This document reflects the “unofficial actions” of the 2023 House of Delegates and it was developed based on notes taken during the meeting of the House. The official actions will be reflected in the minutes of the House of Delegates that will be available in 2024.

<table>
<thead>
<tr>
<th>Resolution Number</th>
<th>House Action</th>
<th>Resolution</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>101H</td>
<td>Adopted</td>
<td>Board of Trustees Resolution 101—Nominations to Councils</td>
<td>Resolved, that the nominees put forward for membership on ADA councils be elected.</td>
</tr>
<tr>
<td>102H</td>
<td>Adopted</td>
<td>Standing Committee on Credentials, Rules and Order Resolution 102—Approval of Certified Delegates</td>
<td>Resolved, that the list of certified delegates and alternate delegates posted on the HOD Supplemental Information library on the House of Delegates community of ADA Connect be approved as the official roster of voting delegates and alternate delegates that constitute the 2023 House of Delegates of the American Dental Association.</td>
</tr>
<tr>
<td>103H</td>
<td>Adopted</td>
<td>Standing Committee on Credentials, Rules and Order Resolution 103—Minutes of the 2022 Session of the House of Delegates</td>
<td>Resolved, that the minutes of the 2022 session of the House of Delegates be approved.</td>
</tr>
<tr>
<td>104H</td>
<td>Adopted</td>
<td>Standing Committee on Credentials, Rules and Order Resolution 104—Adoption of Agenda and Order of Agenda Items</td>
<td>Resolved, that the agenda as presented in the 2023 Manual of the House of Delegates and Supplemental Information be adopted as the official order of business for this session, and be it further Resolved, the Speaker is authorized to alter the order of the agenda as deemed necessary in order to expedite the business of the House.</td>
</tr>
<tr>
<td>105H</td>
<td>Adopted</td>
<td>Standing Committee on Credentials, Rules and Order Resolution 105—Referrals of Reports and Resolutions</td>
<td>Resolved, that the list of referrals recommended by the Speaker of the House of Delegates be approved.</td>
</tr>
<tr>
<td>200H</td>
<td>Adopted</td>
<td>Reference Committee A (Business, Membership and Administrative Matters) Resolution 200—as amended—Consent Calendar</td>
<td></td>
</tr>
</tbody>
</table>
Resolved, that the recommendations of Reference Committee A on the following resolutions be accepted by the House of Delegates.

1. **Resolution 201**—Adopt—Rescission of Policy, Differential Charges According to Membership Status (Worksheet:2000) $: None

   **COMMITTEE RECOMMENDATION:** Vote Yes

2. **Resolution 202**—Adopt—Amendment of Policy, Nonmember Utilization of ADA Member Benefits (Worksheet:2002) $: None

   **COMMITTEE RECOMMENDATION:** Vote Yes

3. **Resolution 203RC**—Adopt Resolution 203RC in lieu of Resolution 203—Amendment of Policy, Clarification of Dental Professional Credentials (Worksheet:2003) $: None

   **COMMITTEE RECOMMENDATION:** Vote Yes

4. **Resolution 204**—Adopt—Rescission of the Policy, Institutional Advertising (Worksheet:2005) $: None

   **COMMITTEE RECOMMENDATION:** Vote Yes

5. **Resolution 205**—Adopt—Rescission of Policy, Diversity in Association Membership Marketing and Consumer-Related Materials (Worksheet:2007) $: None

   **COMMITTEE RECOMMENDATION:** Vote Yes


   **COMMITTEE RECOMMENDATION:** Vote Yes

7. **Resolution 207**—Adopt—Amendment of the Policy, Standards for Dental Society Publications (Worksheet:2013) $: None

   **COMMITTEE RECOMMENDATION:** Vote Yes

8. **Resolution 208**—Adopt—Membership Category Reform (Worksheet:2019) $: None

   **COMMITTEE RECOMMENDATION:** Vote Yes

   COMMITTEE RECOMMENDATION: Vote Yes


   COMMITTEE RECOMMENDATION: Vote Yes

11. Resolution 211—Adopt—Amendment of the Policy, Mechanism for Complaints and Referrals (Worksheet:2026) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

12. Resolution 212RC—Adopt Resolution 212RC in lieu of Resolution 212: Amendments to the ADA Bylaws Regarding Faculty Membership (Worksheet:2030) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

13. Resolution 214—Adopt—Recession of the Policy, Guidelines for an Advertising Code (Worksheet:2034) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

14. Resolution 215—Adopt—Nominations to the Strategic Forecasting Committee (Worksheet:2038) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

15. Resolution 217—Refer—Amendment to the ADA Member Conduct Policy (Worksheet:2091) $: None

   COMMITTEE RECOMMENDATION: Vote Yes on Referral

16. Resolution 218—Adopt—Amendment of the ADA Volunteer and Non-Staff Travel and Expense Policy (Worksheet:2094) $: 215,000

   COMMITTEE RECOMMENDATION: Vote Yes
<table>
<thead>
<tr>
<th>Resolution Number</th>
<th>Action Type</th>
<th>Resolution Title</th>
<th>Resolution Text</th>
</tr>
</thead>
</table>
| 202H              | Adopted—Consent Calendar Action | Council on Membership Resolution 202—Amendment of Policy, Nonmember Utilization of ADA Member Benefits | Resolved, that the ADA policy, Nonmember Utilization of ADA Member Benefits (Trans.1990:532), be amended as follows (additions are underscored; deletions are stricken):  

Resolved, that the ADA Board of Trustees review the policies pertaining to nonmember utilization of ADA member benefits and take whatever action is necessary to ensure that a nonmember cannot utilize ADA member benefits to imply membership and/or promote their practice to the public, and be it further  

Resolved, that the pricing differential for ADA products and/or services between members and nonmembers be at the maximum the law will allow in order to increase the tangible benefits of being a member of the ADA member-nonmember price differential for ADA products and services should demonstrate and highlight the value of ADA membership. |
| 203H              | Adopted—Consent Calendar Action | Reference Committee A (Business, Membership and Administrative Matters) Resolution 203RC adopted in lieu of Council on Communications Resolution 203—Amendment of Policy, Clarification of Dental Professional Credentials | Resolved, that the policy titled Clarification of Dental Professional Credentials (Trans.2003:354) be amended as follows (additions are underlined; deletions are stricken):  

Resolved, that the ADA establish an area pages on the ADA web sites (ADA.org and MouthHealthy.org) to assist consumers in making an informed choice of a dental practitioner that includes, but is not limited to:  

1. The names of all of the nine ADA recognized specialties;  
2. The names, phone numbers and web sites of the ADA recognized specialty organizations;  
3. Information from the ADA Principles of Ethics and Code of Professional Conduct about advertising by general dentists and specialists, guidelines for announcing limitation of practice and the use of other credentials;  
4. Other appropriate information that would help consumers make an informed choice. |
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<thead>
<tr>
<th>Resolution</th>
<th>Action</th>
<th>Policy Description</th>
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</thead>
<tbody>
<tr>
<td>204B</td>
<td>Adopted—Consent Calendar Action</td>
<td>Council on Communications Resolution 204—Rescission of the Policy, Institutional Advertising</td>
</tr>
<tr>
<td>205H</td>
<td>Adopted—Consent Calendar Action</td>
<td>Council on Membership Resolution 205—Recession of Policy, Diversity in Association Membership Marketing and Consumer-Related Materials</td>
</tr>
<tr>
<td>206H</td>
<td>Adopted—Consent Calendar Action</td>
<td>Council on Communications Resolution 206—Rescission of Policy, Guidelines for State Boards of Dental Examiners on the Definition of Routine Dental Services for the Purposes of Dentists’ Advertisements</td>
</tr>
<tr>
<td>207H</td>
<td>Adopted—Consent Calendar Action</td>
<td>Council on Communications Resolution 207—Amendment of the Policy, Standards for Dental Society Publications</td>
</tr>
</tbody>
</table>

**Resolved,** that constituent and component societies be encouraged to provide this information on their websites and in yellow page ads.

**Resolved,** that the policy titled Institutional Advertising (*Trans.*1979:598) be rescinded.

**Resolved,** that the ADA policy, Diversity in Association Membership Marketing and Consumer-Related Materials (*Trans.*1995:606), be rescinded.

**Resolved,** that the policy titled Guidelines for State Boards of Dental Examiners on the Definition of Routine Dental Services for Purposes of Dentists’ Advertisements (*Trans.*1977:616, 945) be rescinded.

**Resolved,** that the policy titled Standards for Dental Society Publications (*Trans.*1997:303, 660; 2010:602) be amended as follows (additions are underlined; deletions are stricken):

Standards for Dental Society Publications has been edited to incorporate developments since the document was revised by the Council on Journalism in 1969 and approved by the House of Delegates. These Standards are for dental society published publications; other publications, such as those published by a for-profit subsidiary, may require different or additional considerations.

**Objective:** The dental society publication is both an educational tool and a channel of communication between the dental society and members. An increasing number of dental society publications are posted on the Internet and the content is potentially accessible by the general public. This fact should be taken into consideration during the editing process.

While emphasis in content may vary, the objectives of the publication should be (1) to broaden the dentist’s professional knowledge and improve their competence so they can provide better health service, and (2) to keep them informed on professional affairs. To accomplish these objectives, a society’s publication should:
1. inform the dentist on issues of concern to the profession;
2. communicate the dental society’s policies and actions on professional issues;
3. report the news and latest developments in the profession;
4. communicate government rules and regulations;
5. assist the dental society with membership recruitment and retention efforts;
6. inform and market to members available benefits and services;
7. provide a forum to address the needs and concerns of members, including the latest issues;
8. recognize the achievement and efforts of individuals who have worked hard for the advancement of the profession;
9. elicit the support and participation of the membership; and
10. maintain a balanced content with an attractive and interesting format.

The objectives of other dental publications, such as school, alumni, dental student, fraternity and commercial, should closely parallel those of dental society publications, namely education and communication, and the same standards should apply to all dental publications.

**Types of Publications:** Each dental society should first determine the type or types of publications that will best serve the needs of its members—newsletter, tabloid, bulletin, journal or a combination of newsletter and journal. The type(s) of publications selected by the dental society will depend on the purpose to be served, but the type(s) selected should be well designed, attractive and readable—the best the society can afford. When possible, a graphic arts designer should be employed to design a pleasing and practical format.

**Frequency of Publication:** To communicate adequately with members, journals and newsletters should be sent on a regular basis. The dental society should issue some form of publication, preferably monthly but no less than four times a year.

**Content:** The dental society’s publication is one of the few tangible items it has to offer members. It should be regarded as one of the chief architects of a dental society’s image. A dental society’s effectiveness is often perceived by how well the publication serves the needs and expectations of the members. The publication, in order to be relevant, must continually reflect the trends affecting the profession.

The format of the publication will, to some extent, determine its content. However, the following items are recommended: scientific articles; editorials; reports on current issues; national and local dental news; dental society actions and reports; information on dental programs, benefits and services; information on government rules and regulations; profiles of members with outstanding achievement; and a section where members can express their opinions.
**Dental Society Responsibilities:** The major responsibilities of the dental society, as owner of the publication, are selecting the editor, managing editor and/or business manager, either by election or appointment; determining the type, scope and frequency of the publication; establishing written editorial and advertising policies for the guidance of the editor; and determining how the publication will be financed. The governing body of the society may appoint a committee to act in an advisory capacity to the editor, yet permitting them necessary editorial freedom.

Editing a dental publication is not one person’s job, just as a dental publication does not belong to one person. The editor must be sensitive to the needs and concerns of dental society officials and the membership at large. Although the editor has the freedom to determine the content of a dental society’s publication, they should adhere to the standards of publication outlined in this document. Dental society officials have the obligation to restrict that freedom if the editor fails to abide by these standards. The editor may receive a stipend and should have adequate editorial and secretarial assistance. In addition, the editor’s expenses should be paid to journalism conferences, where they can learn to produce a better journal, and to other meetings which should be reported to the members. The editor’s budget should also include funds to cover legal fees, including for consultation, as appropriate.

The dental society should subsidize the cost of its publication as it does other services to its members. The publication should not be required to be self-supporting. Additional revenue may be obtained from subscription fees and from the sale of appropriate advertising.

**Selection of the Editor:** The editor should be selected for their ability and appointed or elected for a term of from three to five years, with the option to reappoint for additional terms. The dental society that changes editors every year or two is doing itself a disservice, as training and experience make the editor more valuable to their society. Similarly, the dental society that retains an editor for too long will stagnate, preventing the expression of new ideas and depriving other individuals from the opportunity to hold the office of editor.

**Duties of the Editor:** The editor should attend meetings of the administrative body of the dental society. They should understand that it is their chief job to communicate rather than make policy. By having direct access to discussions and to all information pertaining to issues being considered by the society, they will be better prepared to report on those issues to the members. The editor should be mindful of legal and other publishing considerations that could affect the society.

**Editorial Staff:** The size of the editorial staff will depend on the size and frequency of the publication. The staff of the larger publication may include a managing editor, business manager, advertising manager, art director, assistant editors, associate editors, manuscript editors, district editors or correspondents and a secretary. The minimum staff should include district correspondents and a part-time secretary to...
prepare copy for the printer. The staff should be well trained. This can be done by the editor, by distributing a manual of instruction and by staff journalism conferences.

A manual for district editors or correspondents should contain the following information: the type of material to be submitted for publication (news—personal or dental society, editorials, reports or features), guidelines on preferred style, instructions on how to prepare the copy, length of copy and a schedule for submission of material. The manual may also contain aids to better writing.

Publication Policies: The following policies are recommended for maintaining the standards of professional journalism:

1. **Ownership.** The dental society should control both the editorial and advertising content of its publications.

2. **Content and Format.** The content and format of the publication should be in keeping with professional ideals and be representative of the strength and vision of its sponsor. The editor should frequently monitor the readership to determine whether the content of the communication is relevant to the interests of the readership and is effectively presented. This may be accomplished through periodic readership surveys and analysis of remarks, letters and editorials. The editor should encourage dentists who submit articles to dental society publications to be ADA members.

3. **Scientific Articles.** Scientific articles should be supported by adequate scientific evidence. It is advisable for editors to have scientific articles peer reviewed by experts in the appropriate fields of research or clinical practice to ensure that articles are scientifically, structurally and ethically sound. Statistical analysis in scientific papers should be reviewed by experts to avoid publishing intentional or unintentional distortions that would support a paper’s theories. Articles that have been peer reviewed should be labeled as such. Scientific information must also be clearly distinguishable from advertisements.

4. **News.** News sources should be examined for reliability, potential bias and conflict of interest. These sources should be identified whenever possible. The publishing of hearsay or information given by sources that wish to remain anonymous or offer favors in exchange for publication should be avoided. Care should be taken that advocacy is not inadvertently published as news. Facts for news or any other articles should never be deliberately distorted.

5. **Editorials.** Opinion should be clearly identified to avoid confusion with fact. Editorials and commentaries should be clearly labeled as such.
6. **Advertising.** If the publication carries advertising, the sponsoring dental society should control it. Ideally, advertising should be placed in the publication so that it does not interfere with the continuity of the scientific or editorial material. The publication should have a written advertising code to assist the editor, managing editor or business manager in evaluating the advertising. Where practical, this code should include guidelines for the acceptance of:

   a. **Ads for Products and Services.** Ads should be included only for those products that have been found safe, effective and scientifically sound; and for those services that have been found to be reputable and of value.

   b. **Classified Advertisements.**

      The code should also include guidelines for nonacceptance of advertisements. No advertising claims should be permitted which are false, misleading or deceptive.

7. **Photographs and Illustrations.** Photographs should not be altered through darkroom techniques or digitized manipulation. Altered photographs are as misleading as falsified statistics. Photographs and illustrations should not be used—either overtly or by implication—to negatively portray individuals or the dental society.

8. **Protection.** The publication should be copyrighted to protect the rights of the publisher and authors and to prevent unethical and unauthorized use of the material. The editor must operate within the limits of copyright laws. In addition, the editor should take appropriate steps, including the placement of appropriate disclaimers to protect the society and those involved in the publication from other legal risk, including antitrust, libel and anything that would affect the society’s tax status. Mistakes should be rectified in print as soon as possible.

9. **Reprint Policy.** Occasionally, the editor receives a request from another publication for an article or for permission to reprint articles from publications. Evaluation of such a request should be based primarily on the standards, not solely the ownership, of the publication making the request. A written policy should be established to serve as a guide in acting on requests for permission to reprint articles and to guard against the inappropriate use of reprinted material.

**Standards for Evaluation:** The following standards can be used for evaluating all dental publications, both professional and commercial:
1. **Worthwhile Content.** The content of the publication, both editorial and advertising, should be in accord with the objectives of the American Dental Association—to encourage the improvement of the oral health of the public, to promote the art and science of dentistry and to represent the interests of the members of the dental profession and the public it serves.

2. **Appropriate Advertising Standards.** The publication should have advertising standards which prohibit the acceptance of advertising for products whose safety and effectiveness have not been demonstrated. The claims for the products, particularly those affecting oral health, should be supported by scientific evidence.

3. **Sound, Appropriately Intended Articles.** Scientific articles appearing in the publication should be supported by adequate scientific evidence; nonscientific articles should be in keeping with the purposes of the profession. Quoted authors must be given due credit. The publishing of papers by authors with conflicts of interest or hidden agendas should be identified and avoided. The publication of papers with questionable coauthorship should also be avoided.

4. **Protection of Members.** The publication staff and the officers of the dental society must take care that individuals, all levels of organized dentistry and the public are not harmed through unfair and damaging statements or through appearing to endorse potentially injurious goods and services. Stereotypical views of persons based on racial, ethnic, religious, political, cultural or occupational identification, gender or sexual preference are to be avoided. The publication should be judicious about naming colleagues who may be accused of violations of the dental practice act, insurance fraud, criminal activity or malpractice until due process has run its course.

5. **Honesty.** The publication may report controversy, but it should never create it. Distortion of facts, unbalanced management of issues, and managed information may self-serve the short-term goals of the governance of the parent organization, but such practices eventually undermine the integrity of the dental society and its publications.

6. **Lawful Conduct.** The publication should avoid inclusion of materials that may lead to legal prosecution, including with respect to laws on copyright and trademark, libel and antitrust.

<table>
<thead>
<tr>
<th>208</th>
<th>Not Adopted</th>
<th>ADA Seventh District Resolution 208—Membership Category Reform</th>
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<tbody>
<tr>
<td></td>
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<td>Resolved, with priority, that the appropriate ADA agencies work collaboratively to develop Bylaws language that creates a tripartite membership model that includes individual-based membership and practice-based membership as an alternative option,</td>
</tr>
<tr>
<td>Resolution</td>
<td>Action</td>
<td>Text</td>
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| 209H | Adopted—Consent Calendar Action | **Board of Trustees Resolution 209B in lieu of Council on Membership Resolution 209—Amendment of Policy, Application Process for Direct ADA Membership**  
**Resolved,** that the ADA policy, Application Process for Direct ADA Membership (*Trans*.1989:539), be amended as follows (additions are **underscored**; deletions are **stricken**):  
- **Resolved,** that the American Dental Association verify eligibility of direct members on an annual basis and urge constituent societies to assist in the verification of employment status of direct members, and be it further  
- **Resolved,** that the American Dental Association encourage constituent and component societies to promote tripartite membership to ADA direct member **federally employed dentists** consistent with the ADA *Bylaws*. |
| 210H | Adopted | **Reference Committee A (Business, Membership and Administrative Matters) Resolution 210RC adopted in lieu of Task Force to Eliminate Barriers for Underrepresented Minorities into the Dental Profession Resolution 210 and Seventeenth Trustee District Resolution 210S-1—Proposed Resolution to Reauthorize Task Force**  
**Resolved,** that the Task Force to Eliminate Barriers for Underrepresented Minorities into the Dental Profession be reauthorized to continue building and finalizing the online resource/website, establishing criteria for pathway program grants, monitoring the success and implementation of the historically underrepresented racial and ethnic (HURE) DAT fee waivers consistent with the need-based fee waiver program, and assessing any additional requirements or needs arising from the HURE programs, and be it further  
- **Resolved,** that the president consider continuity in the composition of the Task Force in their appointments, and be it further  
- **Resolved,** that the ADA reinvite diverse dental groups, including but not limited to American Association of Women Dentists, American Dental Education Association, National Dental Association, Society of American Indian Dentists, Hispanic Dental Association and Korean American Dental Association, to continue collaborating on the online resource, pathways programs grants, DAT fee waivers and any additional or needs arising from the HURE programs, and be it further |
<table>
<thead>
<tr>
<th>Resolution</th>
<th>Council on Communications Resolution 211—Amendment of the Policy, Mechanism for Complaints and Referrals</th>
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<tbody>
<tr>
<td>Resolved</td>
<td>that the policy titled Mechanism for Complaints and Referrals (Trans.1972:669) be amended as follows (additions are underlined; deletions are stricken):</td>
</tr>
<tr>
<td>Resolved</td>
<td>that in the interest of the public and the profession, dental societies at the appropriate level should establish a mechanism to give attention to complaints, including fee complaints, and the existence of the mechanism should be made known to the public, and be it further</td>
</tr>
<tr>
<td>Resolved</td>
<td>that in the interest of the public, dental societies at the appropriate level should establish a mechanism to respond to patient requests for referral to dentists, and be it further</td>
</tr>
<tr>
<td>Resolved</td>
<td>that local dental societies should continue to operate and publicize emergency dental referral services that provide ready accessibility of professional services in emergencies or take prompt action to establish an emergency referral service.</td>
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</tbody>
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<thead>
<tr>
<th>Resolution</th>
<th>Reference Committee A (Business, Membership and Administrative Matters) Resolution 212RC in lieu of Council on Membership Resolution 212—Amendments to the ADA Bylaws and Governance Manual Regarding Faculty Membership</th>
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</thead>
<tbody>
<tr>
<td>Resolved</td>
<td>that Chapter I. MEMBERSHIP, Section 20. MEMBERSHIP ELIGIBILITY, Subsection A. ACTIVE MEMBER, of the ADA Bylaws be amended to read as follows (new language underscored, deletions stricken):</td>
</tr>
<tr>
<td></td>
<td>A. ACTIVE MEMBER. Any person holding a D.D.S., D.M.D. or equivalent degree* or qualified faculty member** shall be eligible to be an active member of this Association if they meet the following qualifications:</td>
</tr>
<tr>
<td></td>
<td>a. Maintains membership in good standing in this Association as that term is defined in these Bylaws; and</td>
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<td></td>
<td>b. Is licensed and/or registered to practice dentistry where the laws and regulations of a constituent’s jurisdiction require licensure and/or registration in order to be a member of the constituent***; and</td>
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<tr>
<td></td>
<td>c. Is a member in good standing of the constituent and component where the member either resides, or is employed or practices; or if not a member of such constituent and component is:</td>
</tr>
</tbody>
</table>
1. employed by or is serving on active duty in one of the federal dental services*** on a full-time basis and is not otherwise employed or practicing dentistry within the jurisdiction of a constituent or component; or

2. employed or practicing dentistry in a country other than the United States and is a graduate of a dental school or a graduate of a training program accredited by the Commission on Dental Accreditation; or

3. otherwise ineligible for active membership in a constituent or component where the individual resides, is employed, or practices.

An individual qualifying pursuant to subsections c.1 through 3 shall be referred to as a “direct member.”

As used in these Bylaws, the term “equivalent degree” means a degree that the jurisdiction involved deems sufficient to allow the degree holder to sit for a full and complete dentist’s licensure examination in the jurisdiction without any additional training.

** As used herein, the term “qualified faculty member” means a dentist holding a D.D.S., D.M.D. or a degree in dentistry conferred by a school outside of the United States who submits annually an affidavit attesting that they are employed in a CODA accredited academic setting providing dental education more than two (2) days or sixteen (16) hours per week.

*** As used herein, the term “constituent” means a dental association organized in a state or territory of the United States or in Washington, D.C. that is chartered by the ADA House of Delegates. The term “component” means a local dental association that may be created within the boundaries of a constituent by the constituent.

**** The term “federal dental services” as used herein shall mean the dental departments of the Air Force, the Army, the Navy, the Public Health Service, the department of Veterans Affairs and other federal agencies.

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<tr>
<th>213</th>
<th>Referred to the Appropriate Agency for Further Study and Report to the 2024 House of Delegates</th>
<th>Second Trustee District Resolution 213—Addressing Non-Members Advertising as Tripartite Members on Social Media Websites</th>
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<tbody>
<tr>
<td></td>
<td>Resolved, that the appropriate ADA agency report annually to the ADA House of Delegates on the status of complaints received of non-members who falsely advertise ADA, state or local dental society membership on social media websites, and be it further</td>
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</tr>
<tr>
<td></td>
<td>Resolved, that this annual report include the number of non-members that renewed, how many were issued a ‘cease and desist’ letter and how many removed the inappropriate references.</td>
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<tr>
<th>214H</th>
<th>Adopted—Consent Calendar Action</th>
<th>Council on Communications Resolution 214—Rescission of the Policy, Guidelines for an Advertising Code</th>
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</table>
Board of Trustees Resolution 215—Nominations to the Strategic Forecasting Committee

Resolved, that the following individuals’ appointments by the ADA Board of Trustees to the Strategic Forecasting Committee for the respective terms as indicated are hereby ratified.

North Geographic Trustee District Region:
Dr. Cissy K. Furusho, Illinois, 8th District, 2023-2026
Dr. Thomas M. Paumier, Ohio, 7th District, 2023-2025

East Geographic Trustee District Region:
Dr. James E. Galati, New York, 2nd District, 2023-2026
Dr. Christopher G. Liang, Maryland, 4th District, 2023-2025

West Geographic Trustee District Region:
Dr. Kurt S. Lindemann, Montana, 11th District, 2023-2025
Dr. Michael R. Varley, Colorado, 14th District, 2023-2026

South Geographic Trustee District Region:
Dr. Deborah S. Bishop, Alabama, 5th District, 2023-2025
Dr. Mark Chaney, Louisiana, 12th District, 2023-2026

Board of Trustees Resolution 216—Establishment of Dues Effective January 1, 2024

Resolved, that the dues of ADA active members shall be $570.00 effective January 1, 2024.

Sixth Trustee District Resolution 217—Amendment to the ADA Member Conduct Policy

Resolved, that the ADA Member Conduct Policy (Trans.2011:530; 2020:335) item (1) be revised to include government officials and legislators as amended below (additions are underlined):

1. Members’ discussions, social media activities, communications and interactions with other dentists, dentist members, Association officers, trustees and staff, government officials and legislators, should be respectful and free of demeaning, derogatory, offensive or defamatory language.

Fifth Trustee District Resolution 218—as Amended—Amendment of the ADA Volunteer and Non-Staff Travel and Expense Policy
**Resolved,** that starting with the 2024 budget, the Board of Trustees be urged to increase the ADA volunteer’s per diem daily stipend and non-staff daily stipend be increased from $75 to $150 at a rate of twice the Meal and Incidental Expenses (M&IE) Chicago GSA.

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<th>300H</th>
<th>Adopted</th>
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<tr>
<td><strong>Resolution 300</strong>—as amended—Consent Calendar</td>
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</table>

**Resolved,** that the recommendations of Reference Committee B on the following resolutions be accepted by the House of Delegates.

1. **Resolution 301RC**—Adopt Resolution 301RC in lieu of Resolution 301—Amendment of Policy, Statement on Preventive Coverage in Dental Benefits Plans (Worksheet:3000) $: None

   **COMMITTEE RECOMMENDATION:** Vote Yes

2. **Resolution 302**—Adopt—Amendment of Policy, Statement on Managed Care and Utilization Management (Worksheet:3002) $: None

   **COMMITTEE RECOMMENDATION:** Vote Yes

3. **Resolution 303RC**—Adopt Resolution 303RC in lieu of Resolution 303, 303B and 303BS-1—Amendment of Policy, Statement to Encourage U.S. Dental Schools to Interact with U.S. Dental Laboratories (Worksheet:3007) $: None

   **COMMITTEE RECOMMENDATION:** Vote Yes

4. **Resolution 304RC**—Adopt Resolution 304RC in lieu of Resolution 304 and 304S-1—Amendment of Policy, Guiding Principles for Dentist Well-Being Activities at the State Level (Worksheet:3009) $: None

   **COMMITTEE RECOMMENDATION:** Vote Yes

5. **Resolution 305RC**—Adopt Resolution 305RC in lieu of Resolution 305 and 305B—Proposed Policy, Payment for Services for Medically Compromised Individuals in Publicly Funded Programs (Worksheet:3012) $: None

   **COMMITTEE RECOMMENDATION:** Vote Yes

6. **Resolution 306RC**—Adopt Resolution 306RC in lieu of 306—Amendment of Policy, Dental Benefits Within Affordable Care Act Marketplace and a Public Option (Worksheet:3017) $: None

   **COMMITTEE RECOMMENDATION:** Vote Yes
7. Resolution 307RC—Adopt Resolution 307RC in lieu of Resolution 307—Proposed Policy, Comprehensive Statement on Dental Medicaid Programs (Worksheet:3018) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

8. Resolution 308RC—Adopt Resolution 308RC in lieu of Resolution 308—Promoting Use of DICOM in Dentistry (Worksheet:3024) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

9. Resolution 309—Adopt—Amendment to the Policy, Policies and Recommendations on Diet and Nutrition (Worksheet:3026) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

10. Resolution 310RC—Adopt Resolution 310RC in lieu of Resolution 310—Amendment of Policy, Orofacial Protectors (Worksheet:3029) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

11. Resolution 311—Adopt—Rescission of Policy, Prevention Research to Aid Low Income Populations (Worksheet:3030) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

12. Resolution 312—Adopt—Human Papillomavirus (HPV) Education and Collaboration (Worksheet:3033) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

13. Resolution 313—Adopt—Incorporating Prescription Drug Monitoring Program (PDMP) Into Practice (Worksheet:3035) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

14. Resolution 315—Not Adopt—Survey of ADA Membership on Medicare (Worksheet:3037) $: 90,000

   COMMITTEE RECOMMENDATION: Vote No

301H Adopted—Consent Calendar Action
Reference Committee B (Dental Benefits, Practice and Related Matters) Resolution 301RC adopted in lieu of Council on Dental Benefit Programs Resolution 301—Amendment of Policy, Statement on Preventive Coverage in Dental Benefits Plans

Statement on Preventive Coverage in Dental Benefits Plans

Resolved, that preventive dentistry refers to the procedures in dental practice and health programs which aid in the prevention of oral diseases, and be it further

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

Resolved, that the ADA urges that all dental benefit plans should include, but not be limited to, the following preventive procedures as covered services for all patients unless otherwise indicated:

- prophylaxis;
- topical fluoride applications;
- application of pit and fissure sealants and reapplication as necessary;
- interim caries arresting medicament application (e.g., silver diamine fluoride);
- space maintainers at appropriate developmental stages;
- oral health risk assessments;
- screening and education for oral and oropharyngeal cancer and other dental/medical related conditions;
- preventive resin restorations;
- resin infiltrations;
- fixed and removable appliances to prevent malocclusion;
- athletic mouth guards;
- prescription or use of supplemental dietary or topical fluoride for home use; and
- in-office patient education, (i.e., oral hygiene instruction, dietary counseling, dental- and medical-related conditions, and tobacco cessation counseling with regard to the promotion of good oral and overall health).

and be it further

Resolved, that the Council on Dental Benefit Programs continue to recommend to third-party payers, service plans, prospective purchasers and policyholders that contract limitations on frequency of providing benefits allow for coverage of preventive services at least “twice in a calendar (or contract) year” and more frequently if risk factors are identified that warrant increased frequency.

302H          Adopted—Consent Calendar Action          Council on Dental Benefit Programs Resolution 302—Amendment of Policy, Statement on Managed Care and Utilization Management
Resolved, that the policy titled, Statement on Managed Care and Utilization Management (Trans.1995:624), be amended as follows (additions underscored; deletions stricken).

Statement on Managed Care and Utilization Management

The American Dental Association shares the national concern expressed by government, business, industry, and the professions about the rising cost of health care. The Association supports legitimate, valid efforts to stabilize the cost of health care in the United States. However, in addressing the problem, it is all too easy to adopt simplistic solutions that, in the short term, will result in less-than-optimum care for patients, and in the long term, will result in increased costs.

The concept of “managed care” has been universally promoted as a method of containing health care costs. After examination of this concept by the Association, it became evident that while the term is widely used, its meaning could not be more elusive.

The American Dental Association defines managed care as follows:

Managed care is any contractual arrangement where payment or reimbursement and/or utilization are controlled by a third party.

This concept represents a cost-containment system that directs the utilization of health care by:

a. restricting the type, level and frequency of treatment;
b. limiting the access to care;
c. controlling the level of reimbursement for services; and
d. controlling referrals to other practitioners.

The Association believes that the public must be served and protected through the appropriate management of:

1. Dental Care. Dental care is managed by the treating dentist. The dentist should provide care, in consultation with the patient, that is evidence-based or scientifically sound and necessary for the diagnosis and treatment of disease to promote, preserve and restore oral health form and function. Dental care is provided by the treating dentist based on a dental evaluation, the development of an individualized treatment plan and a consultation with the patient.

2. Benefit Plan Design. Benefit plan design is managed by plan purchasers. Benefit plan design must be evidence-based or scientifically
sound and promote, preserve and restore oral health form and function clinically relevant and reliable. Plan design may also include cost containment measures, such as annual maximums, copayments, limitations, predeterminations, exclusions, enrollment periods and patient incentives for maintaining oral health.

3. **Program Costs.** Program costs are managed by plan administrators. Oversight of the program may include implementation of the plan agreement through monitoring utilization, preauthorizing treatment, requiring second opinions, reviewing claims and collecting and evaluating claims data.

Definitions of the terms “cost containment” and “managed care” vary greatly and are open to interpretation by various organizations. The Association believes that “managed care,” as currently applied to the practice of medicine, is not relevant to the practice of dentistry. Dentistry is, by and large, a self-contained discipline. In most instances, a general dentist can diagnose and treat a patient’s condition from beginning to end. This fact is reflected in the demographics of the dentist population in the United States: approximately 86% are general practitioners and 14% are in specialty practice, compared with 12% general practitioners and 88% specialists in medicine.

The practice of dentistry is procedural and cognitive. While there are eight recognized dental specialty areas of practice, the licensed general dentist is trained to perform services in all areas of dentistry. When compared with the numerous specialties and subspecialties of medicine, and the increasingly limited area of practice commanded by the “family physician,” the latitude of a dentist’s license to diagnose and treat a patient’s oral health condition becomes clear. In addition, dentistry is almost exclusively an outpatient service, although there are limited situations where treatment is most appropriately performed in a hospital setting. The concept of “case management” has long been a foundation of dental practice in the United States.

Outside the practice of dentistry, there are additional factors that influence the utilization of dentistry, such as benefit plan design which integrates controls through copayments, annual maximums, exclusions and limitations, preauthorizations, etc.

**Statement on Utilization Management**

For these reasons, the Association believes that the concept of managed care is financial in nature and, regardless of the type of plan, refers only to cost containment. Utilization management refers to administration of the plan as it relates to plan design. The Association defines utilization management as “...a
set of techniques used by or on behalf of purchasers of health care to manage the cost of health care prior to its provision by influencing patient care decision making through case-by-case assessment of the appropriateness of care based on accepted dental practices.”

The techniques embraced by utilization management, as defined, should equally serve patients, plan purchasers and the dental profession, by providing the following:

- **Patients**—parameters of care should be based on scientifically sound, clinically relevant and reliable research; plan coverage should be designed and maintained through evaluation and analysis of data; education and information about different types of procedures and their outcomes should be provided; patients should have the opportunity to make treatment decisions based on a clear understanding of available options.

- **Plan Purchasers**—should provide constant feedback regarding the effectiveness of their plans, thus ensuring a meaningful benefit for their employees; should request data regarding the plan’s loss ratio; should communicate with the Association regarding advances in procedures and technology for consideration in updating plan coverage.

- **Dental Profession**—should have the opportunity for involvement in the process of plan design to ensure appropriate treatment based on parameters of care developed and maintained by the profession.

An area of concern for the Association and others is the increased reliance on statistically-based utilization review of claims as a complete program for managing costs.

In dentistry, utilization review initiatives are classified as retrospective review of treatment. This usually takes the form of a statistically-based, dentist-specific system which analyzes patterns of claims reporting under dental care plans.

The statistics compiled under this system are procedure-specific and are used by the utilization review administrator to develop various statistical “norms” which are used to establish dental practice patterns by which all dentists are judged.

The Association believes that statistically-based utilization review should not be used to determine acceptable norms or clinical standards of dental practice. The Association has defined statistically-based utilization review as a system “…that examines the distribution of treatment procedures based on claims information and in order to be reasonably reliable, the application of such claims analyses of specific dentists should include data on type of practice, dentist’s experience, socioeconomic characteristics and geographic location.”
Statistically-based utilization review has fostered a new service area, and the growth of utilization review companies competing for this business must be recognized for its potential to help solve the problem of health care costs, or to substantially add to or create new problems. Treatment plans and claims are being reviewed by clerks, statisticians and actuaries, not by licensed practitioners. Patients are being denied coverage for care based on such reviews.

The Association believes that utilization management, prescribed by the patient’s dentist which protects the lifetime long-term care concerns of the public, is a concept that offers opportunities for patients, plan purchasers, dentists and plan administrators to jointly achieve their common goals: to share information and concerns regarding standards of care; to improve patient education; to develop meaningful benefit coverage; to respond to advances in technology; and to stabilize the cost of health care in the United States.

and be it further

Resolved, that the policies titled, Utilization Management \( (\text{Trans.}1990:541) \) and Regulation of Utilization Management Organizations \( (\text{Trans.}1991:636) \), be rescinded.

| 303H | Adopted—Consent Calendar Action | Reference Committee B (Dental Benefits, Practice and Related Matters) Resolution 303RC adopted in lieu of Council on Dental Practice Resolution 303, Board of Trustees Resolution 303B and Ninth Trustee District Resolution 303BS-1—Amendment of Policy, Statement to Encourage U.S. Dental Schools to Interact with U.S. Dental Laboratories

Resolved. That the following policy entitled Statement to Encourage U.S. Dental Schools to Interact with U.S. Dental Laboratories \( (\text{Trans.}2010:547) \), be amended as follows (additions are underscored, deletions are struck through).

Statement to Encourage U.S. Dental Schools to Interact with U.S. Dental Laboratories

Resolved, that the ADA encourage all U.S. dental schools to use U.S. dental laboratories for fabrication of undergraduate and graduate dental students’ restorative prostheses, in lieu of sending the prescription for these medical devices abroad, and that the ADA believes that the educational process of U.S. dental students would be enhanced by interaction with local dental laboratories, and be it further

Resolved, that the ADA encourage U.S. dental schools to use their own in-house dental laboratories wherever possible in order to facilitate the valuable interaction between dental students and certified dental laboratory technicians as this will afford
the dental students with the valuable experience necessary to facilitate the successful fulfillment of a prescription for fabrication of dental prostheses, and be it further

**Resolved**, that the ADA encourage U.S. dental schools to combine dental education programs with dental laboratory technology programs wherever dental laboratory technology programs are located within commuting distance of the dental school, and that these programs/curricula could include, but are not limited to, dental morphology/occlusion, prosthetic design and fabrication, waxing, casting, surveying of study casts, and incorporation of CAD/CAM technology these programs be encouraged to collaborate on curricula including current prosthetic design and manufacturing trends and techniques.

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<th>304H</th>
<th>Adopted—Consent Calendar Action</th>
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<td>Reference Committee B (Dental Benefits, Practice and Related Matters) Resolution 304RC adopted in lieu of Council on Dental Practice Resolution 304 and Ninth Trustee District Resolution 304S-1—Amendment of Policy, Guiding Principles for Dentist Well-Being Activities at the State Level</td>
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**Resolved**: That the following policy titled, Guiding Principles for Dentist Well-Being Activities at the State Level (*Trans.*2005:330; 2012:442) be amended as follows (additions are underscored; deletions stricken).

**Guiding Principles for Dentist Well-Being Activities at the State Level**

**Resolved**, that the ADA supports efforts by constituent and component dental societies in the development, maintenance, and collaboration with effective programs to identify and assist those dentists and dental students affected by conditions which potentially impair their ability to practice dentistry, and be it further

**Resolved**, that constituent and/or component dental societies be urged to adopt the following Guiding Principles for Dentist Well-Being Activities at the State Level.

**Guiding Principles for Dentist Well-Being Activities at the State Level**

1. **Constituent** Dental societies, on behalf of their well-being programs, are encouraged to negotiate contracts or agreements with state dental boards, licensing agencies and other regulatory agencies to encourage dentists with substance use disorders to get into treatment before they have an alcohol- or drug-related incident.

2. State-level programs to prevent and intervene in dentist and dental team member impairment should be strengthened, supported and well publicized as the most humane and effective method of protecting the interests of the public and of dental professionals.
### Dental Societies and Regulatory Agencies

3. Dental societies are encouraged to engage with state regulatory agencies in their mission to protect the public and providing support for dentists by eliminating barriers and reducing stigma associated with seeking mental and behavioral health services.

4. Dental societies should be advocates for dentists to have the same rights of privacy and confidentiality of personal medical information as other persons.

5. Those dental societies that administer dentist well-being programs are urged to maintain a strong working relationship with their state boards of dentistry and with the appropriate ADA agencies.

6. The dental society should ensure that those who serve as dentist peer assistance volunteers are provided immunity from civil liability, except for willful or wanton acts.

7. The dental society should also ensure that those who serve as dentist peer assistance volunteers are appropriately trained and supervised in these activities.

8. Dental societies in states where services are provided to dentists by multidisciplinary or physician health programs are urged to develop strong relationships with those programs, in order to:
   - educate service providers about the particular needs of dentists and the dynamics of dental practice
   - assist providers in outreach to dentists in need of assistance
   - support dentists and families if treatment is necessary
   - assist program providers in developing monitoring contracts appropriate to individual dentist’s practice situations
   - assist program providers in advocating for program participants with the dental board or licensing agency

9. Constituent and component dental societies are strongly encouraged to offer continuing education programs on the prevention, recognition and treatment of professional impairment.

10. Dental societies are encouraged to support well-being volunteer liaison activities to their dental schools.

### Reference Committee B (Dental Benefits, Practice and Related Matters) Resolution 305RC

**Resolved,** that the following proposed policy be adopted.

**Payment for Services for Individuals with Medical Conditions in Publicly Funded Programs**
Resolved, that the American Dental Association support payment for dental services, under Medicare, when the dental procedure is intrinsically linked and integral to the health outcomes of the covered medical procedure, and be it further

Resolved, that if legislators or regulators seek to support payment for dental care for adults over age 65 for dental services associated with otherwise covered medical procedures in any taxpayer funded public program, then the ADA may support a program that:

- provides a dental benefit for individuals when systematic peer reviewed current scientific evidence as assessed by the ADA supports improved health outcomes for that covered medical condition procedure
- covers the range of services on both in-patient and out-patient basis necessary to achieve the desired improvement in health outcomes
- is adequately funded to support an annually reviewed reimbursement rate such that 80% of dentists within each geographic area receive their full fee (80th percentile) to support access to care
- includes minimal and reasonable administrative requirements including the use of the CDT Code for reporting dental procedures and use of the dental claim form (837D electronic standard or the ADA paper claim form)
- allows freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit; and be it further

Resolved, that the ADA emphasize that dental offices are different from medical offices given the equipment and overhead expenses for procedures routinely performed in every dental office and the current Relative Value Unit (RVU) system in medicine is not applicable to dentistry, and be it further

Resolved, that the following ADA policies be rescinded:

- Modifying the Existing Medicare Dental Coverage: Statutory Dental Exclusion (Trans.2020:347)

306H  Adopted—Consent Calendar Action  Reference Committee B (Dental Benefits, Practice and Related Matters) Resolution 306RC adopted in lieu of Council on Dental Benefit Programs Resolution 306—Amendment of Policy, Dental Benefits Within Affordable Care Act Marketplace and a Public Option

Resolved, that the policy titled, Dental Benefits within Affordable Care Act Marketplace and a Public Option (Trans.2021:284), be amended as follows (additions are underscored; deletions stricken).
DENTAL BENEFITS WITHIN AFFORDABLE CARE ACT MARKETPLACE AND A PUBLIC OPTION

Resolved, that within the Marketplaces established by the Affordable Care Act:

- Dental benefits, both pediatric as well as adult benefits should be considered “Essential Health Benefits”.
- Coverage inside and outside of the Marketplaces must include pediatric and adult dental benefits.
- There should be no dollar-value annual and lifetime maximums in and out of the ACA Marketplaces.
- Dental coverage should be available to consumers through Stand Alone Dental Plans.
- Diagnostic and preventive dental services embedded within Qualified Health Plans should be covered without any additional co-payment, co-insurance or deductibles.
- Dental care is essential across the individual’s life span. Individuals seeking to purchase benefits in the Marketplaces must be able to purchase dental benefits without having to first purchase a medical plan.
- Plan designs should remain flexible and offer consumers adequate choices balancing cost and benefit value.
- Dental Plans offered in the Marketplaces must be required to transparently report Medical (Dental) Loss Ratios (MLR/DLR).
- Cost sharing assistance or premium tax credits should be available to consumers purchasing dental plans.
- Dependent children should be allowed to remain on their parents plans until age 26 in any dental plan.

and be it further,

Resolved, that if a any plan, including a public option plan, that provides dental coverage includes pediatric or adult dental benefit plans were introduced within the Marketplaces established by the Affordable Care Act, then such plans should:

- Allow freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit.
- Not force any providers, including those already participating in existing public programs, to join a Marketplace plan network and instead should support fair market competition, including meaningful negotiation of contracts and annual adjustment of fee schedules.
- Only include minimal and reasonable administrative requirements to promote participation and provide meaningful access.
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<th>307H</th>
<th>Adopted—Consent Calendar Action</th>
<th>Reference Committee B (Dental Benefits, Practice and Related Matters) Resolution 307RC in lieu of Medicaid Task Force Report Resolution 307—Proposed Policy, Comprehensive Statement on Dental Medicaid Programs</th>
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<td>Resolved, that the following proposed policy be adopted.</td>
<td><strong>Comprehensive Statement on Dental Medicaid Programs</strong></td>
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<td>Medicaid is a taxpayer funded public health insurance program based on federal-state partnership. Medicaid covers low-income people including families and children, pregnant women, the elderly, and people with disabilities. Each state and territory determine eligibility criteria and program structure to support delivery of care to underserved populations.</td>
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<td><strong>General Program Considerations:</strong> While children covered by Medicaid programs have access to a mandatory Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, the ADA strongly supports a comprehensive adult dental benefit for the Medicaid-eligible population in an adequately funded program and encourages the federal and state governments to institute an adult dental benefit in Medicaid. The ADA believes that the federal Medicaid match for children and adult dental care should be enhanced to 90/10 or better (FMAP).</td>
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<td><strong>Medicaid Program Structure:</strong> The ADA believes that successful Medicaid programs are those that are supported by a strong state level multi-stakeholder Medicaid Dental Advisory Committee that can provide guidance and analysis of program success, support program integrity and participate in program improvement initiatives. Such a committee should also be supported by a full-time Chief Dental Medicaid Director.</td>
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<td>In addition to a Medicaid Dental Advisory Committee, the ADA believes that state-level peer-review committees with dentists licensed in the state in collaboration with local dental public health professionals, can support Medicaid programs in assessing clinical issues related to administering the Medicaid benefit.</td>
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<td>The ADA encourages state dental associations to remain a significant voice within their state Medicaid programs and in turn should encourage their Medicaid programs to share program decisions which impact access, quality of care and availability of specialty care. The ADA encourages all state dental associations to actively participate in the establishment or continuation of an existing Medicaid Dental Advisory Committee which includes representation from dental public health and dental education professionals, that is recognized by the state Medicaid agency as the professional body to provide recommendations on Medicaid dental issues.</td>
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The ADA strongly believes that every patient should have a dental home and a managed care plan should never be addressed as the “dental home” for a Medicaid enrolled beneficiary.

The ADA also supports the rights and freedom of patients to choose their own dentist, as well as their own Medicaid Managed Care Plan.

**Provider Participation:** The ADA encourages dentists to participate in the Medicaid program. The ADA encourages dentists to refer patients seeking care, to dentists enrolled in Medicaid in those instances wherein they are unable to accommodate them. The ADA supports a dentist’s autonomy to choose their level of participation in Medicaid programs.

Network adequacy for Medicaid programs is dependent on the adequate number and diversity of providers to address the disease burden and promote prevention. The ADA believes that Medicaid programs should establish policies that incentivizes any dentist willing to provide a dental home for children from birth to age 5. Dentists should be allowed to claim a tax credit for the first $10,000 of services (based on the most recent Code on Dental Procedures and Nomenclature (CDT) codes) and credited at a rate consistent with the dentists’ full fees for that region or state.

Opportunities for early-career dentists to engage with state Medicaid programs can be enhanced through loan repayment programs for dentists who are willing to treat a disproportionate number of Medicaid beneficiaries. Such loan repayment programs should be commensurable with the level of Medicaid participation. The ADA also supports additional funding such as enhanced reimbursement to dental schools that treat Medicaid beneficiaries.

Annually reviewed reimbursement, aligned with current Fair Health provider charges data, is necessary to assure adequate compensation such that the majority of dentists in a region would be encouraged/motivated to participate in the program.

**Transparency & Reporting:** The ADA believes that transparency and standardization of reporting data in all Medicaid programs relating to access to care, patient/provider satisfaction rates, and network adequacy is essential for the public, state dental associations, researchers and other stakeholders to effectively assess the success of the Medicaid program regardless of whether the program is administered directly by the state or through managed care contracts. Data should be publicly available on an annual basis. When the Medicaid benefit is administered through managed care contracts, information regarding medical/dental loss ratio should also be made publicly available.

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**Administrative Practices:** To better ensure patient safety and access to care, the ADA believes that Medicaid programs should:

- Based on provider experience, use a single credentialing system across all managed care plans within Medicaid (state specific) to decrease administrative burdens, such that providers who are willing to participate can join the program in a timely manner thus ensuring an adequate network.
- Establish uniform processes to transfer prior authorizations between managed care plans.
- Support coverage for caries risk assessment, case management, transportation, language services, appointment compliance, desensitization visits for patients with disabilities and coordination of other medical appointments.
- Support coverage for preventive services related to tobacco cessation, nutritional counseling, home care practices, and any other services that improve overall health outcomes.
- Conduct any necessary audits through 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.
- Ensure that each managed care entity establishes a designated Provider Advocate position to conduct educational sessions for participating providers and provide ongoing technical and navigational support.
- Address case management for Special Needs patients through enhanced payment schedules.

The ADA encourages state dental associations, whenever possible, to actively participate in any request for information, request for proposals, or contract development processes using resources developed by the Association to ensure appropriate administration of Medicaid managed care.

and be it further

**Resolved,** that the following ADA policies be rescinded:

- Federal Medicaid Funding (Trans.2020:338)
- Tax Incentives for Medicaid Participation (Trans.2020:338)
- State Medicaid Dental Peer Review Committee (Trans.2018:361)
- Peer-to-Peer State Dental Medicaid Audits (Trans.2017:234)
- Chief State Medicaid Dental Officer and Medicaid Dental Advisory Committee (Trans.2015:275)
- Medicaid and Indigent Care Funding (Trans.2006:338; 2014:499; 2021:319)
- Support for Adult Medicaid Dental Services (Trans.2004:327; 2021:323)
- Fee-For-Service Medicaid Programs (Trans.1999:957; 2021:319)
<table>
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<tr>
<th>Reference Committee B (Dental Benefits, Practice and Related Matters) Resolution 308RC in lieu of South Dakota Dental Association Resolution 308—Promoting Use of DICOM In Dentistry</th>
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<td><strong>Resolved</strong>, that the policy statement, Promoting Use of DICOM in Dentistry, be adopted:</td>
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<tr>
<td><strong>Promoting Use of DICOM in Dentistry</strong></td>
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<td><strong>Resolved</strong>, the appropriate ADA agencies collaborate with interested dental specialty societies to understand issues related to DICOM and image exchange to facilitate development of the appropriate and necessary specifications, standards and guidance; and be it further,</td>
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<td><strong>Resolved</strong>, that the appropriate ADA agencies review and facilitate updating the DICOM standards as needed for dentistry, and be it further,</td>
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<td><strong>Resolved</strong>, that after the necessary standards and educational tools are developed, the appropriate ADA agencies urge legislators and/or regulators to require the use of DICOM standards across applicable products or systems that exchange images in dentistry, and be it further</td>
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<td><strong>Resolved</strong>, that the ADA urge the dental software industry to adopt DICOM standards to ensure interoperability between systems.</td>
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<th>Board of Trustees Resolution 309— as amended—Amendment to the Policy, Policies and Recommendations on Diet and Nutrition</th>
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<tr>
<td><strong>Resolved</strong>, that the policy titled Policies and Recommendations on Diet and Nutrition (Trans.2016:330) be amended as follows (additions are underscored; deletions are stricken):</td>
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<tr>
<td><strong>Resolved</strong>, that oral health depends on proper nutrition and healthy eating habits, and necessarily includes avoiding a steady diet of foods containing natural and added sugars, processed starches and low pH-level acids, and be it further</td>
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<tr>
<td><strong>Resolved</strong>, that the ADA American Dental Association acknowledges that oral health depends on proper diet and nutrition, and it is beneficial for consumers to avoid a steady diet of ultra-processed foods—defined as industrial creations reformulated with little if any whole foods, often additives and containing large amounts of added sugar and salt—especially those containing natural and added sugars, processed starches and low pH-level acids as way to help maintain optimal oral health, and be it further</td>
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| **Resolved**, that the ADA supports the findings and recommendations in the Council on Access, Prevention and Interprofessional Relations Supplemental Report 3 to the 2012 House of Delegates: Formulation a Strategic Approach for Addressing the
Complex Emerging Issues Related to Oral Health and Nutrition in the United States

Dentist’s Role in Nutrition and Oral Health

Resolved, that the ADA encourages dentists to routinely counsel their patients about the oral health benefits of maintaining a well-balanced diet and limiting the number of between-meal snacks containing added sugar, and be it further

Resolved, that the ADA encourages dentists to stay abreast of the latest science-based nutrition recommendations and nutrition-related screening, counseling, and referral techniques, and be it further

Resolved, that the ADA encourages dentists to serve on local school wellness planning boards to establish and maintain local school wellness policies that:

- Appropriately balance the nutritional benefits of consuming certain foodstuffs and the risk of tooth decay.
- Promote lifelong healthy behaviors, including brushing twice a day, flossing once a day, limiting consumption of sugary snacks and beverages and seeing the dentist regularly.
- Reflect the inextricable link between oral health and overall health and well-being.
- Promote widespread access to safe drinking water.
- Reduce the consumption of added sugar and sugar-sweetened beverages.
- Oppose programs that promote or otherwise incentivize consumption of ultra-processed foods, including pouring rights contracts, etc.
- Reflect the link between oral health and overall health and well-being.
- Oppose programs that promote or otherwise incentivize consumption of ultra-processed foods, including pouring rights contracts, etc.
- Create environments where healthy foods are an attractive and affordable choice for all students.
- Promote lifelong healthy behaviors, including appropriate oral hygiene measures, limiting consumption of ultra-processed foods containing added sugar, and seeing the dentist regularly.

and be it further...
**Access and Prevention**

**Resolved,** that the ADA supports its members by providing access to current information and educational materials, and cultivating learning opportunities (e.g., continuing education modules, etc.), for dentists the dental professional community to learn more about the relationship between diet, nutrition and oral health—including latest science-based nutrition recommendations and nutrition-related screening and counseling techniques, and be it further

**Resolved,** that the ADA encourages collaborations with health care professionals, dieticians, social workers, community health workers, and other nutrition experts stakeholders to raise interprofessional awareness about the relationship between diet, nutrition and oral health, and be it further

**Resolved,** that the ADA supports projects, as appropriate and feasible, to educate the public about the oral health benefits of maintaining a healthy diet, and to encourage consumers to adopt healthier diets and establish better eating habits to educate the public to maintain a healthy diet and to reduce consumption of added sugar, and be it further

**Resolved,** that the ADA supports public information campaigns to reduce the amount of added sugars consumed in American diets, and be it further

**Resolved,** that the ADA encourages constituent and component dental societies to work with state and local officials to ensure locally administered nutrition and food assistance programs have an oral health component (e.g., WIC, SNAP, NSLP, etc.), and be it further

**Resolved,** that the ADA encourages constituent and component dental societies to work with state and local school officials to prohibit schools from entering into contractual arrangements, including school pouring rights contracts, that incentivize schools to sell and aggressively advertise foods and beverages with high added sugar content on school grounds (e.g., providing free samples, posting signage, branding school equipment, sponsoring events, etc.) collaboration with state and local officials to reduce consumption of ultra-processed foods, especially those containing added sugars, and promote nutritious and healthy diets in schools, and be it further

**Resolved,** that the ADA supports the World Health Organization’s 2015 Guideline on Sugar Intake for Adults and Children, and be it further

**Government Affairs**

**Resolved,** that the ADA should give priority to the following when advancing public policies on diet, nutrition and oral health:
1. Ensuring government-supported nutrition education and food assistance programs (e.g., WIC, SNAP, NSLP, etc.) have an oral health component, such as and general guidelines that promote good oral health.

2. Encouraging federal research agencies to develop the body of high-quality scientific literature examining, among other things, oral health associations with ultra-processed foods and the extent to which dental caries rates fluctuate with changes in total added sugar consumption and over what period(s).

3. Maintaining the separate line-item declaration of added sugars content on Nutrition Facts labels and listing the declared added sugars content in relatable terms (e.g., teaspoons, grams, etc.).

4. Supporting legislative and regulatory actions, as appropriate and feasible, to increase consumer awareness about the role dietary sugar consumption may ultra-processed foods play in maintaining optimal oral health and, including the potential benefits of limiting added sugar consumption in relation to general and oral health.

5. Requiring third-party payers to cover nutrition counseling in dental offices as an essential plan benefit.

<table>
<thead>
<tr>
<th>310H</th>
<th>Adopted—Consent Calendar Action</th>
<th>Reference Committee B (Dental Benefits, Practice and Related Matters) Resolution 310RC in lieu of Council on Advocacy for Access and Prevention Resolution 310—Amendment of Policy, Orofacial Protectors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Resolved</strong>, that the policy titled Orofacial Protectors (<em>Trans</em>.1994:654; 1995:613; 2016:322) be amended as follows (additions are underscored; deletions are struck):</td>
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<tr>
<td></td>
<td><strong>Orofacial Protectors</strong></td>
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<td></td>
<td><strong>Resolved</strong>, that the American Dental Association recognizes the preventive value of oro facial protectors including, but not limited to, mouthguards, helmets, and face shields, and endorses the use of oro facial protectors by all participants in recreational and sports activities with a significant risk of injury at all levels of competition including practice sessions, physical education and intramural programs, and be it further</td>
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<tr>
<td></td>
<td><strong>Resolved</strong>, that the ADA supports collaboration with international and national organizations, sports conferences, sanctioning bodies, school federations, and others to mandate the use of oro facial protectors to prevent or reduce injuries from sports, and be it further</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Resolved</strong>, that the ADA supports dental benefit coverage by third party payors for oro facial protector services.</td>
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<tr>
<td>Resolution</td>
<td>Action</td>
<td>Calendar Action</td>
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<tr>
<td>311H</td>
<td>Adopted—Consent Calendar Action</td>
<td>Council on Advocacy for Access and Prevention Resolution 311—Recission of Policy, Prevention Research to Aid Low Income Populations</td>
</tr>
<tr>
<td>312H</td>
<td>Adopted—Consent Calendar Action</td>
<td>Council on Advocacy for Access and Prevention Resolution 312—Human Papillomavirus (HPV) Education and Collaboration</td>
</tr>
<tr>
<td>313H</td>
<td>Adopted—Consent Calendar Action</td>
<td>Fourteenth Trustee District Resolution 313—Incorporating Prescription Drug Monitoring Program (PDMP) Into Practice</td>
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<td>314</td>
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<td>315</td>
<td>Not Adopted—Consent Calendar Action</td>
<td>Seventeenth Trustee District Resolution 315—Survey of ADA Membership on Medicare</td>
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<tr>
<td>Resolution Number</td>
<td>Status</td>
<td>Recommendation</td>
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<td>Resolved</td>
<td>Adopted</td>
<td>Reference Committee C (Dental Education, Science and Related Matters) Resolution 400— as amended—Consent Calendar: <strong>Resolved</strong>, that the recommendations of Reference Committee C on the following resolutions be accepted by the House of Delegates.</td>
</tr>
<tr>
<td>1. Resolution 401</td>
<td>Refer Resolution 401 in lieu of 401S.1—Amendment of Policy, Comprehensive Policy on Dental Licensure (Worksheet:4000) $: None</td>
<td>COMMITTEE RECOMMENDATION: Vote Yes on Referral</td>
</tr>
<tr>
<td>2. Resolution 402</td>
<td>Adopt—Rescission of the Policy on Requirements for Board Certification (Worksheet:4005) $: None</td>
<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
</tr>
<tr>
<td>3. Resolution 403</td>
<td>Adopt—Rescission of the Policy on Specialty Areas of Dental Practice (Worksheet:4007) $: None</td>
<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
</tr>
<tr>
<td>4. Resolution 404</td>
<td>Adopt—Rescission of the Policy on Examinations for Allied Dental (Non-Dentist) Personnel (Worksheet:4009) $: None</td>
<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
</tr>
<tr>
<td>5. Resolution 405</td>
<td>Adopt—Rescission of ADA Policy on Tooth Whitening Administered by Non-Dentists (Worksheet:4012) $: None</td>
<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
</tr>
<tr>
<td>6. Resolution 408RC</td>
<td>Adopt Resolution 408RC in lieu of Resolution 408—Increasing Allied Dental Personnel in the Workforce (Worksheet:4070) $: None</td>
<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
</tr>
<tr>
<td>7. Resolution 409</td>
<td>Adopt—Methodology of CODA Accreditation Standards (Worksheet:4072) $: None</td>
<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
</tr>
<tr>
<td>Resolution Number</td>
<td>Description</td>
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<tr>
<td>401</td>
<td>Referred to the Appropriate Agency for Further Study and Report to the 2024 House of Delegates</td>
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</tbody>
</table>

### Council on Dental Education and Licensure Resolution 401—Amendment of Policy, Comprehensive Policy on Dental Licensure

**Resolved,** that the ADA Policy on Comprehensive Policy on Dental Licensure (Trans.2018:341) be amended as follows (additions are underlined; deletions are stricken):

**Comprehensive Policy on Dental Licensure**

**General Principles**

- One standard of competency for dental licensure must be in place in order to provide quality oral health care to the public.
- Provisions for freedom of movement across state lines for all dental professionals should exist to facilitate the provision of quality oral health care to the public.
- Federal licensure and federal intervention in the state dental licensure system are strongly opposed.
- Efforts of unlicensed and unqualified persons to gain a right to serve the public directly in the field of dental practice are strongly opposed.
- Elimination of patients in the clinical licensure examination process is strongly supported to address ethical and psychometric concerns, including those identified in the ADA Council on Ethics, Bylaws and Judicial Affairs statement entitled Ethical Considerations When Using Patients in the Examination Process (Reports 2008:103). State dental societies and dental boards are urged to work toward acceptance of valid and reliable clinical assessments that do not require single-encounter performance of procedures on patients.
- The state boards of dentistry in each state or licensure jurisdiction are the sole licensure and regulating authorities for all dentists and allied dental personnel.
- State dental boards are supposed to ensure that all dental board members are free of real and perceived conflicts of interest. The Association believes that dental board members should not serve simultaneously as examiners with a clinical testing agency.
- State dental boards are encouraged to require verification of completion of continuing dental education as a condition for re-registration of dental licenses.
- Dentists identified as deficient through properly constituted peer review mechanisms should undergo assessment and corrective competency-based education and such provisions should be included in laws, rules and regulations.
Initial Licensure
States are urged to accept the following common core of requirements for initial licensure:

1. Completion of a DDS or DMD degree from a university-based dental education program accredited by the Commission on Dental Accreditation.
2. Successful passage of the National Board Dental Examination, a valid and reliable written cognitive test.
3. A determination of clinical competency for the beginning practitioner, which may include any of the following assessment pathways:
   - Acceptance of clinical examination results from any clinical testing agency that do not involve the use of single encounter procedure-based examinations involving patients; or
   - Graduation from CODA-accredited PGY-1 program, that is, a residency program at least one year in length at a CODA-accredited clinically based postdoctoral general dentistry and/or successful completion of at least one year of a specialty residency program; or
   - An Objective Structured Clinical Examination (OSCE), that is, a valid and reliable non-patient based examination that requires candidates to use critical thinking and their clinical knowledge and skills to successfully complete dental procedures; or
   - Completion of a portfolio-type examination (such as employed by the California Dental Board) or similar assessment, that uses the evaluation mechanisms currently applied by the dental schools to assess and document student competence; or
   - An Objective Structured Clinical Examination (OSCE), that is, a valid and reliable non-patient based examination consisting of multiple, standardized stations that require candidates to use their clinical and skills to successfully complete one or more dental problem-solving tasks.

For initial licensure in dentistry, international graduates of non-CODA accredited dental education programs should possess the following educational credentials: 1) completion of a university-based dental education program accredited by the Commission on Dental Accreditation (CODA) leading to a DDS or DMD degree or 2) graduation from an advanced dental education program in general dentistry accredited by the Commission on Dental Accreditation.

Curriculum Integrated Format Clinical Examination
A Curriculum Integrated Format (CIF) clinical examination addresses ethical concerns associated with single encounter patient-based examinations currently administered by dental clinical testing agencies. A CIF provides candidates opportunities to successfully complete independent “third-party” clinical assessments on patients of record prior to graduation from a dental education program accredited by the Commission on Dental Accreditation.

The curriculum-integrated format, as defined below, should only be employed as a licensure examination until a non-patient based licensure examination is developed that protects the public and meets psychometric standards. The Association believes that the following CIF provisions must be required by state boards of dentistry and incorporated by testing agencies for protection of the patient:

- A CIF examination must be performed by candidates on patients of record within an appropriately sequenced treatment plan.

- The competencies assessed by the clinical examining agency must be selected components of current dental education program curricula and reflective of current dental practice.

- All portions of the CIF examination must be available at multiple times within each institution during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake prior to graduation any portions of the examination which they have not successfully completed.

Graduates of Non-CODA Accredited Dental Education Programs

For initial licensure in dentistry, international graduates of non-CODA accredited dental education programs should possess the following educational credentials: 1) completion of a university-based dental education program accredited by the Commission on Dental Accreditation (CODA) leading to a DDS or DMD degree or 2) graduation from a postgraduate program in general dentistry accredited by the Commission on Dental Accreditation.

Licensure Compacts

State dental societies and dental boards should support licensure compacts to allow freedom of movement for practitioners across state lines. Licensure compacts increase licensees’ mobility, facilitate quality oral health care for the public, and support relocating challenges for military members and their families. Licensure compacts benefit licensing boards by providing agreement on uniform licensure requirements, a
shared data system for access to primary source documentation of applicant credentials and tracking of adverse actions. They enhance cooperation and immediate availability of information between state boards critical to protecting the public.

**Licensure by Credentials**

In addition to participating in licensure compacts, States also should have provisions for licensure of dentists who do not participate in licensure compacts. These individuals should demonstrate they are currently licensed in good standing and also have not been the subject of final or pending disciplinary action in any state or jurisdiction in which they have been licensed. This should also apply to experienced, internationally trained dentists, who have been licensed in a U.S. jurisdiction, and who may or may not have graduated from a CODA-accredited dental school.

Appropriate credentials may include:

- DDS or DMD degree from a dental education program accredited by the Commission on Dental Accreditation
- Specialty certificate/master's degree from an accredited advanced dental education program
- Specialty Board certification
- GPR/AEGD certificate from an accredited advanced dental education program
- Current, unencumbered license in good standing
- Passing grade on Documentation of successful completion of an initial clinical competency assessment licensure exam, unless initial license was granted via completion of PGY-1, Portfolio examination, or other state-approved pathway for assessment of clinical competency.
- Documentation of completion of continuing education

For dentists who hold a current, unencumbered dental license in good standing in any jurisdiction, state dental boards should:

- Not require completion of Accept pathways that allow for licensure without completing an additional clinical examination, e.g., by credentials, reciprocity, and/or endorsement.
- Consider participation in licensure compacts
- Implement specialty licensure by credentials and/or specialty licensure to
facilitate licensure portability of dental specialists.

- Make provisions available for a limited or volunteer license for dentists who wish to provide services without compensation to critical needs populations within a state in which they are not already licensed.
- Make provisions available for limited teaching permits for faculty members at teaching facilities and dental programs accredited by the Commission on Dental Accreditation.
- Make provisions available for active-duty military dentists, military spouses and veterans of the armed services.

State dental boards are encouraged to grant the same benefits of licensure mobility to internationally trained dentists who are licensed by their respective jurisdictions.

**Licensure by Credentials for Dentists Who Are Not Graduates of CODA-Accredited Dental Education Programs**

State dental societies and dental boards are strongly encouraged to grant the same benefits of licensure mobility to U.S. currently licensed dentists who were licensed by their respective jurisdictions prior to state implementation of the requirement for graduation from a CODA-accredited dental school with a DDS or DMD degree.

| 401S-1 | Referred to the Appropriate Agency for Further Study and Report to the 2024 House of Delegates | Ninth District Resolution 401S-1—Amendment of Policy, Comprehensive Policy on Dental Licensure

**Resolved**, that the ADA Policy on Comprehensive Policy on Dental Licensure (*Trans.2018:341*) be amended as follows (additions are underlined; deletions are stricken):

**Comprehensive Policy on Dental Licensure**

**General Principles**

- One standard of competency for dental licensure must be in place in order to provide quality oral health care to the public.
- Provisions for freedom of movement across state lines for all dental professionals should exist to facilitate the provision of quality oral health care to the public.
- Federal licensure and federal intervention in the state dental licensure system are strongly opposed.
- Efforts of unlicensed and unqualified persons to gain a right to serve the public directly in the field of dental practice are strongly opposed.
• Elimination of patients in the clinical licensure examination process is strongly supported to address ethical and psychometric concerns, including those identified in the ADA Council on Ethics, Bylaws and Judicial Affairs statement entitled Ethical Considerations When Using Patients in the Examination Process (Reports 2008:103). State dental societies and dental boards are urged to work toward acceptance of valid and reliable clinical assessments that do not require single-encounter performance of procedures on patients.

• The state boards of dentistry in each state or licensure jurisdiction are the sole licensure and regulating authorities for all dentists and allied dental personnel.

• State dental boards are supposed to ensure that all dental board members are free of real and perceived conflicts of interest. The Association believes that dental board members should not serve simultaneously as examiners with a clinical testing agency.

• State dental boards are encouraged to require verification of completion of continuing dental education as a condition for re-registration of dental licenses.

• Dentists identified as deficient through properly constituted peer review mechanisms should undergo assessment and corrective competency-based education and such provisions should be included in laws, rules and regulations.

Initial Licensure

States are urged to accept the following common core of requirements for initial licensure:

1. Completion of a DDS or DMD degree from a university-based dental education program accredited by the Commission on Dental Accreditation.

2. Successful passage of the National Board Dental Examination, a valid and reliable written cognitive test.

3. A determination of clinical competency for the beginning practitioner, which may include any of the following assessment pathways:
   • Acceptance of clinical examination results from any clinical testing agency that do not involve the use of single encounter procedure-based examinations involving patients; or
   • Graduation from CODA-accredited PGY-1 program, that is, a residency program at least one year in length at a CODA-accredited clinically based postdoctoral general dentistry and/or successful completion of at least one year of a specialty residency program; or
• An Objective Structured Clinical Examination (OSCE), that is, a valid and reliable non-patient based examination that requires candidates to use critical thinking and their clinical knowledge and skills to successfully complete dental procedures; or

• Completion of a portfolio-type examination (such as employed by the California Dental Board) or similar assessment, that uses the evaluation mechanisms currently applied by the dental schools to assess and document student competence; or

• An Objective Structured Clinical Examination (OSCE), that is, a valid and reliable non-patient based examination consisting of multiple, standardized stations that require candidates to use their clinical and skills to successfully complete one or more dental problem-solving tasks.

For initial licensure in dentistry, international graduates of non-CODA accredited dental education programs should possess the following educational credentials: 1) completion of a university-based dental education program accredited by the Commission on Dental Accreditation (CODA) leading to a DDS or DMD degree or 2) graduation from an advanced dental education program in general dentistry accredited by the Commission on Dental Accreditation.

**Curriculum Integrated Format Clinical Examination**

A Curriculum Integrated Format (CIF) clinical examination addresses ethical concerns associated with single encounter patient-based examinations currently administered by dental clinical testing agencies. A CIF provides candidates opportunities to successfully complete independent "third-party" clinical assessments on patients of record prior to graduation from a dental education program accredited by the Commission on Dental Accreditation.

The curriculum integrated format, as defined below, should only be employed as a licensure examination until a non-patient based licensure examination is developed that protects the public and meets psychometric standards. The Association believes that the following CIF provisions must be required by state boards of dentistry and incorporated by testing agencies for protection of the patient:

- A CIF examination must be performed by candidates on patients of record within an appropriately sequenced treatment plan.

- The competencies assessed by the clinical examining agency must be selected components of current dental education program curricula and reflective of current dental practice.

- All portions of the CIF examination must be available at multiple times within each institution during dental school to ensure that
patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake prior to graduation any portions of the examination which they have not successfully completed.

Graduates of Non-CODA Accredited Dental Education Programs

For initial licensure in dentistry, international graduates of non-CODA accredited dental education programs should possess the following educational credentials: 1) completion of a university-based dental education program accredited by the Commission on Dental Accreditation (CODA) leading to a DDS or DMD degree or 2) graduation from a postgraduate program in general dentistry accredited by the Commission on Dental Accreditation.

Licensure Compacts

State dental societies and dental boards should support licensure compacts to allow freedom of movement for practitioners across state lines. Licensure compacts increase licensees’ mobility, facilitate quality oral health care for the public, and support relocating challenges for military members and their families. Licensure compacts benefit licensing boards by providing agreement on uniform licensure requirements, a shared data system for access to primary source documentation of applicant credentials and tracking of adverse actions. They enhance cooperation and immediate availability of information between state boards critical to protecting the public.

Licensure by Credentials

In addition to participating in licensure compacts, States also should have provisions for licensure of dentists who do not participate in licensure compacts. These individuals should demonstrate they are currently licensed in good standing and also have not been the subject of final or pending disciplinary action in any state or jurisdiction in which they have been licensed. This should also apply to experienced, internationally trained dentists, who have been licensed in a U.S. jurisdiction, and who may or may not have graduated from a CODA-accredited dental school.

Appropriate credentials may include:

- DDS or DMD degree from a dental education program accredited by the Commission on Dental Accreditation
- Specialty certificate/master's degree from an accredited advanced dental education program
• Specialty Board certification
• GPR/AEGD certificate from an accredited advanced dental education program
• Current, unencumbered license in good standing
• Passing grade on Documentation of successful completion of an initial clinical competency assessment, license exam, unless initial license was granted via completion of PGY-1, Portfolio examination, or other state-approved pathway for assessment of clinical competency.
• Documentation of completion of continuing education

For dentists who hold a current, unencumbered dental license in good standing in any jurisdiction, state dental boards should:

• Not require completion of Accept pathways that allow for licensure without completing an additional clinical examination, e.g., by credentials, reciprocity, and/or endorsement.
• Consider participation in licensure compacts
• Implement specialty licensure by credentials and/or specialty licensure to facilitate licensure portability of dental specialists.
• Make provisions available for a limited or volunteer license for dentists who wish to provide services without compensation to critical needs populations within a state in which they are not already licensed.
• Make provisions available for limited teaching permits for faculty members at teaching facilities and dental programs accredited by the Commission on Dental Accreditation.
• Make provisions available for dentists who are active duty military, military spouses and or veterans of the armed services.

State dental boards are encouraged to grant the same benefits of licensure mobility to internationally trained dentists who are licensed by their respective jurisdictions.

Licensure by Credentials for Dentists Who Are Not Graduates of CODA-Accredited Dental Education Programs

State dental societies and dental boards are strongly encouraged to grant the same benefits of licensure mobility to U.S. currently licensed dentists who were licensed by their respective jurisdictions prior to state implementation of the requirement for graduation from a CODA-accredited dental school with a DDS or DMD degree.
<table>
<thead>
<tr>
<th>Resolution</th>
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<th>Calendar Action</th>
<th>Resolution Title</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>402H</td>
<td>Adopted—Consent Calendar Action</td>
<td>Council on Dental Education and Licensure Resolution 402—Rescission of the Policy and Requirements for Board Certification</td>
<td>Resolved, that the policy, Requirements for Board Certification (Trans.1975:690; 2018:325) be rescinded.</td>
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<td>406</td>
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<td>WITHDRAWN</td>
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<td>407</td>
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<td>WITHDRAWN</td>
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<tr>
<td>408H</td>
<td>Adopted—Consent Calendar Action</td>
<td>Reference Committee C (Dental Education, Science and Related Matters) Resolution 408RC in lieu of Seventeenth Trustee District Resolution 408—Increasing Allied Personnel in the Workforce</td>
<td>Resolved, that the appropriate agency use the CODA ad hoc committee findings to suggest programs to attract students into allied educational programs and careers, and be it further Resolved, that the appropriate agency recommend programs and policies to urge CODA to improve the ability of Allied Programs to expand enrollment, such as, faculty ratios and the associated costs of tuition for these programs, and be it further Resolved, that the appropriate agency report back to the 2024 House of Delegates.</td>
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<tr>
<td>409H</td>
<td>Adopted</td>
<td>Seventeenth Trustee District Resolution 409—as amended—Methodology of CODA Accreditation Standards</td>
<td>Resolved, that the ADA urge CODA to demonstrate transparent methodology for teacher to student ratios and educational requirements for part time teachers and adjunct instructors in all allied educational programs, and be it further</td>
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<tr>
<td>Resolution</td>
<td>Recommendation</td>
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<tr>
<td>501</td>
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<tr>
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<td>507</td>
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<tr>
<td>508</td>
<td>Refer on referral</td>
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</table>

**Resolved,** that the ADA urge CODA to allow Registered Allied personnel with ten or more years of experience to act as part time and/or adjunct faculty for Allied Dental educational programs who have other faculty who meet current requirements actively teaching in the same program. *and be it further*  
**Resolved,** that the ADA urge CODA to revise its faculty to student ratio for Dental Hygiene education programs from (1 to 5) to (1 to 6) to be consistent with other allied dental education programs.

### Reference Committee D (Legislative, Health, Governance and Related Matters)

**Resolution 500—**as amended—Consent Calendar

**Resolved,** that the recommendations of Reference Committee D on the following resolutions be accepted by the House of Delegates.

1. **Resolution 501**—Adopt—Bylaws Amendment to Clarify Non-Voting Members of the House of Delegates (Worksheet:5000) $: None
   
   COMMITTEE RECOMMENDATION: Vote Yes

2. **Resolution 503**—Not Adopt—Amendment to the ADA Bylaws to Clarify Presidential Authority to Establish Workgroups or Task Forces and Appoint Members (Worksheet:5003) $: None
   
   COMMITTEE RECOMMENDATION: Vote No

3. **Resolution 504S-1**—Adopt Resolution 504S-1 in lieu of Resolution 504—Proposal to Postpone the ADA Governance Study to Account for Strategic Forecasting (Worksheet:5005a) $: None
   
   COMMITTEE RECOMMENDATION: Vote Yes

4. **Resolution 505**—Adopt—Report of the Special Committee on ERISA (Worksheet:5009) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

5. **Resolution 507**—Adopt—Amendment to the Policy, Activity to Stop Unlicensed Dental or Dental Hygiene Practice (Worksheet:5014) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

6. **Resolution 508**—Refer—Amendment to the Manual of the House of Delegates: Approving Minutes of the ADA House of Delegates (Worksheet:5017) $15,000

   COMMITTEE RECOMMENDATION: Vote Yes on Referral

   COMMITTEE RECOMMENDATION: Vote Yes

8. Resolution 510—Adopt—Proposed Policy, Public Funding for Oral Health Care Provided at Academic Dental Institutions (Worksheet:5025) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

9. Resolution 511—Adopt—Rescission of the Policy, Reduced Fee Programs for the Elderly Poor (Worksheet:5028) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

10. Resolution 512—Adopt—Rescission of the Policy, Education of AARP on Benefits of Oral Health Agenda (Worksheet:5031) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

11. Resolution 513—Adopt—Rescission of the Policy, Dentists as Providers in all Public and Private Health Care Programs and Discrimination in Payment for Services Performed by a Licensed Dentist (Worksheet:5034) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

12. Resolution 514—Adopt—Proposed Policy, Engaging Community-Based Health Centers (Worksheet:5037) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

13. Resolution 515—Adopt—Amendment of Policy, Use of Dentist-To-Population Ratios (Worksheet:5041) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

14. Resolution 516RC—Adopt Resolution 516RC in lieu of Resolution 516—Amendment to the Campaign Rules (Worksheet:5043) $: None

   COMMITTEE RECOMMENDATION: Vote Yes

15. Resolution 517—Adopt—Preventing Unfair Discrimination (Worksheet:5045) $30,000
<table>
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<tr>
<th></th>
<th>COMMITTEE RECOMMENDATION: Vote Yes</th>
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<tbody>
<tr>
<td>16. <strong>Resolution 518RC</strong>—Adopt Resolution 518RC in lieu of Resolution 518—Amend the Duties of the Committee on Constitution and Bylaws (Worksheet:5046) $: None</td>
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<tr>
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<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
</tr>
<tr>
<td>501H</td>
<td><strong>Adopted—Consent Calendar Action</strong></td>
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<tr>
<td></td>
<td>Board of Trustees Resolution 501—as amended by the Standing Committee on Constitution and Bylaws—Bylaws Amendment to Clarify Non-Voting Members of the House of Delegates</td>
</tr>
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<td><strong>Resolved</strong>, that CHAPTER III. HOUSE OF DELEGATES, Section 10. MEMBERS, C. NON-VOTING MEMBERS, of the ADA Bylaws be amended as follows (additions underscored; deletions stricken):</td>
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<td></td>
<td>C. NON-VOTING MEMBERS. The <strong>Speaker of the House of Delegates and elective and appointive officers and trustees</strong> members of the Board of Trustees of this Association shall be members of the House of Delegates without the power to vote and shall not serve as delegates. Past presidents of this Association shall be members of the House of Delegates without the power to vote unless designated as delegates.</td>
</tr>
<tr>
<td>502H</td>
<td><strong>Adopted</strong></td>
</tr>
<tr>
<td></td>
<td>Board of Trustees Resolution 502—as Amended by House Action and by the Standing Committee on Constitution and Bylaws (Standing Committee Amendment is double underlined; double strikethrough)—Amendment of the ADA Governance Manual and Rules of the House of Delegates to Revise the Installation Ceremony Schedule</td>
</tr>
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<td><strong>Resolved</strong>, that Chapter IV, Section D. of the Governance and Organizational Manual of the American Dental Association be amended as shown below (deletions stricken through):</td>
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<td>D. <strong>Installation.</strong> The elective officers shall be installed at the last meeting of the annual session of the House of Delegates. The President-elect shall be installed as President at the next annual session of the House following election. The Second Vice President shall be installed as First Vice President at the next annual session of the House following election.</td>
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<td>and be it further</td>
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<td><strong>Resolved</strong>, that the section entitled “Installation of New Officers and Trustees” contained in the Rules of the House of Delegates be amended as follows (additions underlined; deletions stricken through):</td>
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</tbody>
</table>
Installation ceremonies for new officers and trustees shall take place at a on Tuesday afternoon as the first item of business with the time specified by the Speaker of the House and the installation ceremony schedule shall be published in The Manual of the House of Delegates.

<table>
<thead>
<tr>
<th>Resolution</th>
<th>Status</th>
<th>Text</th>
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</thead>
</table>
| 503        | Not Adopted       | Board of Trustees Resolution 503—Amendment to the ADA Bylaws to Clarify Presidential Authority to Establish Workgroups or Task Forces and Appoint Members

**Resolved**, that Chapter X., Section 20. of the ADA Bylaws be amended as follows (additions underscored, deletions stricken through):

Section 20. SPECIAL COMMITTEE. A special committee is a group formed to perform tasks not otherwise assigned by the Bylaws or the Governance Manual. A special committee will cease to exist at the earlier of the completion of its assigned tasks or at the adjournment sine die of the annual session of the House of Delegates following its creation.

A. ESTABLISHMENT AND DUTIES. The House of Delegates, Board of Trustees, ADA President, councils and commissions of the ADA may establish special committees. The resolution or motion or, in the case of the ADA President, written declaration, establishing a special committee shall specify the tasks and scope of responsibility assigned to the special committee.

B. MEMBERSHIP AND MEMBER APPOINTMENT, TERM AND TENURE. The resolution, or motion or written declaration establishing a special committee shall specify the number and type of committee members, their method of selection and the term and tenure of members of the Committee.

C. RULES OF OPERATION. The rules of operation and procedures of special committees shall be as set forth in the Governance Manual and the rules of body establishing the special committee.

D. FUNDING. Unless otherwise specified in the resolution or motion establishing a special committee, any funding required by the special committee to fulfill its assigned tasks shall be the responsibility of the body establishing the special committee. In the case of a special committee being established by the President, any funding required by the special committee to fulfill its assigned tasks shall be the responsibility of the Board of Trustees.

E. REPORTING. All reports of a special committee shall be directed to the body that established the committee.
F. PRIVILEGE OF THE FLOOR. Chairs and members of special committees who are not members of the House of Delegates shall have the right to participate in the debate on any reports originating with their respective special committees but shall have no other rights unless that person is a duly credentialed delegate or alternate delegate.

and be it further

Resolved, that Chapter VI., Section 90.A. of the ADA Bylaws be amended by the inclusion of a newly enumerated duty, as follows (additions underscored, deletions stricken through):

Section 90. DUTIES:

A. PRESIDENT. It shall be the duty of the President to:

* * *

g. Declare the establishment of special committees.
gh. Review travel reimbursements for the Treasurer.
hi. Perform such other duties as may be provided in these Bylaws and/or the Governance Manual.

<table>
<thead>
<tr>
<th>504H</th>
<th>Adopted</th>
<th>Ninth Trustee District Resolution 504S-1 in lieu of Board of Trustees Resolution 504—as amended—Proposal to Postpone the ADA Governance Study to Account for Strategic Forecasting</th>
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<tbody>
<tr>
<td></td>
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<td>Resolved, that the ADA recognize that the 2022 House of Delegates establishment of the Strategic Forecasting Committee has the potential to have impact upon the governance structure of the Association, and be it further</td>
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<td>Resolved, as Resolution 56H-2002 (Trans.2002:375) and Resolution 38H-2011 (Trans.2011:524) combine to direct a governance study be completed and for which the results and recommendations be presented to the 2024 House of Delegates, that any such governance study instead be deferred such that the results and recommendations be delivered to the 2027 House of Delegates, thus giving the Strategic Forecasting Committee sufficient time for any governance impact to be reflected in such a study, and be it further</td>
</tr>
<tr>
<td>Resolution No.</td>
<td>Action</td>
<td>Title of Resolution</td>
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<tr>
<td>505H</td>
<td>Adopted—Consent Calendar Action</td>
<td>Special Committee on ERISA Resolution 505—Report of the Special Committee on ERISA</td>
</tr>
<tr>
<td>506H</td>
<td>Adopted</td>
<td>Second Trustee District Resolution 506—Amendment of the Rules of the House of Delegates to Permit the Motion to Table</td>
</tr>
<tr>
<td>507H</td>
<td>Adopted—Consent Calendar Action</td>
<td>Council on Government Affairs Resolution 507—Amendment to the Policy, Activity to Stop Unlicensed Dental or Dental Hygiene Practice</td>
</tr>
<tr>
<td>Resolution</td>
<td>Description</td>
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<td><strong>Resolved</strong>, that the designated state practice act enforcement authority should be expeditious in prosecuting individuals who are practicing dentistry or dental hygiene without a license, and be it further</td>
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<td><strong>Resolved</strong>, that individuals found to be practicing dentistry or dental hygiene without a proper license should be prosecuted to the fullest extent of the law.</td>
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<td>and be it further</td>
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<tr>
<td><strong>Resolved</strong>, that the policy titled Activity to Stop Unlicensed Dental or Dental Hygiene Practice (*Trans.*1999:949) be rescinded.</td>
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**First Trustee District Resolution 508—Amendment to the Manual of the House of Delegates: Approving Minutes of the ADA House of Delegates**

**Resolved**, that the Standing Committee on Credentials, Rules and Order of the House of Delegates be tasked with reviewing and approving the minutes of the House of Delegates, followed by final approval of the minutes by the House of Delegates at its next annual session, and be it further

**Resolved**, that the Committee will meet in a timely manner in order to complete its deliberations and submit the approved minutes to the Secretary of the House of Delegates within ninety (90) days following the close of the House of Delegates *sine die*, and be it further

**Resolved**, that the Standing Committees of the House of Delegates section of the *Manual of the House of Delegates and Supplemental Information* be amended as follows:

**Standing Committees of the House of Delegates**

In order to conduct its business, the House of Delegates uses three standing committees: (1) the Committee on Credentials, Rules and Order; (2) the Committee on Constitution and Bylaws; and (3) the Strategic Forecasting Committee. The Committee on Credentials, Rules and Order is composed of nine members of the House of Delegates appointed by the President. The Committee on Constitution and Bylaws is composed of not more than eight nor less than six members of the Council on Ethics, Bylaws and Judicial Affairs appointed by the President in consultation with the Speaker of the House of Delegates and the Council Chair. These committees are largely concerned with procedural matters. A description of their specific duties follows.

*Committee on Credentials, Rules and Order*. This standing committee of the House of Delegates consists of nine (9) members from the officially certified delegates and alternate delegates, who are appointed by the President at least sixty (60) days in
advance of each session. It is the duty of the Committee to present the agenda and recommend for approval such rules as are necessary for the conduct of the business of the House of Delegates. The report of this committee is prepared in collaboration with the officers of the House of Delegates and is presented at the opening of the first meeting of the House. In addition, this committee has the duty to conduct hearings and to make recommendations on the eligibility of delegates and alternate delegates to a seat in the House of Delegates when a seat is contested, maintains a continuous roll call and periodically reports on the roll call to the House of Delegates, determines the presence of a quorum and supervises voting and election procedures. The Committee also has the responsibility to consult with the Speaker and Secretary of the House of Delegates on matters relating to the order of business and special rules of order as required. The Committee is tasked with reviewing and approving the minutes of the House of Delegates, which are drafted by the Secretary of the House of Delegates. The Committee will meet in a timely manner in order to complete its deliberations and submit the approved minutes to the Secretary of the House of Delegates within ninety (90) days following the adjournment sine die of the House of Delegates. Final approval of the minutes will be acted on by the House of Delegates at its next annual session. The Committee is on duty throughout the annual session and until it has submitted the approved minutes of the House of Delegates to the Secretary of the House of Delegates.

and be it further

Resolved, that this resolution and its amendment to the Manual of the House of Delegates and Supplemental Information shall take effect at the adjournment sine die of the 2024 ADA House of Delegates.


Resolved, that the following policy titled Availability of Dentists for American Indians and Alaska Natives be adopted:

Resolved, that the American Dental Association supports enhancing federal appropriations dedicated to helping the Indian Health Service Division of Oral Health increase the number of dentists that are available to treat American Indians and Alaska Natives, and be it further

Resolved, that the ADA supports collaborating with the Indian Health Service to close gaps in access to dental care and address the current and future oral health needs of American Indians and Alaska Natives, including the practical and cost-effective use of dentists in private practice, recent graduates of pre- and postgraduate educational programs (i.e., externships, internships, and other
advanced education), and dentists in the Tri Service Military Reserve, and be it further

**Resolved,** that the ADA supports and encourages American Indian and Alaska Native students to pursue careers in dentistry.

and be it further


<table>
<thead>
<tr>
<th>510H</th>
<th>Adopted—Consent Calendar Action</th>
<th>Council on Government Affairs Resolution 510—Proposed Policy, Public Funding for Oral Health Care Provided at Academic Dental Institutions</th>
</tr>
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<tbody>
<tr>
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<td>Resolved, that the following policy titled Public Funding for Oral Health Care Provided at Academic Dental Institutions be adopted:</td>
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<td>Resolved, that the American Dental Association supports enhancing federal and state funding for academic dental institutions to provide oral health care services to underserved, unserved and uninsured indigent populations.</td>
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<td>and be it further</td>
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<td></td>
<td>Resolved, that the policy titled Legislation to Increase Federal and State Funding of Oral Health Care Services Provided at Academic Dental Institutions (*Trans.*2002:404) be rescinded.</td>
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</tbody>
</table>

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<thead>
<tr>
<th>511H</th>
<th>Adopted—Consent Calendar Action</th>
<th>Council on Government Affairs Resolution 511—Rescission of the Policy, Reduced Fee Programs for the Elderly Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Resolved, that the policy titled Reduced Fee Programs for the Elderly Poor (*Trans.*1980:591) be rescinded.</td>
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<td>Resolved, that the policy titled Education of AARP on Benefits of Oral Health Agenda (*Trans.*1989:568) be rescinded.</td>
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</tbody>
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<thead>
<tr>
<th>513H</th>
<th>Adopted—Consent Calendar Action</th>
<th>Council on Government Affairs Resolution 513—Rescission of the Policy, Dentists as Providers in all Public and Private Health Care Programs and Discrimination in Payment for Services Performed by a Licensed Dentist</th>
</tr>
</thead>
</table>
Resolved, that the policy titled Dentists as Providers in All Public and Private Health Care Programs and Discrimination in Payment for Services Performed by a Licensed Dentist (Trans.1990:559) be rescinded.

514H  Adopted  Council on Government Affairs Resolution 514—as amended—Proposed Policy, Engaging Community-Based Health Centers

Resolved, that the following policy titled Engaging Community-Based Health Centers be adopted as follows:

Resolved, that the American Dental Association supports and encourages collaboration between organized dentistry and efforts to improve the efficiency and effectiveness of community-based health centers at all levels of the tripartite to improve the oral health of vulnerable, uninsured, underinsured and underserved communities, to provide for the oral health of the vulnerable and underserved seeking care at these facilities, and be it further

Resolved, that the Association encourages increased contracting between community health centers and private practice dentists to improve access to dental care for the vulnerable and underserved in their communities, member dentists to participate on community health center boards and constituent dental societies to consider health center dentist participation on their boards to foster collaboration to improve oral health, and be it further

Resolved, that Association encourages constituent dental societies to foster relationships with state and regional primary care associations to strengthen the oral health safety net, dentists to participate on community health center boards and other administrative bodies to ensure community-based health centers and private practice dentists are collaborating effectively to treat the vulnerable and underserved in their communities, and be it further

Resolved, that the Association encourages community health center dental programs and private practice dental practices to consider contractual relationships as allowed by federal regulations, to improve access to dental care for vulnerable, uninsured, underinsured and underserved communities, constituent dental societies to foster relationships with state and regional primary care associations to jointly develop dental advisory boards to ensure community health centers and private practice dentists are collaborating effectively to treat the vulnerable and underserved in their communities,

and be it further

Resolved, that the policies titled Community Health Centers (Trans.2002:415; 2016:314) and Health Centers (Trans.2005:338; 2016:338) be rescinded.
<table>
<thead>
<tr>
<th>Resolution Number</th>
<th>Action Details</th>
<th>Resolved Details</th>
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</table>
| 515H              | Adopted—Consent Calendar Action | Council on Government Affairs Resolution 515—Amendment of Policy, Use of Dentist-to-Population Ratios  

**Resolved**, that the policy titled Use of Dentist-to-Population Ratios (*Trans.* 1984:538; 1996:681; 2021:314) be amended as follows (additions are underscored; deletions are stricken):  

**Use of Dentist-to-Population Ratios Determining Health Professional Shortage Areas**  

**Resolved**, that the American Dental Association supports and encourages the accurate, timely, and objective determination of federal and state dental health professional shortage area designations, and be it further  

**Resolved**, that the ADA opposes using dentist-to-population ratios as the exclusive measure for designating dental health professional shortage areas or evaluating or recommending programs for dental education or dental care.  

<table>
<thead>
<tr>
<th>Resolution Number</th>
<th>Proposed Action Details</th>
<th>Resolved Details</th>
</tr>
</thead>
</table>
| 516H              | Adopted—Consent Calendar Action | Reference Committee D (Legislative, Health, Governance and Related Matters) Resolution 516RC in lieu of Election Commission Resolution 516—Amendment to the Campaign Rules  

**Resolved**, that the Election Commission and Campaign Rules be amended by the inclusion of the following paragraph (additions underscored):  

18. No printed campaign-related material may be distributed in the House of Delegates or to delegates and alternate delegates.  

19. Candidates may prepare a piece of campaign literature to be electronically distributed to the delegates and alternate delegates following a candidate’s announcement of candidacy for elective officer. Such campaign literature shall be sized so that if printed the literature is no larger than four single-sided sheets of 8½ x 11 inch paper. If desired, a second piece of campaign literature of similar length may be electronically distributed to the delegates and alternate delegates following the candidates' receipt from the ADA of the final list of certified delegates and alternate delegates.  

20. Each candidate may prepare a video to be distributed as described below to delegates and alternate delegates and other members of the House of Delegates.  

21. Candidate brochures, videos or other campaign-related communications can include photographs and likenesses of the candidate, but shall not include any photograph, likeness or mention of any other current officer of the ADA or current member of the ADA Board of Trustees.
Each piece of literature and any video developed by any candidate shall be submitted to the ADA for review and approval prior to being distributed. Such literature review may take up to five (5) business days to complete. Video reviews will be completed as quickly as possible but are dependent on the length of the video. The candidates shall obtain permissions to use the likeness or image of any non-familial third party that appears in a piece of campaign literature or in any video. Candidates shall state that such permissions have been obtained when submitting the literature and any video for review. The permission should be retained by the candidates and submitted to the ADA only if requested.

and be it further

**Resolved**, that the remaining paragraphs of the Election Commission and Campaign Rules be renumbered accordingly.

<table>
<thead>
<tr>
<th>517H</th>
<th>Adopted—Consent Calendar Action</th>
<th>Fourteenth Trustee District Resolution 517—Preventing Unfair Discrimination</th>
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</thead>
<tbody>
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<td><strong>Resolved</strong>, that the appropriate ADA agency create a pilot project to assist a limited number of states to develop and advocate for legislation or regulation that prevents discrimination in licensing, credentialing, and other matters against dentists who have received counseling, therapy, or treatment for mental health issues, and be it further</td>
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<td><strong>Resolved</strong>, that the resources developed by this project, including model legislation, be compiled into a toolkit for other state associations to use in their advocacy efforts, and be it further</td>
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<td><strong>Resolved</strong>, that a report on these activities be prepared for the 2024 House of Delegates.</td>
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<thead>
<tr>
<th>518H</th>
<th>Adopted—Consent Calendar Action</th>
<th>Reference Committee D (Legislative, Health, Governance and Related Matters) Resolution 518RC in lieu of Ninth Trustee District Resolution 518—Amend the Duties of the Committee on Constitution and Bylaws</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Resolved</strong>, that the paragraph describing the Committee on the Constitution and Bylaws found on page 21 of the 2023 Manual of the House of Delegates entitled Standing Committees of the House of Delegates, be amended as follows (additions underscored and deletions stricken):</td>
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<td><strong>Committee on Constitution and Bylaws.</strong> The Standing Committee on Constitution and Bylaws shall consist of not more than eight (8) nor less than six (6) members of the Council on Ethics, Bylaws and Judicial Affairs of this Association appointed by the President in consultation with the Speaker of the House of Delegates and the Council Chair. The Committee reviews the wording of all proposed amendments to the Constitution, Bylaws, and Governance Manual and the Manual of the House of Delegates that are submitted prior to the first</td>
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meeting of each new session of the House of Delegates. The Standing Committee either approves the text of the amendment as written or redrafts the resolution to accomplish the intent of the maker in the form currently used by the House of Delegates. The Standing Committee files a report of its findings and actions at the first meeting of the House of Delegates and then adjourns. Thereafter, and until the House of Delegates adjourns sine die, the Speaker of the House and the Chair of the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) are responsible for reviewing any new resolutions or changes to resolutions that propose amendments to the Constitution, Bylaws, and Governance Manual and Manual of the House of Delegates. Each reference committee is required to clear the wording of a proposed amendment either with the Standing Committee or, if the amendment is proposed after the Standing Committee adjourns, with the Speaker who, with the Chair of CEBJA, will determine whether the language of the amendment is in appropriate form.