program: Review oral care products and product categories, research studies and the current regulatory framework regarding the provision of pH information on OTC oral care products.

Success Measure: Submission of report with recommendations to the 2018 House of Delegates.

Target: Submission of standalone report to the 2018 House of Delegates.

Outcome: At its June 2018 meeting, the Council approved forwarding a report to the 2018 House of Delegates that presents a collaborative approach to address this referred House resolution. The Council's response to Resolution 45-2017 will be submitted to the House of Delegates as a separate report.

Resolution Objective: Resolution 86H-2016 Optimizing Oral 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.

In 2018, the Council followed a stepwise implementation plan to convene two of three planned expert panels that will review the available evidence on preoperative oral health assessment and optimization for patients undergoing the following medical or surgical procedures:

- 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
- Organ transplant patients prior to surgery.

Initiative/Program: Evidence-based reviews conducted by Council-appointed expert panels.

Success Measure: Completion of manuscript with recommendations from the first review project (addressing cardiac patient care) by fourth quarter 2018; completion of in-person expert panel meeting for the second review project (head and neck cancer) by fourth quarter 2018.

Target: Completion of first expert-panel review project by December 2018, and completion of the in-person meeting for the second expert panel project (addressing head and neck cancer) by December 2018.

Outcome: The first expert panel (cardiac patient care) met in July 2018 to perform evidence synthesis and report development. The second expert panel (head and neck cancer) intends to hold its in-person meeting in fourth quarter 2018.

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2021.

Policy Review

In accordance with the Association's five-year review cycle for ADA policy statements, the Council evaluated the following ADA policies in spring 2018:

Dental Office Wastewater Policy (*Trans.*2003:387)

ADA Action Plan on Amalgam in Dental Office Wastewater (*Trans.*2007:441; 2002:422)

In June 2017, the EPA published a [final rule](#) that will require most dental facilities in the United States to install amalgam separators by July 2020. Because these ADA policies define best management practices (BMPs) and encourage dentists to adhere to BMPs (including use of amalgam separators compliant with ISO 11143), senior staff from the Council and CDP agreed that both policies should be under CDP's

purview as lead agency, with CSA serving as secondary agency to address scientific considerations as needed. CDP agreed to review these policies in 2019.

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
 Kenneth McDougall, 2020, North Dakota*
 Kolman, Paul, 2019, Indiana
 Meckler, Edward, 2020, Ohio
 Maher, John, 2021, 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 2017, ADABEI Goals Included:

- Financial Sustainability
 - Increase Non-Dues Revenue for the ADA
 - Key Provider Renewals (PBHS, Mercedes-Benz, Digital Dental Record, UPS)
- Increase Member Value
 - Increase Member Engagement and Data Centric Focus
 - Improve Member Experience and Customer Service
 - Improve Marketing Tactics and Segmentation Based on Data
- New Product Development and Existing Product Enhancements
 - Based on Member Research
- Develop Organization with Capacity to Meet Stakeholder Needs
 - Internal Organization Capacity
 - Increase Collaboration with ADA and State Dental Societies

Throughout 2017, ADABEI staff achieved each of the goals.

- Exceeded Financial Goals (See Tables 1,2 and 3)
 - Total Program: Exceeded Plan by \$245,000 or 6.6%
 - ADABEI Net: Exceeded Plan by \$107,000 or 39.6%
 - ADA Net: Exceeded Plan by \$138,000 or 4.0%
- Completed Contract Renewals
 - PBHS (Marketing & Secure Email)
 - Mercedes-Benz (Luxury Cars)
 - UPS (Shipping)
 - Digital Dental Record (Online Backup and Digital Records)
- Added Two New Providers
 - CyraCom (Interpretive Services)
 - HealthFirst (Emergency Medical Kits)
- Increased State Royalty Sharing and Co-Endorsements
 - 49 State Co-Endorsements
 - 574 Product Co-Endorsements (28.6% Increase)
 - \$1,130,000 State Royalty Sharing (3.3% Increase)
- Member Value and Engagement
 - High Member Engagement
 - Product Inquiries = 50,173
 - New Accounts = 18,049

* ADA Trustee

ADABEI Financials

Total Program Financials

In 2017, the total program earned \$7,167,000 in gross revenue as a result of service fees to ADABEI and royalties to the ADA and finished 2017 with net income (pre-tax) of \$3,954,000.

Table 1. 2017 Total Program Financials

	2017 Actuals	2017 Budget	Variance (\$)	Variance (%)
Revenue	\$7,167,000	\$6,896,000	\$271,000	3.9%
Expenses	\$3,213,000	\$3,187,000	(\$26,000)	(0.8%)
Net (Pre-Tax)	\$3,954,000	\$3,709,000	\$245,000	6.6%

ADABEI Financials

In 2017, ADABEI earned \$2,460,000 in gross revenue as a result of service fees to ADABEI from the program and finished 2017 with net income (pre-tax) of \$377,000, driven in large part by strong product performance and managing expenses below budget.

Table 2. 2017 ADABEI Financials

	2017 Actuals	2017 Budget	Variance (\$)	Variance (%)
ADABEI Revenue	\$2,460,000	\$2,393,000	\$67,000	2.8%
Expenses	\$2,083,000	\$2,123,000	\$40,000	1.9%
Net (Pre-Tax)	\$377,000	\$270,000	\$107,000	39.6%

ADA Financials

In 2017, the ADA earned royalties of \$4,707,000 from endorsed providers in the program, exceeding the budget by \$204,000 or 4.5%. The variance was driven by better than expected performance, primarily from the financial services (U.S. Bank, Chase) and marketing (PBHS) products.

State dental societies may choose to co-endorse products and services and share in program revenue through a license agreement. In 2017, the ADA paid \$1,130,000 in royalties to states and exceeded the budget due to additional states joining the program and co-endorsements.

Table 3. 2017 ADA Financials

	2017 Actuals	2017 Budget	Variance (\$)	Variance (%)
ADA Royalties	\$4,707,000	\$4,503,000	\$204,000	4.5%
State Royalty Share	\$1,130,000	\$1,064,000	(\$66,000)	(6.2%)
Net (Pre-Tax)	\$3,577,000	\$3,439,000	\$138,000	4.0%

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 2017, the program included 19 products and services from 16 providers:

- Credit Card—U.S. Bank
- Credit Card Processing—Chase
- 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
- Interpretive Services—CyraCom
- Amalgam Separators, Emergency Medical Kits and Sharps Management—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 Inside Pass Program and Meridian One Corporation
- Computers & Technology—Lenovo and Meridian One Corporation

Renewed and New Business

ADABEI completed renewals with four providers, including PBHS, Mercedes-Benz, UPS and Digital Dental Record. These products have been utilized by more than 12,000 ADA members and generate more than \$700,000 in total program revenue, per year.

Product development continued to be a key focus for ADABEI, including business and lifestyle products, as well as those that can help practices manage compliance related issues. In addition to member surveys and focus groups, ADABEI staff met frequently with other professional associations to share ideas and best practices as well as ongoing discussions with a number of affinity product brokers.

In 2017, dialogues were conducted with 71 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 2017, Interpretive Services (CyraCom), to meet Sec. 1557 requirements and Emergency Medical Kits (HealthFirst).

ADA Foundation

Calnon, William R., 2018, New York, president and interim executive director
 Fujimoto, Patsy K., 2019, Hawaii, vice president of audit
 Green, Edward J., 2021, Georgia, vice president of grants
 Kiesling, Roger L., 2019, Montana, vice president of finance
 Maggio, Frank A., 2018, Illinois, vice president of development
 Panagakos, Fotinos S., 2021, New Jersey, vice president of governance
 Lynch, Michael C., 2019, New Jersey, vice president of science

Members at Large:

Asai, Rickland G., 2018, Oregon*
 Bruck, Ann, 2020, Minnesota
 Dolan, Teresa A., 2019, Pennsylvania
 Fujimoto, Luis J., 2018, New York
 Gallant, Marshall L., 2019, Colorado
 Hayes, Mary J., 2021, Illinois
 Himmelberger, Linda K., 2021, Pennsylvania*
 Icyda, Teri-Ross, 2018, Florida
 Klemmedson, Daniel J., 2019, Arizona*
 Lieb, Howard I. A., 2020, New York
 Morell, Maritza, 2020, Massachusetts
 Penrose, Michele, 2020, Michigan
 Roberts, Gary L., 2021, Louisiana
 Thompson, Roy, 2020, Tennessee*

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

As the philanthropic arm of the ADA, the ADA Foundation (ADAF) engages in activities that improve the health of the public both in the U.S. and internationally.

Primary areas of focus are access to care and research which include the following:

- 1) Supporting game-changing oral health research through the ADA Foundation Volpe Research Center (VRC) which provides a physical presence in a world-renowned, national venue that drives oral health research; and
- 2) Improving the public's oral health by expanding access to care through:
 - o Give Kids A Smile® (GKAS), through which volunteers provide free oral health services to underserved children;
 - o International programs, which support the improvement of global oral health; and
 - o Grants, scholarships and awards that improve the public's oral health while supporting tomorrow's leaders in dentistry.

ADAF programs drive positive oral health outcomes as well as support the needs of the dental profession. Outcomes from ADAF programs can be leveraged in ADA advocacy efforts to influence policy and funding decisions that affect how oral health care is delivered. ADAF programs also provide social-responsibility engagement opportunities at the national membership level, which is particularly important for those who wish to align themselves with organizations that are giving back to people in need. Research has shown that Millennials and other younger-generation dentists seek out organizations that offer "passion projects."

This report includes a summary of the ADAF programs and their impact.

*ADA Trustee

ADA Foundation Volpe Research Center

The VRC advances the oral health of the public through basic and applied research by focusing on the development of dental materials and treatment technologies. All ongoing research applies the principles of metrology and standards to ensure measurement confidence and reliability of materials and results.

This year, the VRC was successfully realigned within the National Institute of Standards and Technology (NIST) Material Science and Engineering Division (MSED). The official announcement was made in April 2018, and the transition is underway and will continue for approximately the next six months. Talks continue between VRC staff and the MSED regarding VRC's alignment with NIST research priorities. Two major programmatic areas of focus entail advanced dental materials, oral sensors/devices, and bioscience related to advanced dental materials and oral sensors. All research is aligned with and supports Material Measurement Laboratory (VRC's host laboratory at NIST), strategic targets and NIST mission. Through these research programs VRC and NIST continue the longest lasting public-private partnership in the country (in existence from 1928).

A new Cooperation Research and Development Agreement (CRADA) between the VRC and NIST will reflect the most recent re-alignment in the VRC's research priorities (dental materials, sensors, and devices; and bioscience as it relates to those priorities) with MSED as a host division.

Achievements:

Program I: Advanced dental materials

The goal of this program is to develop new generation(s) of improved dental materials by employing new chemistries and material design principles to yield multifunctional restoratives. The program also entails development of new measurement standards/metrology that may find utility in both biomedical and industrial applications. The program includes the following projects:

- New dental restorative materials
- Evaluation of resin stability using nanotechnologies
- Nano-hydroxyapatites
- Carbonated hydroxyapatite-based dosimetry
- Novel composites with functionalized surfaces

The anticipated milestones have been reached for the fifth year of the U01 project "Novel dental resin composites with extended service life" (Principal Investigator (PI): Dr. Sun) and for the second year of the R01 project "Antimicrobial and remineralizing composites for Class V restorations" (PI: Dr. Skrtic). Both projects are funded by the National Institute of Dental and Craniofacial Research (NIDCR).

A new R01 application "pH-sensitive, acid-enhanced antimicrobial compounds targeting acid-producing bacteria" (Multi-PIs: Dr. Sun and the researchers from the Forsyth Institute) was submitted to NIDCR on February 5, 2018. Results of the scientific merit review will be revealed in July this year.

Another R01 application entitled "New approaches to biostability and durability of dental materials" (PI: Dr. Sun) was submitted to NIDCR on June 5, 2018. The proposal will be reviewed in October/November this year.

A grant application "Novel bioactive composite materials for treatment of periodontal disease" (PI: Mr. Frukhtbeyn) has been selected for support from the ADAF's Research Funds.

Program II: Oral Sensors-Devices

This program seeks to develop sensors and small devices that can be applied in the oral cavity to monitor oral fluids (saliva, gingival crevicular fluid), tissues and restorations. Devices with the incorporated sensors will be employed to test physical, chemical and biological properties of dental restorations utilizing model platforms. The program includes the following projects:

- Implantable oral sensors
- Improved periodontal instrument

- Oral microfluidic platforms
- Occupational hazard assessment of new dental materials
- Effects of e-cigarette on host-microbial interaction and surface characteristics

The R01 grant application (E-cigarettes and Perturbations in Oral Microbial-mucosal Homeostasis) with the PI Dr. Kumar from The Ohio State University and VRC's Dr. J. Kim as Co-Investigator received an excellent score for scientific merit. VRC will receive a sub-award.

Grant applications "Engineering oral tissue on-a-chip models to mimic diabetic periodontal disease" (PI: Dr. Alimperti), "Update on oral cancer risk from emerging tobacco products for dental professionals" (PI: Dr. J. Kim) and "Smart periodontal advanced diagnostic tool for assessing periodontal disease" (PI: Dr. S. Kim) have been selected for support from the ADAF's Research Funds.

Bioscience related to advanced dental materials (Program I) and oral sensors (Program II)

The emphasis of this program is to develop improved testing methods for biocompatibility, cytotoxicity and antimicrobial testing of materials/devices outlined in Programs I and II. Current ANSI and ISO standards are limited to *in vitro* tissue model systems that poorly mimic *in vivo* tissues. This program integrates testing platforms into devices to provide controlled environments for real-time physical, chemical and biological evaluations. This program includes the following projects:

- Biocompatibility and antimicrobial activity of dental restoratives
- Organotypic 3D pulp cell/extra cellular matrix platform

Other Accomplishments:

- Fourteen manuscripts published in peer-reviewed journals
- Sixteen presentations at scientific meetings
- One provisional patent application submitted to the U.S. Patent and Trademark Office
- VRC scientists continue to collaborate with industry and academia on a variety of projects

Impact:

Benefit to NIST: The proposed collaborative work reinforces NIST-developed measurement techniques and may lead to development of new applications for quantitative standards/measurements.

Benefit to ADAF/ADA: Ability to capitalize on NIST's preeminent place in metrology.

Benefit to the public/dental community: Since the mouth is the sentinel to the human body, successful restoration of oral tissues/functions and ability to identify and prevent diseases through the real-time diagnostic tools (oral sensors) is of utmost importance to the general population. The ultimate translation of research findings into dental clinics additionally benefits dental practitioners and dental manufacturers.

Further Action Plans:

- Maintain strong presence at the scientific conferences and publication record
- Continue efforts for external research support/submission of proposals to funding agencies such as NIH, NSF, DOD and industry
- Further engage with industrial and academic partners
- Nourish the NIST partnership

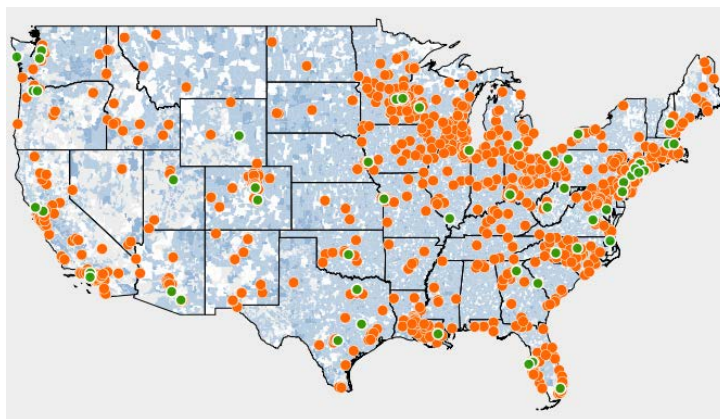
Give Kids A Smile®

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, more than 5.5 million underserved children have received oral health services through GKAS.
- More than half a million volunteers in all 50 states—including 144,000 dentists and 445,000 other volunteers—have participated over the program's history.
- Nearly 1,500 GKAS events took place across the U.S. in 2017 (see Chart 1 below).
- The ADAF collaborated with Henry Schein, Inc. to facilitate distribution of \$1,413,236 in in-kind product donations to GKAS programs across the U.S. in 2018.
- To date, 69 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.

Chart I: GKAS Events in 2017



Future Priorities and Impact:

- Finalize a multi-year GKAS strategic plan to improve focus and ensure sustainable growth for the program, particularly in the areas of data collection, continuity of care, communications and external partnerships.
- Launch a revamped GKAS data collection system and mobile app, with the goal of driving full participation in data collection, resulting in greater accuracy in GKAS program statistics.
- Continue stewarding current sponsor relationships while cultivating new mutually beneficial relationships within and outside of the dental arena.

Tiny Smiles, a program of Give Kids A Smile

The ADAF, in collaboration with Scholastic, Inc., the publishing and education company, launched the Tiny Smiles national oral health education program in 2017. Tiny Smiles is targeted at dentists (pediatric and general), pediatricians, OB/GYNs, and early childhood educators, with the goal of positively changing oral health care behaviors in parents and caregivers of children ages 0 (birth) to five.

Achievements:

Tiny Smiles was kicked off with a pilot/test phase in 2017. Four thousand oral health education kits were mailed to early childhood facilities, daycare centers, dentists' (general and pediatric) offices and pediatrician/OBGYN offices in seven targeted markets. See the pilot program materials at www.scholastic.com/givekidsasmile. ADAF and Scholastic staff collected and analyzed qualitative and quantitative data about the effectiveness of the materials and the messaging. The data indicated a significant improvement in participants' understanding of key messages, and also an increase in visits to

the dentist, following exposure to the materials. A representative from Scholastic made a presentation to the ADAF Board in December 2017, at which time the ADAF decided to proceed with a broader, national launch of the program, following some minor revisions to the materials as indicated by the collected data.

Future Priorities and Impact:

A soft national launch of the Tiny Smiles program is planned for 2018, with approximately 10,000 oral health influencer kits to be mailed to dentists' (general and pediatric) offices, pediatrician/OBGYN offices, and early childhood facilities/daycare centers. The program has the potential to reach 500,000 parents and caregivers of children ages 0 (birth) to five with the goal of reducing the incidence of early childhood caries. The ADAF Development team is in the process of researching potential sponsorship opportunities to offset continued development and implementation expenses.

International Programs

ADAF international programs strive 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 May 2018, 68 representatives of international volunteer dental projects, including U.S. dental school global outreach programs, attended the International Volunteer Dental Project Best Practices Workshop, which was hosted by the ADAF. To facilitate ongoing education and knowledge-sharing beyond this workshop, five of the workshop segments were video-recorded and are available on ADAFoundation.org.
- In March 2018, the ADAF launched the [Grant for International Volunteer Dental Projects](#). This two-year pilot program will award four grants of up to \$5,000 each in both 2018 and 2019. The ADAF received twenty-four nominations by the May 1, 2018 deadline. The 2018 recipients were confirmed in June.
- In April 2018, the [Health Volunteers Overseas \(HVO\)-ADA Foundation Volunteer Fellowship](#) was announced. New dentists and/or first time HVO volunteers may apply for funding of up to \$1,500 to defray some of their travel-related expenses to volunteer at an HVO oral health program site.
- The international volunteer website attracted 14,306 views, 3,925 users and 5,072 sessions from January 1–June 18, 2018.
- In partnership with HVO, volunteer dentists completed 24 oral health assignments in Haiti, Laos, Nepal, Peru, St. Lucia, Tanzania and Vietnam which resulted in over 300 providers of dental service and education being trained.

Future Priorities and Impact:

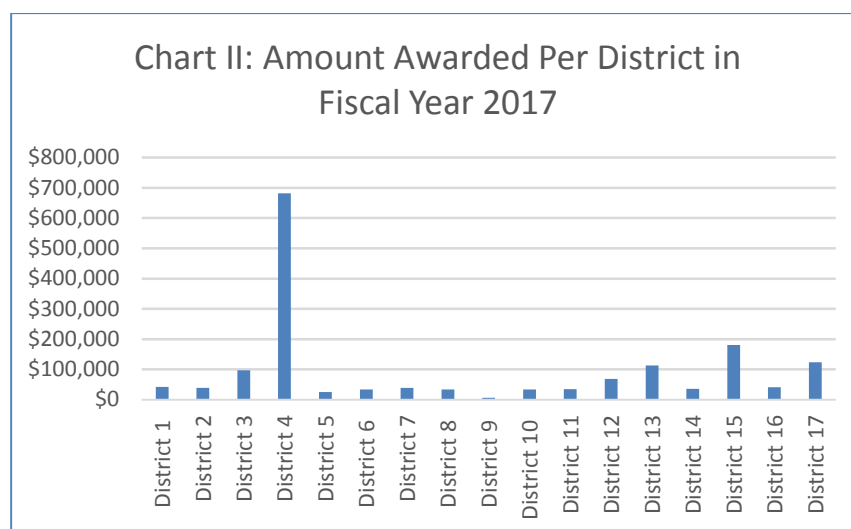
- Expand the ADAF GKAS program to international locations.
- Conduct education courses and events on international volunteerism during ADA 2018 – America's Dental Meeting and 2019 annual meeting.
- In collaboration with HVO and other organizations, identify and implement programs to train dentists and promote the importance of oral health with the ultimate goal of improving access to care in communities of need.
- Explore future opportunities to bring together representatives of international volunteer dental projects, including U.S. dental school global outreach programs so that collaboration amongst these groups and the impact they have on communities in need is maximized.

Grants, Awards and Scholarships

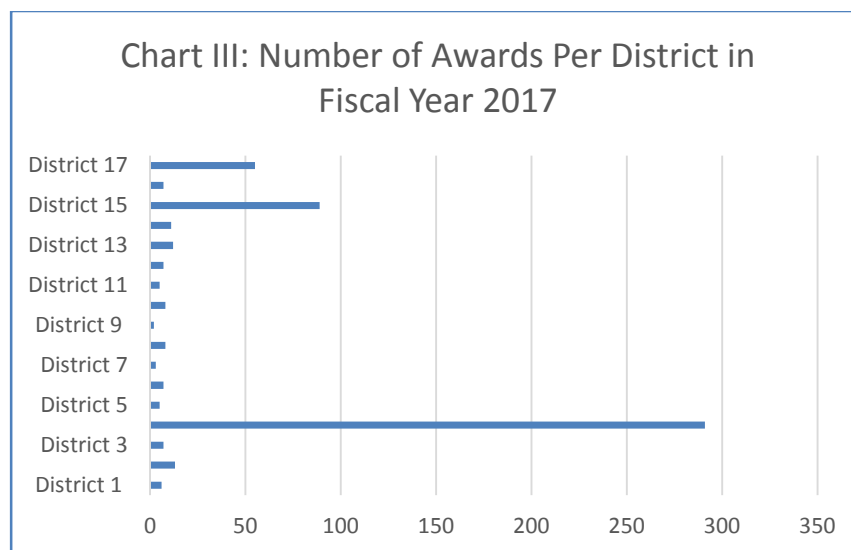
Through its grants, awards and scholarship programs, the ADAF invests in better oral health for all. Access to care, research and education programs support the achievement of optimal oral health.

Achievements:

- The ADAF awarded a total of \$1,674,579 in grants, awards and scholarships in 2017 (exclusive of GKAS in-kind product donations).
- The ADAF provided funding to 548 recipients in one or more of the following areas: charitable assistance, access to care, research and education.
- These awards positively reached all 17 districts, and promoted ADAF priorities in 31 states and territories including Puerto Rico and the Virgin Islands. See the [ADAF District Reports](#).
- The amount awarded for each ADAF dental student scholarship was increased from \$2,500 (approximately 52 scholarships) to \$20,000 (seven scholarships awarded in 2017–2018). This change was made in order to increase impact and help aid students with the rising cost of student debt.
- To support both oral cancer prevention and periodontal research, the ADAF will provide the VRC with more than \$856,000 in funding over a 24-month period to support new and ongoing initiatives. The funding will be directed toward one primary project related to oral cancer, and approximately three projects related to periodontal research. This funding is an investment in ADAF research that provides “seed money” for researchers who are in the midst of early research and allows them to be more competitive when they vie for larger grants in the future.



(Exclusive of GKAS in-kind product donations. The total for District 4 reflects ADA Foundation Emergency Disaster Grants to dentists affected by Hurricane Maria, primarily in Puerto Rico.)



(Exclusive of GKAS in-kind product donations. The total for District 4 reflects ADA Foundation Emergency Disaster Grants to dentists affected by Hurricane Maria, primarily in Puerto Rico.)

Future Priorities and Impact:

- Collaborate with ADA Member and Client Services to partner with identified priority state dental associations and provide State Collaboration Grants which will offer an opportunity for the ADAF to enhance relationships with state dental associations while at the same time supporting the ADA in their initiative to prioritize local and component societies.
- Determine the feasibility of implementing Community Dental Health Coordinator Scholarships in 2019.
- Implement a request for proposal for a new Senior American Access to Care Grant (for people ages 62 and over) to meet the rising need of older adults struggling with access to oral health care.
- Explore opportunities to collaborate with organizations that are leaders in providing dentistry to patients with special needs and provide grants to support these efforts and define innovative best practices.

Communications

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

Achievements:

- Created and published a series of [ADA Foundation District Impact Reports](#) that describe and quantify the ADAF's program impact in each state and district.
- At the request of the ADA and ADAF Boards, launched an [ADA Foundation Facebook page](#) in March 2018 (239 follows as of July 13, 2018).
- Continued to build engagement around the [Give Kids A Smile Facebook page](#) (7,412 follows as of July 13, 2018).
- Expanded the ADAF's presence at ADA 2017 beyond the organization's traditional booth on the exhibit floor, to include two additional booth presences: 1) at the headquarters hotel near Delegate registration, and 2) near the entrance to the House of Delegates.
- Coordinated an expanded ADAF fundraising effort during ADA 2017, resulting in \$56,331 in donations collected solely at the exhibit booth counters, with a total of \$108,390 in donations collected October 18– 31, 2017. Thank you to all who donated.

- Expanded the ADAF's website, ADAFoundation.org, to include the international volunteer opportunities search function and an in-depth "how to" guide on international volunteering, all of which was previously hosted by an outside vendor.
- Increased the ADAF visibility among American Student Dental Association (ASDA) members in an effort to build awareness among dental students to build and strengthen lifelong relationships. In addition to exhibiting at the two primary ASDA meetings each year, the ADAF invested in several paid "Mouthing Off" blog posts in 2018, including:
 - 1) Dr. Nipa Thakkar's "[Leadership After Graduation](#)"; and
 - 2) Jessica Latimer's "[Building leadership and service into your dental education.](#)"

Future Priorities and Impact:

- Develop ADAF messaging to communicate the positive impact of ADAF charitable programs and research, in order to engage current and future donors.
- Develop and implement a 90th anniversary promotional and fundraising campaign for the VRC.
- Increase engagement and communication with the ADA Washington, D.C. office and build on mutual areas of impact.
- Collaborate with ADA staff to increase the ADAF's presence in ADA-wide communications strategies and tactics throughout the next year.

ASDA and the New Dentist Committee

Achievements:

The ADAF is continuing its effort to grow awareness among dental students and young dentists to build and strengthen lifelong relationships. In addition to the previously mentioned ADAF promotions through ASDA's channels, Dr. Calnon gave a presentation about the ADAF to the New Dentist Committee at its July 14–15 meeting.

Future Priorities and Impact:

- Continue to increase general awareness of the ADAF's work to improve the oral health of the public among dental students and new dentists.
- Build lifelong relationships with individual dental students and new dentists in order to increase engagement with both volunteers and donors.

Development

Achievements:

The ADAF welcomed its new development team on board in April. Fundraising efforts are a priority and are underway.

Future Priorities and Impact:

The goal is to significantly increase fundraising activities, especially among individual donors including ADA member dentists, with strategic direction from the ADAF Board of Directors and the ADA Board of Trustees. Impact will not be seen immediately because time is needed to build an infrastructure, cultivate relationships with donors and build a pipeline of donors. Staff, along with the Development Committee, has finalized a development plan outline for the remainder of 2018. The development team will prepare a draft plan for fiscal year 2019 to present to the ADAF Board at its September 2018 meeting.

As part of the fundraising effort, the ADAF will:

- Continue the expanded ADAF presence and messaging at the ADA annual meeting.

- Increase communications about the research being done at the VRC in order to garner additional funds.
- Increase focus on underserved special needs and senior populations.
- Connect and collaborate with dental students and young dentists in order to foster lifelong relationships with their ADAF.
- Connect and collaborate with state dental executive directors, component dental societies, ADPAC and State PAC members to engage, educate and influence legislators and policymakers.



**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Consolidated Financial Statements and Supplemental Schedules

December 31, 2017 and 2016

(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, 2017 and 2016, 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, 2017 and 2016, 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 27, 2018

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Consolidated Statements of Financial Position

December 31, 2017 and 2016

Assets	2017	2016
Cash and cash equivalents	\$ 8,613,540	9,707,799
Receivables, net	9,536,703	7,720,912
Deferred taxes	19,657	58,266
Income taxes receivable	16,101	173,735
Prepaid expenses and other assets	5,207,002	4,180,207
Inventories, net	583,294	650,451
Marketable securities and alternative investments	166,895,820	160,950,809
Property and equipment, net	38,709,768	34,883,496
Funds held for deferred compensation	7,707,751	6,935,006
Total assets	<u>\$ 237,289,636</u>	<u>225,260,681</u>
Liabilities and Net Assets		
Accounts payable and accrued liabilities	\$ 9,727,089	14,765,443
Deferred revenue	13,453,314	13,414,062
Income taxes payable	—	500
Liability for deferred compensation	7,707,751	6,935,006
Postretirement benefit obligation	12,426,717	11,378,082
Pension liability	53,047,890	56,388,326
Total liabilities	<u>96,362,761</u>	<u>102,881,419</u>
Net assets:		
Unrestricted	123,987,908	106,690,579
Temporarily restricted	7,623,414	13,549,841
Permanently restricted	9,315,553	2,138,842
Total net assets	<u>140,926,875</u>	<u>122,379,262</u>
Total liabilities and net assets	<u>\$ 237,289,636</u>	<u>225,260,681</u>

See accompanying notes to consolidated financial statements.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Consolidated Statements of Activities

Years ended December 31, 2017 and 2016

	2017				2016			
	Unrestricted	Temporarily restricted	Permanently restricted	Total	Unrestricted	Temporarily restricted	Permanently restricted	Total
Revenue:								
Membership dues	\$ 56,457,565	—	—	56,457,565	54,476,016	—	—	54,476,016
Advertising	6,547,670	—	—	6,547,670	6,093,544	—	—	6,093,544
Rental income	6,086,183	—	—	6,086,183	3,920,757	—	—	3,920,757
Publication and product sales	6,411,076	—	—	6,411,076	6,422,985	—	—	6,422,985
Testing and accreditation fees	26,330,790	—	—	26,330,790	25,109,693	—	—	25,109,693
Meeting and seminar income	6,958,646	—	—	6,958,646	8,071,495	16,800	—	8,088,295
Grants, contributions, and sponsorships	1,801,992	4,017,542	—	5,819,534	2,147,294	4,028,321	—	6,175,615
Royalties and service fees	19,409,761	—	—	19,409,761	19,396,551	—	—	19,396,551
Investment income	20,312,539	2,048,966	—	22,361,505	7,170,676	752,208	—	7,922,884
Other income	3,432,778	35,500	—	3,468,278	2,993,748	—	—	2,993,748
Net assets released from restrictions	4,851,724	(4,851,724)	—	—	4,188,380	(4,188,380)	—	—
Total revenue	158,600,724	1,250,284	—	159,851,008	139,991,139	608,949	—	140,600,088
Expenses:								
Staff compensation, taxes, and benefits	65,214,268	—	—	65,214,268	62,940,063	—	—	62,940,063
Printing, publication, and marketing	10,747,110	—	—	10,747,110	9,288,362	—	—	9,288,362
Meeting expenses	2,385,869	—	—	2,385,869	2,565,711	—	—	2,565,711
Travel expenses	7,176,089	—	—	7,176,089	6,852,562	—	—	6,852,562
Consulting fees and outside services	18,343,228	—	—	18,343,228	10,237,532	—	—	10,237,532
Professional services	9,882,082	—	—	9,882,082	9,606,293	—	—	9,606,293
Office expenses	4,780,717	—	—	4,780,717	4,837,614	—	—	4,837,614
Facility and utility expenses	6,332,628	—	—	6,332,628	5,840,052	—	—	5,840,052
Grants and awards	6,476,060	—	—	6,476,060	6,220,560	—	—	6,220,560
Endorsement expenses	1,440,068	—	—	1,440,068	1,391,376	—	—	1,391,376
Depreciation and amortization	6,758,056	—	—	6,758,056	6,413,520	—	—	6,413,520
Bank and credit card fees	1,546,097	—	—	1,546,097	1,438,627	—	—	1,438,627
Other expenses	1,098,314	—	—	1,098,314	1,502,205	—	—	1,502,205
Total expenses	142,180,586	—	—	142,180,586	129,134,477	—	—	129,134,477
Net income from operations before income tax expense	16,420,138	1,250,284	—	17,670,422	10,856,662	608,949	—	11,465,611
Income tax expense	1,455,413	—	—	1,455,413	1,351,200	—	—	1,351,200
Net income	14,964,725	1,250,284	—	16,215,009	9,505,462	608,949	—	10,114,411
Pension – and postretirement health plan – related changes other than net periodic pension cost	2,332,604	—	—	2,332,604	(2,783,389)	—	—	(2,783,389)
Change in net assets	17,297,329	1,250,284	—	18,547,613	6,722,073	608,949	—	7,331,022
Net assets at beginning 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
Reclassification of temporarily restricted relief fund to an endowment fund	—	(7,176,711)	7,176,711	—	—	—	—	—
Net assets at end of year	\$ 123,987,908	7,623,414	9,315,553	140,926,875	106,690,579	13,549,841	2,138,842	122,379,262

See accompanying notes to consolidated financial statements.

**AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES**

Consolidated Statements of Cash Flows
Years ended December 31, 2017 and 2016

	<u>2017</u>	<u>2016</u>
Cash flows from operating activities:		
Change in net assets	\$ 18,547,613	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	(2,332,604)	2,783,389
Depreciation and amortization	6,758,056	6,413,520
Deferred income tax expense	38,609	840
Net change in unrealized appreciation in fair value of marketable securities and alternative investments	(13,935,109)	(5,424,449)
Net realized gain on sale of marketable securities and alternative investments	(5,551,828)	(7,565)
Net assets released from restrictions and used for operations	4,851,724	4,188,380
Change in actuarial value of gift annuity obligations	—	(49,538)
Provision for uncollectible accounts	(24,534)	85,007
Changes in assets and liabilities:		
Receivables, net	(1,791,257)	1,023,911
Income taxes payable (receivable), net	157,134	(340,640)
Prepaid expenses and other assets	(1,026,795)	(1,937,071)
Inventories, net	67,157	(62,147)
Accounts payable, accrued liabilities, and other liabilities	(5,038,354)	1,229,907
Deferred revenue	39,252	1,133,053
Postretirement benefit obligation	1,048,635	284,977
Pension liability	(1,007,832)	(541,130)
Net cash provided by operating activities	<u>799,867</u>	<u>16,111,466</u>
Cash flows from investing activities:		
Purchase of marketable securities and alternative investments	(30,526,868)	(47,152,071)
Sale and maturity of marketable securities and alternative investments	44,068,794	41,758,633
Acquisitions of property and equipment	(10,584,328)	(5,450,654)
Net cash provided by (used in) investing activities	<u>2,957,598</u>	<u>(10,844,092)</u>
Cash flows from financing activities:		
Net assets released from restrictions and used for operations	(4,851,724)	(4,188,380)
Payments to charitable gift annuitant	—	(15,002)
Net cash used in financing activities	<u>(4,851,724)</u>	<u>(4,203,382)</u>
Net increase (decrease) in cash and cash equivalents	(1,094,259)	1,063,992
Cash and equivalents at beginning of year	<u>9,707,799</u>	<u>8,643,807</u>
Cash and cash equivalents at end of year	<u>\$ 8,613,540</u>	<u>9,707,799</u>
Supplemental disclosure of cash flow information:		
Cash paid for income taxes, net	\$ 1,259,169	1,690,000

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, 2017 and 2016 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 \$141,480 and \$128,933 in 2017 and 2016, 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 is 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) 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.

(k) 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.

(l) 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 \$5,792,033 and \$4,829,263 at December 31, 2017 and 2016, 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.

(m) 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.

(n) 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.

(o) 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.

(p) 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 2017 or 2016.

The Association has disclosed investments for which fair value is measured using net asset value per share as a practical expedient outside the fair value hierarchy in accordance with ASC Subtopic 820-10.

(q) 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 is in the process of evaluating the impact of this statement and 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 is in the process of evaluating 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, 2017 and 2016 consist of the following:

	2017	2016
Trade receivables	\$ 4,317,866	3,971,299
Royalties receivable	2,271,155	2,326,268
Grants and contracts receivable	33,929	276,199
Tenant receivables	3,675,663	1,634,652
Pledges receivable	42,915	435,510
Other	100,094	76,317
Total	10,441,622	8,720,245
Less allowance for doubtful receivables	(904,919)	(999,333)
Net receivables	<u>\$ 9,536,703</u>	<u>7,720,912</u>

Unconditional promises for which payment has not been received are recorded in the consolidated financial statements as pledges receivable and revenue of the appropriate net asset category.

Unconditional promises are expected to be realized in the following periods from December 31, 2017 and 2016:

	2017	2016
Unconditional promises to give	\$ 42,915	442,330
Less unamortized discount	—	(6,820)
	42,915	435,510
Less allowance for uncollectible pledges	(900)	(800)
Net pledges receivable	<u>\$ 42,015</u>	<u>434,710</u>
Amounts due in:		
Less than one year	\$ 41,765	432,185
One to five years	250	2,525
Total	<u>\$ 42,015</u>	<u>434,710</u>

(3) Marketable Securities and Alternative Investments

Marketable securities at December 31, 2017 and 2016 consisted of the following:

	2017	
	Cost	Market
Money market funds	\$ 32,816	32,816
Bonds and bond funds	49,571,404	48,665,398
Equities and equity funds	86,456,881	100,194,409
Alternative investment funds	14,542,396	18,003,197
	<u>\$ 150,603,497</u>	<u>166,895,820</u>

	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
	<u>\$ 159,566,636</u>	<u>160,950,809</u>

The fair value of marketable securities and alternative investments held in the Reserve Division amounted to \$124,569,044 and \$121,017,646 at December 31, 2017 and 2016, respectively.

Investment income is included in the accompanying consolidated statements of activities for the years ended December 31, 2017 and 2016 as follows:

	2017	2016
Interest and dividends	\$ 2,874,568	2,490,870
Change in net unrealized appreciation in fair value of marketable securities and alternative investments	13,935,109	5,424,449
Net realized gain on sale of marketable securities and alternative investments	<u>5,551,828</u>	<u>7,565</u>
Total investment income	<u>\$ 22,361,505</u>	<u>7,922,884</u>

(4) Fair Value Measurements

(a) Fair Value of Financial Instruments

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

- The carrying amount reported in the consolidated statements of financial position for the following approximates fair value because of the short maturities of these instruments: cash equivalents, accounts payable, and accrued liabilities.
- Fair values of the Association's investments held as marketable securities are estimated based on prices provided by its investment managers and its custodian bank. Fair value for money market funds, equities and equity funds, 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 includes 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, 2017 and 2016:

	2017				Redemption or liquidation	Days' notice
	Level 1	Level 2	Level 3	Total		
Cash and cash equivalents	\$ 8,613,540	—	—	8,613,540	Daily	One
Marketable securities and alternative investment funds:						
Money market funds	32,816	—	—	32,816	Daily	One
Fixed income mutual funds	48,568,111	—	—	48,568,111	Daily	One
Equity mutual funds	100,194,409	—	—	100,194,409	Daily	One
Corporate bonds	—	97,287	—	97,287	Daily	One
Alternative investment funds:						
Blackstone Partners Offshore Fund (1)				9,162,942	Semiannual	95
Wellington Archipelago Fund (1)				8,840,255	Quarterly	45
Total alternative investment funds				18,003,197		
Total marketable securities and alternative investment funds	148,795,336	97,287	—	166,895,820		

	2017				Redemption or liquidation	Days' notice
	Level 1	Level 2	Level 3	Total		
Funds held for deferred compensation:						
Money market funds	\$ 1,140,664	—	—	1,140,664	Daily	One
Equity mutual funds	5,146,303	—	—	5,146,303	Daily	One
Fixed income mutual funds	518,986	—	—	518,986	Daily	One
Corporate bonds	—	901,798	—	901,798	Daily	One
Total funds held for deferred compensation	6,805,953	901,798	—	7,707,751		
Total assets at fair value	\$ 164,214,829	999,085	—	183,217,111		

- (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.

	2016				Redemption or liquidation	Days' notice
	Level 1	Level 2	Level 3	Total		
Cash and cash equivalents	\$ 9,707,799	—	—	9,707,799	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		

	2016				Redemption or liquidation	Days' notice
	Level 1	Level 2	Level 3	Total		
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	\$ 160,262,115	943,695	—	177,593,614		

(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, 2017 and 2016.

The Association is invested in alternative investment funds at December 31, 2017 and 2016 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 \$18,003,197 and \$16,387,804 at December 31, 2017 and 2016, 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, 2017 and 2016 consisted of the following:

	2017		
	Chicago, IL	Washington, D.C.	Total
Land	\$ 712,113	3,030,000	3,742,113
Building	12,381,169	11,572,308	23,953,477
Building improvements	75,208,430	4,301,067	79,509,497
Furniture and equipment	54,654,950	1,335,988	55,990,938
Tenant leasehold improvements	9,597,654	3,212,105	12,809,759
	<u>152,554,316</u>	<u>23,451,468</u>	<u>176,005,784</u>
Less accumulated depreciation and amortization	<u>122,091,412</u>	<u>15,204,604</u>	<u>137,296,016</u>
	<u>\$ 30,462,904</u>	<u>8,246,864</u>	<u>38,709,768</u>
	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	3,057,310	6,037,833
	<u>142,455,842</u>	<u>22,965,614</u>	<u>165,421,456</u>
Less accumulated depreciation and amortization	<u>116,406,077</u>	<u>14,131,883</u>	<u>130,537,960</u>
	<u>\$ 26,049,765</u>	<u>8,833,731</u>	<u>34,883,496</u>

The Association leases portions of both the headquarters building in Chicago, Illinois, and the Washington, D.C. office building to unrelated parties under operating leases with varying terms. These amounts may be adjusted upon renewal of the leases. Minimum future rentals to be earned from leases currently in effect as of December 31, 2017 are as follows:

2018	\$ 5,831,996
2019	6,171,285
2020	5,162,909
2021	4,861,942
2022	4,301,363
Thereafter	<u>35,037,367</u>
	<u>\$ 61,366,862</u>

Building expenses include the cost of facilities occupied by the Association, as well as those costs related to other tenants.

(6) Deferred Compensation

Pursuant to agreements between the Association and certain officers and employees of the Association and its affiliates, portions of their compensation have been retained by the Association and invested as directed by those participants. The assets are owned by the Association until distributed to the participants after termination of employment or services.

(7) Income Taxes

On December 22, 2017, the President signed into law H.R. 1, originally known as the Tax Cuts and Jobs Act. The new law includes several provisions that result in substantial changes to the tax treatment of tax-exempt organizations and their donors. The Association has reviewed these provisions and the potential impact and concluded the enactment of H.R. 1 will not have a material effect on the operations of the organization.

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 \$19,657 and \$58,266 as of December 31, 2017 and 2016, 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 \$3,187 and \$4,578 at December 31, 2017 and 2016, 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, 2017 and 2016. Income tax expense for the years ended December 31, 2017 and 2016 is as follows:

	<u>2017</u>	<u>2016</u>
Current:		
Federal	\$ 1,109,008	1,022,291
State	<u>307,796</u>	<u>328,909</u>
Current income tax expense	<u>1,416,804</u>	<u>1,351,200</u>
Deferred:		
Federal	32,666	76,753
State	7,334	11,547
Change in valuation allowance	<u>(1,391)</u>	<u>(88,300)</u>
Deferred income tax expense	<u>38,609</u>	<u>—</u>
Income tax expense	<u>\$ 1,455,413</u>	<u>1,351,200</u>

Net deferred tax assets at December 31, 2017 and 2016 consisted of the following:

	<u>2017</u>	<u>2016</u>
Deferred tax assets resulting from:		
Postretirement health benefits	\$ 40,628	58,266
Depreciation	491	—
Unrealized appreciation in fair value of marketable securities	(21,462)	—
Capital loss carryforward	<u>3,187</u>	<u>4,578</u>
Total deferred tax assets, net	22,844	62,844
Valuation allowance	<u>(3,187)</u>	<u>(4,578)</u>
Total deferred tax assets, net of valuation allowance	\$ <u><u>19,657</u></u>	<u><u>58,266</u></u>

(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 2017 and 2016.

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:

	2017		
	Employees' retirement trust	Employees' supplemental trust	Total
Change in projected benefit obligation:			
Projected benefit obligation, beginning of year	\$ 205,456,084	1,441,960	206,898,044
Service cost	2,220,788	—	2,220,788
Interest cost	9,475,132	65,593	9,540,725
Actuarial loss	18,673,042	109,486	18,782,528
Benefits paid	(10,509,488)	(92,796)	(10,602,284)
Projected benefit obligation, end of year	\$ <u>225,315,558</u>	<u>1,524,243</u>	<u>226,839,801</u>
Change in plan assets:			
Fair value of plan assets, beginning of year	\$ 150,509,718	—	150,509,718
Actual return on plan assets	27,616,681	—	27,616,681
Employer contributions	6,175,000	92,796	6,267,796
Benefits paid	(10,509,488)	(92,796)	(10,602,284)
Fair value of plan assets, end of year	\$ <u>173,791,911</u>	<u>—</u>	<u>173,791,911</u>
Funded status, end of year:			
Fair value of plan assets	\$ 173,791,911	—	173,791,911
Benefit obligation	<u>225,315,558</u>	<u>1,524,243</u>	<u>226,839,801</u>
Funded status	\$ <u>(51,523,647)</u>	<u>(1,524,243)</u>	<u>(53,047,890)</u>
Amounts recognized in the accompanying consolidated statements of financial position:			
Pension liability	\$ 51,523,647	1,524,243	53,047,890
Accumulated benefit obligation in net periodic benefit expense and included as accumulated charges to unrestricted net assets:			
Prior service cost	\$ (3,953,493)	—	(3,953,493)
Net actuarial loss	<u>76,358,099</u>	<u>—</u>	<u>76,358,099</u>
Net amounts included as an accumulated charge to unrestricted net assets	\$ <u>72,404,606</u>	<u>—</u>	<u>72,404,606</u>

	2017		
	Employees' retirement trust	Employees' supplemental trust	Total
Components of net periodic benefit cost:			
Service cost	\$ 2,220,788	—	2,220,788
Interest cost	9,475,132	65,593	9,540,725
Expected return on plan assets	(10,514,860)	—	(10,514,860)
Prior service cost	(1,491,883)	—	(1,491,883)
Recognized net loss	7,191,278	—	7,191,278
Net periodic benefit cost	<u>\$ 6,880,455</u>	<u>65,593</u>	<u>6,946,048</u>
Calculation of change in unrestricted net assets:			
Accumulated unrestricted net assets, end of year	\$ 72,404,606	—	72,404,606
Reversal of accumulated unrestricted net assets, prior year	<u>(76,423,294)</u>	<u>—</u>	<u>(76,423,294)</u>
Change in unrestricted net assets, prior year	<u>\$ (4,018,688)</u>	<u>—</u>	<u>(4,018,688)</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:			
Net loss experienced during the year	\$ 1,680,707	—	1,680,707
Amortization of prior service cost due to plan amendments	1,491,883	—	1,491,883
Amortization of unrecognized net loss	<u>(7,191,278)</u>	<u>—</u>	<u>(7,191,278)</u>
Net amounts recognized in unrestricted net assets	<u>\$ (4,018,688)</u>	<u>—</u>	<u>(4,018,688)</u>
Estimate of amounts that will be amortized out of unrestricted net assets into net pension expense in 2018:			
Net loss	\$ 6,134,185	—	6,134,185
Prior service cost	(1,491,883)	—	(1,491,883)
Weighted average assumptions as of December 31:			
Discount rate	4.03%	4.03%	
Expected return on plan assets	7.20	7.20	
Rate of compensation increase	3.00	3.00	

	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	<u>\$ 205,456,084</u>	<u>1,441,960</u>	<u>206,898,044</u>
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	<u>\$ 150,509,718</u>	<u>—</u>	<u>150,509,718</u>
Funded status, end of year:			
Fair value of plan assets	\$ 150,509,718	—	150,509,718
Benefit obligation	<u>205,456,084</u>	<u>1,441,960</u>	<u>206,898,044</u>
Funded status	<u>\$ (54,946,366)</u>	<u>(1,441,960)</u>	<u>(56,388,326)</u>
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:			
Prior service cost	\$ (5,445,376)	—	(5,445,376)
Net actuarial loss	<u>81,868,670</u>	<u>—</u>	<u>81,868,670</u>
Net amounts included as an accumulated charge to unrestricted net assets	<u>\$ 76,423,294</u>	<u>—</u>	<u>76,423,294</u>

	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	<u>\$ 5,795,421</u>	<u>67,460</u>	<u>5,862,881</u>
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, prior year	(74,451,120)	—	(74,451,120)
Change in unrestricted net assets	<u>\$ 1,972,174</u>	<u>—</u>	<u>1,972,174</u>
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	<u>\$ 1,972,174</u>	<u>—</u>	<u>1,972,174</u>
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	

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 \$6,267,796 to the Plan in 2017. The minimum funding contributions for the Plan years 2017 and 2016 were \$6,089,090 and \$5,424,172, 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:

2018	\$ 10,366,034
2019	10,573,642
2020	11,102,738
2021	11,781,151
2022	11,997,460
Thereafter	<u>66,913,650</u>
	<u>\$ 122,734,675</u>

The expected benefits are based on the same assumptions used to measure the Association's benefit obligations at December 31 and include estimated future employee service.

The actual allocations for the pension assets as of December 31, 2017 and 2016, and target allocations by asset category, are as follows:

Asset category	2017	
	Actual allocation	Target allocation
Fixed income	38%	40%
Equity:		
Domestic small cap	12	11
Domestic large cap value	10	10
Domestic large cap growth	18	18
International	22	21
	<u>100%</u>	<u>100%</u>

Asset category	2016	
	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
	<u>100%</u>	<u>100%</u>

Pension assets are allocated with a goal to achieve diversification between and within various asset classes. The target asset allocations are expected to earn an average annual rate of return of approximately 7.2% 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, 2017 and 2016.

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 and common collective trust fund: 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 transfers into or out of Level 1, Level 2, or Level 3 during the year ended December 31, 2017 or 2016.

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2017 and 2016:

	2017				Redemption or liquidation	Days' notice
	Total	Level 1	Level 2	Level 3		
Guaranteed investment contract (1)	\$ 1,576,242				Daily	One
Common Collective Trust fund:						
William Blair Small-Mid Cap Growth Fund	9,690,150	9,690,150	—	—	Daily	Ten
Equity mutual funds:						
Dodge & Cox Stock Fund	17,729,996	17,729,996	—	—	Daily	One
Vaughan Nelson Opportunity Fund	9,719,333	9,719,333	—	—	Daily	One
Vanguard Institutional Index Fund	13,927,797	13,927,797	—	—	Daily	One
T. Rowe Price Growth Fund	17,503,512	17,503,512	—	—	Daily	One
Templeton Institutional Funds, Inc.						
International Equity series	18,854,716	18,854,716	—	—	Daily	One
GMO International equity fund	19,003,469	19,003,469	—	—	Daily	One
Total equity mutual funds	96,738,823	96,738,823	—	—		
Fixed income mutual funds:						
Vanguard Intermediate-Term Index Bond Fund	10,413,077	10,413,077	—	—	Daily	One
Vanguard Long-Term Bond Index Fund	17,830,046	17,830,046	—	—	Daily	One
Vanguard Long-Term Corporate Bond Fund	37,572,821	37,572,821	—	—	Daily	One
Total fixed income mutual funds	65,815,944	65,815,944	—	—		
Accrued fees	(29,248)	—	—	—		
Total	\$ 173,791,911	172,244,917	—	—		

- (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.

	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.

(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 2017 and 2016, the Association contributed 4% per year of each eligible employee's base salary. The Association's contributions under the plan were \$1,607,657 and \$1,641,844 in 2017 and 2016, 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. No payments were made to participants in 2017. Payments totaling \$18,096 were made to participants in 2016. In 2013, the Association decided to terminate the plan, and accordingly, no awards were earned in 2017 or 2016. The plan was phased out by the end of 2017 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 2017 and 2016, 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 2017 and 2016, 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:

	<u>2017</u>	<u>2016</u>
Change in benefit obligation:		
Benefit obligation, beginning of year	\$ 11,378,082	11,093,105
Service cost	351,296	359,269
Interest cost	507,912	510,886
Actuarial loss (gain)	535,267	(273,594)
Benefits paid	<u>(345,840)</u>	<u>(311,584)</u>
Benefit obligation, end of year	\$ <u>12,426,717</u>	<u>11,378,082</u>
Change in plan assets:		
Employer contributions	\$ 345,840	311,583
Benefits paid	<u>(345,840)</u>	<u>(311,583)</u>
Plan assets, end of year	\$ <u>—</u>	<u>—</u>
Funded status, end of year:		
Benefit obligation	\$ 12,426,717	11,378,082
Accumulated benefit obligation	12,426,717	11,378,082

	<u>2017</u>	<u>2016</u>
Components of net periodic benefit cost:		
Service cost	\$ 351,296	359,269
Interest cost	507,912	510,886
Amortization of prior service cost	(1,459,910)	(1,459,910)
Recognized net loss	<u>309,093</u>	<u>375,101</u>
Net periodic benefit cost	<u>\$ (291,609)</u>	<u>(214,654)</u>
Amounts recognized in the accompanying consolidated statements of financial position:		
Postretirement benefit obligation	\$ 12,426,717	11,378,082
Amounts not yet reflected in net periodic benefit expense and included as accumulated charges to unrestricted net assets:		
Net actuarial loss	\$ 4,771,552	4,545,378
Prior service cost	<u>(4,759,303)</u>	<u>(6,219,213)</u>
Net amounts included as an accumulated charge to unrestricted net assets	<u>\$ 12,249</u>	<u>(1,673,835)</u>
Calculation of change in unrestricted net assets:		
Accumulated unrestricted net assets, end of year	\$ 12,249	(1,673,835)
Reversal of accumulated unrestricted net assets, prior year	<u>1,673,835</u>	<u>2,485,050</u>
Change in unrestricted net assets	<u>\$ 1,686,084</u>	<u>811,215</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net loss (gain) experienced during the year	\$ 535,267	(273,594)
Amortization of net loss	(309,093)	(375,101)
Amortization of prior service cost	<u>1,459,910</u>	<u>1,459,910</u>
Net amounts recognized in unrestricted net assets	<u>\$ 1,686,084</u>	<u>811,215</u>
Estimate of amounts that will be amortized out of unrestricted net assets into net postretirement benefit expense in 2017 and 2016:		
Net gain	\$ (209,269)	(204,040)
Prior service cost	<u>(1,459,910)</u>	<u>(1,459,910)</u>

	<u>2017</u>	<u>2016</u>
Weighted average assumptions used to determine obligations at December 31:		
Discount rate	4.03%	4.68%
Weighted average assumptions used to determine net periodic benefit cost for the years ended December 31:		
Discount rate	4.68%	4.86%
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:

	<u>Gross payments</u>
2018	\$ 473,815
2019	515,626
2020	552,794
2021	576,291
2022	603,306
2023–2026	3,453,508

(9) Net Assets

Temporarily restricted net assets at December 31, 2017 and 2016 were available for the following purposes:

	<u>2017</u>	<u>2016</u>
Campaign for innovation in dental education	\$ —	74,961
Trusts	1,187,485	1,138,301
Extramural programs	113,520	113,520
Research	1,491,713	1,468,739
Awards	134,931	154,960
Education	521,212	460,805
Access	2,654,044	2,562,986
Political and legislative	948,774	589,638
Relief Program	571,735	6,985,931
	<u>\$ 7,623,414</u>	<u>13,549,841</u>

Temporarily restricted trusts include funds restricted by donors for periodontal research, public education in dental health, and memorial commemoration.

Temporarily restricted net assets were released from donor restrictions during 2017 and 2016 by incurring expenses satisfying the restricted purposes as follows:

	<u>2017</u>	<u>2016</u>
Campaign for innovation in dental education	\$ —	59,623
Trusts	768	535
Research	46,002	468
Awards	40,079	35,062
Education	77,416	21,579
Access	2,957,200	1,991,327
Political and legislative	1,397,728	1,893,047
Relief Program	<u>332,531</u>	<u>186,739</u>
	<u>\$ 4,851,724</u>	<u>4,188,380</u>

Permanently restricted net assets totaled \$9,315,553 and \$2,138,842 at December 31, 2017 and 2016 respectively. 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 approached the Illinois Attorney General about lifting the restriction on a portion of the Relief Fund due to its large size. The Illinois Attorney General agreed to modify the restriction, but in an alternative way. The Illinois Attorney General agreed that (i) the entire fund would be converted to a permanent endowment fund from which the ADAF Board would determine the prudent level of annual expenditure; and (ii) the annual expenditure would be applied first to fund Relief Grants, and the excess, if any, would be limited to the following purposes, which the Attorney General viewed as more closely aligned with the original purpose of the Relief Fund: (a) dental service to underserved and vulnerable populations; (b) scholarships to disadvantaged dental students; (c) public education and outreach about oral health to underserved and vulnerable populations; (d) emergency dental care in disaster-stricken communities, or emergency assistance to dentists who are victims of disaster. The Circuit Court of Cook County – Chancery Division agreed.

Accordingly, \$7,176,711 of previously reported temporarily restricted net assets have been reclassified as permanently restricted net assets in the 2017 consolidated financial statements. This is included as reclassification of temporarily restricted relief fund to an endowment fund in the accompanying 2017 consolidated statement of activities. The purpose of the relief fund is, first and foremost, to support the relief program (Relief Program), which provides financial assistance to dentists and their dependents who, because of accidental injury, a medical condition, or advanced age, are not self-supporting. If there are funds available in a given year, after fulfilling support for the Relief Program, they may be used to fund for the four enumerated purposes outlined above.

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 2017 and 2016, the ADAF had the following activities related to endowment net assets:

	2017			
	Unrestricted	Temporarily restricted	Permanently restricted	Total
Endowment net assets, beginning of year	\$ —	790,743	2,138,842	2,929,585
Investment returns:				
Interest and dividends	—	71,805	—	71,805
Realized gain on sale of investments	—	76,451	—	76,451
Net unrealized appreciation on investments	—	443,321	—	443,321
Total investment returns	—	591,577	—	591,577
Investment management fee	—	(1,568)	—	(1,568)
Appropriation of endowment assets for expenditures	—	(100,987)	—	(100,987)
Reclassification of temporarily restricted relief fund to an endowment fund	—	—	7,176,711	7,176,711
Total change in endowment net assets	—	489,022	7,176,711	7,665,733
Endowment net assets, end of year	\$ —	1,279,765	9,315,553	10,595,318

		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

(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, 2017 and 2016:

	2017	2016
General fund:		
Administrative services	\$ 7,217,165	6,829,860
Human resources	1,844,337	2,146,093
Legal affairs	4,078,323	4,033,052
Government affairs	9,455,045	9,064,568
Communications	7,973,539	6,630,280
Membership and dental society services	7,282,515	7,659,951
Conference and meeting services	8,071,914	9,093,441
Finance and operations	12,293,356	11,302,085

	2017	2016
Salable materials	\$ 4,704,674	4,050,307
Central administration	8,271,841	8,040,385
Information technology and standards	13,641,961	13,083,831
Dental practice	5,187,393	5,361,974
Health policy resources center	2,629,275	2,696,758
Education	15,687,798	15,565,268
Science	5,168,473	4,941,358
Publishing	7,941,903	7,583,952
Business relations	—	641,679
Activities funded from reserves	9,345,781	327,468
Grant from ADA to ADAF	3,679,000	2,361,000
	<u>134,474,293</u>	<u>121,413,310</u>
Reserve division investment account	667,255	(232,566)
Eliminations of intercompany activities:		
Grant from ADA to ADAF	(3,679,000)	(2,361,000)
Headquarters building management office rent expense	(31,392)	(31,392)
	<u>131,431,156</u>	<u>118,788,352</u>
ADPAC total expenses including income tax expense	2,709,066	2,898,260
ADAF total expenses	9,873,223	8,907,908
ADABEI total expenses including income tax expense	2,271,918	2,185,783
Eliminations of intercompany activities:		
ADABEI rental charges	(99,985)	(102,650)
Staffing, compensation, and benefits	(783,440)	(767,984)
Professional services	(36,378)	(40,488)
Printing, publication, and marketing	(231,312)	(176,069)
Research expenses	(72,500)	(80,000)
Overhead recovery	(114,411)	(112,724)
In-kind administrative expenses	(1,311,338)	(1,014,711)
	<u>(1,311,338)</u>	<u>(1,014,711)</u>
Total expenses including income tax expense	<u>\$ 143,635,999</u>	<u>130,485,677</u>

(12) Commitments and Contingencies

Although management is not aware of any pending or threatened litigation, the Association may be subject to legal actions, claims, and proceedings arising in the ordinary course of business. The ultimate resolution of these matters, including any related financial effects on the Association, would be addressed if and when they are known. The Association has not provided for any potential future losses arising from the resolution of these matters in the accompanying consolidated financial statements. Despite the inherent uncertainties of litigation, management does not believe that the lawsuits would have a material adverse impact on the financial condition of the Association at this time.

(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, 2017 through June 27, 2018, 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, 2017

General fund											
Assets	Operating division	Reserve division					ADPAC	ADAF	ADABEI	Eliminations	Total
	Operating account	Capital formation account	Capital fund	Reserve royalties fund	Investment account	Total general fund					
Cash and cash equivalents	\$ 6,375,410	—	—	—	—	6,375,410	904,719	503,628	829,783	—	8,613,540
Receivables, net	8,818,174	—	—	—	—	8,818,174	—	118,483	600,046	—	9,536,703
Due from affiliates	912,139	—	—	—	(1,054,945)	(142,806)	—	327,164	(184,358)	—	—
Deferred taxes	—	—	—	—	—	—	—	—	19,657	—	19,657
Income taxes receivable	(166,044)	—	—	—	—	(166,044)	—	—	182,145	—	16,101
Prepaid expenses and other assets	5,149,519	—	—	—	—	5,149,519	46,584	10,899	—	—	5,207,002
Inventories, net	583,294	—	—	—	—	583,294	—	—	—	—	583,294
Marketable securities and alternative investments	14,575,502	—	2,687,448	38,579,764	83,301,832	139,144,546	—	25,792,501	1,958,773	—	166,895,820
Investment in subsidiaries	—	3,134,238	—	—	—	3,134,238	—	—	—	(3,134,238)	—
Property and equipment, net	37,972,645	—	—	—	—	37,972,645	—	716,073	21,050	—	38,709,768
Funds held for deferred compensation	7,707,751	—	—	—	—	7,707,751	—	—	—	—	7,707,751
Total assets	\$ 81,928,390	3,134,238	2,687,448	38,579,764	82,246,887	208,576,727	951,303	27,468,748	3,427,096	(3,134,238)	237,289,636
Liabilities and Net Assets											
Accounts payable and accrued liabilities	\$ 8,657,094	—	—	—	—	8,657,094	2,529	754,285	313,181	—	9,727,089
Deferred revenue	13,453,314	—	—	—	—	13,453,314	—	500,000	—	(500,000)	13,453,314
Liability for deferred compensation	7,707,751	—	—	—	—	7,707,751	—	—	—	—	7,707,751
Postretirement benefit obligation	—	—	—	—	12,426,717	12,426,717	—	—	—	—	12,426,717
Pension liability	53,047,890	—	—	—	—	53,047,890	—	—	—	—	53,047,890
Total liabilities	82,866,049	—	—	—	12,426,717	95,292,766	2,529	1,254,285	313,181	(500,000)	96,362,761
Net assets (deficit):											
Common stock	—	—	—	—	—	—	—	—	100,100	(100,100)	—
Additional paid-in capital	—	—	—	—	—	—	—	—	500,000	(500,000)	—
Unrestricted	(937,659)	3,134,238	2,687,448	38,579,764	69,820,170	113,283,961	—	10,224,270	2,513,815	(2,034,138)	123,987,908
Temporarily restricted	—	—	—	—	—	—	948,774	6,674,640	—	—	7,623,414
Permanently restricted	—	—	—	—	—	—	—	9,315,553	—	—	9,315,553
Total net assets (deficit)	(937,659)	3,134,238	2,687,448	38,579,764	69,820,170	113,283,961	948,774	26,214,463	3,113,915	(2,634,238)	140,926,875
Total liabilities and net assets	\$ 81,928,390	3,134,238	2,687,448	38,579,764	82,246,887	208,576,727	951,303	27,468,748	3,427,096	(3,134,238)	237,289,636

See accompanying independent auditors' report.

Schedule 2

AMERICAN DENTAL ASSOCIATION
AND SUBSIDIARIES

Consolidated Statement of Activities with Supplementary Consolidating Information

Year ended December 31, 2017

	General fund										
	Operating division	Reserve division				Total general fund	ADPAC	ADAF	ADABEI	Eliminations	Total
	Operating account	Capital formation account	Capital fund	Reserve royalties fund	Investment account						
Revenue:											
Membership dues	\$ 56,457,565	—	—	—	—	56,457,565	—	—	—	—	56,457,565
Advertising	6,743,770	—	—	—	—	6,743,770	—	—	—	(196,100)	6,547,670
Rental income	6,217,560	—	—	—	—	6,217,560	—	—	—	(131,377)	6,086,183
Publication and product sales	6,441,288	—	—	—	—	6,441,288	—	—	—	(30,212)	6,411,076
Testing and accreditation fees	26,330,790	—	—	—	—	26,330,790	—	—	—	—	26,330,790
Meeting and seminar income	6,926,246	—	—	—	—	6,926,246	—	32,400	—	—	6,958,646
Grants, contributions, and sponsorships	1,088,039	—	—	—	—	1,088,039	1,720,882	3,088,113	—	(77,500)	5,819,534
Grant from ADA	—	—	—	—	—	—	—	3,179,000	—	(3,179,000)	—
Royalties and service fees	16,923,756	—	—	—	—	16,923,756	—	56,719	2,429,286	—	19,409,761
Investment income	2,376,116	290,874	—	5,322,938	11,402,967	19,392,895	482	3,146,505	112,497	(290,874)	22,361,505
Other income	3,582,797	—	—	—	—	3,582,797	35,500	88	686	(150,793)	3,468,278
In-kind services	—	—	—	—	—	—	1,311,338	783,440	—	(2,094,778)	—
Total revenue	133,087,927	290,874	—	5,322,938	11,402,967	150,104,706	3,068,202	10,286,265	2,542,469	(6,150,634)	159,851,008
Expenses:											
Staff compensation, taxes, and benefits	59,966,287	—	—	—	657,032	60,623,319	—	4,636,164	738,225	(783,440)	65,214,268
Printing, publication, and marketing	9,697,253	—	—	—	—	9,697,253	125,919	280,750	869,093	(225,905)	10,747,110
Meeting expenses	2,265,965	—	—	—	—	2,265,965	33,277	63,766	22,861	—	2,385,869
Travel expenses	6,736,795	—	—	—	—	6,736,795	11,840	385,571	41,883	—	7,176,089
Consulting fees and outside services	17,760,589	—	—	—	—	17,760,589	147,398	406,751	28,490	—	18,343,228
Professional services	9,333,631	—	—	—	10,223	9,343,854	17,140	437,200	120,266	(36,378)	9,882,082
Office expenses	4,415,395	—	—	—	—	4,415,395	20,191	331,342	19,196	(5,407)	4,780,717
Facility and utility expenses	6,361,602	—	—	—	—	6,361,602	—	112	102,291	(131,377)	6,332,628
Grants and awards	2,373,074	—	—	—	—	2,373,074	1,011,050	3,138,936	25,500	(72,500)	6,476,060
Grant to ADA Foundation	3,679,000	—	—	—	—	3,679,000	—	—	—	(3,679,000)	—
Endorsement expenses	1,440,068	—	—	—	—	1,440,068	—	—	—	—	1,440,068
Depreciation and amortization	6,629,171	—	—	—	—	6,629,171	—	126,546	2,339	—	6,758,056
Bank and credit card fees	1,507,452	—	—	—	—	1,507,452	30,413	7,700	532	—	1,546,097
Other expenses	1,029,568	—	—	—	—	1,029,568	—	58,385	124,776	(114,415)	1,098,314
In-kind administrative expenses	—	—	—	—	—	—	1,311,338	—	—	(1,311,338)	—
Total expenses	133,195,850	—	—	—	667,255	133,863,105	2,708,566	9,873,223	2,095,452	(6,359,760)	142,180,586
Net income (loss) from operations before income tax expense	(107,923)	290,874	—	5,322,938	10,735,712	16,241,601	359,636	413,042	447,017	209,126	17,670,422
Income tax expense	1,278,447	—	—	—	—	1,278,447	500	—	176,466	—	1,455,413
Net income (loss)	(1,386,370)	290,874	—	5,322,938	10,735,712	14,963,154	359,136	413,042	270,551	209,126	16,215,009
Pension—and postretirement health plan—related changes other than net periodic pension cost	4,018,688	—	—	—	(1,686,084)	2,332,604	—	—	—	—	2,332,604
Change in net assets	2,632,318	290,874	—	5,322,938	9,049,628	17,295,758	359,136	413,042	270,551	209,126	18,547,613
Net assets (deficit) at beginning 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
Equity transfers	9,378,268	—	—	6,574,890	(12,777,812)	—	—	—	—	—	—
Net assets (deficit) at end of year	\$ (937,659)	3,134,238	2,687,448	38,579,764	69,820,170	113,283,961	948,774	26,214,463	2,513,815	(2,034,138)	140,926,875

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, 2017

	General fund					ADPAC	ADAF	ADABEI	Eliminations	Total	
	Operating division	Reserve division									
	Operating account	Capital formation account	Capital fund	Reserve royalties fund	Investment account						Total general fund
Cash flows from operating activities:											
Change in net assets	\$ 2,632,318	290,874	—	5,322,938	9,049,628	17,295,758	359,136	413,042	270,551	209,126	18,547,613
Adjustments to reconcile change in net assets to net cash provided by (used in) operating activities:											
Pension—and postretirement health plan—related changes other than net periodic pension cost	(4,018,688)	—	—	—	1,686,084	(2,332,604)	—	—	—	—	(2,332,604)
Depreciation and amortization	6,629,171	—	—	—	—	6,629,171	—	126,546	2,339	—	6,758,056
Deferred income tax expense	—	—	—	—	—	—	—	—	38,609	—	38,609
Net unrealized appreciation in fair value of marketable securities and alternative investments	10,422	—	—	(3,126,342)	(8,529,848)	(11,645,768)	—	(2,212,190)	(77,151)	—	(13,935,109)
Net realized loss (gain) on sale of marketable securities and alternative investments	8,256	—	—	—	(5,069,717)	(5,061,461)	—	(490,119)	(248)	—	(5,551,828)
Net assets released from restrictions and used for operations	—	—	—	—	—	—	1,397,728	3,453,996	—	—	4,851,724
Change in actuarial value of gift annuity obligations	—	—	—	—	—	—	—	—	—	—	—
Provision for uncollectible accounts	(34,134)	—	—	—	—	(34,134)	—	9,600	—	—	(24,534)
Equity in net income of other investments	—	(290,874)	—	—	—	(290,874)	—	—	—	290,874	—
Changes in assets and liabilities:											
Receivables, net	(2,344,462)	—	—	—	—	(2,344,462)	10,000	579,886	(36,681)	—	(1,791,257)
Income taxes payable (receivable), net	175,948	—	—	—	—	175,948	—	—	(18,814)	—	157,134
Prepaid expenses and other assets	(988,619)	—	—	—	—	(988,619)	(42,498)	4,322	—	—	(1,026,795)
Inventories, net	67,157	—	—	—	—	67,157	—	—	—	—	67,157
Accounts payable, accrued liabilities, and other liabilities	(4,969,152)	—	—	—	—	(4,969,152)	(15,414)	(169,217)	115,429	—	(5,038,354)
Due from/to affiliated organizations	2,407,566	—	—	—	(2,491,535)	(83,969)	—	(53,355)	137,324	—	—
Deferred revenue	39,252	—	—	—	—	39,252	—	500,000	—	(500,000)	39,252
Postretirement benefit obligation	1,686,084	—	—	—	(637,449)	1,048,635	—	—	—	—	1,048,635
Pension liability	(1,007,832)	—	—	—	—	(1,007,832)	—	—	—	—	(1,007,832)
Net cash provided by operating activities	293,287	—	—	2,196,596	(5,992,837)	(3,502,954)	1,708,952	2,162,511	431,358	—	799,867
Cash flows from investing activities:											
Purchase of marketable securities and alternative investments	(8,651,226)	—	(4,581,000)	(8,771,486)	(7,666,576)	(29,670,288)	—	(821,234)	(35,346)	—	(30,526,868)
Sale and maturity of marketable securities and alternative investments	8,243,653	—	7,756,346	—	26,437,225	42,437,224	—	1,631,322	248	—	44,068,794
Acquisitions of property and equipment	(10,055,793)	—	—	—	—	(10,055,793)	—	(505,146)	(23,389)	—	(10,584,328)
Net cash provided by (used in) investing activities	(10,463,366)	—	3,175,346	(8,771,486)	18,770,649	2,711,143	—	304,942	(58,487)	—	2,957,598
Cash flows from financing activities:											
Net assets released from restrictions and used for operations	—	—	—	—	—	—	(1,397,728)	(3,453,996)	—	—	(4,851,724)
Equity transfers funded with cash	9,378,268	—	(3,175,346)	6,574,890	(12,777,812)	—	—	—	—	—	—
Net cash provided by (used in) financing activities	9,378,268	—	(3,175,346)	6,574,890	(12,777,812)	—	(1,397,728)	(3,453,996)	—	—	(4,851,724)
Net increase (decrease) in cash and cash equivalents	(791,811)	—	—	—	—	(791,811)	311,224	(986,543)	372,871	—	(1,094,259)
Cash and equivalents at beginning of year	7,167,221	—	—	—	—	7,167,221	593,495	1,490,171	456,912	—	9,707,799
Cash and cash equivalents at end of year	\$ 6,375,410	—	—	—	—	6,375,410	904,719	503,628	829,783	—	8,613,540

See accompanying independent auditors' report.