

**UNOFFICIAL REPORT OF ACTIONS
AMERICAN DENTAL ASSOCIATION HOUSE OF DELEGATES
Washington, D.C.: October 25-28, 2025**

This document reflects the “unofficial actions” of the 2025 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 2026.

Resolution Number	House Action	Resolution	Notes
101H	Adopted	Board of Trustees Resolution 101—Nominations to Councils Resolved , that the nominees put forward for membership on ADA councils be elected.	
102H	Adopted	Board of Trustees Resolution 102—Nomination to Fill a Commission Vacancy Resolved , that Dr. Harold Mark Livingston of Mississippi be elected to fill a vacancy on the National Commission on Recognition of Dental Specialties and Certifying Boards for a term that ends at the close of the 2027 House of Delegates.	
103H	Adopted	Standing Committee on Credentials, Rules and Order Resolution 103—Approval of Certified Delegates Resolved , that the list of certified delegates and alternate delegates posted in 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 2025 House of Delegates of the American Dental Association.	
104H	Adopted	Standing Committee on Credentials, Rules and Order Resolution 104—Adoption of Agenda and Order of Agenda Items Resolved , that the agenda as presented in the <i>2025 Manual of the House of Delegates and Supplemental Information</i> 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.	

105H	Adopted	<p>Standing Committee on Credentials, Rules and Order Resolution 105—Referrals of Reports and Resolutions</p> <p>Resolved, that the list of referrals recommended by the Speaker of the House of Delegates be approved.</p>	
200H	Adopted	<p>Reference Committee A (Business, Membership and Administrative Matters) Resolution 200—as amended—Consent Calendar</p> <p>Resolved, that the recommendation of Reference Committee A on the following resolution be accepted by the House of Delegates.</p> <p>1. Resolution 201—Not Adopt—Resolution 201 in lieu of Resolution 201S-1— Establishment of a Task Force to Study the Creation of a Committee of the House of Delegates on Budget (Worksheet:2000) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote No</p> <p>2. Resolution 203—Not Adopt—Establishing the National Union of ADA Employed Dentists (NUAED) to Promote Workplace Protections, Ethics, and Professional Support (Worksheet:2003) \$300,000</p> <p>COMMITTEE RECOMMENDATION: Vote No</p> <p>3. Resolution 204—Not Adopt—Restoring Budgetary Oversight to the House of Delegates and Establishing Transparency for Major Expenditures (Worksheet:2011) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote No</p> <p>4. Resolution 205—Refer—Resolution on Fiscal Responsibility and Modernization of ADA Governance Operations (Worksheet:2016) \$60,000</p> <p>COMMITTEE RECOMMENDATION: Vote Yes on Referral</p> <p>5. Resolution 207—Not Adopt—Amendment to the Manual of the House of Delegates Section Titled Representation of Constituents and Periodic Reapportionment of Delegates and Alternate Delegates (Worksheet:2019) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote No</p>	

		<p>6. Resolution 208—Not Adopt—Strengthening Financial Oversight and Accountability of the ADA Board of Trustees (Worksheet:2007) \$900,000</p> <p>COMMITTEE RECOMMENDATION: Vote No</p> <p>7. Resolution 210RC—Adopt Resolution 210RC in lieu of Resolution 210 and Resolution 210B—Addressing Food Insecurity in U.S. Dental Students (Worksheet:2028) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>8. Resolution 212—Refer—Optimizing the House of Delegates Structure and Operations (Worksheet:2031) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes on Referral.</p> <p>9. Resolution 213—Not Adopt—Growing ADA Membership Through Transparent and Accessible Governance (Worksheet:2144) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote No</p> <p>10. Resolution 214—Not Adopt—Adoption of Mission-Based Accounting Framework (Worksheet:2034) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote No</p> <p>11. Resolution 217—Adopt Resolution 217 in lieu of Resolution 217S-1—Amendment of ADA Policy on Posting of Financial Information (Worksheet:2089) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>12. Resolution 218—Adopt—Empowering the Council on Communications to Ensure Integrity and Member Representation in Public-Facing Communications (Worksheet:2159) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>13. Resolution 220—Adopt—Nominations to the Strategic Forecasting Committee (Worksheet:2060) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p>	
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		<p>22. Resolution 232—Not Adopt—Forensic Audit to Rebuild Trust in the ADA and its Board of Trustees to Strengthen Member Retention and Growth (Worksheet:2190) \$ 2,000,000</p> <p>COMMITTEE RECOMMENDATION: Vote No.</p>	
201	Not Adopted— Consent Calendar Action	<p>Strategic Forecasting Committee Resolution 201 in lieu of Fifth Trustee District Resolution 201S-1—Establishment of a Task Force to Study the Creation of a Committee of the House of Delegates on Budget</p> <p>Resolved, that a task force be convened to study the creation of a standing committee of the House of Delegates on Budget, and be it further</p> <p>Resolved, that the duties of the standing committee would include oversight of the ADA operating budget and spending from ADA reserves, and be it further</p> <p>Resolved, that the task force be appointed by the President and comprised of up to nine members, including two representatives each from the Strategic Forecasting Committee and the Board of Trustees; the ADA Treasurer; President or President-elect; and the Executive Director, and be it further</p> <p>Resolved, that the task force shall meet electronically and report its findings and recommendations to the 2026 House of Delegates.</p>	
202	WITHDRAWN		
203	Not Adopted	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 203—Establishing the National Union of ADA Employed Dentists (NUAED) to Promote Workplace Protections, Ethics, and Professional Support</p> <p>Resolved, that the American Dental Association shall establish the National Union of ADA Employed Dentists (NUAED) as a voluntary, membership-based union available to any employed dentist who is also a member of the ADA, and be it further</p> <p>Resolved, that the NUAED shall operate in full legal compliance with applicable labor, antitrust, and association law, with legal oversight guiding its structure and separation from ADA governance, and be it further</p> <p>Resolved, that participation in NUAED shall be optional and no employer, including private practices, shall be required or expected to hire union-affiliated dentists, and be it further</p>	

		<p>Resolved, that the NUAED shall provide member services including legal and contract review; professional advocacy (such as support during employment disputes or internal disciplinary actions); ethical and workplace support (such as guidance on production pressure, discrimination, or unethical directives); and—where legally permitted— participation in salary and benefit negotiations, and be it further</p> <p>Resolved, that excluding implementation costs, the NUAED shall be financially self-sustaining, funded exclusively through voluntary union dues or participation fees paid by its members, and structured in compliance with federal antitrust and labor laws, including the FTC’s association guidance and the National Labor Relations Act, with no ADA dues or general association funds used to subsidize its operations, and be it further</p> <p>Resolved, that the NUAED shall be governed by an independent board of directors elected by its members, and that this board shall be responsible for ensuring the union’s legal compliance, member services, and operational integrity, in accordance with all applicable laws and its own bylaws, and be it further</p> <p>Resolved, that the Board of Trustees shall designate a temporary implementation group to support the development of the NUAED and deliver a progress update to the 2026 House of Delegates, and be it further</p> <p>Resolved, that this union shall serve as a benefit-driven support system to help employed dentists protect their rights and elevate standards of professionalism across all practice settings.</p>	
204	<p>Not Adopted— Failed to receive a 2/3 affirmative vote</p>	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 204—Restoring Budgetary Oversight to the House of Delegates and Establishing Transparency for Major Expenditures</p> <p>Resolved, that Chapter V. BOARD OF TRUSTEES, Section 80. DUTIES, of the ADA <i>Bylaws</i> be amended as follows (additions <u>underlined</u>, deletions stricken through):</p> <p><i>Section 80. DUTIES.</i> It shall be the duty of the Board of Trustees to:</p> <ul style="list-style-type: none"> A. Provide for the purchase, sale, mortgage, maintenance and supervision of all properties or offices of this Association. B. Appoint the Executive Director and, when necessary, an interim Executive Director. C. Determine the date and place for convening annual House of Delegates and 	

		<p>scientific sessions and provide for the management and general arrangements for each.</p> <p>D. Cause the Treasurer, the Executive Director and employees of the Association entrusted with Association funds to be bonded by a surety company.</p> <p>E. Cause all accounts of the Association to be audited by a certified public accountant at least once a year.</p> <p>F. Collaborate with the House of Delegates in setting the strategic direction of the Association in alignment with the mission and vision of the Association.</p> <p>F.G. Prepare and propose <u>Adopt</u> a budget <u>to the House of Delegates for each ensuing the following year, including a recommendation for consistent with the Strategic Forecast.</u></p> <p>H. Recommend the dues of active members for the following year.</p> <p>G.I. Establish recommended qualifications for the offices of Treasurer and Speaker of the House of Delegates.</p> <p>HJ. Submit to the House of Delegates nominations for membership to the councils and commissions, except as otherwise provided in these <i>Bylaws</i>.</p> <p>IK. Act upon commission and committee nominations for consultants as set forth in the <i>Governance Manual</i>.</p> <p>JL. Review the reports of councils and special committees of the Association and to make recommendations concerning such reports to the House of Delegates.</p> <p>KM. Submit an annual report of its activities to the House of Delegates.</p> <p>LN. Appoint special committees of the Association in accordance with these <i>Bylaws</i>.</p> <p>MO. Render a final judgment on what constitutes a conflict of interest except with respect to the work of the Commission on Dental Accreditation.</p> <p>NP. Establish dues for the international member category.</p>	
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		<p>and be it further</p> <p>Resolved, that Chapter XII. FINANCES, Section 40. APPROVAL OF ANNUAL BUDGET of the ADA <i>Bylaws</i> be amended as follows (additions <u>underlined</u>, deletions stricken through):</p> <p><u>Section 40. APPROVAL OF ANNUAL BUDGET. The proposed annual budget shall be submitted by the Board of Trustees to the members of the House of Delegates at least ninety (90) days prior to the opening meeting of the annual session, shall be referred to a reference committee on budget for hearings at the annual session and then shall be considered for approval as a special order of business. In the event the budget submitted is not approved, all recommendations for changes shall be referred to the Board of Trustees to prepare and present a revised budget. This procedure shall be repeated until a budget for the ensuing fiscal year shall be adopted. Following the adoption of a resolution on the Strategic Forecast, and by the end of the calendar year, the Board of Trustees shall adopt a budget for the following year incorporating the Strategic Forecast as approved by the House of Delegates.</u></p> <p>and be it further</p> <p>Resolved, that Chapter V. BOARD OF TRUSTREES, Section F.2., of the ADA <i>Governance Manual</i> be amended as follows (additions <u>underlined</u>, deletions stricken through):</p> <p>F. Duties. The Board shall perform the following activities as part of its management responsibilities:</p> <p style="text-align: center;">* * *</p> <p>2. Notice of the Board of Trustee's proposed budget and a resolution containing the Board of Trustee's recommendation for active member dues required by the ADA <i>Bylaws</i> shall be sent electronically to each constituent and posted on ADA Connect or its equivalent for the House of Delegates not less than thirty (30) <u>ninety (90)</u> days before the first scheduled meeting of the House of Delegates to permit prompt, adequate notice by each constituent to its delegates and alternate delegates to the House of Delegates. The resolution containing the Board of Trustee's recommendation for active member dues shall be also announced to the general membership in an official publication of the Association at least fifteen (15) days in advance of the commencement of the annual session of the House of Delegates.</p>	
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		<p>and be it further</p> <p>Resolved, that these amendments shall take effect at the close of the 2025 House of Delegates.</p>	
205	<p>Referred to the appropriate ADA agency for further study and report to the 2026 House of Delegates—Consent Calendar Action</p>	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 205—Resolution of Fiscal Responsibility and Modernization of ADA Governance Operations</p> <p>Resolved, that the American Dental Association establish a Task Force on Governance on Efficiency and Travel Oversight to study the modernization of the ADA governance and fiscal responsibility, and be it further</p> <p>Resolved, that the Task Force be composed of seven members appointed by the ADA President which shall meet virtually, and be it further</p> <p>Resolved, that the Task Force:</p> <ol style="list-style-type: none"> 1. review the past five years of Board of Trustees Retreat travel and meeting-related expenditures; evaluate venue selection and the duration of meetings relative to governance output; and recommend cost-saving strategies based on best practices from comparable associations, with findings and implementation progress reported annually to the House of Delegates; 2. study a remote-first policy for all councils, committees, commissions, task forces, and Board meetings, utilizing Zoom or equivalent platforms as the default method of conducting business, and require that in-person gatherings be explicitly justified by cost-benefit analysis consistent with the ADA Strategic Plan and the values of environmental sustainability, member equity, and financial accountability; and 3. study expand equitable access and structural accountability by: <ol style="list-style-type: none"> a. requiring hybrid participation and remote voting rights across all levels of governance where feasible; b. conducting a delegate census and apportionment review based on verified attendance and engagement data, with specific attention to states whose delegate counts appear disproportionate to participation levels; and 	

		<p>c. adopting standardized travel policies and cost controls that emphasize per diem enforcement, zone-based meeting models, and a “save-first” mindset to reduce the overall financial burden on member dues.</p> <p>and be it further</p> <p>Resolved, that the Task Force report to the 2026 House of Delegates.</p>	
206	UNASSIGNED		
207	Not Adopted— Consent Calendar Action	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 207—Amendment to the <i>Manual of the House of Delegates</i> Section title Representation of Constituents and Periodic Reapportionment of Delegates and Alternate Delegates</p> <p>Resolved, that the section of the <i>Manual of the House of Delegates</i> titled Representation of Constituents and Periodic Reapportionment of Delegates and Alternate Delegates, be amended as follows (additions <u>underlined</u>, deletions stricken through):</p> <p>A. Goal of Delegate Apportionment</p> <p>The allocation of the remaining delegates over the minimum number of delegates allocated to each constituent and the District of Columbia Dental Society shall be made pursuant to the delegate allocation methodology set forth in this section of the <i>Manual of the House of Delegates</i>. The goals of the delegate apportionment scheme adopted by the ADA is to (i) achieve as close to proportional representation of active, life and retired members of constituents and federal dental services (Army, Air Force, Navy, Veterans Administration, and Public Health) as possible while providing for the minimum representational requirements set forth in the <i>Governance and Organizational Manual of the American Dental Association</i> (<i>Governance Manual</i>); (ii) providing for representation of the American Student Dental Association; and (iii) maintaining the size of the House of Delegates as close to 473 delegates as possible while meeting the other goals recited in this herein.</p> <p>B. <u>A.</u> Delegate Allocation Methodology</p> <p>Commencing in 2014-2026, based on the representational requirements and goals set forth in this <i>Manual</i> and in the <i>Governance Manual</i>, delegates shall be allocated according to the allocation methodology set forth below. Thereafter, to account for membership fluctuations, delegate allocations shall be reviewed and delegates shall be reallocated by the Secretary of the House of Delegates every four (4) <u>three</u> (3)</p>	

		<p>years among the Association's constituents, the five (5) federal dental services and the American Student Dental Association in accordance with that same methodology. Delegate allocations shall be based on the Association's year-end membership records for the second calendar year preceding the year in which the delegate allocations become effective <u>using a formula of one (1) voting delegate per 700 active members, rounded to the nearest whole number, while ensuring that each constituent, federal dental service and the American Student Dental Association retains at least one (1) voting delegate.</u> The review of delegates shall take place as soon as possible after the membership numbers on which the delegate allocations are based are available. The Secretary of the House of Delegates shall publish the new delegate allocations expeditiously thereafter to the constituent dental societies, the five (5) federal dental services and the American Student Dental Association. The delegate allocations shall also be published in this Manual. <u>The American Student Dental Association shall be allocated a number of voting delegates that is 1.5% of the total constituent and federal dental services delegates, with a maximum of five (5) delegates.</u> The delegate allocation methodology is as follows:</p> <ol style="list-style-type: none"> <li data-bbox="743 654 1692 1138">1. The Target Delegate Number. For purposes of allocating delegates, the target number of delegates to be used in calculating the allocation is four hundred seventy-three (473). From that target number two delegates will be deducted for each constituent and federal dental service except that only a single delegate will be deducted from each of the Colegio de Cirujanos Dentistas de Puerto Rico and the Virgin Islands Dental Association unless the number of members in either of those societies is equal to or greater than the number of members in the smallest state constituent, in which case a minimum of two (2) delegates will be deducted from the target delegate number for that entity. In addition, five (5) delegates will be deducted from the target delegate number for the American Student Dental Association. For purposes of the delegate allocation methodology set forth in the Manual of the House of Delegates, the remaining number of delegates in the target number of delegates following the deductions of delegates listed above from the target number of delegates shall be referred to as the "net delegate allocation pool." <li data-bbox="743 1174 1692 1260">2. Allocation to the American Student Dental Association. Five (5) delegates shall be allocated to the American Student Dental Association regardless of the number of members. 	
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		<p>3- Determination of the True Proportional Delegate Counts for each Constituent and each Federal Dental Service. Divide each constituent's and each federal dental service's total membership by the total constituent and federal dental service membership of the Association. Multiply the resulting percentage of membership for each constituent and federal dental service by the target number of delegates set forth in section B.1. of this methodology less the number of delegates allocated to the American Student Dental Association in section B.2. of this allocation methodology. The resulting true proportional delegate numbers will be used later in the delegate allocation methodology.</p> <p>4- Determination of Constituents and Federal Dental Services that Qualify to Receive More than the Minimum Delegate Allocation.</p> <p>a- Divide the total constituent and federal dental service membership of the Association by the target number of delegates set forth in section B.1. of this allocation methodology less the number of delegates allocated to the American Student Dental Association in section B.2. of this methodology. Compare the resulting number against the membership numbers for the Colegio de Cirujanos Dentistas de Puerto Rico, and Virgin Islands Dental Association if they received a single delegate pursuant to the review performed in section B.1. of this allocation methodology. If the membership numbers of any of those entities are less than the result of the calculation, allocate the number of delegates deducted from the target delegate allocation number for each such entity and exclude those entities from the remaining steps of the delegate allocation methodology.</p> <p>b- Take the result of the calculation performed in section B.4.a. of this allocation methodology and multiply it by two (2). Compare the resulting number against the membership numbers for each constituent society and each federal dental service for which two (2) delegates were deducted from the target delegate allocation number in section B.1. of this methodology. If the membership of any of those constituent societies and federal dental services are less than that number, allocate the number of delegates deducted from the target delegate allocation number for each such entity and exclude those entities from the remaining steps of the delegate allocation methodology.</p> <p>5- Calculation of Non-Minimum Membership Total. Subtract the total membership numbers of each constituent and federal dental service identified as being excluded from the remaining steps of the delegate</p>	
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		<p>allocation methodology from the total constituent and federal dental service membership of the Association. The resulting nonminimum membership total will be used in the remaining delegate allocation methodology steps.</p> <p>6- Allocation of Remaining Delegates.</p> <p>a- Divide each remaining constituent's and federal dental service's membership by the non-minimum membership total determined in section 5, above, to arrive at their percentages of the non-minimum membership total.</p> <p>b- Calculate the remaining number of delegates to be allocated by subtracting from the target number of delegates listed in section B.1. of this allocation methodology the delegates allocated to the American Student Dental Association in section B.2. of this methodology and the delegates allocated by the minimum allocation steps in sections B.4.a. and B.4.b., above.</p> <p>c- For each remaining constituent and federal dental service, multiply its percentage of the non-minimum membership total determined by the calculation in section B.6.a., above, and the remaining number of delegates to be allocated as determined by the calculation in section B.6.b. of this allocation methodology. Round the result to the nearest whole number.</p> <p>d- For each remaining constituent and federal dental service, multiply the resulting percentage of membership obtained in section B.3. above, by the target number of delegates specified in section B.1., above, less the number of delegates allocated to the American Student Dental Association pursuant to section B.2. of this methodology and round the result to the nearest whole number.</p> <p>e- For each remaining constituent and federal dental service, subtract the result obtained in section B.6.d. of this allocation methodology from the result obtained in section B.6.c. hereof. If the result is negative, use the result obtained in section B.6.d. as that constituent's allocated delegate total. If the result is zero or positive, use the result obtained in section B.6.c. of this methodology as that constituent's allocated delegate total.</p>	
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		<p>7- Finalize the Delegate Allocation. Add together the final delegate allocations for the constituents, federal dental services and the American Student Dental Association determined through the calculations of sections B.2., B.4.a., B.4.b. and B.6.e. of this allocation methodology. The result is the total delegates allocated. The total delegates allocated should vary no more than six percent (6%) from the target number of delegates set forth in paragraph B.1. of this subsection.</p> <p>8- Calculating the Fairness Ratio. Divide each constituent's and each federal dental service's percentage of total delegates (the constituent's allocated delegates divided by the total delegates allocated as determined by the calculation set forth in subparagraph B.7 of this methodology less the number of delegates allocated to the American Student Dental Association) by its percentage of total membership as calculated in B.3., above. Except for those constituents that only receive the minimum number of allocated delegates, the resulting "fairness ratio" should deviate by a small amount on either side of 1, with 1 representing a perfectly proportional delegate allocation. The fairness ratio for constituents and federal dental services that receive only the minimum allocation of delegates may deviate from 1 to a larger degree because those constituents and federal dental services may be overrepresented.</p> <p><u>B. C-</u> Suspension of The Representation of a Constituent</p> <p>The representation of a constituent in the House of Delegates may be suspended by a two-thirds (2/3) affirmative vote of the House of Delegates present and voting upon a determination by the House of Delegates that the constitution or bylaws of the constituent violate the <i>Constitution</i> or <i>Bylaws</i> of this Association. Any such suspension shall not be in effect until the House of Delegates has voted that the constitution or bylaws of the constituent violate the <i>Constitution</i> or <i>Bylaws</i> of this Association and the constituent has one (1) year following notification of the specific violation within which to correct the violation.</p> <p>Amendment of this section of the <i>Manual of the House of Delegates</i> shall be by a two-thirds (2/3) affirmative vote of the delegates present and voting.</p> <p>and be it further</p>	
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		<p>Resolved, that the ADA <i>Governance Manual</i>, Chapter II. CONSTITUENT AND COMPONENTS, Section B.2., be amended as follows (additions <u>underlined</u>, deletions stricken through):</p> <p>B. Constituents.</p> <p style="text-align: center;">***</p> <p>2. Privilege of Representation.</p> <p>a. Delegates. Each state constituent, the District of Columbia Dental Society and each federal dental service <u>and the American Student Dental Association</u> shall be entitled to a minimum of two (2) delegates <u>one (1) delegate</u> in the House of Delegates. Each territorial constituent shall be entitled to a minimum of two (2) delegates in the House of Delegates if its total membership is equal to or greater than the size of the smallest state constituent; otherwise the territorial constituent shall receive one (1) delegate. The remaining number of delegates shall be allocated as set forth in the <i>Manual of the House of Delegates (House Manual)</i>.</p> <p>and be it further</p> <p>Resolved, that the ADA <i>Bylaws</i>, CHAPTER III. HOUSE OF DELEGATES, Section 10.D., be amended as follows (additions <u>underlined</u>, deletions stricken through):</p> <p>Section 10. MEMBERS.</p> <p style="text-align: center;">***</p> <p>D. ELECTION OR SELECTION. A constituent's delegates shall be elected or, in the case of a constituent's alternate delegates elected or selected by one or more of the following methods:</p> <p>a. By the membership at large of that constituent;</p> <p>b. By the constituent's governing legislative body, House of Delegates, or Board of Directors, or in the case of alternate delegates, at the discretion of the constituent; or</p> <p>c. By a component with respect to the delegates representing that component.</p> <p>Each federal dental service and the American Student Dental Association may establish its own method for electing or selecting delegates, except that the</p>	
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		<p>American Student Dental Association shall select its five (5) delegates from its even numbered regions in even numbered years, and the odd numbered regions in odd numbered years, with their alternate delegates selected from the opposite groups of regions.</p>	
<p>208</p>	<p>Not Adopted— Consent Calendar Action</p>	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 208—Strengthening Financial Oversight and Accountability of the ADA Board of Trustees</p> <p>Resolved, that Chapter III. HOUSE OF DELEGATES, Section 70. SESSIONS, of the ADA <i>Bylaws</i> be amended as follows (additions <u>underlined</u>, deletions stricken through):</p> <p>Section 70. SESSIONS.</p> <p>A. ANNUAL MEETING. The House of Delegates shall meet annually pursuant to an official call as required by the Governance Manual.</p> <p>B. SPECIAL SESSIONS. A special session of the House of Delegates shall be called upon the request of the Board of Trustees or the House of Delegates in accordance with the procedures set forth in the Governance Manual.</p> <p><u>C. VIRTUAL SESSIONS. The House of Delegates shall convene three additional regular sessions each year using a secure virtual platform, scheduled in accordance with procedures outlined in the Governance Manual.</u></p> <p>and be it further</p> <p>Resolved, that Chapter III. HOUSE OF DELEGATES, Section A.1. of the <i>Governance Manual</i> be amended as follows (additions <u>underlined</u>, deletions stricken through):</p> <p>A. Convening Sessions of the House of Delegates.</p> <p>1. Special Sessions. A special session of the House of Delegates shall be called by the President on a three-fourths (3/4) affirmative vote of the members of the Board of Trustees or on written request of delegates representing at least one-third (1/3) of the constituents and not less than one-fifth (1/5) of the number of officially certified delegates of the last House of Delegates. The time and place of a special session shall be determined by the President, provided the time selected shall be not more than forty-five (45) days after the request was received. The business of a special session shall be limited to that stated in the official call except by unanimous consent.</p>	

		<p><u>2. Regular Virtual Sessions. In addition to the annual in-person session, the House of Delegates shall meet three additional times per year virtually, under the procedures specified in this Manual.</u></p> <p>and be it further</p> <p>Resolved, that Chapter V. BOARD OF TRUSTEES, Section 90. MEETINGS, of the ADA <i>Bylaws</i> be amended as follows (additions underlined, deletions stricken through):</p> <p>A. REGULAR MEETINGS. The Board of Trustees shall hold a minimum of three regular meetings each year. The number and dates of regular meetings to be held for the ensuing year shall be determined in advance by the Board of Trustees.</p> <p>A. <u>REGULAR MEETINGS. The Board of Trustees shall hold no more than two in-person regular meetings each year. All other regular meetings shall be conducted virtually using suitable communications equipment. The number and dates of regular meetings to be held for the ensuing year shall be determined in advance by the Board of Trustees.</u></p> <p>B. SPECIAL MEETINGS. Special meetings of the Board of Trustees may be called at any time either by the President or at the request of five voting members of the Board, provided notice is given to each member in advance of the meeting.</p> <p>C. PLACE OF MEETINGS. Regular or special meetings may be held in a single geographic location or from multiple remote locations through the use of suitable communications equipment. Such meetings shall be conducted in accordance with rules and procedures established by the Board of Trustees.</p> <p>and be it further</p> <p>Resolved, that the Board of Trustees be urged to adopt written policies to prioritize cost savings and strengthen financial oversight by:</p> <ol style="list-style-type: none"> 1. reducing discretionary expenses related to hotels, travel, retreats, meeting venues, and ceremonial functions; 2. requiring that all travel be reviewed and pre-approved by the ADA Finance Committee, and permitted only when the travel is essential to ADA business; 	
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		<ol style="list-style-type: none"> 3. defining “essential business” as responsibilities that cannot reasonably be fulfilled through remote participation, delegation, or postponement; 4. limiting overseas travel to situations where international representation is required to maintain strategic alliances or fulfill regulatory obligations; 5. strongly encouraging that only a single designated representative attends external meetings or conferences, unless multiple attendees are essential to fulfilling clearly defined strategic objectives of the Association; 6. requiring that Board of Trustees’ travel or discretionary expenditures anticipated to exceed \$10,000 per occurrence receive additional pre-approval from the Finance Committee; 7. requiring quarterly financial reports summarizing international activities, travel costs, external partnerships, and discretionary spending, with an executive summary made available to all ADA members; 8. commissioning an independent forensic audit of the past five fiscal years related to the financial activities of the Board of Trustees and Executive Office, with findings reported to the House of Delegates. <p>and be it further</p> <p>Resolved, that the Board of Trustees submit a report to the 2026 House of Delegates.</p>	
209	Not Adopted	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 209—Ending Unproductive Spending on FDI and Reinvesting in Member-Focused Priorities</p> <p>Resolved, that beginning in Fiscal Year 2026, the American Dental Association discontinue all funding and participation in the FDI World Dental Federation, and be it further</p> <p>Resolved, that in the event any future proposal is made to reinstate ADA participation in or financial support for the FDI World Dental Federation, such action shall require prior approval by the ADA House of Delegates through the adoption of a resolution which shall include a report of such spending from 2021-2025, and be it further</p> <p>Resolved, that the American Dental Association reallocate any savings from discontinued FDI participation to activities that strengthen ADA programs, improve</p>	

		member services, or support strategic priorities identified through the Strategic Forecast, provided that such activities clearly align with the ADA's mission and demonstrate documented value to members through outcomes such as advocacy impact, membership engagement, or operational sustainability.	
210H	Adopted	<p>Reference Committee A Resolution 210RC in lieu of Dr. Spencer Bloom, delegate, Illinois, Resolution 210 and Board of Trustees Resolution 210B—Addressing Food Insecurity in U.S. Dental Students</p> <p>Resolved, that the American Dental Association recognizes food insecurity among dental students as an urgent threat to the wellbeing of the next generation of oral health professionals and in collaboration with the appropriate ADA agency encourages constituents, and their respective foundations and other stakeholders including ADEA and ASDA to assist initiation of programs to address this issue.</p>	
211	Resolution will lay over to the 2026 House of Delegates since this resolution proposes a Constitutional amendment	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 211—Amendment to the <i>Manual of the House of Delegates: Strategic Forecasting Committee</i></p> <p>Resolved, that Article IV. GOVERNMENT, of the ADA <i>Constitution</i> be amended be amended as follows (additions <u>underlined</u>):</p> <p style="padding-left: 40px;">Section 10. LEGISLATIVE BODY. The legislative and governing body of this Association shall be a House of Delegates. <u>As the governing body of this Association, the House of Delegates shall monitor and oversee Association activities to ensure congruence and alignment with Association strategic forecasts.</u></p> <p style="padding-left: 40px;">Section 20. ADMINISTRATIVE BODY. The administrative body of this Association shall be a Board of Trustees.</p> <p>and be it further</p> <p>Resolved, that the charter of the Strategic Forecasting Committee as it appears in under the Standing Committees of the House of Delegates in the <i>Manual of the House of Delegates and Supplemental Information</i> be deleted in its entirety and be replace with new charter language as follows:</p> <p style="padding-left: 40px;">Strategic Forecasting Committee</p> <p style="padding-left: 40px;">I. Purpose</p> <p style="padding-left: 40px;">The Strategic Forecasting Committee (SFC) is a standing committee of the House of Delegates. Its purpose is to evaluate and monitor the alignment between the</p>	

		<p>Association’s strategic plan and its actual operations, budgets, programs and governance. The SFC serves as the principal liaison between the House of Delegates, the Board of Trustees, ADA staff, and Councils on matters of long-range planning, accountability, and organizational performance.</p> <p>The Committee shall serve as the year-round strategic representative of the House of Delegates, maintaining continuity between annual House sessions and providing ongoing oversight and feedback on behalf of the Association.</p> <p>II. Duties</p> <p>The SFC receives its direction from the House of Delegates and shall:</p> <ol style="list-style-type: none"> 1. Evaluate the alignment of ADA programs, council initiatives, and Board actions with the House-approved Strategic Forecast; 2. Participate in the development and periodic revision of the Strategic Forecast in collaboration with the Board; 3. Monitor implementation of the Strategic Forecast across ADA governance entities; 4. Identify structural, operational, or cultural barriers to strategic alignment; 5. Conduct structured, member-driven strategic inquiry through subcommittees and Action Groups; 6. Monitor cross-council collaboration on multi-disciplinary initiatives; 7. Evaluate whether ADA Councils are executing the strategic responsibilities assigned to them by the House of Delegates, and identify when work has been delayed, abandoned, or misaligned with the Strategic Forecast; 8. Recommend changes to ADA governance, structure, or policy when necessary to fulfill strategic goals; 9. Report annually to the House of Delegates, with the option to submit midyear updates as warranted; 10. Report to the House on gaps between budgeted resources and Strategic Forecast execution, in coordination with the Board of Trustees; and 	
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		<p>11. Issue formal alerts, findings, or recommendations to the House of Delegates when significant misalignment between the Strategic Forecast and ADA activities is identified, including risks related to implementation, governance, or organizational transparency.</p> <p>III. Composition</p> <p>The SFC shall consist of the following twenty (20) voting members:</p> <ul style="list-style-type: none"> • Seventeen (17) members of the House of Delegates, one from each ADA trustee district, nominated by their respective district caucuses and confirmed by the House of Delegates; at least one shall be a new dentist; selected through a rotating assignment among the districts. If a district does not have a qualifying candidate in its rotation year, the turn may pass to the next district in sequence. The Speaker of the House shall coordinate the rotation schedule to ensure fairness and continuity. • Two (2) members of the Board of Trustees, representing different trustee districts; • One (1) additional member with expertise in forecasting, strategy, governance, or finance, appointed by the President. <p>Non-voting members shall include:</p> <ul style="list-style-type: none"> • The ADA President, President-elect, Treasurer, and Executive Director (<i>ex officio</i>); • Council chairs may serve as consultants when participating on specific agenda items related to their council's strategic responsibilities. <p>Terms and Appointment:</p> <ul style="list-style-type: none"> • House members: two-year terms, may be renominated and reappointed once for a total tenure on the Committee of four years. • Trustee members: one-year term, and shall be eligible for reappointment once; • The Chair shall be elected by voting members of the SFC and serve a two-year term and shall be eligible to serve a second two-year term. <p>No voting member may concurrently serve on an ADA council or commission.</p> <p>IV. Access, Oversight, and Authority</p>	
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		<p>The SFC shall have full and timely access to:</p> <ul style="list-style-type: none"> • Strategic plans and forecast documentation; • Budget alignment and resource allocation data; • Council work plans and performance reports; • Operational metrics related to strategic implementation. <p>All requests for information shall be fulfilled within 30 days unless an extension is granted by the President . Any failure to provide requested information shall be documented and reported to the House of Delegates. The SFC Chair may request a formal response or corrective action from the Board of Trustees or Executive Director.</p> <p>The authority of the Strategic Forecasting Committee to request information and deliver reports shall not be subject to approval, veto, or suppression by the Board of Trustees, ADA staff, or any other governance body.</p> <p>The SFC shall not direct operational decisions but may issue findings, recommendations, or alerts to the House of Delegates regarding strategic misalignment, missed benchmarks, or governance breakdowns.</p> <p>V. Meetings</p> <ul style="list-style-type: none"> • The SFC shall meet at least four (4) times annually. • No more than one meeting per year may be held in person; the remainder shall be virtual. • A quorum shall consist of a majority of the twenty (20) voting members. • Meeting minutes or summaries (excluding confidential material) shall be made available to the House upon request. <p>VI. Reporting</p> <p>The SFC shall deliver:</p> <ol style="list-style-type: none"> 1. An Annual Report to the House of Delegates summarizing: <ul style="list-style-type: none"> ○ Strategic alignment progress, ○ Gaps or challenges encountered, ○ Recommendations for improvement. 2. Optional Midyear Briefings on urgent or time-sensitive issues. 	
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212	Referred to the appropriate agency for further study and report to the 2026 House of Delegates	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 212—Optimizing the House of Delegates Structure and Operations</p> <p>Resolved, that the ADA transition ceremonial and non-governance activities during the House of Delegates session to digital formats in time for the 2026 House of Delegates, except for components that are part of the installation service, including:</p> <ul style="list-style-type: none"> • Digital recognition of retiring officers, trustees, and trustee spouses • Digital remarks by the ADA Alliance and ADPAC Chair <p>and be it further</p> <p>Resolved, that all live speeches delivered by the ADA President, President-Elect, and Executive Director be limited to four (4) minutes each, and be it further</p> <p>Resolved, that the ADA <i>Governance and Organizational Manual</i>, Chapter VI. Elective Officers of the Association, Section B. Nominations, be amended as follows (additions are <u>underlined</u>; deletions are stricken through):</p> <p>1. President-Elect and Second Vice President. Nominations for the offices of President-elect and Second Vice President shall be made in accordance with the order of business. Candidates for these elective offices shall be nominated from the floor of the House of Delegates by a simple declaratory statement, which may be followed by an acceptance speech not to exceed four (4) minutes by the candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. Seconding a nomination is not permitted. No nominations or acceptance speeches shall be delivered from the floor of the House of Delegates. <u>Nomination statements and acceptance speeches shall be submitted electronically in video format not to exceed four (4) minutes each in accordance with the protocol established by the Speaker of the House of Delegates. These pre-recorded materials shall be made available to all delegates prior to the first meeting.</u></p> <p>2. Treasurer. The search for Treasurer shall be announced in an official publication of the Association in November of the final year of the incumbent Treasurer’s term, together with the recommended qualifications for that position as provided in the <i>Bylaws</i>. Candidates for the office of Treasurer shall apply by submitting a standardized Treasurer <i>Curriculum Vitae</i> form to the Executive Director at least one hundred twenty (120) days prior to the convening of the House of Delegates. Each candidate’s application shall be reviewed by the Board of Trustees. At least sixty (60) days prior to the convening of the House of Delegates the Executive Director shall</p>	
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		<p>provide all members of the House of Delegates, with each candidate's standardized Treasurer <i>Curriculum Vitae</i> and the determination of the Board of Trustees as to whether the candidate meets the recommended qualifications for the office of Treasurer. No other candidate shall be nominated from the floor of the House of Delegates. Nominations shall be made in accordance with the order of business. Each nomination may be followed by an acceptance speech not to exceed four (4) minutes by the candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. Seconding a nomination is not permitted. No further nominations for the office of Treasurer shall be accepted from the floor of the House. No nominations or acceptance speeches shall be delivered from the floor of the House of Delegates. Candidates for the Office of</p> <p><u>Treasurer shall submit a nomination statement and acceptance speech electronically in video format, not to exceed four (4) minutes each in accordance with the protocol established by the Speaker of the House of Delegates. These pre-recorded materials shall be made available to all delegates prior to the first meeting.</u> If there are no eligible candidates for the office of Treasurer when the House of Delegates meets, the term of the incumbent Treasurer shall be extended by one (1) year. Should the incumbent Treasurer be unwilling or unable to serve an additional one (1) year term, the office of Treasurer shall be filled in accordance with the vacancy provisions of this chapter of the <i>Governance Manual</i>. Under these circumstances, former Treasurers of this Association not otherwise eligible to serve as Treasurer due to term limits will be eligible to serve as Treasurer until the House of Delegates can elect a Treasurer.</p> <p>3. Speaker of the House of Delegates. The search for Speaker of the House shall be announced in an official publication of the Association in November of the final year of the incumbent Speaker of the House's term. Candidates for the office of Speaker of the House shall apply by submitting a <i>curriculum vitae</i> along with a statement supporting their qualifications to the Executive Director at least one hundred twenty (120) days prior to the convening of the House of Delegates. At least sixty (60) days prior to the convening of the House of Delegates the Executive Director shall provide all members of the House of Delegates with each candidate's <i>Curriculum Vitae</i> and statement of qualifications for the office of Speaker of the House. If no candidate has applied and submitted the required documentation, then the Association shall inform all delegates of this circumstance and the period to apply shall be extended to thirty (30) days prior to the convening of the House of Delegates. Only candidates who have applied and submitted the required documentation shall be nominated from the floor of the House of Delegates. If thirty (30) days prior to the convening of the House of Delegates no candidate has applied and submitted the required documentation then the Association shall inform all delegates of this circumstance and also inform</p>	
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		<p>them that nominations shall be permitted from the floor of the House of Delegates. Nominations for the office of Speaker of the House shall be made in accordance with the order of business. Each nomination may be followed by an acceptance speech not to exceed four (4) minutes by the candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. Seconding a nomination is not permitted. No nominations or acceptance speeches shall be delivered from the floor of the House of Delegates. Candidates for the office of Speaker of the House shall submit a nomination statement and acceptance speech electronically in video format, not to exceed four (4) minutes each in accordance with the protocol established by the Speaker of the House of Delegates. These pre-recorded materials shall be made available to all delegates for review prior to the first meeting. If there are no candidates for the office of Speaker of the House nominated when the House of Delegates meets, the term of the incumbent Speaker of the House shall be extended by one (1) year. Should the incumbent Speaker of the House be unwilling or unable to serve an additional one (1) year term, the office of Speaker of the House shall be filled in accordance with the vacancy provisions of this chapter of the <i>Governance Manual</i>. Under these circumstances, former Speakers of the House not otherwise eligible to serve as Speaker due to term limits will be eligible to serve as Speaker until the House of Delegates can elect a Speaker of the House.</p> <p>and be it further</p> <p>Resolved, that the section titled Nomination Procedures in the Standing Rules of the House of Delegates published in the <i>Manual of the House of Delegates</i> be amended as follows (additions <u>underlined</u>; deletions stricken through):</p> <p>Nominations for President-elect, Second Vice President, Treasurer and Speaker of the House of Delegates are made from the floor of the House of Delegates at the first meeting by a simple declaratory statement and may be followed by an acceptance speech not to exceed four (4) minutes by the candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. Seconding a nomination is not permitted.</p> <p>The nominations of these officers will be made at the first meeting. <u>Nomination statements and acceptance speeches electronically in video format shall be made prior to the first meeting.</u> The details of the nomination procedure are set forth in the <i>Governance Manual</i>.</p>	
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213	Not Adopted	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 213—Growing ADA Membership Through Transparent and Accessible Governance</p> <p>Resolved, that the American Dental Association support the adoption of accessible leadership models across the tripartite structure by developing and sharing voluntary model policies and best practices that allow member dentists to serve based on skill, readiness, and interest, and be it further</p> <p>Resolved, that the appropriate ADA agencies recommend to the Board of Trustees a pilot to address at least one modern leadership pathway at the national level—such as open calls for nominations, merit-based appointments, or project-based leadership roles (e.g., short-term task forces, working groups, or initiative-based appointments)—and share results and implementation tools with constituent and component societies to support broader adoption, and be it further</p> <p>Resolved, that the Board of Trustees and all governing bodies be urged to limit the use of closed sessions to matters that clearly require confidentiality under the <i>American Institute of Parliamentarians Code of Parliamentary Procedure, Second Edition</i>, and be it further</p> <p>Resolved, that the American Dental Association report annually to the House of Delegates on progress made toward implementing modern leadership pathways.</p>	
214	Not Adopted— Consent Calendar Action	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 214—Adoption of Mission-Based Accounting Framework</p> <p>Resolved, that the Board of Trustees is urged to adopt mission-based accounting as the official budgeting and financial reporting framework of the Association, and be it further</p> <p>Resolved, that the Board of Trustees is urged to begin implementing a mission-based accounting system in phases, starting with selected departments or major program areas, and prioritize cost tracking, alignment scoring, and transparency within existing resource capacity, and be it further</p> <p>Resolved, that the Board of Trustees is urged to present to the House of Delegates by 2026 a detailed implementation schedule with annual milestones, identifying which</p>	

		<p>departments or functions will be incorporated each year, to ensure full adoption across all ADA departments and subsidiaries by the 2028 House of Delegates, and be it further</p> <p>Resolved, that the Board of Trustees is urged to assess and prioritize the financial and human resources necessary to support this transition, including certified nonprofit financial expertise, and integrate implementation planning into the Association's operational and strategic planning processes, and be it further</p> <p>Resolved, that beginning in 2027, the Board of Trustees be urged to include with each proposed annual budget a public summary detailing: (1) the percentage of spending allocated to mission-aligned programs, (2) major programs and initiatives by total cost and strategic goal served, and (3) areas where cost transparency is not yet achievable, with a plan to close those gaps.</p>	
215	<p>Referred to the appropriate agency for further study and report to the 2026 House of Delegates</p>	<p>Reference Committee A Resolution 215RC in lieu of Eighth Trustee District Resolution 215—Amendment to the <i>Governance and Organizational Manual of the American Dental Association to Provide an Extended and Sustained Dues Discount for Early Career Dentists</i></p> <p>Resolved, that the <i>Governance and Organizational Manual of the American Dental Association</i>, Chapter I. MEMBERSHIP MATTERS, Section B. Dues, Special Assessments and Related Matters, Subsection 1. Dues, paragraph a. Active Members, be amended as follows, effective for the 2027 membership renewal year (additions are <u>underlined</u>; deletions are stricken):</p> <p style="padding-left: 40px;">B. Dues, Special Assessments and Related Financial Matters.</p> <p style="padding-left: 80px;">1. Dues. Under the ADA <i>Bylaws</i>, the House of Delegates has the duty to annually set the dues of active members for the ensuing year. Dues are due and payable on January 1, except where a member has opted to pay dues in installments pursuant to a plan offered by the member's constituent, in which case, dues are paid according to the plan's requirements.</p> <p style="padding-left: 80px;">The schedule of annual dues for each of the membership categories specified in the ADA <i>Bylaws</i> is as follows:</p> <p style="padding-left: 40px;">a. Active Members.</p> <p style="padding-left: 80px;">i. From degree award through conclusion of the first full year following an award of a D.D.S. or D.M.D. degree: The member is exempt from the payment of dues.</p>	

- ii. ~~Second through fifth full years~~ following degree award: ~~Fifty percent (50%)~~ twenty-five percent (25%) of active member dues as set by the House of Delegates pursuant to the ADA *Bylaws*.
- iii. ~~Third~~ Sixth full year following degree award and thereafter: One hundred percent (100%) of active member dues as set by the House of Delegates pursuant to the ADA *Bylaws*.
- iv. Members becoming active members after July 1, except for those whose membership has lapsed for failure to pay the current year's dues and/or any special assessment, shall pay fifty percent (50%) of any annual dues then in effect. Those members becoming active members after October 1, except for those whose membership has lapsed for failure to pay the current year's dues and/or any special assessment, shall be exempt from the payment of any annual dues then in effect.

and be it further

Resolved, that the *Governance and Organizational Manual of the American Dental Association*, Chapter I. Membership Matters, Section B. Dues, Special Assessments and Related Matters, Subsection 2. Special Assessments, paragraph a. Active Members, be amended as follows, effective for the 2027 membership renewal year (additions are underlined; deletions are ~~stricken~~):

- 2. Special Assessments. Pursuant to the ADA *Bylaws*, the House of Delegates has the power to levy special assessments. Any special assessment for a calendar year is due and payable on January 1, except where a member has opted to pay in installments pursuant to a plan offered by the member's constituent; in which case, the special assessment is paid according to the plan's requirements.

The schedule of special assessment allocation for each of the membership categories specified in the ADA *Bylaws* is as follows:

- a. Active Members.
 - i. From degree award through conclusion of the first full year following an award of a D.D.S. or D.M.D. degree: the member is exempt from the payment of any special assessment then in effect.
 - ii. ~~Second through fifth full years~~ following degree award: ~~Fifty percent (50%)~~ twenty-five percent (25%) of any special assessment then in effect.
 - iii. ~~Third~~ Sixth full year following degree award and thereafter: One hundred percent (100%) of any special assessment then in effect.

		<p>iv. On a one-time only basis, those members becoming active members after July 1, except for those whose membership has lapsed for failure to pay the current year's dues and/or any special assessment, shall pay fifty percent (50%) of any special assessment then in effect. On a one-time only basis, those members becoming active members after October 1, except for those whose membership has lapsed for failure to pay the current year's dues and/or any special assessment, shall be exempt from the payment of any special assessment then in effect.</p> <p>and be it further</p> <p>Resolved, that the following policy, Early Career Reduced Dues Program, be adopted as follows:</p> <p><u>Resolved, that the American Dental Association urge constituents and components to implement a pricing structure for early career dentists (membership years from degree award through conclusion of fifth full year) similar to the American Dental Association.</u></p> <p>and be it further</p> <p>Resolved, that the ADA policy on Two-Year Recent Graduate Reduced Dues Program (<i>Trans</i>:2008;2021:277) be rescinded.</p>	
216	<p>Resolution will lay over to the 2026 House of Delegates since this resolution proposes a Constitutional amendment</p>	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 216—Establishing a Standing Committee on Oversight of ADA Communications and Public Trust</p> <p>Resolved, that Article IV. GOVERNMENT, of the ADA <i>Constitution</i> be amended as follows (additions <u>underscored</u>):</p> <p>Section 10. LEGISLATIVE BODY. The legislative and governing body of this Association shall be a House of Delegates. <u>In its role as the governing body of this Association, the House of Delegates shall be responsible for (i) reviewing non-scientific content of all Association print and electronic publications and social media sites; (ii) detecting and correcting instances of misinformation concerning dentistry, the dental profession and the Association; and (iii) policing the use and misuse of the ADA brand so that the integrity of the ADA brand is assured.</u></p> <p>Section 20. ADMINISTRATIVE BODY. The administrative body of this Association shall be a Board of Trustees.</p>	

		<p>and be it further</p> <p>Resolved, that Chapter III. HOUSE OF DELEGATES, Section 50. DUTIES, of the ADA <i>Bylaws</i> be amended as follows (additions <u>underscoring</u>):</p> <p style="padding-left: 40px;">Section 50. DUTIES: It shall be the duty of the House of Delegates to:</p> <p style="text-align: center;">***</p> <p style="padding-left: 40px;"><u>J. Monitor and guide the activities of the Council on Communications.</u></p> <p>and be it further</p> <p>Resolved, that Chapter III, HOUSE OF DELEGATES, Section 110. COMMITTEES, of the ADA <i>Bylaws</i> be amended as follows (additions <u>underscoring</u>, deletions stricken through):</p> <p style="padding-left: 40px;">Section 110. COMMITTEES. The standing committees of the House of Delegates shall be the Committee on Constitution and Bylaws, the Committee on Credentials, Rules and Order, the Strategic Forecasting Committee, <u>and the Standing Committee on Oversight of ADA Communications and Public Trust</u>, and such Reference Committees as shall in the determination of the Speaker of the House of Delegates be necessary to complete the business of the House of Delegates</p> <p>and be it further</p> <p>Resolved, that Chapter V. BOARD OF TRUSTEES, Section 70. POWERS, of the ADA <i>Bylaws</i> be amended as follows (additions <u>underscoring</u>, deletions stricken through):</p> <p style="padding-left: 40px;">Section 70. POWERS. The Board of Trustees shall be the managing body of the Association, vested with the power to:</p> <p style="text-align: center;">***</p> <p style="padding-left: 40px;"><u>L. Monitor and guide the activities of all councils and special committees and, with the exception of the Council on Communications, all councils.</u></p> <p>and be it further</p>	
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		<p>Resolved, that Chapter V. BOARD OF TRUSTEES, Section E. Powers, of the ADA <i>Governance Manual</i> be amended as follows (additions <u>underscored</u>, deletions stricken through):</p> <p>E. Powers</p> <p>1. The Board of Trustees shall report to the House of Delegates for approval any interim actions taken with respect to councils and special committees, consistent with the exercise of its power to supervise, monitor and guide, on an interim basis, the activities of all councils and special committees <u>and, with the exception of the Council on Communications, all councils</u>, including the establishment of rules and procedures that authorize the transaction of business by ballot without a meeting.</p> <p>and be it further</p> <p>Resolved, that Chapter XIX. PUBLICATIONS, Section A. <i>The Journal of the American Association</i>, be amended as follows (deletions stricken through):</p> <p>A. <i>The Journal of the American Association. The Journal of the American Dental Association</i>, hereinafter referred to as <i>The Journal</i>, shall be published with a frequency and at a subscription rate that shall be determined by the Board of Trustees. The object of <i>The Journal</i> shall be to report, chronicle and evaluate activities of scientific and professional interest to members of the dental profession. Except as otherwise provided in the powers of the Board of Trustees in the ADA Bylaws, the editor of <i>The Journal</i> shall have the authority to determine its editorial content, including scientific-based content, and shall, with the assistance of an editorial board, establish and maintain a written editorial policy for <i>The Journal</i>.</p> <p>and be it further</p> <p>Resolved, that the <i>Manual of the House of Delegates and Supplemental Information</i>, page 21, be amended as follows (additional <u>underscored</u>, deletions stricken through):</p> <p>Standing Committees of the House of Delegates</p> <p>In order to conduct its business, the House of Delegates uses three <u>four</u> standing committees: (1) the Committee on Credentials, Rules and Order; (2) the Committee on Constitution and Bylaws; and (3) the Strategic Forecasting Committee; <u>and (4) the Standing Committee on Oversight of ADA Communications and Public Trust.</u> 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</p>	
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		<p>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. The Standing Committee on Oversight of ADA Communications and Public Trust is composed of seven members of the House of Delegates appointed annually by the Speaker of the House of Delegates. These committees are largely concerned with procedural matters. A description of their specific duties follows.</p> <p>and be it further</p> <p>Resolved, that the <i>Manual of the House of Delegates and Supplemental Information</i> be amended to add the Standing Committee on Oversight of ADA Communications and Public Trust governance structure under this new Standing Committee as follows:</p> <p>Standing Committee on Oversight of ADA Communications and Public Trust Duties and Scope of Responsibility</p> <p>The Standing Committee on Oversight of ADA Communications and Public Trust shall:</p> <ol style="list-style-type: none"> 1. Review ADA-controlled non-scientific materials, including but not limited to ADA News, JADA opinion content and guest editorials, Morning Huddle articles, social media posts, digital campaigns, and member-facing communications, to ensure alignment with House-adopted policy, ADA ethical standards, and member values, and recommend corrective action to the Board of Trustees when misalignment is identified. 2. Evaluate ADA-controlled materials, including CE advertising, vendor promotions, dentist-facing editorial content, and other communications that carry the ADA name or appear on ADA platforms, to ensure consistency with House-adopted policy and member values, and recommend corrective action to the Board of Trustees when necessary. 3. Monitor reputational risk arising from third-party communications, vendor affiliations, public media, or misinformation, and recommend corrective action or clarification to the Board of Trustees as needed to preserve ADA credibility and the reputation of the profession. 4. Operate in coordination with the Council on Communications and other relevant ADA agencies, with oversight responsibility limited to non-scientific content, communications, and affiliations that may impact ADA's reputation, 	
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		<p>brand consistency, or alignment with ADA policy, and shall not supersede the Council on Communications’ duties under Chapter VIII, Section K2 of the ADA Governance and Organizational Manual.</p> <p>5. Review CE-related promotions and advertisements appearing on ADA-controlled platforms to identify potential misrepresentation of compliance with ADA Continuing Education Recognition Program (CERP) standards or ADA policy, and refer concerns to the Commission for Continuing Education Provider Recognition (as defined in ADA <i>Bylaws</i>, Chapter IX, Section 30.C.) or the appropriate governing body.</p> <p>6. Identify advertisements or communications on ADA-controlled platforms that appear to conflict with ADA policy, ethical standards, or established criteria, and recommend appropriate removal, revision, or clarification to the responsible governing body or staff authority for further action, using a process that includes notice to the originator, an opportunity to respond, and the option for appeal to the Board of Trustees.</p> <p>Composition</p> <ul style="list-style-type: none"> • The Standing Committee on Oversight of ADA Communications and Public Trust shall consist of seven members of the House of Delegates, appointed annually by the President. • Members shall have relevant expertise in communications, continuing education, editorial oversight, ethics, or reputational risk management. • Members shall serve a term of two years and may be reappointed for a total maximum tenure of four years. 	
217H	<p>Adopted— Consent Calendar Action</p>	<p>Board of Trustees Resolution 217 in lieu of Seventeenth Trustee District Resolution 217S-1—Amendment of ADA Policy on Posting of Financial Information</p> <p>Resolved, that the ADA policy on Posting of Financial Information (<i>Trans.</i>2009:493; 2012:407) be amended as follows (additions are <u>underlined</u>):</p> <p>Resolved, that the ADA post in the delegates’ section of ADA.org, ADA Connect, or the equivalent, copies of all audited financial statements reports and management letters associated with the audited financial statement report of the ADA and its subsidiaries within 30 days after the Board of Trustees review, and be it further</p>	

		Resolved , that the ADA <u>email a notification to the House of Delegates with a link to where the reports are posted</u> in the delegates’ section of ADA.org, ADA Connect, or the equivalent, copies of the quarterly financial reports within 30 days after Board of Trustees review.	
218H	Adopted— Consent Calendar Action	Council on Communications Resolution 218—Empowering the Council on Communications to Ensure Integrity and Member Representation in Public-Facing Communications Resolved , that the ADA promote at regular intervals the methods for which current and potential ADA members can submit concerns, feedback, and content suggestions, about ADA communications. Reports with this feedback will be shared with the Council on Communications quarterly or upon request, and be it further Resolved , that the Council on Communications evaluate the ADA communications channels, to ensure content being released aligns with the Association’s current policies, mission and goals, and report back to the House of Delegates in 2026.	
219	UNASSIGNED		
220	Declared Moot	Strategic Forecasting Committee Resolution 220—Nominations to the Strategic Forecasting Committee	
221	Declared Moot	Strategic Forecasting Committee Resolution 221—Amendments to Direct to Dentist Component of Strategic Forecast	
222	Declared Moot	Strategic Forecasting Committee Resolution 222—Amendments to Tripartite Component of Strategic Forecast	
223H	Adopted by a 60% affirmative vote	Board of Trustees Resolution 223—as amended—Establishment Of Dues Effective January 1, 2026 Resolved , that the dues of ADA active members shall be \$618.00 <u>\$627</u> effective January 1, 2026.	
224H	Adopted by a 2/3 affirmative vote	Seventeenth Trustee District Resolution 224—Dissolution of the ADA Strategic Forecasting Committee Resolved , that Chapter III. HOUSE OF DELEGATES, <i>Section 50. DUTIES</i> , of the ADA <i>Bylaws</i> be amended as follows (additions <u>underscoring</u> , deletions stricken through):	

Section 50. DUTIES: It shall be the duty of the House of Delegates to:

* * *

~~E. Establish, in collaboration with the Board of Trustees, the strategic direction of the Association in alignment with the mission and vision of the Association, which shall be established by the House of Delegates.~~

~~F. Establish a mechanism by which the Strategic Forecasting Plan, including the progress of each of the strategic initiatives of the American Dental Association to achieve and confirm the progress for the current five-year vision, is reported on, amended if necessary, and adopted by majority vote, at least annually.~~

GE. Establish the dues of active members for the following year.

HF. Serve as the court of appeal from decisions of the Council on Ethics, Bylaws and Judicial Affairs involving disputes arising between constituents or between a constituent and a component, as provided in of these *Bylaws*.

IG. Provide sufficient support to the ADA Foundation in addition to non-Association funding to assure the continued viability of the Foundation's research activities.

and be it further

Resolved, that Chapter III. HOUSE OF DELEGATES, *Section 110. COMMITTEES*, of the ADA *Bylaws* be amended as follows (deletions ~~stricken through~~):

Section 110. COMMITTEES: The standing committees of the House of Delegates shall be the Committee on *Constitution and Bylaws*, the Committee on Credentials, Rules and Order, ~~the Strategic Forecasting Committee~~ and such Reference Committees as shall in the determination of the Speaker of the House of Delegates be necessary to complete the business of the House of Delegates.

and be it further

Resolved, that Chapter V. BOARD OF TRUSTEES, *Section 80. DUTIES*, of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

Section 80. DUTIES: It shall be the duty of the Board of Trustees to:

* * *

~~F.~~ Collaborate with the House of Delegates in setting the strategic direction of the Association in alignment with the mission and vision of the Association.

~~G.~~ Adopt a budget for the following year, consistent with the Strategic Forecasting Plan.

~~H.~~ Recommend the dues of active members for the following year.

~~I.~~ Establish recommended qualifications for the offices of Treasurer and Speaker of the House of Delegates.

~~J.~~ Submit to the House of Delegates nominations for membership to the councils and commissions, except as otherwise provided in these *Bylaws*.

~~K.~~ Act upon commission and committee nominations for consultants as set forth in the *Governance Manual*.

~~L.~~ Review the reports of councils and special committees of the Association and to make recommendations concerning such reports to the House of Delegates.

~~M.~~ Submit an annual report of its activities to the House of Delegates.

~~N.~~ Appoint special committees of the Association in accordance with these *Bylaws*.

~~O.~~ Render a final judgment on what constitutes a conflict of interest except with respect to the work of the Commission on Dental Accreditation.

~~P.~~ Establish dues for the international member category.

~~Q.~~ Ask that the ADA Foundation provide the Board of Trustees with a request for any funding in furtherance of Chapter III, Section 50.G of these *Bylaws* so said request can be considered during the Association's annual budgeting activities.

~~R.~~ Perform such other duties as are provided for in these *Bylaws*.

and be it further

		<p>Resolved, that the <i>Manual of the House of Delegates and Supplemental Information</i> be amended as follows (additions <u>underscored</u>, deletions stricken through):</p> <p>Standing Committees of the House of Delegates</p> <p>In order to conduct its business, the House of Delegates uses <u>two</u> three standing committees: (1) the Committee on Credentials, Rules and Order; <u>and</u> (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.</p> <p>and be it further</p> <p>Resolved, that the charter of the Strategic Forecasting Committee, as set forth in the <i>Manual of the House of Delegates</i>, be deleted in its entirety.</p>	
225	Referred to the appropriate agency for further study and report to the 2026 House of Delegates	<p>Fourteenth Trustee District Resolution 225—Seeking Funding and Support for the Institute for ADA Leadership Institute</p> <p>Resolved, that the Leadership Institute, formerly known as the Institute for Diversity in Leadership (IDL), be restored, and be it further</p> <p>Resolved, that the appropriate ADA agency identify and secure sustainable alternative funding mechanisms to ensure the long-term viability of the program, and be it further</p> <p>Resolved, that the appropriate ADA agency create a formal evaluation and transparent reporting system for the Leadership Institute that tracks both historic and ongoing outcomes, including the number and roles of alumni who have advanced into leadership positions within the tripartite, and be it further</p> <p>Resolved, that the appropriate ADA agency provide a report for the House of Delegates outlining the Association’s strategic goals for inclusion, fairness and belonging, and be it further</p>	

		<p>Resolved, that the appropriate ADA agency seek a coalition including other dental and health professional associations to share best practices and strengthen leadership diversity initiatives across the healthcare professions.</p>	
226H	Adopted— Consent Calendar Action	<p>Fourteenth Trustee District Resolution 226—Discontinue Council and Commission Self-Assessments</p> <p>Resolved, that Resolution 41H-2018, Self-Assessments (<i>Trans.2018:331</i>), be rescinded.</p>	
227H	Adopted— Consent Calendar Action	<p>Fourteenth Trustee District Resolution 227—Amendment to the ADA Bylaws and ADA Governance and Organizational Manual Regarding Flexibility in Scheduling Scientific Sessions</p> <p>Resolved, that Chapter V. Board of Trustees, Section 80. Duties, of the <i>ADA Bylaws</i> be amended as follows (addition <u>underscored</u>):</p> <p style="text-align: center;">* * *</p> <p style="padding-left: 40px;">C. Determine the date and place for convening annual House of Delegates and <u>any</u> scientific sessions and provide for the management and general arrangements for each.</p> <p style="text-align: center;">* * *</p> <p>and be it further</p> <p>Resolved, that Chapter XVIII. Scientific Meetings, Section B., of the <i>Governance and Organizational Manual</i> of the American Dental Association be amended as follows (additions <u>underlined</u>, deletions stricken through):</p> <p style="padding-left: 40px;">A. Object. The scientific session of this Association is established to foster the presentation and discussion of subjects pertaining to the improvement of the health of the public and the science and art of dentistry.</p> <p style="padding-left: 40px;">B. Time and Place. The Scientific session of the Association shall<u>may</u> be held annually at a time and place selected by the Board of Trustees. Such Selection shall be made at least one (1) year in advance.</p> <p style="padding-left: 40px;">C. Trade and Laboratory Exhibits. Products and services of the dental trade and dental laboratories and other products and services may be exhibited at each</p>	

		<p>scientific session under the direction of the Board of Trustees and in accordance with the rules and regulations established by that body.</p> <p>D. Admission. Admission to meetings of the scientific sessions shall be limited to members of this Association who are in good standing and to others admitted in accordance with rules and regulations established by the Board of Trustees.</p>	
228H	Adopted	<p>Fourteenth Trustee District Resolution 228—Grants for State-Level Wellness Initiatives</p> <p>Resolved, that the ADA Foundation be urged to seek funds to support dentist wellness from dental suppliers, third-party payers, and other interests, and be it further</p> <p>Resolved, that as the ADA Foundation provides funding, the American Dental Association will administer a wellness initiative grant program for state constituents to create innovative wellness programs in their states.</p>	
229H	Adopted	<p>Ninth Trustee District Resolution 229—Amendment to the Standing Rules of the House of Delegates</p> <p>Resolved, that the Rules of the House of Delegates, as published in the <i>Manual of the House of Delegates</i>, in the section titled, “Meeting Schedule and Order of Business,” be amended as follows (additions <u>underlined</u>, deletions stricken through):</p> <p>Consistent with procedures established in the <i>Manual of the House of Delegates</i>, the Speaker and Secretary of the House are responsible for the day-to-day business of the House. Included are selection of the on-site location and facilities and determination of times for convening and adjourning each meeting, the order of business the agenda, subject to the approval of the House. Any substantive consolidation or expansion of the meeting schedule can take place only with the prior approval of the House. The Speaker, in consultation with the Board of Trustees and appropriate ADA leadership, may modify the meeting schedule, including the use of virtual or hybrid formats, when such changes improve efficiency or better accommodate the business of the House. The House shall be informed of any substantive changes as soon as practical. The sequencing of resolutions, for House action, will be organized by the Speaker of the House of Delegates, in consultation with the Secretary of the House of Delegates, as necessary.</p>	

230H	Adopted— Consent Calendar Action	<p>Ninth Trustee District Resolution 230—Comprehensive Report of ADA Budget</p> <p>Resolved, that the House of Delegates receive a comprehensive report on the annual budget when adopted, and be it further</p> <p>Resolved, that the next governance study make specific recommendations on how to ensure the budget is made available to the House of Delegates.</p>	
231	Ruled Out of Order	<p>Dr. Spencer Bloom, delegate, Illinois, Resolution 231</p>	
232	WITHDRAWN		
300H	Adopted	<p>Reference Committee B (Dental Benefits, Practice, Science, Health and Related Matters) Resolution 300—as amended—Consent Calendar</p> <p>Resolved, that the recommendations of Reference Committee B on the following resolutions be accepted by the House of Delegates.</p> <p>1. Resolution 301RC— Adopt Resolution 301RC in lieu of Resolution 301— Establishment of a Dentist-Facing ADA Certification Program for Dental Software and Imaging Platforms (Worksheet:3086) \$60,000</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>2. Resolution 303RC—Adopt Resolution 303RC in lieu of Resolution 303—Supporting Tribal Self-Determination in Oral Health Workforce Decisions (Worksheet:3089) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>3. Resolution 304—Adopt—Ensuring the Separation of Dental Benefit Administration and Clinical Practice Ownership (Worksheet:3000) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>4. Resolution 305—Refer —Provisional Credentialing to Support Patients, Early-Career Dentists, Practice Owners, and ADA Membership Growth (Worksheet:3003) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes on Referral</p>	

		<p>5. Resolution 306—Adopt—Amendment of Policy, Bulk Benefit Payment Statements (Worksheet:3005) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>6. Resolution 307RC—Adopt Resolution 307RC in lieu of Resolution 307—Amendment of Policy, Maximum Fees for Non-Covered Services (Worksheet:3007) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>7. Resolution 308RC—Adopt Resolution 308RC in lieu of Resolution 308 and Resolution 308S-1—Amendment of Policy, Statement on Dental Consultants (Worksheet:3009) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>8. Resolution 309RC—Adopt Resolution 309RC in lieu of Resolution 309 and Resolution 309S-1—Amendment of Policy, Authorization of Benefits (Worksheet:3014) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>9. Resolution 310—Adopt—Amendment of Policy, Third-Party Payment Choices (Worksheet:3016) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>10. Resolution 311RC—Adopt Resolution 311RC in lieu of Resolution 311—Amendment of Policy on Third-Party Payers Overpayment Recovery Practices (Worksheet:3018) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>11. Resolution 312RC—Adopt Resolution 312RC in lieu of Resolution 312— Proposed Policy, Administrative Principles of Supplemental Dental Benefits in Medicare Advantage Plans (Worksheet:3021) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p>	
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301	Not Adopted	<p>Reference Committee B Resolution 301RC in lieu of Dr. Steven Saxe, delegate, Nevada, Resolution 301—Establishment of a Dentist-Facing ADA Certification Program for Dental Software and Imaging Platforms</p> <p>Resolved, that the appropriate ADA agency convene a task force, including representatives from relevant ADA councils and independent experts in software engineering, data security, dental informatics, and regulatory compliance, to explore the establishment of a voluntary ADA Certification Program that identifies dental software platforms and imaging systems meeting defined criteria for security, interoperability, regulatory compliance, and data ownership, and be it further</p> <p>Resolved, that such exploration shall also include a financial assessment of projected costs, potential revenue, and resource requirements to ensure the sustainability and value of the proposed certification program, and be it further</p> <p>Resolved, that a report outlining findings and recommendations shall be presented to the Board of Trustees for further action and report to the 2026 House of Delegates.</p>	
302	UNASSIGNED		
303	TABLED (2/3 affirmative vote)	<p>Reference Committee B Resolution 303RC in lieu of Dr. Spencer Bloom, delegate, Illinois, Resolution 303.</p>	
304H	Adopted— Consent Calendar Action	<p>Board of Trustees Resolution 304—Ensuring the Separation of Dental Benefit Administration and Clinical Practice Ownership</p> <p>Resolved, that the American Dental Association use policies that protect clinical autonomy, minimize conflicts of interest, and preserve the integrity of the independent dentist-patient relationship to guide in the drafting of model legislation and encourage constituent societies in the pursuit of legislation to prohibit entities which administer, underwrite, or manage dental benefit plans from owning, controlling, or exercising undue influence over dental practices or dental service organizations (DSOs).</p>	

<p>305</p>	<p>Referred to the appropriate ADA agency for further study and report to the 2026 House of Delegates— Consent Calendar Action</p>	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 305—Provisional Credentialing to Support Patients, Early-Career Dentists, Practice Owners, and ADA Membership Growth</p> <p>Resolved, That the American Dental Association create a task force, appointed for up to one year or until its work is completed, charged with developing a model framework for provisional insurance credentialing of licensed, malpractice-insured dentists actively applying to join a network, allowing such dentists to treat patients at in-network rates while full credentialing is completed, and be it further</p> <p>Resolved, that the task force be charged with the following responsibilities:</p> <ol style="list-style-type: none"> 1. Work with third-party payers, regulatory stakeholders, and subject matter experts to create a system that protects patients, verifies licensure and liability insurance, and maintains payer integrity; 2. Evaluate artificial intelligence (AI)-based credentialing platforms, including but not limited to LightSpun and CAQH ProView, to determine which features can support—but not replace—provisional credentialing workflows and whether any systems can meaningfully reduce administrative lag; 3. Review credentialing standards already in use in the medical field, and consider best practices for dental-specific provisional credentialing guidelines, such as a 15-day eligibility window with completion within 60 days; and 4. Explore whether the ADA can create or facilitate credentialing support services—such as background checks, licensure and liability insurance verification, or pre-submission data screening—to assist both payers and ADA members, and whether such a program could serve as a meaningful membership benefit, especially for younger dentists and for practice owners seeking to streamline onboarding of new associates. <p>and be it further</p> <p>Resolved, that the Council on Dental Benefit Programs review the work of the task force and, if appropriate, draft a resolution for submission to the 2026 House of Delegates for adoption as ADA policy, and in the interim, consider using the framework to guide voluntary engagement and advocacy efforts with third-party payers, and be it further</p>	
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		<p>Resolved, that the task force be composed of up to seven members, including at least one early-career dentist, one member with expertise in dental benefits or credentialing, and one member of the Council on Dental Benefit Programs, and be it further</p> <p>Resolved, that if in-person meetings are required, funding shall be provided in accordance with existing ADA policy, and be it further</p> <p>Resolved, that the ADA ensure all activities under this resolution, including engagement with insurance carriers, remain voluntary, non-binding, and fully compliant with applicable federal and state antitrust laws.</p>	
306H	Adopted— Consent Calendar Action	<p>Council on Dental Benefit Programs Resolution 306—Amendment of Policy, Bulk Benefit Payment Statements</p> <p>Resolved, that the policy titled, Bulk Benefit Payment Statements (<i>Trans.</i>1990:536; 2013:308;2015:243) be amended as follows (additions are <u>underscored</u>; deletions are stricken).</p> <p style="text-align: center;">Bulk Benefit Payment Statements</p> <p>Resolved, that the ADA goes on record as being opposed to bulk payments by a third-party payer. In the interest of facilitating prompt settlement of patients' accounts, When bulk benefit payments may be are made by a third-party but they <u>should include a statement containing complete individual explanation of benefits for each claim included in the bulk payment which should conform to the ADA EOB Statement or, at a minimum, should include</u> the following information for each claim payment represented in the bulk payment:</p> <ol style="list-style-type: none"> 1. Subscriber (employee) name; 2. Patient name; 3. Dates of service; 4. Specific service reported on the submitted claim, by <i>CDT Code</i> number and nomenclature; 5. Total fee charged; 6. Statement indicating how the submitted procedures were adjudicated; 7. Total covered expense; 8. Total benefits paid; 9. In instances where benefits are reduced or denied, an explanation of the reason(s) why the total covered expense differs from the total fee charged, consistent with Association policy on Explanation of Benefits Statements; and 	

		<p>10. If the bulk payment amount on the EOB reflects the final amount paid to the dentist, taking into account any secondary plan payment, then the individual claim amounts should also be adjusted appropriately to avoid discrepancy between the individual claim amounts listed on the EOB and the bulk payment amount.</p> <p>and be it further</p> <p>Resolved, that third party payers should not withhold funds from current bulk benefit payments as a means of settling disputes over prior claims experience with the dentist or another dental office and that state dental societies be encouraged to seek legislation to resolve this problem, and be it further</p> <p>Resolved, that bulk payments should be issued to dentists at intervals of not longer than every ten business days, and be it further</p> <p>Resolved, that the Council on Dental Benefit Programs work with the insurance industry and third party payers to incorporate this policy into their administrative procedures.</p>	
307H	Adopted— Consent Calendar Action	<p>Reference Committee B Resolution 307RC in lieu of Council on Dental Benefit Programs Resolution 307—Amendment of Policy, Maximum Fees for Non-Covered Services</p> <p>Resolved, that the policy titled, Maximum Fees for Non-Covered Services (<i>Trans.</i>2010:616; 2020:317) be amended as follows (additions are <u>underscored</u>; deletions are stricken).</p> <p style="text-align: center;">Maximum Fees for Non-Covered Services <u>Reimbursement</u></p> <p>Resolved, that the Association opposes any third-party contract provisions that establish limits on dentists’ charges for services that are not “covered services,” and be it further</p> <p>Resolved, that “covered service” is defined as any service for which reimbursement is actually provided on a given claim. A “covered service” should not include <u>procedures or services not paid for by the dental benefit plan on a given claim for reasons including but not limited to benefit limitations (e.g., waiting periods, frequency limits, alternate benefits, or Least Expensive Alternative Treatment (LEAT)) or the patient having exceeded the annual maximum,</u> and be it further</p>	

		<p><u>Resolved, that the ADA opposes any contractual language that prohibits a dentist from charging their full fee to a patient for a procedure or service not paid for by the benefit plan or imposing a de-minimis payment, and be it further</u></p> <p><u>Resolved, that denials for non-covered services are not a determination of medical necessity and should not be communicated to a patient as such, and be it further</u></p> <p><u>Resolved, that the ADA opposes any mandates for fee discounts for procedures for which the plan pays no benefit, and be it further</u></p> <p>Resolved, that the carrier provides payment for the covered services under the patient's policy in an amount that reflects the costs of the services rendered by using the current year's averaged fee from similar geographic areas and adjusts such amounts every year to reflect inflation.</p>	
308H	Adopted— Consent Calendar Action	<p>Reference Committee B Resolution 308RC in lieu of Council on Dental Benefit Programs Resolution 308 and Ninth Trustee District Resolution 308S-1— Amendment of Policy, Statement on Dental Consultants</p> <p>Resolved, that the policy titled, Statement on Dental Consultants (<i>Trans.2010:555</i>) be amended as follows (additions are <u>underscored</u>; deletions are stricken).</p> <p style="text-align: center;">Statement on Dental Consultants</p> <p>Third-party payers and plan purchasers have used dental consultants in order to streamline the claims review process for many years.</p> <p>The American Dental Association initially saw a positive potential in the use of dental consultants by third-party payers as a means of receiving professional advice on certain aspects of dental benefits plans. While the ADA still believes that there is value to third-party payers' use of dental consultants, it also believes that some clear distinctions must be made between dental consultants and dental claims reviewers.</p> <p>Dental claims reviewers work under supervision. They do not necessarily have, or need, clinical dental or dental practice background, and are trained specifically by the third-party payer to review dental claims that are uncomplicated and require straightforward processing.</p>	

		<p>Dental consultants are licensed dentists who, even if not currently practicing, have at least many ten <u>five (5)</u> years of experience in practice and can and should:</p> <ul style="list-style-type: none"> • Offer a professional opinion regarding complicated dental treatment • Provide their name, degree, license number and direct phone number to the treating dental office • Request <u>Seek</u> consultations from specialists for certain specialty-related cases, when necessary • Provide advice to third-party payers regarding the merit and value of dental benefits plan designs • Educate plan purchasers regarding the impact alternative, less costly treatment may have on the life of a tooth, overall oral health, etc. • Alert third-party payers when dentists' treatment patterns are changed by cost containment strategies to the detriment of the patients • Provide guidance to third-party payers regarding the importance of the dentist/patient relationship • Inform third-party payers, plan sponsors and subscribers about the availability and value of the profession's peer review system • Initiate dialogue with organized dentistry regarding questionable <u>emerging</u> treatment modalities • Inform the dental profession of those treatment procedures on which questions of judgment between the dentist and the dental consultant are most likely to result in areas of disagreement • Discuss treatment decisions with dentists on a professional level • Explain clearly to practicing dentists the provisions of particular contracts and the benefit limitations of those contracts • Demonstrate knowledge of contract interpretation, and laws and regulations governing dental practice in those jurisdictions affected by their consulting activities, as well as accepted standards of administrative procedure within the dental benefits industry • Dentists reviewing claims submissions must be licensed in the United States, preferably <u>and</u> within the jurisdiction of the dentist treating the patient in accordance with applicable state law <p>Dentists have a fundamental obligation to serve the best interests of the public and their profession. This obligation can never be abrogated for any reason. In order to maintain independent thought and judgment regarding dental matters, dental consultants should be competent with regard to current clinical procedures and practice through such mechanisms as continuing education, or have been in practice for a minimum of ten <u>five (5)</u> years immediately preceding employment as a</p>	
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		<p>dental consultant, and remain involved in the continuing dental education process in order to stay current with clinical procedures and changing technology.</p> <p>It is strongly recommended that dental consultants be members of the American Dental Association <u>and adhere to the ADA's Code of Ethics</u>,</p> <p>and be it further</p> <p>Resolved, that when a third-party payer such as a Health Maintenance Organization (HMO), capitation program, or Preferred Provider Organization (PPO) denies a claim for treatment or tests required for treatment it considers dentally or medically unnecessary, the denial should be subject to automatic review by independent qualified dental consultant licensed within the state of the treating dentist, and be it further</p> <p>Resolved, that the American Dental Association distribute copies of this Statement to all third-party payers <u>following any revisions or at least every five (5) years</u>, and be it further</p> <p>Resolved, that third-party payers, including dental consultants to payers, should not exceed their legitimate role in the processing of dental benefit claims, and specifically, third-party payers and dental consultants should not:</p> <ul style="list-style-type: none"> • Change code numbers as submitted without written permission of the attending-treating dentist • Redefine code numbers, nomenclatures or descriptors except as provided for in their CDT license agreements • Disapprove complex cases without seeking the advice of appropriately trained consultants <p>and be it further</p> <p>Resolved, that the ADA urge third-party payers and administrators to identify dental consultants by name in any correspondence to attending-treating dentists.</p>	
309H	Adopted— Consent Calendar Action	<p>Reference Committee B Resolution 309RC in lieu of Council on Dental Benefit Programs Resolution 309 and Seventeenth Trustee District Resolution 309S-1—Amendment of Policy, Authorization of Benefits</p> <p>Resolved, that the policy titled, Authorization of Benefits (<i>Trans.</i>1994:665; 2013:306; 2017:264) be amended as follows (additions are <u>underscored</u>; deletions are stricken).</p> <p style="text-align: center;"><u>Authorization-Assignment of Benefits</u></p>	

		<p>Resolved, that the American Dental Association supports the right of each <u>dentist dental provider</u> to accept or reject assignment of benefits from any dental benefits plan, and be it further</p> <p>Resolved, that the Association supports the right of every patient to assign their benefits to the treating dentist <u>provider</u> and to have the assignment honored by the third-party payer, and be it further</p> <p>Resolved, that the insurer providing coverage under a dental benefit plan shall <u>honor a written assignment of benefit that is made by a patient to a provider, for services provided to the patient, and that is signed by the covered person, until a written termination notice is received directly from the patient, and be it further</u></p> <p>Resolved, that upon meeting the requirements of assignment of benefits, the <u>insurer shall make payments for covered services directly to the provider regardless of their network status, and be it further</u></p> <p>Resolved, that the non-contracting provider retains the right to request the <u>remaining balance of the provider's full fee directly from the patient, and be it further</u></p> <p>Resolved, that the ADA opposes the use of third-party repricing practices or any other methods that restrict beneficiaries from seeking care from any providers of their choice, especially those to whom they have assigned the right to payment or reimbursement, and be it further</p> <p>Resolved, the ADA is opposed to any practice that misrepresents a patient's financial responsibility when benefits are assigned, and be it further</p> <p>Resolved, that when a third-party payer submits <u>sends</u> payment directly to the patient, contrary to the patient's authorized preference, the <u>dentist provider</u> has the right to request payment directly from the patient. If the patient declines, then it is the third-party payer's responsibility to submit <u>send</u> the correct payment to the <u>dentist provider</u> within fifteen <u>ten</u> (10) days of being notified of the incorrect payment, and to submit <u>send</u> the payment to the <u>dentist provider</u> whether or not the third-party payer has received reimbursement from the patient, and be it further</p> <p>Resolved, that in those states where dentists <u>providers</u> are not notified of the rescission of a prior assignment of benefits, the Association encourages state dental societies to seek legislative relief.</p>	
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310H	Adopted— Consent Calendar Action	<p>Council on Dental Benefit Programs Resolution 310—Amendment of Policy, Third-Party Payment Choices</p> <p>Resolved, that the policy titled, Third-Party Payment Choices (<i>Trans.2017:265</i>) be amended as follows (additions are <u>underscored</u>; deletions are stricken).</p> <p style="text-align: center;">Third-Party Payment Choices</p> <p>The American Dental Association urges third-party payers to support a dentist’s right to receive a traditional paper check in lieu of alternative payment methods as payment for services rendered to a beneficiary of a dental benefits program. The ADA opposes third-party payer payment methodologies that require a dentist to accept virtual credit card payments, electronic funds transfer (EFT) payments or any other payment options as the only payment option without an opportunity to choose a paper check.</p> <p>Virtual credit cards may apply processing fees, and these fees can be much higher than the fees agreed upon by the dentist when signing the original merchant credit service agreement credit card agreement.</p> <p>While EFT improves efficiency for the payers and may, in the long term, be beneficial for dental practices, there are some dental offices that may incur problems due to their current patient management systems not being fully equipped to handle end-to-end electronic claims processing, in particular bulk claim payments. Under current circumstances, dentists are simply left with having to deal with bank charges levied to adopt EFT or paying to get upgraded to new software simply to handle EFT and electronic remittance advice (ERA) transactions seamlessly. This results in little to no improvement in practice efficiency.</p> <p>Resolved, in addition, that the ADA believes <u>all</u> dental claims should be reimbursed within fifteen (15) <u>ten (10)</u> business days from receipt of the claim by the third-party payer, <u>and be it further</u></p> <p>Resolved, <u>that when initiating or changing payments to a health care provider using electronic funds transfer payments, or virtual credit card payments, insurers must notify the health care provider of all fees associated with a particular payment method, advise the provider of all available methods of payment, and provide clear instructions to the health care provider as to how to select or change an alternative payment method, and be it further</u></p>	
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311H	Adopted— Consent Calendar Action	<p>Reference Committee B Resolution 311RC in lieu of Council on Dental Benefit Programs Resolution 311—Amendment of Policy on Third-Party Payers Overpayment Recovery Practices</p> <p>Resolved, that the policy titled, Third-Party Payers Overpayment Recovery Practices (<i>Trans.</i> 1999:930; 2013:312; 2021:284) be amended as follows (additions <u>underlined</u>; deletions stricken through):</p> <p style="text-align: center;">Third-Party Payers Overpayment Recovery Practices</p> <p><u>Resolved, that third-party payers should not retroactively deny, adjust, withhold or seek recoupment or refund of a paid claim for dental care expenses submitted by a provider for any reason (including lapse of eligibility), other than fraud or for duplicate payments on claims received from the same plan for the same patient, same services and on the same date of service from a provider, and be it further</u></p> <p><u>Resolved, that third-party payers should not retroactively deny, adjust, withhold or seek recoupment or refund of a paid claim, including payments made to a different unaffiliated dentist or for a different patient within the practice covered by the same third-party payer, and be it further</u></p> <p><u>Resolved, that when seeking recoupment for any alleged overpayment on a specific patient’s claims, third party payers:</u></p> <ul style="list-style-type: none"> • <u>should not retroactively deny, adjust, or seek recoupment or refund of a paid claim for dental care expenses after the expiration of six months from the date of the initial claim submission</u> • <u>should not place withholds on future payments for alleged overpayments but instead should seek a refund from the provider after providing information about why the alleged refund is due, including the name of the patient, service provided, date of service and the reason for the recoupment</u> 	

		<ul style="list-style-type: none"> • <u>should allow six months to contest the refund request from the date of proper notice of recoupment from the payer.</u> • <u>should notify the patient of the overpayment within thirty (30) days of identifying the overpayment</u> <p><u>and be it further</u></p> <p><u>Resolved</u>, that the ADA is opposed to the inclusion of hold-harmless clauses favoring the carrier in third-party payer contracts, and be it further</p> <p><u>Resolved</u>, that third party payers, administering self-funded and fully-insured plans, be urged to adopt these guidelines as an industry-wide standard for alleged overpayment of benefits to dentists.</p> <p><u>Resolved</u>, that the American Dental Association shall and its constituent societies are urged to seek or support legislation to prevent third-party payers from withholding assigned benefits or recouping payment when a payment made in error has been made on behalf of a different patient covered by the same third-party payer or because of an alleged overpayment to a different dentist, and be it further.</p> <p><u>Resolved</u>, that dental plans should not retroactively deny, adjust, or seek recoupment or refund of a paid claim for dental care expenses submitted by a provider for any reason, other than fraud or for duplicate payments on claims received from the same plan for the same service from a provider, after the expiration of six months from the date that the initial claim was paid. The plan must provide information about why a refund is due, including the name of the patient, date of service and service provided along with the reason for the overpayment and allow the provider six months before the refund must be paid. The provider should be allowed 30 days to contest the refund request, and be it further</p> <p><u>Resolved</u>, that dental plans, representing self-funded and fully-insured plans, be urged to adopt these guidelines as an industry-wide standard for alleged overpayment of benefits to dentists.</p>	
312H	Adopted— Consent Calendar Action	<p>Reference Committee B Resolution 312RC in lieu of Council on Dental Benefit Programs Resolution 312—Proposed Policy, Administrative Principles of Supplemental Dental Benefits in Medicare Advantage Plans</p> <p>Resolved, that the proposed policy titled, “Administrative Principles of Supplemental Dental Benefits in Medicare Advantage Plans” be adopted.</p>	

Administrative Principles of Supplemental Dental Benefits in Medicare Advantage Plans

Resolved, that the American Dental Association advocates on behalf of patients to ensure that supplemental benefits by Medicare Advantage (MA) plans maintain, at a minimum, the following principles:

- Medicare Advantage plan reporting of medical (dental) loss ratio (MLR) should clearly distinguish dental from medical services, requiring that at least 85% of the premium or equivalent dollars allocated to provide supplemental dental benefits be spent on dental care, as required for medical services during Medicare Advantage reporting periods by federal statute.
- Centers for Medicare and Medicaid Services (CMS) should collect and publicly report standardized utilization and cost data for MA dental benefits, including enrollee out-of-pocket spending, plan spending, network participation, and service utilization.
- Supplemental benefits should not be subject to any regulations applicable to Part A and Part B covered services offered within a Part C plan.
- MA plans should not be allowed to reduce dental benefits after initial enrollment in a way that misleads enrollees. Plans should be required to disclose benefit changes clearly before the annual enrollment period.
- Purchasers should be provided with a summary of benefits information available in formats that are easy to understand and compare plans prior to purchase.
- Marketing materials for MA dental benefits should clearly specify which services are covered, cost-sharing obligations, and network limitations.
- Standardized benefit categories should be clearly defined to allow for easy comparison across plans. Options should include combinations of plan designs that:
 - Offer both freedom of choice and network-based plans although network-based plans should not lower the available benefit when a patient chooses to go out of network.

		<ul style="list-style-type: none"> ○ Offer both annual maximum limited benefit products and true insurance products (i.e., with no annual maximum) with out-of-pocket maximum protections. • MA supplemental dental networks should not automatically include providers from commercial dental networks. • Providers must have a separate opt-in process to join an MA network, with clear terms and reimbursement structures. • If a provider explicitly consents, they may participate in both networks, but participation in one should not imply participation in the other. • Providers who have opted-in to participation in an MA network must be given the opportunity to change their election annually or upon contract amendments. 	
313	TABLED (2/3 affirmative vote)	Council on Advocacy for Access and Prevention Resolution 313	
314H	Adopted as amended	<p>Reference Committee B Resolution 314RC—as amended—in lieu of Council on Advocacy for Access and Prevention Resolution 314—Proposed Policy on Patient Care within Special Populations</p> <p>Resolved, that the following new policy titled “Patient Care within Special Populations” be adopted:</p> <p style="text-align: center;">Patient Care within Special Populations</p> <p>Resolved, that the appropriate agencies of the American Dental Association be tasked to identify gaps and support initiatives and legislation to improve training and education to and maintain oral health needs of individuals with cognitive or physical impairments, or conditions including intellectual, developmental, or sensory disabilities, and be it further</p>	

		<p>Resolved, that constituent and component dental societies be encouraged to support state or local educational and legislative initiatives to improve and maintain the oral health of such persons regardless of their age, and be it further</p> <p>Resolved, that dental and allied health programs be encouraged to educate students about the oral health needs and issues throughout the lifespan of these individuals, and be it further</p> <p>Resolved, that constituent and component dental societies be encouraged to work with health care facility administrators, homebound individuals, staff of group homes, and other responsible parties to assure that any such individuals are receiving comprehensive dental care under the supervision of a licensed dentist, <u>and be it further</u></p> <p><u>Resolved, that the phrase “people with intellectual disabilities” be utilized when referring to persons previously acknowledged as “mentally retarded”</u></p> <p>and be it further</p> <p>Resolved, that the following policies be rescinded:</p> <ul style="list-style-type: none"> • ADA Policy on the Aged, Blind and Disabled (<i>Trans.</i>2002:390; 2012:455) • Dental Care in Institutional and Homebound Settings (<i>Trans.</i>1986:518; 2013:341) 	
315H	Adopted— Consent Calendar Action	<p>Council on Advocacy for Access and Prevention Resolution 315—Proposed Policy on Dental Care Provided within a Hospital Setting</p> <p>Resolved, that the following policy titled “Dental Care Provided Within a Hospital Setting” be adopted:</p> <p style="text-align: center;">Dental Care Provided Within a Hospital Setting</p> <p>Resolved, the American Dental Association believes that all dentists who provide care in hospital settings should be eligible for rights and privileges similar to any other staff member that should include performance of history and physical examinations, diagnosis, treatment and admission in accordance with their</p>	

		<p>education, training and current competencies, consistent with the protocols and guidelines of the hospital where they have privileges, and be it further</p> <p>Resolved, that the American Dental Association supports active hospital medical staff membership for qualified dentists that request such appointment, and be it further</p> <p>Resolved, that dentists who receive such membership be encouraged to be active in the hospital and in its related committees.</p> <p>and be it further</p> <p>Resolved, that the following policies be rescinded:</p> <ul style="list-style-type: none"> • Guidelines for Hospital Dental Privileges (<i>Trans.</i>2015:274) • Hospital Medical Staff Membership (<i>Trans.</i>1999:923) 	
316H	Adopted— Consent Calendar Action	<p>Council on Advocacy for Access and Prevention Resolution 316—Amendment of Policy, Definition of a Dental Home</p> <p>Resolved, that the policy titled Definition of a Dental Home (<i>Trans.</i>2005:322; 2010:548; 2014:505) be amended to read as follows (additions are <u>underscored</u>; deletions are stricken).</p> <p style="text-align: center;">Definition of a Dental Home</p> <p>Dental Home. The ongoing relationship between the dentist who is the Primary Dental Care Provider and the patient/<u>caregiver</u>, which includes <u>continuously accessible</u> comprehensive oral health care, <u>and the relationship to overall systemic health</u> beginning before age one, and continuing throughout the patient’s lifetime, with appropriate referral <u>and interprofessional collaboration</u> as necessary.</p>	
317H	Adopted— Consent Calendar Action	<p>Council on Advocacy for Access and Prevention Resolution 317—Amendment of Policy, Groundwater with Natural Levels of Fluoride Higher than 2.0 Parts Per Million</p> <p>Resolved, that the policy titled Groundwater with Natural Levels of Fluoride Higher Than 2.0 Parts Per Million (<i>Trans.</i>1999:921) be amended to read as follows (additions are <u>underscored</u>; deletions are stricken).</p>	

		<p style="text-align: center;">Groundwater With Natural Levels of Fluoride Higher Than <u>Above</u> 2.0 Parts Per Million</p> <p>Resolved, that the American Dental Association urge encourages state and local dental societies to continue efforts to educate professionals and consumers about the role <u>importance and safety</u> of fluoride in community oral health, and be it further</p> <p>Resolved, that the Association urge encourages these state dental societies to encourage <u>support</u> state and local dental public health <u>programs</u> and drinking water authorities to identify the state’s groundwater sectors with natural fluoride levels that exceed 2.0 parts per million, and be it further</p> <p>Resolved, that the Association encourage state and local dental societies to communicate with local health and drinking water authorities regarding standards for fluoride levels, and be it further</p> <p>Resolved, that the Association encourage dentists to become familiar with the water fluoride concentrations in their area of practice that exceed 2.0 parts per million and provide appropriate counseling to parents and caregivers of young children to reduce the risk of <u>severe</u> dental fluorosis in permanent teeth, and be it further</p> <p>Resolved, that the Association encourage dentists to educate pediatric health care workers <u>professionals</u> about groundwater sectors and water systems with <u>local</u> fluoride levels that exceed 2.0 parts per million so that parents and caregivers of young children receive appropriate counseling to reduce the risk of <u>severe</u> dental fluorosis in permanent teeth.</p>	
318H	Adopted— Consent Calendar Action	<p>Reference Committee B Resolution 318RC in lieu of Council on Advocacy for Access and Prevention Resolution 318 and Sixteenth Trustee District Resolution 318S-1—Amendment of Policy, Operational Policies and Recommendations Regarding Community Water Fluoridation</p> <p>Resolved, that the policy titled Operational Policies and Recommendations Regarding Community Water Fluoridation (<i>Trans.</i>1997:673; 2015:273) be amended to read as follows (additions are <u>underscored</u>; deletions are stricken).</p> <p style="text-align: center;">Operational Policies and Recommendations Regarding Community Water Fluoridation</p>	

		<p>Resolved, that 1. The the Association endorses community water fluoridation as a <u>beneficial, safe, socially equitable, and cost saving</u> safe, beneficial and cost-effective and socially equitable public health measure for preventing dental caries in children and adults, <u>and be it further</u></p> <p>Resolved, that 2. The the Association supports the fluoridation of community water systems as recommended by the <u>2015 U.S. Public Health Service Recommendation, the Centers for Disease Control and Prevention, Healthy People 2030, 2022 World Health Organization Global oral health status report, and the Morbidity and Mortality Weekly Report (MMWR) June 2, 2023/ 72(22);593-596. Community Water Fluoridation Levels to Promote Effectiveness and Safety in Oral Health -United States, 2016-2021,</u> and be it further</p> <p>Resolved, that the Association supports ongoing research on the safety and effectiveness of community water fluoridation, <u>and be it further</u></p> <p>Resolved, that 3. The the Association urges-encourages individual dentists and dental societies to exercise <u>collaborative</u> leadership in all phases of activity which that lead to the initiation and continuation of community water fluoridation, <u>including by making scientific knowledge and resources available to relevant communities of interest, the community and collaborating with state and local agencies</u> and be it further</p> <p>Resolved, that 4. The the Association encourages governmental, philanthropic and other entities to make funding available to communities seeking to initiate and/or maintain community water fluoridation, <u>and be it further</u></p> <p>Resolved, that 5. The the Association supports the following actions to maintain the quality of <u>the nation's national</u> community water fluoridation and its infrastructure:</p> <ul style="list-style-type: none"> • performance of periodic assessments of community water fluoridation infrastructure needs by appropriate state agencies; • allocation of needed resources to or by appropriate state agencies to upgrade and maintain the fluoridation infrastructure; and • observance of the standards established by the appropriate <u>municipal authorities and state agencies</u> related to engineering and administrative recommendations for water fluoridation, <u>in accordance with guidance issued by the Centers for Disease Control and Prevention</u> and be it further 	
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		<p>Resolved, that the Association encourages for communities to receive a minimum <u>90-day notification to any proposed implementation, cessation, or change in community water fluoridation status.</u></p>	
319H	Adopted— Consent Calendar Action	<p>Reference Committee B Resolution 319RC in lieu of Council on Advocacy for Access and Prevention Resolution 319—Amendment of Policy, School Based Oral Health Programs</p> <p>Resolved, that the policy titled School-Based Oral Health Programs (<i>Trans.2010:557</i>), be amended to read as follows (additions <u>underscored</u>; deletions are stricken).</p> <p style="text-align: center;">School-Based Oral Health Programs</p> <p>Resolved, that the American Dental Association recognizes that school-based oral health programs can<u>should</u> play an important role in preventing, <u>identifying, managing and controlling dental caries diseases of the oral cavity</u> in children and adolescents and can<u>should</u> assist in the referral of those patients to establish a dental home, <u>if needed</u>, and be it further</p> <p>Resolved, that the ADA create a page on its Web site dedicated to providing information on school-based oral health programs including links to external resources designed to assist professional providers, school boards and the public establish and maintain such programs in a safe and ethical manner, and be it further</p> <p>Resolved, that the ADA approach national school agencies, including but not limited to the National School Boards Association, to discuss possible collaborations to promote materials pertaining to <u>collaborates with key national organizations to promote and support school-based oral health programs, and be it further</u></p> <p>Resolved, that the ADA encourages state and local dental societies to promote and support school based oral health programs.</p>	
320H	Adopted as amended	<p>Reference Committee A Resolution 320RC in lieu of Council on Advocacy for Access and Prevention Resolution 320 and Sixteenth Trustee District Resolution 320S-1—Amendment to the Policy, Community Based Topical Fluoride Programs</p> <p>Resolved, that the policy titled Community-Based Topical Fluoride Programs (<i>Trans.2014:507</i>) be amended to read as follows (additions are <u>underscored</u>; deletions are stricken).</p>	

		<p style="text-align: center;">Community-Based Topical Fluoride Programs</p> <p>Resolved, the American Dental Association recognizes that community-based topical fluoride programs, <u>including fluoride varnish and silver diamine fluoride</u>, are safe and efficacious <u>throughout the lifespan</u> in reducing <u>and managing</u> dental caries <u>when diagnosed and/or directed by a licensed dentist, and be it further</u></p> <p>Resolved, that <u>advocacy efforts to add topical fluoride products as a dental benefit throughout the lifespan by third-party payors be encouraged.</u></p>	
321H	Adopted— Consent Calendar Action	<p>Reference Committee B Resolution 321RC in lieu of Council on Advocacy for Access and Prevention Resolution 321—Amendment of Policy, Bottled Water, Home Water Treatment Systems and Fluoride Exposure</p> <p>Resolved, that the policy titled Bottled Water, Home Water Treatment Systems and Fluoride Exposure (<i>Trans.</i> 2002:390; 2013:342; 2021:327) be amended to read as follows (additions are <u>underscored</u>; deletions are stricken).</p> <p style="text-align: center;">Bottled Water, Home Water Treatment Systems and Fluoride Exposure</p> <p>Resolved, that in order to ensure optimal fluoride intake, the American Dental Association supports actions by its members to educate their patients and communities regarding the <u>safety of tap water</u>, level of fluoride in bottled water, <u>all commercially available packaged water such as bottled, canned, or boxed</u>, and the possible removal of fluoride by some home water treatment systems <u>such as reverse osmosis</u>, and be it further</p> <p>Resolved, that the American Dental Association urges <u>encourages</u> its members to inquire about their patients’ primary and secondary water sources <u>and overall water consumption</u> as part of the health history, and be it further</p> <p>Resolved, that the American Dental Association supports the labeling of bottled packaged water with the fluoride concentration of the product and company contact information including address, telephone number and website, and be it further</p> <p>Resolved, that the American Dental Association urges <u>encourages</u> its members and the public to refer to the International Bottled Water Association’s “List of Brands Containing Fluoride,” and be it further</p>	

		<p>Resolved, that the American Dental Association supports <u>widespread education of the public on the Centers for Disease Control and Prevention oral health website in order to better understand the fluoride levels in their community.</u> the inclusion of information on the effect of various home water treatment system's on water fluoride levels.</p>	
322H	<p>Adopted— Consent Calendar Action</p>	<p>Reference Committee B Resolution 322RC in lieu of Council on Advocacy for Access and Prevention Resolution 322—Amendment of Policy, Comprehensive Guidelines for Medicaid Dental Reviews</p> <p>Resolved, that the policy titled Guidelines for Medicaid Dental Reviews (<i>Trans.2020:335</i>) be amended to read as follows (additions are <u>underscored</u>; deletions are stricken through).</p> <p style="text-align: center;">Comprehensive Policy on Guidelines for Medicaid Dental Reviews</p> <p>Resolved, that the American Dental Association encourages state dental associations to work with their respective state Medicaid agency to adopt such guidelines for Medicaid Dental Reviews and/or in States that use a managed care model to incorporate such guidelines into their request for proposal (RFP) to third-party payers interested in managing the dental benefit:</p> <p style="text-align: center;">Guidelines for Medicaid Dental Reviews</p> <p>The Auditor/Reviewer shall demonstrate adherence, not only to individual State Board regulations and requirements, but also an understanding, acceptance and adherence to Medicaid State guidelines and specific specialty guidelines as applicable. In addition, the Auditor/Reviewer shall demonstrate experience in treatment planning specific patient demographic groups and/or unique care delivery sites that influence treatment planning being reviewed.</p> <p>It is recommended that entities, which conduct Medicaid Dental reviews and audits, utilize auditors and reviewers who:</p> <ol style="list-style-type: none"> 1. Have a current active license to practice dentistry in the State where audited treatment has been rendered and be available to present their findings. 2. Are of the same specialty (or equivalent education) as the dentist being audited. 	

		<ol style="list-style-type: none"> 3. Document and reference the guidelines of an appropriate dental or specialty organization as the basis for their findings, including the definition of <i>Medical Necessity</i> being used within the review. 4. Have a history of treating Medicaid recipients in the state in which the audited dentist practices. 5. Have experience treating patients in a similar care delivery setting as the dentist being audited, such as a hospital, surgery center or school-based setting, especially if a significant portion of the audit targets such venues. <p>In addition, these entities shall be expected to conduct the review and audit in an efficient and expeditious manner, including:</p> <ol style="list-style-type: none"> 1. Stating a reasonable period of time in which an audit can proceed before dismissal can be sought 2. Defining the reasonable use of extrapolation in the initial audit request. <p><u>In its initial communication with the provider, the auditing entity should state the expected and reasonable period of time in which the audit can be adequately performed. An audit shall be dismissed if it exceeds one hundred eighty (180) days.</u></p> <p><u>The ADA opposes extrapolation, a statistical technique used by auditors to estimate a provider's total overpayment based on the error rate found in a sample of claims.</u></p> <p><u>An overpayment determination must be based on evidence showing an overpayment for each individual claim.</u></p>	
323H	Adopted— Consent Calendar Action	<p>Council on Dental Practice Resolution 323—Amendment of Policy, Diagnostic Testing by Dentists</p> <p>Resolved, that the following policy entitled Diagnostic Testing by Dentists (<i>Trans.2020:321</i>) be amended as follows (additions are <u>underscored</u>, deletions are stricken).</p> <p style="text-align: center;">Diagnostic Testing by Dentists</p>	

		<p>Resolved, that dentists with the requisite knowledge and skills can order and administer diagnostic medical tests to screen patients for chronic diseases and other medical conditions that could complicate dental care or put the patient and staff at risk, and be it further</p> <p>Resolved, that point of care testing to screen is within a dentist’s scope of practice, and be it further</p> <p>Resolved, that point of care testing results be communicated with the patient and the patient be referred to their physician for appropriate diagnoses and treatment, and be it further</p> <p>Resolved, that dentists comply with federal and state requirements, as appropriate, to administer the tests.</p>	
324H	Adopted— Consent Calendar Action	<p>Reference Committee B Resolution 324RC in lieu of Council on Dental Practice Resolution 324 and Fifth Trustee District Resolution 324S-1—Proposed Policy, Statement on Workforce and Allied Dental Teams</p> <p>Resolved, that the following policy, Statement on Workforce and Allied Dental Teams, be adopted (additions <u>underlined</u>; deletions stricken through).</p> <p style="text-align: center;">Statement on Workforce and Allied Dental Teams</p> <p>The American Dental Association has the responsibility to provide guidance to all agencies, organizations and governmental bodies, such as state dental boards and legislatures, that have an interest in, or responsibility and authority for, decisions on utilization, education, and supervision of allied dental personnel. The ADA supports a diverse team of allied dental personnel whose training and functions complement the dentist, prioritize patient access, and provide quality care.</p> <p>Dentistry is committed to improving the health of the American public by delivering the highest quality comprehensive oral health care in a consistent, safe, and accessible manner. A healthy workforce supported by a collaborative, well distributed, and appropriately skilled and scoped team under the supervision of a licensed dentist is essential to fulfilling this commitment. Having a sufficient number of students of various backgrounds interested in pursuing careers in dentistry and a healthy number of graduates to provide care to all who require it depends upon a number of critical factors, including sufficient government support of dental higher education, overcoming current faculty shortages, providing affordable student loan</p>	

		<p>programs, advanced public health training and ensuring the financial viability of dental practices.</p> <p>The American Dental Association supports the development of state legislation to resolve issues related to access to dental care promulgated through increasing a healthy, skilled, well distributed workforce consistent with the following principles.</p> <p>A. Consistent Definitions Terms referring to the dental access and members of the Allied Dental Team are defined and utilized consistently.</p> <p>B. Ongoing Curated Research Data regarding the provision of dental care shall be updated, collected and reported, including</p> <ul style="list-style-type: none"> • Forecasting of public demand for dental services; • Research on Health Professional Shortage Areas (HPSAs); and • <u>Understanding that the ADA opposes using dentist-to -population ratios as the exclusive measure for designating dental health professional shortage areas or for evaluating or recommending programs for dental education or dental care; and</u> • Research to ensure that the supply of dental team personnel remains sufficient to serve the population. <p>C. Healthy Workforce</p> <ul style="list-style-type: none"> • Dental societies are encouraged to engage with state regulatory agencies in their mission to protect the public and provide support for dentists by eliminating barriers and reducing stigma associated with seeking mental and behavioral health services, including substance use disorders. • Dental societies should be advocates for dentists to have the same rights of privacy and confidentiality of personal medical information as other persons. <p>D. Financial Appropriations for Education Loans, Including Tax Relief The ADA supports</p> <ul style="list-style-type: none"> • Decreasing financial barriers to pursue dental and allied dental team education; • Mitigating financial barriers to practice in preferred choice of practice; • Using federal and state funds to offset federal student loans in exchange for public service, practicing in underserved areas, 	
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		<p>academic teaching and research positions, and filling other gaps in areas of national need;</p> <ul style="list-style-type: none"> • Removing barriers that prohibit those with private graduate student loans from taking advantage of state and federal student loan repayment programs; • Tax deductibility of interest on health profession student loans; and • Tax exemption for scholarship assistance and stipends awarded to health professions students under federal programs. • Both federal and state tax incentives should be available to improve distribution of dentists in underserved areas regardless of practice type such as Federally Qualified Health Centers, Community Health Centers or private practices. <p>E. Availability of Dentists and Allied Dental Team</p> <ul style="list-style-type: none"> • The dentist is the only health care provider who is able to diagnose and perform surgical and irreversible procedures. • The ADA supports care delivery models consistent with the requirement that dentists are solely able to determine delegation within the dental team, within parameters set by the state dental practice act. • Dental hygiene licensure and practice must require graduation from a CODA-accredited dental hygiene program, or successful completion of an equivalent program that ensures clinical competency as approved by the state licensing board. • The ADA supports the use of multiple entry pathways to the dental assisting career and encourages advancement, education and job qualifications for dental assistants through voluntary credentialing in duties permitted by the state dental practice act. The ADA believes that licensure of dental assistants would create an unnecessary barrier to entry to the profession. • The ADA supports opportunities for military trained and federal service trained allied dental team be incorporated into state level workforce at the level of their competency. • The ADA may support pilot programs that do not jeopardize the patient's oral health, as based on a valid assessment demonstrating that the program is necessary to fulfill an unmet need and the program does not allow a nondentist to diagnose, treatment plan or perform irreversible or surgical procedures. 	
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		<ul style="list-style-type: none"> • The ADA strongly urges that there should be a single state board of dentistry in each state which serves as the sole licensing and regulatory authority for all dental personnel. • The ADA strongly urges state dental boards to require examination of candidates for dental licensure separately from candidates for allied dental (non-dentist) licensure. • The ADA supports licensure mobility pathways under which Allied Dental Personnel licensed in good standing in one state may be licensed for practice in another state without completing an additional clinical examination, provided such pathways ensure that skill requirements remain in place for patient safety. • Any proposed new member of the dental team shall be an individual supervised by a dentist and be based upon a determination of need, sufficient education and training, and a scope of practice that ensures the protection of the public's oral health. <p>F. Scope of Dental Practice Laws Protected</p> <ul style="list-style-type: none"> • The primary purpose of dentists delegating functions to allied dental personnel is to increase the capacity of the profession to provide patient care while retaining full responsibility for diagnosis and the quality of care. • The ADA supports the authority of each state government to adopt and enforce laws and rules that regulate the practice of dentistry and enhance the oral health of the public within its jurisdiction. • In utilizing teledentistry, the extent of the supervision of allied dental personnel should conform to the applicable dental practice act in the state, territory or jurisdiction of the United States where the patient receives services and where the dentist is licensed. • Preventive care services are an integral part of the comprehensive practice of dentistry and should be rendered in accordance with the needs of the patient as determined by a diagnosis and treatment plan developed and executed by the dentist. • The scope of function and the level of supervision of the allied dental team member should be determined by the state licensing boards with input from the American Dental Association and the state dental societies. • Supervision of allied dental team members may be personal, direct, or indirect, according to the following definitions: 	
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		<p><i>Personal supervision.</i> A type of supervision in which the dentist is personally operating on a patient and authorizes the dental allied personnel to aid treatment by concurrently performing a supportive procedure.</p> <p><i>Direct supervision.</i> A type of supervision in which a dentist is in the dental office or treatment facility, personally diagnoses and treatment plans the condition to be treated, personally authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the dental allied personnel, and evaluates their performance before dismissal of the patient.</p> <p><i>Indirect supervision.</i> A type of supervision in which a dentist is in the dental office or treatment facility, has personally diagnosed and treatment planned the condition to be treated, authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the allied dental personnel, and will evaluate the performance of the allied dental personnel.</p> <p><i>General supervision.</i> A type of supervision in which a dentist is not required to be in the dental office or treatment facility when procedures are provided but has personally diagnosed and treatment planned the condition to be treated, has personally authorized the procedures, and will evaluate the performance of the allied dental personnel. In order to assure the safety of the patient, the following criteria must be followed whenever functions are performed under general supervision.</p> <ol style="list-style-type: none"> 1. Any patient to be treated by a dental hygienist must first become a patient of record of a dentist or facility. A patient of record is defined as one who: <ol style="list-style-type: none"> a. has been examined by the dentist; b. has had a medical and dental history completed and evaluated by the dentist; and c. has had his/her oral condition diagnosed and a treatment plan developed by the dentist. 2. The dentist must provide to the dental hygienist prior written authorization to perform clinical dental hygiene services for that patient of record. Such authorization should remain in effect for a limited time period as specified by state law. 3. The dentist shall examine the patient following performance of clinical services by the dental hygienist. Such examination shall be performed 	
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		<p>within a reasonable time as determined by the nature of the services provided, the needs of the patient and the professional judgment of the dentist.</p> <p><i>Public Health Supervision.</i> A type of supervision in which a licensed dental hygienist may provide dental hygiene services, as specified by state law or regulations, when such services are provided as part of an organized community program in various public health settings, as designated by state law, and with general oversight of such programs by a licensed dentist designated by the state.</p> <p>G. Distribution of Dental Homes</p> <ul style="list-style-type: none"> • Dental care is essential to overall health and should be available to all populations, regardless of their geographic location or demographics. <p>H. Non-Dental Providers or Non-dental Home Settings</p> <p>No provision of this guidance shall be interpreted to expand the scope of dental practice to allow untrained and/or unqualified personnel to perform any dental service.</p> <ul style="list-style-type: none"> • It is essential that non-dentists who provide preventive dental services utilize care coordination to refer the patient to a dentist for a comprehensive examination and to establish a dental home with a report of the services rendered given to the custodial parent or legal guardian. • Provision of preventive dental services by non-dental health care providers also requires completion of an appropriate educational program that includes dental disease risk assessment, dental caries and dental preventive techniques appropriate for the age groups under their care. • Non-dental health care professional training programs should include basic oral health education in the curricula. • When the employer of the dental hygienist is not a licensed dentist, the method of compensation and other working conditions for the dental hygienist must not interfere with the quality of dental care provided or the relationship between the responsible supervising dentist and the dental hygienist. <p>and be it further</p>	
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		<p>Resolved, that the following policies be rescinded.</p> <ul style="list-style-type: none"> • Statement Supporting the Dental Team Concept (<i>Trans.2013:313</i>) • ADA's Position on Dental Mid-Level Provider (<i>Trans.2008:439</i>) • Maintenance of Multi-Pathway Options for Dental Assistants (<i>Trans.1996:696</i>) • Statement on Credentialing Dental Assistants (<i>Trans.1995:634</i>) • Federal Student Loan Forgiveness (<i>Trans.2022:XXX</i>) • Federal Student Loan Programs (<i>Trans.2019:297</i>) • Federal Student Loan Repayment Incentives (<i>Trans.2019:297</i>) • Tax Treatment of Student Loan Interest, Scholarships and Stipends (<i>Trans.2019:298</i>) • ADA's Position on New Members of the Dental Team (<i>Trans.2009:419</i>) • Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform Irreversible Procedures (<i>Trans.2010:521</i>) • Diagnosis or Performance of Irreversible Dental Procedures by Nondentists (<i>Trans.2004:328; 2010:494</i>) • Measuring the Demand for Dental Services (<i>Trans.1995:623</i>) • Support for Programs That Forecast Public Demand for Dental Services (<i>Trans.1995:609</i>) • Dental Needs Survey (<i>Trans.1985:588</i>) • Determining Health Professional Shortage Areas (<i>Trans.1984:538; 1996:681; 2021:320; 2023:XXX</i>) • Comprehensive Policy Statement on Allied Dental Personnel (<i>Trans.1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307; 2010:505; 2021:330</i>) • Policy on Licensure of Dental Assistants (<i>Trans.2000:474</i>) 	
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325H	Adopted— Consent Calendar Action	<p>Reference Committee B Resolution 322RC in lieu of Council on Dental Practice Resolution 325—Proposed Policy, Glossary of Workforce Terms</p> <p>Resolved, that the Glossary of Workforce Terms be adopted (additions <u>underlined</u>; deletions stricken through).</p> <p style="text-align: center;">Glossary of Workforce Terms</p> <p>This Glossary is designed to assist in developing a common language for discussion of allied dental personnel issues by dental professionals and public policy makers. It should be noted that some of the terms included do not lend themselves to rigid definition and can only be described as to use and meaning. Also, certain terms are defined in dental practice acts and regulations, which vary from state to state.</p> <p>Allied Dental Personnel/Team: Team members who assist the dentist in the provision of oral health care and who are employed in dental offices or other patient care facilities, with roles and responsibilities based on (1) the best interests of the patient; (2) the team member’s education, training and credentialing; (3) considerations of efficiency in delivery patterns; and (4) valid, independent research demonstrating the feasibility and practicality of utilizing allied dental personnel in such roles in actual practice settings. The allied dental team roles recognized by the ADA are dental hygienists, dental assistants, community dental health coordinators, and dental laboratory technicians.</p> <p>Assessment/Dental Assessment: A limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment.</p> <p>Authorization: The act by a dentist of giving permission or approval to the dental allied personnel to perform legally allowable functions, in accordance with the dentist’s diagnosis and treatment plan.</p> <p>Community Dental Health: (1) The overall oral health status of a geographically based population group, (2) the branch of dentistry concerned with the distribution and causes of oral diseases in the population and the management of resources for their prevention and treatment and (3) commonly used to refer to programs which are designed to improve the oral health status of the population as a whole and conducted under the direction of a dentist (such as access programs, education programs, fluoridation and school-based mouthrinse programs).</p>	
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		<p>avoid misleading the public, no occupational title other than dental hygienist should be used to describe this allied team member.</p> <p>Dental Laboratory Technician/Certified Dental Technician: An individual who has the skill and knowledge in the fabrication of dental appliances, prostheses and devices in accordance with a dentist's laboratory work authorization. To avoid misleading the public, no occupational title other than dental laboratory technician or certified dental technician (when appropriate) should be used to describe this allied team member.—</p> <p>Dental Professional: Any member of the dental team that communicates directly with the patient about their dental needs. This person may be the dentist, hygienist, assistant, financial advisor, office manager, or patient coordinator.</p> <p>Dental Therapist: A dental therapist is an individual who has completed an accredited educational program and has been licensed by a state board of dentistry <u>as a dental therapist to perform duties under the direction of a dentist</u> diagnose and provide services as authorized by their state dental practice act. Functions that may be legally delegated to the dental therapist vary based on the educational preparation of the dental therapist, state dental practice acts and regulations, and the collaborative management agreement between the therapist and their supervising dentist.</p> <p>Diagnosis: The determination by a dentist of the oral health condition of an individual patient, achieved through the evaluation of data gathered by means of history taking, direct examination, patient conference, and interpretation of such clinical aids and tests as may be necessary in the judgment of the dentist.</p> <p>Expanded Functions: Additional tasks, services or capacities, often including direct patient care services, which may be legally delegated by a dentist to allied dental personnel. The scope of expanded functions varies based on state dental practice acts and regulations but is generally limited to reversible procedures which are performed under the personal, direct or indirect supervision of a dentist. Authorization to perform expanded functions generally requires specific training in the function. Also referred to as expanded duties or extended functions.</p> <p>Expanded Function Dental Auxiliary/Assistant (EFDA): An individual who has trained and demonstrated proficiency in the expanded functions prescribed <u>prescribed</u> by their practice act. These functions are outside of the scope of a licensed hygienist or a dental assistant, and require additional training and</p>	
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		<p>certification prior to their performance in a dental office. An EFDA works under the supervision of a dentist.</p> <p>Functions: An action or activity proper to an individual; a task, service or capacity which has been legally delegated by a dentist to allied dental personnel. Also referred to as duties or services.</p> <p>Irreversible Procedure: any procedure that alters the natural form and function of a patient's maxillofacial region in a way that cannot be readily undone, including but not limited to the removal of tooth structure.</p> <p>Limited Examination/Evaluation: A dentist performs an evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.</p> <p>Mid-Level provider: Any individual with limited dental training who does not hold a DDS or DMD degree and is not a recognized member of the allied dental team as defined in this glossary. They may perform limited dental procedures as diagnosed by a dentist in accordance with state law and as defined in state practice acts/regulation. Note this excludes Dental Hygienists and Dental Therapists.</p> <p>Oral Preventive Assistant (OPA): an expanded function dental assistant who has undergone approved academic and clinical training and demonstrated proficiency in the functions prescribed by their practice act. The OPA works under the direct supervision of a dentist, and provides preventive care to healthy child and adult patients that have routine care or gingivitis. The scope of an OPA is prescribed in state practice acts, but is generally limited to: measuring periodontal pockets, removing supragingival calculus, application of fluoride and silver diamine fluoride, and provision of oral hygiene instructions.</p> <p>Preventive Care Services: The procedures used to prevent the initiation of oral diseases, which may include screening, fluoride therapy, nutritional counseling, plaque control, and sealants.</p> <p>Screening: Identifying the presence of gross lesions of the hard or soft tissues of the oral cavity.</p>	
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		<p>Structured Course in Radiography: A planned sequence of instruction of specified content, designed to meet stated educational objectives and to include evaluation of attainment of those objectives.</p> <p>Supervising Dentist: A dentist present on the premises of a care setting that is responsible for authorizing, directing, overseeing, and evaluating all care provided by allied dental personnel.</p> <p>Supervision: The authorization, direction, oversight and evaluation by a dentist of the activities performed by dental allied personnel.</p> <p><i>Personal supervision.</i> A type of supervision in which the dentist is personally operating on a patient and authorizes the dental allied personnel to aid treatment by concurrently performing a supportive procedure.</p> <p><i>Direct supervision.</i> A type of supervision in which a dentist is in the dental office or treatment facility, personally diagnoses and treatment plans the condition to be treated, personally authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the dental allied personnel, and evaluates their performance before dismissal of the patient.</p> <p><i>Indirect supervision.</i> A type of supervision in which a dentist is in the dental office or treatment facility, has personally diagnosed and treatment planned the condition to be treated, authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the allied dental personnel, and will evaluate the performance of the allied dental personnel.</p> <p><i>General supervision.</i> A type of supervision in which a dentist is not required to be in the dental office or treatment facility when procedures are provided but has personally diagnosed and treatment planned the condition to be treated, has personally authorized the procedures, and will evaluate the performance of the allied dental personnel. In order to assure the safety of the patient, the following criteria must be followed whenever functions are performed under general supervision.</p> <ol style="list-style-type: none"> 1. Any patient to be treated by a dental hygienist must first become a patient of record of a dentist or facility. A patient of record is defined as one who: <ol style="list-style-type: none"> a. has been examined by the dentist; b. has had a medical and dental history completed and evaluated by the dentist; and 	
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		<p>c. has had their oral condition diagnosed and a treatment plan developed by the dentist.</p> <p>2. The dentist must provide to the dental hygienist prior written authorization to perform clinical dental hygiene services for that patient of record. Such authorization should remain in effect for a limited time period as specified by state law.</p> <p>3. The dentist shall examine the patient following performance of clinical services by the dental hygienist. Such examination shall be performed within a reasonable time as determined by the nature of the services provided, the needs of the patient and the professional judgment of the dentist.</p> <p><i>Public Health Supervision.</i> A type of supervision in which a licensed dental hygienist may provide dental hygiene services, as specified by state law or regulations, when such services are provided as part of an organized community program in various public health settings, as designated by state law, and with general oversight of such programs by a licensed dentist designated by the state.</p> <p>Surgical Procedure: The cutting or removal of hard or soft tissue.</p> <p>Treatment Plan: The sequential guide for the patient's care as determined by the dentist's diagnosis and used by the dentist for the restoration to and/or maintenance of optimal oral health.</p>	
326H	Adopted— Consent Calendar Action	<p>Council on Dental Practice Resolution 326—Proposed Policy on Dentists' Professional Judgement and Treatment Planning</p> <p>Resolved, that the following policy, Dentists' Professional Judgement and Treatment Planning be adopted.</p> <p style="text-align: center;">Dentists' Professional Judgement and Treatment Planning</p> <p>Resolved, that the American Dental Association (ADA) affirms that the diagnosis of a patient's oral health condition and the development of a resulting treatment plan are the exclusive responsibility and professional prerogative of the treating dentist, arrived at through consultation and agreement with the informed patient. This fundamental aspect of the patient-dentist relationship is essential for the delivery of high-quality, patient-centered oral healthcare and should not be compromised by external influences, and be it further</p>	

		<p>Resolved, that the ADA strongly opposes any undue influence or interference from third party payers, employers, managed care organizations, or other entities that may compromise a dentist's ability to exercise their independent clinical judgment and provide optimal, evidence-based patient care. The selection of diagnostic modalities, the determination of appropriate treatment procedures, and the establishment of a comprehensive treatment plan must be based on the dentist's professional evaluation of the patient's individual needs, clinical findings, and the best available scientific evidence, and be it further</p> <p>Resolved, that the ADA emphasizes the critical importance of open, honest, and transparent communication between the dentist and the patient throughout the diagnostic and treatment planning process. Shared decision-making, based on a thorough discussion of treatment options, potential risks and benefits, and consideration of the patient's preferences and values, is integral to achieving informed consent and fostering a strong patient-dentist partnership, and be it further</p> <p>Resolved, that the American Dental Association opposes any external policies, financial incentives, or administrative practices that incentivize, or mandate treatment decisions based on cost containment or non-clinical factors, rather than on the dentist's professional judgment and the patient's best interests, and be it further,</p> <p>Resolved, that dentists must be free to recommend and provide necessary care without fear of inappropriate denial or limitation of benefits based on arbitrary or non-validated criteria, and be it further</p> <p>Resolved, that the American Dental Association supports the dentist's role in utilizing appropriate and evolving diagnostic technologies and in applying the principles of evidence-based dentistry to inform their clinical decision-making, and be it further</p> <p>Resolved, that the dentist's professional judgment is informed by their education, training, clinical experience, and understanding of current scientific literature, and be it further</p> <p>Resolved, that the American Dental Association urges constituent and component dental societies to actively support and advocate for the principles of dentist's professional judgment and treatment planning within their respective jurisdictions. This includes resisting policies or regulations that infringe upon the dentist's ability to provide patient-centered care and promoting an environment where dentists can freely exercise their professional expertise in the best interest of their patients.</p>	
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		<p>and be it further</p> <p>Resolved, that the policies entitled “Infringement on Dentists Judgement” (<i>Trans.</i>1991:634; 2016:61), and “Dentist’s Freedom to Exercise Individual Clinical Judgement” (<i>Trans.</i>1997:705) be rescinded.</p>	
327H	Adopted— Consent Calendar Action	<p>Council on Dental Practice Resolution 327—Recission of Policy, Summary of Recommendation, Report 5 of the Board of Trustees to the House of Delegates, on Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care</p> <p>Resolved, that the following policy entitled Summary of Recommendations, Report 5 of the Board of Trustees to the House of Delegates, on Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care (<i>Trans.</i>1979:357, 596; 2020:287) be rescinded.</p>	
328H	Adopted— Consent Calendar Action	<p>Council on Dental Practice Resolution 328—Recission of Policy, Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care</p> <p>Resolved, that the following policy entitled Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care (<i>Trans.</i>1979:357, 596; 2020:287) be rescinded.</p>	
329	Declared Moot	<p>Strategic Forecasting Committee Resolution 329—Amendments to Public Profession Component of Strategic Forecast</p>	
330H	Adopted— Consent Calendar Action	<p>Board of Trustees Resolution 330B in lieu of Seventeenth Trustee District Resolution 330—Amendment of Policy on Comprehensive Statement on Oral Health Services During Pregnancy</p> <p>Resolved, that the policy on Comprehensive Statement on Oral Health Services During Pregnancy (<i>Trans.</i>2024:XXX) be amended as follows (additions <u>underlined</u>, deletions stricken through):</p> <p>Resolved, that the ADA encourage all pregnant persons and person of child-bearing age to have a regular dental examinations and dental treatment as needed throughout all stages of pregnancy, and be it further</p> <p>Resolved, that the ADA acknowledges that preventive, diagnostic, restorative and surgical dental treatment rendered to promote health and eliminate disease is safe</p>	

		<p>throughout pregnancy, is supported by the American College of Obstetrics and Gynecology, and is effective at maintaining the oral and overall health <u>during pregnancy of the pregnant person</u>, and be it further</p> <p>Resolved, that dental coverage of pregnant persons be extended for one-year post-partum to be included in all dental benefit programs to improve the dental health of the pregnant person during pregnancy as well as to promote Age One dental visits for very young children, and be it further</p> <p>Resolved, that the ADA supports federal advocacy efforts to increase funding for women’s oral health research, ensure that women are adequately represented as research subjects in dental clinical trials, and help disseminate research information on women’s oral health issues as needed and appropriate.</p>	
331H	Adopted— Consent Calendar Action	<p>Seventeenth Trustee District Resolution 331—Proposed Policy on Comprehensive Statement on Research of Women’s Oral Health Conditions</p> <p>Resolved, that the policy on Comprehensive Statement on Research of Women’s Oral Health Conditions be adopted:</p> <p>Resolved, that the ADA supports federal advocacy efforts to increase funding for women’s oral health research, ensure that women are adequately represented as research subjects in dental clinical trials, and help disseminate research information on women’s oral health issues as needed and appropriate, and be it further</p> <p>Resolved, that this research should include and not be limited to the effect of synthetic and naturally occurring hormones on oral health as well as different age ranges—pre-pubescent, childbearing age, perimenopause, menopause and post menopause.</p>	
332H	Adopted— Consent Calendar Action	<p>Reference Committee B Resolution 332RC in lieu of Seventeenth Trustee Resolution 332—Strategy to Protect Community Water Fluoridation Through Rapid Response, Expert Engagement, and Public Education</p> <p>Resolved, the American Dental Association prioritize efforts to counter misleading claims regarding the safety and efficacy of community water fluoridation, fluoride supplementation, and fluoride varnish, and be it further</p> <p>Resolved, that the American Dental Association provide ongoing education to all interested dentists, through recorded presentations and literature on current and pressing fluoridation topics.</p>	

333H	Adopted— Consent Calendar Action	<p>Reference Committee B Resolution 333RC in lieu of Fourteenth Trustee District Resolution 333—Promoting Accuracy, Transparency, and Equitable Access in Dental Benefit Administration</p> <p>Resolved, that the policy Standards for Dental Benefit Plans (<i>Trans. 1988:478; 1989:547; 1993:696; 2000:458; 2001:428; 2008:453; 2010:546</i>) be amended by the addition of the following numbered sections (additions are <u>underscored</u>; deletions are stricken).</p> <p>25. Published lists of in-network dentists should be accurate, up-to-date, and should list only dentists that are currently available for timely care at the listed site. Duplicative, out-of-date, and otherwise inaccurate listings should be deleted or corrected within a reasonable interval of any changes of status. Benefit plans are responsible for maintaining the accuracy of listings and should confirm the accuracy on at least a monthly <u>quarterly</u> basis or in alignment with state laws.</p> <p>26. Plans should provide for insured patients to easily submit appeals of claim decisions or other grievances related to coverage, preferably through access to an online portal. Responses should be provided in a timely way to facilitate patients receiving needed care without undue delay.</p> <p>and be it further</p> <p>Resolved, that the updated standards be communicated to organizations that represent dental benefit plan providers.</p>	
334H	Adopted— Consent Calendar Actions	<p>Fourteenth Trustee District Resolution 334—Freedom of Purchase and Repair</p> <p>Resolved, that the ADA recognizes the protection of intellectual property and proprietary software rights and supports dentists' rights to resell and utilize used dental equipment and purchased hardware without remote disabling by manufacturers, and be it further</p> <p>Resolved, that the ADA encourages the development of a fair and competitive secondary market for dental equipment, ensuring dentists retain the right to resell, repair, and fully utilize equipment they have purchased, and be it further</p> <p>Resolved, that the ADA explore opportunities to advocate, both within organized dentistry and with external stakeholders, for policies and regulations that protect dentists' ownership rights and prevent anti-competitive restrictions on the use and resale of dental equipment.</p>	

335H	<p>Adopted— Consent Calendar Action</p>	<p>Ninth Trustee District Resolution 335—Transparency of AI Use in Claims Adjudication</p> <p>Resolved, that third-party payers disclose to benefit plan members, patients, and submitting providers the use of generative artificial intelligence (GenAI) tools in claims review and adjudication, and be it further</p> <p>Resolved, that such disclosure include the reasons why the claim was selected for review and GenAI use was necessary, and be it further</p> <p>Resolved, that for transparency of the risk exposure and level of bias a claim may experience from the application of GenAI in the adjudication process, disclosure should include the name and model of the AI tool used, how it was trained for this task, the prompts or inputs applied to adjudicate the claim, and whether the use was internal by a human, automated, or a contracted human reviewer, and be it further</p> <p>Resolved, that disclosure affirm the application of such tools in the adjudication process was subject to human oversight, how confidential information was protected, and the steps taken to mitigate biased, false, or misleading determinations.</p>	
336	<p>Referred to the appropriate ADA agency for further study and report to the 2026 House of Delegates— Consent Calendar Action</p>	<p>Thirteenth Trustee District Resolution 336—Recognition of Type 1 Diabetes as a Distinct Oral Health High At-Risk Category</p> <p>Resolved, that the American Dental Association (ADA) recognize individuals with Type 1 Diabetes (T1D) as a distinct oral health at-risk population, separate from those with Type 2 Diabetes, and be it further</p> <p>Resolved, that the appropriate ADA agencies review and propose updates to relevant policies, educational materials, and advocacy efforts to reflect the unique oral health risks and management needs of individuals with T1D, particularly children and adolescents, and be it further</p> <p>Resolved, that ADA explore opportunities to support interdisciplinary collaboration and oral health preventive strategies—such as the development of oral health guidance at the time of T1D diagnosis—to improve long-term outcomes and reduce oral health disparities in this.</p>	

400H	Adopted	<p>Reference Committee C (Dental Education and Related Matters) Resolution 400—as amended—Consent Calendar</p> <p>Resolved, that the recommendations of Reference Committee C on the following resolutions be accepted by the House of Delegates.</p> <p>1. Resolution 401—Refer—Minimum Hands-On Standards for Safe Dental Practice and CODA Governance (Worksheet:4002) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes on Referral</p> <p>2. Resolution 402—Not Adopt—Development of the Dental School Educational Value Index (DEVI) (Worksheet:4008) \$200,000</p> <p>COMMITTEE RECOMMENDATION: Vote No</p> <p>3. Resolution 404aRC—Adopt 404aRC in lieu of Resolution 404a and Resolution 404aS-1—Amendment of the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists (Worksheet:4014) \$: none</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>4. Resolution 404b—Not Adopt 404b in lieu of Resolution 404bS-1—Amendment of the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists (Worksheet:4010) \$: none</p> <p>COMMITTEE RECOMMENDATION: Vote No</p> <p>5. Resolution 405RC—Adopt 405RC in lieu of Resolutions 405, 405S-1, and Resolution 405S-2—Support for In-Person Continuing Education Requirements (Worksheet:4056) \$: none</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>6. Resolution 406—Refer—Compact Neutrality, Standards Integrity, and Governance Accountability in National Licensure Portability (Worksheet:4134) \$: none</p> <p>COMMITTEE RECOMMENDATION: Vote Yes on Referral</p>	
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401	<p>Referred to the appropriate ADA agency for further study and report back to the 2026 House of Delegates—Consent Calendar Action</p>	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 401—Minimum Hands-On Standards for Safe Dental Practice and CODA Governance</p> <p>Resolved, that the American Dental Association (ADA) strongly encourages the Commission on Dental Accreditation (CODA) to establish and enforce a reasonable minimum national standard for patient-based clinical procedures required for graduation—emphasizing that competency must be demonstrated through direct performance, not observation, and be it further</p> <p>Resolved, that CODA be encouraged to revise accreditation standards to ensure all graduates receive verifiable, patient-centered procedural experience essential for safe, independent practice, recognizing that as a surgical discipline, dentistry demands repetition of clinical procedures across all major disciplines, including but not limited to operative dentistry, restorative dentistry, endodontics, periodontics, oral surgery, and fixed and removable prosthodontics, in accordance with the ethical obligation to protect patients and the public, and be it further</p> <p>Resolved, that the ADA strongly encourages CODA to strengthen its governance and accountability by reviewing conflict of interest policies for Commissioners, Review Committee Members, and Site Evaluators affiliated with accredited institutions, and be it further</p> <p>Resolved, that the American Dental Association (ADA) strongly encourages the Commission on Dental Accreditation (CODA) to strengthen its communication and engagement with the American Dental Association through the existing ADA/CODA Workgroup, and be it further</p> <p>Resolved, that the ADA strongly encourages CODA to consult with the American Dental Education Association (ADEA), the Academy of General Dentistry (AGD), and appropriate specialty organizations in dentistry to establish clear minimum requirements for clinical competency, including specific patient-based procedural experiences necessary for safe, independent dental practice.</p>	
402	<p>Not Adopted</p>	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 402—Development of the Dental School Educational Value Index (DEVI)</p> <p>Resolved, that the American Dental Association, through appropriate agencies and in collaboration with ADEA, AGD, Specialty Associations) and ASDA) stakeholders, shall develop and publish the Dental School Educational Value Index (DEVI) as a public-facing, outcomes-based transparency system, and be it further</p>	

		<p>Resolved, that DEVI shall include voluntarily reported and verifiable metrics such as:</p> <ul style="list-style-type: none"> • Average number of procedures completed across core disciplines • Student-to-faculty ratios (general and specialty) • Total educational cost and sources of funding • Access to wellness resources, food assistance programs, and mental health services • Reported levels of graduate confidence, satisfaction, and support for diversity and inclusion <p>and be it further</p> <p>Resolved, that the ADA shall encourage all accredited dental schools to adopt standardized, outcomes-based reporting on an annual basis and ensure these findings are made publicly accessible through DEVI to help students make informed, equitable, and future-ready choices, and be it further</p> <p>Resolved, that DEVI shall be promoted as a voluntary, collaborative transparency initiative, and participating schools shall be recognized for their leadership in educational excellence, and be it further</p> <p>Resolved, that the ADA explore collaboration with the Commission on Dental Accreditation (CODA) to identify which outcome metrics may be appropriate for inclusion in the accreditation self-study process, while maintaining DEVI as a separate, ADA-supported tool to improve institutional accountability and public trust.</p>	
403	UNASSIGNED		
404aH	Adopted	<p>Reference Committee C Resolution 404aRC—as amended—in lieu of Council on Dental Education and Licensure Trustee District Resolution 404a and Seventeenth Trustee District Resolution 404aS-1—Amendment of the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists</p> <p>Resolved, that the <i>Guidelines for the Use of Sedation and General Anesthesia by Dentists</i> (Trans.2007:282; 2012:468; 2016:277) be amended as presented in Appendix 1 (additions <u>double underlined</u>; deletions double stricken).</p> <p><i>Note: 404aH-2025 Appendix 1 appears on pages 134-146.</i></p>	

404b	Not Adopted— Consent Calendar Action	<p>Council on Dental Education and Licensure Resolution 404b in lieu of Seventeenth Trustee District Resolution 404bS-1—Amendment of the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists</p> <p>Resolved, that the House of Delegates transfer the responsibility and maintenance of the <i>Guidelines for the Use of Sedation and General Anesthesia by Dentists</i> to the Council on Dental Education and Licensure.</p>	
405H	Adopted	<p>Reference Committee C Resolution 322RC—as amended—in lieu of Eleventh Trustee District Resolution 405, Fifth Trustee District 405S-1 and Eleventh Trustee District Resolution 405S-2—Support for In-Person Continuing Education Requirements</p> <p>Resolved, to promote provider wellness and professional collaboration opportunities, the American Dental Association encourages state boards and state/local components to require a minimum amount of in-person continuing education and activities for licensure renewal encourage in-person continuing education and activities, and be it further</p> <p>Resolved, that the American Dental Association encourages state/local components to identify and minimize barriers to in-person attendance for educational events and activities.</p>	
406	Referred to the appropriate ADA agency for further study and report to the 2026 House of Delegates— Consent Calendar Action	<p>Dr. Spencer Bloom, delegate, Illinois, Resolution 406—Compact Neutrality, Standards Integrity, and Governance Accountability in National Licensure Portability</p> <p>Resolved, that the American Dental Association (ADA) shall not endorse, promote, testify in support of, or lobby for any specific licensure portability compact unless and until that compact is formally adopted by the House of Delegates as official ADA policy, and be it further</p> <p>Resolved, that the American Dental Association (ADA) direct the Council on Dental Education and Licensure (CDEL) to develop criteria for any future licensure compact supported by the Association, specifically for initial licensure, which shall require either an examination that assesses psychomotor (hand-skills-based examination) and cognitive dental skills or completion of a structured postgraduate year one (PGY-1) pathway, and be it further</p> <p>Resolved, that any future compact supported by the ADA shall require full licensure in each participating state, preserve state dental board oversight and disciplinary authority,</p>	

		and maintain professional and clinical standards that protect patient safety and public trust.	
407H	Adopted	<p>Reference Committee C Resolution 407RC—as amended—in lieu of Council on Dental Education and Licensure Resolution 407—Development of ADA Pediatric Guidelines for the Use of Sedation and General Anesthesia by Dentists</p> <p>Resolved, that the Council on Dental Education and Licensure develop pediatric guidelines for the use of sedation and general anesthesia by dentists, reflecting the unique clinical and educational needs of dental practice and the distinct considerations in pediatric care, in consultation with the American Academy of Pediatric Dentistry (AAPD), Academy of General Dentistry, American Society of Dentist Anesthesiologists, American Dental Society of Anesthesiology, American Association of Oral Maxillofacial Surgeons, American Academy of Periodontology, <u>American Academy of Pediatrics</u>, American Society Anesthesiologists, and other stakeholders, including pediatric specialists, with a report to the 2026 House of Delegates, and be it further</p> <p>Resolved, that the guidelines include mandatory reporting of adverse events by all anesthesia providers <u>the provider of dental care and the provider of anesthesia care for a particular event, for the purpose of continuous quality improvement in anesthesia services and patient safety.</u></p>	
408H	Adopted	<p>Reference Committee C Resolution 408RC—as amended—in lieu of Council on Dental Education and Licensure Resolution 408 and Board of Trustees Resolution 408B—Response to Resolution 404H-2024: Amendment of Comprehensive Policy on Dental Licensure</p> <p>Resolved, that the ADA Policy on Comprehensive Policy on Dental Licensure (<i>Trans.</i>2018:341) be amended as follows (additions are underlined; deletions are stricken):</p> <p style="text-align: center;">COMPREHENSIVE POLICY ON DENTAL</p> <p><u>Section 1: General Principles</u></p> <ul style="list-style-type: none"> • 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. 	

		<ul style="list-style-type: none"> • 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 <u>and psychometric</u> 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, <u>territory,</u> or jurisdiction <u>of the United States</u> are the sole licensure and regulating authorities for all dentists and allied dental personnel. • <u>State dental boards should ensure that all dental board members are free from conflicts of interest for all decision-making and deliberations.</u> • <u>Unless mandated by statute or state regulation, dental board members should not serve simultaneously as examiners for testing agencies to avoid conflict of interest concerns.</u> • 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. <p><u>Section 2: Initial Licensure for Graduates of CODA-accredited Dental Education Programs</u></p> <p>States are urged to accept the following common core of requirements for initial licensure:</p> <ol style="list-style-type: none"> 1. <u>Education:</u> Completion of a DDS or DMD degree from a university-based dental education program accredited by the Commission on Dental Accreditation. 2. <u>National Board Examination:</u> Successful passage <u>completion</u> of the <u>Integrated National Board Dental Examination,</u> a valid and reliable written cognitive test. 3. <u>Clinical Competency:</u> <u>Successful completion of a state-approved clinical competency assessment that is valid and reliable, which may include graduation from a CODA accredited PGY-1 or AEGD program and/or successful completion of at least one year of a CODA approved specialty</u> 	
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		<p><u>residency program.</u> A determination of clinical competency for the beginning practitioner, which may include: Acceptance of clinical examination results from any clinical testing agency; 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</p> <ul style="list-style-type: none"> • 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 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 knowledge and skills to successfully complete one or more dental problem-solving tasks. <p>Curriculum Integrated Format Clinical Examination</p> <p>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:</p> <ul style="list-style-type: none"> • 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. 	
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Section 3: Licensure for Internationally Educated Dentists Graduates of Non-CODA Accredited Dental Education Programs

Initial Licensure for International Graduates of Non-CODA Accredited Dental Education Programs

For initial licensure in dentistry, ~~internationally educated graduates who did not complete a of non-CODA-accredited dental education programs should~~ shall possess the following for ~~educational credentials-dental licensure:~~

1. **Education:** Completion of a CODA-accredited dental education program, including: a CODA-accredited advanced standing program resulting in a DDS/DMD degree or a CODA-accredited advanced dental education program of at least two years.
 2. **National Board Examination:** Successful completion of the Integrated National Dental Board Examination.
 3. **Clinical Competency:** Successful completion of a state-approved clinical competency assessment that is valid and reliable, which may include graduation from a CODA accredited PGY-1 ~~or AEGD~~ program and/or successful completion of at least one year of a CODA approved specialty residency program.
- ~~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.~~

Internationally Educated Dentists Employed as Faculty

States should have specific provisions for licensure of internationally educated dentists who are full- or part-time faculty at an accredited dental education program.

Section 4: Licensure Portability

Licensure Compact:

A licensure compact ~~is strongly supported to should~~ allow freedom of movement for practitioners across state lines. ~~The development of a licensure compact must be led by a coalition of the communities of interest under the guidance of the National Center for Interstate Compacts, the nation's only technical assistance provider on interstate compacts.~~ A dental licensure compact increases licensees' mobility, facilitates quality oral health care for the public, supports relocating challenges for federal dental services dentists, spouses of uniformed service members and/or

veterans of the federal dental services and their families, and is cost-effective for the practitioner. A licensure compact benefits licensing boards by providing agreement on uniform licensure requirements, a shared data system for access to primary source documentation of applicant credentials and tracking adverse actions. It enhances cooperation and immediate availability of information between state boards, which is critical to protecting the public, while preserving state sovereignty over dental practice.

Licensure by Credentials:

In addition to a licensure compact, sStates should have provisions for licensure of dentists-licensing dentists and dental specialists who demonstrate they are currently licensed in good standing and also have not been the subject of final or pending disciplinary action in any state, territory or jurisdiction in which they have been licensed without requiring completion of an additional competency assessment. 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. The ADA urges dental boards to adopt a standardized set of credentials that are acceptable for licensure among states.

State dental boards should have credentialing provisions available for limited and/or volunteer licenses for dentists who wishing to provide services without compensation to critical needs underserved populations within a state in which they are not already licensed and for dentist faculty members teaching in programs accredited by the Commission on Dental Accreditation.

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 accredited program
- Specialty Board certification
- GPR/AEGD certificate from accredited program
- Current license in good standing
- Passing grade on an initial clinical licensure exam, unless initial license was granted via completion of PGY1, Portfolio examination, or other state-approved pathway for assessment of clinical competency.
- Documentation of completion of continuing education

		<p>For dentists who hold a current dental license in good standing in any jurisdiction, state dental boards should:</p> <ul style="list-style-type: none"> • 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. <p>Licensure by Credentials for Dentists Who Are Not Graduates of CODA-Accredited Dental Education Programs</p> <p>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.</p>	
409aH	Adopted	<p>Reference Committee C Resolution 409aRC—as amended—in lieu of Council on Dental Education and Licensure Resolution 409a and Seventeenth Trustee District Resolution 409S-1a—Amendment of the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students</p> <p>409aRC. Resolved, that the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (<i>Trans.</i>2007:282; 2012:469; 2016:277) be amended as presented in Appendix 1 (additions <u>double underlined</u>; deletions double stricken).</p> <p><i>Note: 4049aH-2025 Appendix 1 appears on pages 147-162.</i></p>	
409b	Not Adopted— Consent Calendar Action	<p>Council on Dental Education and Licensure Resolution 409b in lieu of Seventeenth Trustee District Resolution 409bS-1—Amendment of the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students</p> <p>Resolved, that the House of Delegates transfer the responsibility and maintenance of the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students to the Council on Dental Education and Licensure.</p>	

410H	Adopted	<p>Reference Committee C Resolution 410RC in lieu of Resolution 410—Feasibility Study of a Postgraduate Year One (PGY-1) Licensure Pathway</p> <p>Resolved, that the Council on Dental Education and Licensure (CDEL) study the feasibility of a nationally available postgraduate residency program as a licensure pathway, and report back to the 2026 House of Delegates with findings and recommendations.</p>	
411	Not Adopted	<p>Fourteenth Trustee District Resolution 411—Accurate Determination of Dental School Cost of Attendance</p> <p>Resolved, the American Dental Association (ADA) encourages each dental school to perform an annual survey of dental student expenses and make necessary changes to offset the increasing cost of living and attendance, and be it further</p> <p>Resolved, the ADA will encourage schools to survey students to determine if the estimated cost of attendance truly reflects the actual cost of attendance.</p>	
412	TABLED (2/3 affirmative vote)	<p>Fourteenth Trustee District Resolution 412</p>	
500H	Adopted	<p>Reference Committee D (Legislative, Governance and Related Matters) Resolution 500—as amended—Consent Calendar</p> <p>Resolved, that the recommendations of Reference Committee D on the following resolutions be accepted by the House of Delegates.</p> <ol style="list-style-type: none"> 1. Resolution 507B—Adopt Resolution 507B in lieu of Resolution 507—Supporting Plaintiffs’ In Re: Zelis Repricing Antitrust Litigation Lawsuit to Promote Fair Reimbursement and Transparency in Dental Insurance (Worksheet:5008) \$100,000 COMMITTEE RECOMMENDATION: Vote Yes 2. Resolution 508—Refer—Amendment to the ADA Election Commission and Campaign Rules (Worksheet:5078) \$: None COMMITTEE RECOMMENDATION: Vote Yes on Referral 	

		<p>3. Resolution 512—Adopt—Amendment to Section 3.E. of the ADA <i>Principles of Ethics and Code of Professional Conduct</i> (Worksheet:5011) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>4. Resolution 513—Adopt—Amendment to Section 5 of the ADA <i>Principles of Ethics and Code of Professional Conduct</i> (Worksheet:5012) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>5. Resolution 514—Adopt—Amendment to Chapter VIII., Section G. of the <i>Governance Manual</i> (Worksheet:5015) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>6. Resolution 517—Refer—Amendment to ADA Policy on Medical (Dental) Loss Ratio (Worksheet:5096) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes on Referral</p> <p>7. Resolution 518—Adopt—Amendments to the Charter Language of the Strategic Forecasting Committee (Worksheet:5018) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>8. Resolution 520—Not Adopt—Strengthening ADA Transparency to Grow and Retain Membership Through Majority and Minority Board Reports (Worksheet:5103) \$150,000</p> <p>COMMITTEE RECOMMENDATION: Vote No</p> <p>9. Resolution 522B—Adopt Resolution 522B in lieu of Resolution 522—Transparency in Dental Practice Ownership, Management and Outside Investors (Worksheet:5107) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>10. Resolution 523—Adopt—Report of the Special Committee on ERISA (Worksheet:5060) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p>	
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		<p>11. Resolution 524—Refer—Structured Debate Format for ADA Elected Positions (Worksheet:5125) \$7,500</p> <p>COMMITTEE RECOMMENDATION: Vote Yes on Referral</p> <p>12. Resolution 527—Not Adopt—Coordinating Dental Advocacy Through a National Task Force for Greater Unity and Impact (Worksheet:5111) \$30,000</p> <p>COMMITTEE RECOMMENDATION: Vote No</p> <p>13. Resolution 528—Adopt—Preservation of Rights of ADA Members Serving the ADA House of Delegates (Worksheet:5119) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p> <p>14. Resolution 531—Adopt—Addressing Apparent Inaccuracies in the 2026-2029 Delegate Allocation (Worksheet:5124) \$: None</p> <p>COMMITTEE RECOMMENDATION: Vote Yes</p>	
501	WITHDRAWN		
502	WITHDRAWN		
503	Referred to the appropriate ADA agency for further study and report to the 2026 House of Delegates	<p>Dr. Spencer Bloom, delegate, Illinois, Resolution 503—Protection of State Autonomy</p> <p>Resolved, that the ADA policy, Legislative Assistance by the Association (<i>Trans.</i>1977:948; 1986:530; 2019:310) be amended as follows (additions <u>underscored</u>; deletions are stricken):</p> <p>Resolved, that the American Dental Association shall not assist any organization, agency, group or individual who is attempting to alter the laws of a state without the <u>written</u> consent and approval of the constituent society, and be it further</p> <p>Resolved, that when the American Dental Association is aware of pending legislation within a state which is in opposition to existing Association policy or is otherwise detrimental to the best interests of the public, the Association shall inform the constituent society of the implications of such legislation, urge the constituent</p>	

		<p>society to take appropriate action and offer assistance in addressing the issue, <u>and be it further</u></p> <p>Resolved, that the ADA shall require that all legislative initiatives, partnerships, model policies, compacts, or public advocacy efforts with external organizations be formally reviewed and approved by the House of Delegates before they are publicly promoted or implemented as official ADA policy, and be it further</p> <p>Resolved, that the Association shall support constituent societies when asked to collaborate in state-level advocacy and shall provide timely guidance if proposed legislation may impact ADA policy or the public interest.</p> <p><u>and be it further</u></p> <p>Resolved, that the ADA will publish a quarterly Governance Transparency Report on ADA.org, which will summarize:</p> <ol style="list-style-type: none"> 1. <u>the progress of referred resolutions,</u> 2. <u>actions taken by councils and staff,</u> 3. <u>any related advocacy or partnership activity, and</u> 4. <u>clear timelines for updates to the House of Delegates.</u> 	
504	<p>Resolution will lay over to the 2026 House of Delegates since this resolution proposes a Constitutional amendment</p>	<p>Dr. Spencer Bloom, delegate, Illinois, Resolution 504—Reinforcing Editorial Integrity and Transparency by Empowering the Council on Communications</p> <p>Resolved, that Article IV. GOVERNMENT, of the ADA <i>Constitution</i> be amended as follows (additions <u>underscored</u>):</p> <p><i>Section 10.</i> LEGISLATIVE BODY. The legislative and governing body of this Association shall be a House of Delegates. <u>In its role as the governing body of this Association, the House of Delegates shall be responsible for publication decisions over and editorial oversight for all non-scientific content appearing in any Association publication or communications channel.</u></p> <p><i>Section 20.</i> ADMINISTRATIVE BODY. The administrative body of this Association shall be a Board of Trustees.</p> <p><u>and be it further</u></p> <p>Resolved, that Chapter III. HOUSE OF DELEGATES, <i>Section 50.</i> DUTIES, of the ADA Bylaws be amended as follows (additions <u>underscored</u>):</p>	

Section 50. DUTIES: It shall be the duty of the House of Delegates to:

J. Oversee all non-scientific content, including content relating to ADA policies, advocacy efforts or legislative agendas, published in ADA journals, periodicals and other communications channels, including online sites maintained by the Association.

and be it further

Resolved, that Chapter V. BOARD OF TRUSTEES, Section 70. POWERS, of the ADA *Bylaws* be amended as follows (additions underscoring, deletions ~~stricken through~~):

E. Cause *The Journal of the American Dental Association* to be published as the official publication of the Association, including appointment of an editor and an editorial board nominated by the editor.

F. Cause to be published such other publications as may be deemed advisable.

~~G. Cause to be published in or omitted from any official publication of the Association any article relating to ADA policies, advocacy efforts or legislative agendas.~~

and be it further

Resolved, that Chapter XIX. PUBLICATIONS, Section A., of the ADA *Governance and Organizational Manual*, be amended as follows (additions underlined, deletions ~~stricken through~~):

A. *The Journal of the American Dental Association. The Journal of the American Dental Association*, hereinafter referred to as *The Journal*, shall be published with a frequency and at a subscription rate that shall be determined by the Board of Trustees. The object of *The Journal* shall be to report, chronicle and evaluate activities of scientific and professional interest to members of the dental profession. The Editor of *The Journal* shall retain full responsibility for peer-reviewed scientific content. Oversight of all non-scientific editorial content—including editorials, commentaries, and other opinion-based material—shall fall under the authority of the ADA Council on Communications. The Council may carry

~~out this responsibility directly or through a designated subcommittee of member dentists, consistent with policies adopted by the House of Delegates. Except as otherwise provided in the powers of the Board of Trustees in the ADA Bylaws, the editor of *The Journal* shall have the authority to determine its editorial content, including scientific-based content, and shall, with the assistance of an editorial board, establish and maintain a written editorial policy for *The Journal*.~~

and be it further

Resolved, that Chapter XIX. PUBLICATIONS, Section B., of the ADA *Governance and Organizational Manual* be amended as follows (additions underlined, deletions ~~stricken through~~):

- B. Other Journals. ~~The Association may publish or cause to be published other journals in the field of dentistry subject to the direction and regulations of the Board of Trustees.~~ The Association may publish such other journals or periodicals as may be authorized by the Board of Trustees. Editorial oversight of all non-scientific content in such publications shall be provided by the Council on Communications or its designated subcommittee, to ensure consistency with adopted ADA policy and editorial standards.

and be it further

Resolved, that Chapter VIII. COUNCILS, Section K.2., of the ADA *Governance and Organizational Manual* be amended as follows (additions underlined, deletions ~~stricken through~~):

- K. Areas of Responsibility.

* * *

- 2. Council on Communications. The areas of subject matter responsibility of the Council shall be:
 - a. Advise on the management of the Association's reputation;
 - b. Develop, recommend and maintain ADA strategic communications plans;
 - c. Advise ADA agencies on branding;
 - d. Advise on prioritization and allocation of communications resources; and
 - e. Advise on communications and marketing for constituents and components, upon request;

		<p>f. <u>Serve as the editorial oversight authority for all ADA public-facing and member-facing non-scientific content, including but not limited to JADA, ADA News, ADA.org, email newsletters, social media, and other communications platforms. The Council shall ensure such content reflects House-adopted policy and adheres to established standards of editorial integrity. The Council shall also ensure that ADA communication platforms allow for the timely publication of dissenting or alternate viewpoints in response to editorial or opinion-based content and may establish standards for how such counterpoints are solicited, selected, and displayed. The Council may delegate review responsibilities to a standing subcommittee composed of member dentists, appointed to advise on editorial consistency and fairness; and</u></p> <p>g. <u>Include, in its annual report to the House of Delegates reporting on the following:</u></p> <ul style="list-style-type: none"> i. <u>An overview of ADA communications channels, including both public-facing and member-facing platforms;</u> ii. <u>A summary of current editorial standards and any updates adopted by the Council;</u> iii. <u>Aggregated member feedback on communications content or messaging;</u> iv. <u>A summary of compliance with House-adopted editorial policy across platforms; and</u> v. <u>Any instances of unreviewed non-scientific content found to conflict with ADA policy and any corrective recommendations made by the Council.</u> <p>and be it further</p> <p>Resolved, that ADA staff—including dentists employed in staff roles—shall not use official ADA communication platforms, including publications, email communications, websites, or social media accounts, to publish or promote content that conflicts with policy adopted by the House of Delegates or may reasonably be perceived as undermining the independence of the dental profession or reducing it to a transactional model of care, and be it further</p> <p>Resolved, that when non-scientific content is disseminated without appropriate editorial oversight and is found to conflict with House-adopted policy or established editorial standards, the Council on Communications may recommend correction or clarification in consultation with the Executive Director, and be it further</p>	
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		<p>Resolved, that if the ADA engages external marketing, media, public relations, or research consultants to support messaging that may affect public- or dentist-facing editorial content—such as ADA-branded publications, email communications, or digital platforms—the Council on Communications shall be notified of the engagement and provided an informational summary of its scope and purpose, to ensure alignment with adopted editorial policy and the Council’s subject matter responsibilities.</p>	
505	<p>Referred to the appropriate ADA agency for further study and report to the 2026 House of Delegates</p>	<p>Hawaii Dental Association Resolution 505—Transparency and Oversight in ADA Policy Promotion of Licensure Portability Compact Advocacy</p> <p>Resolved, that while the ADA House of Delegates has authorized the exploration of licensure portability through compact models, the ADA shall not promote, publicly advocate for, announce partnerships, or assist in the implementation of any specific compact, policy, program, product, legislative initiative, or external partnership, and be it further</p> <p>Resolved, that the ADA shall publish a quarterly accountability report, accessible on ADA.org and ADA Connect, which:</p> <ol style="list-style-type: none"> 1. Clearly summarizes the status and disposition of all resolutions referred to councils, including explicit progress updates, documentation of staff and council actions; 2. Discloses any public advocacy or partnership activities undertaken related to referred resolutions; and 3. Includes projected timelines for recommendations returning to the House of Delegates. 	
506	<p>Referred to the appropriate ADA agency for further study and report to the 2026 House of Delegates—Consent Calendar Action</p>	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 506—Delaying Board of Trustees Members and Speaker of the House Eligibility to Run for Elected Office to Protect Governance Integrity</p> <p>Resolved, that the Election Commission and Campaign Rules be amended by the addition of a new section titled Candidate Eligibility to be placed before the section titled Election Commission Rules Governing the Conduct of Campaigns for all ADA Elective Officers to read as follows (additions <u>underlined</u>, deletions stricken through):</p> <p style="text-align: center;">Candidate Eligibility</p> <p><u>Only an active, life or retired member, in good standing, of this Association shall be eligible to serve as an elective officer. Current members of the Board of Trustees and the Speaker of the House of Delegates are not eligible to run for elective office</u></p>	

		<p><u>for a period of one year after completing their term of service on the Board of Trustees. This eligibility limitation does not apply to the Treasurer and/or Speaker when running for a second consecutive three-year term as provided in Chapter VI. ELECTIVE OFFICERS OF THE ASSOCIATION, of the <i>Governance and Organization Manual</i>.</u></p> <p>and be it further</p> <p>Resolved, that the American Dental Association <i>Governance and Organizational Manual</i>, Chapter VI. ELECTIVE OFFICERS OF THE ASSOCIATION, Section A. Eligibility, be amended to read as follows (additions <u>underlined</u>, deletions stricken through):</p> <p>A. Eligibility. Only an active, life or retired member, in good standing, of this Association shall be eligible to serve as an elective officer. No trustee or other elected officer is eligible to serve simultaneously as Treasurer or Speaker of the House of Delegates. <u>Current members of the Board of Trustees and the Speaker of the House are not eligible to run for elective office for a period of one year after completing their term of service on the Board of Trustees. This eligibility limitation does not apply to the Treasurer and/or Speaker when running for a second consecutive three-year term.</u></p> <p>and be it further</p> <p>Resolved, that this Resolution shall take effect at the close of the 2025 House of Delegates.</p>	
507H	Adopted— Consent Calendar Action	<p>Board of Trustees Resolution 507B in lieu of Dr. Steven Saxe, delegate, Nevada Resolution 507—Supporting Plaintiffs’ in Re: Zelis Repricing Antitrust Litigation Lawsuit to Promote Fair Reimbursement and Transparency in Dental Insurance</p> <p>Resolved, that the Board of Trustees be urged to formally support the plaintiffs in the federal antitrust case of in <i>Re: Zelis Repricing Antitrust Litigation</i> (Case No.: 1:25 -cv-10734-BEM; consolidated with Case Nos: 1:25 –CV-11092-BEM and 1:25-CV-11167-BEM), as a landmark enforcement of the Competitive Health Insurance Reform Act of 2020 (Pub. L. No. 116-327) among other claims, and be it further</p> <p>Resolved, that the ADA allocate financial support and expert resources, subject to legal review and appropriate oversight, through the ADA Health Policy Institute (HPI)—including claims data, reimbursement trend reports, and coding analytics—to assist in the litigation and any resulting legal or policy actions, and be it further</p>	

		<p>Resolved, that the ADA assist collaborate with Plaintiffs' legal counsel, <u>if needed to share existing relevant ADA data, develop expert reports,</u> and, where appropriate, submit or support legal filings such as an amicus briefs, and be it further</p> <p>Resolved, that the ADA utilize legal, public affairs, and Health Policy Institute resources to urge the U.S. Department of Justice and Federal Trade Commission to investigate alleged collusion and market manipulation in the dental insurance industry, consistent with the authority granted under the Competitive Health Insurance Reform Act of 2020 (Pub. L. No. 116-327).</p>	
508	<p>Referred to the appropriate ADA agency for further study and report to the 2026 House of Delegates—Consent Calendar Action</p>	<p>Dr. Spencer Bloom, delegate, Illinois, Resolution 508—Amendment to the ADA Election Commission and Campaign Rules</p> <p>Resolved, that the Election Commission and Campaign Rules as set forth in the <i>Manual of the House of Delegates</i> be deleted in its entirety, and be it further</p> <p>Resolved, that Chapter VI. ELECTIVE OFFICERS OF THE ASSOCIATION, of the <i>Governance and Organizational Manual of the American Dental Association</i> be amended by addition of a new Section G. as follows:</p> <p style="text-align: center;"># # #</p> <p>G. Election Commission and Campaign Rules. The following Campaign Rules govern the announcement and conduct of campaigns for ADA elective officers. These Campaign Rules will be distributed annually to all candidates, delegates, alternate delegates and other parties of interest. Candidates for elective officers are expected to abide by the Campaign Rules. These Campaign Rules shall also apply to any individual who has not yet formally declared candidacy but has taken substantive steps indicating an intent to run for elective office, including but not limited to campaign planning, fundraising, or public discussion of their potential candidacy. Such individuals shall be bound by the same ethical, financial, and procedural standards outlined in this document.</p> <p style="text-align: center;">Procedures Concerning Interpretation and Distribution of the Campaign Rules</p> <ol style="list-style-type: none"> 1. To the extent one or more candidates has a question concerning the interpretation of the Campaign Rules or whether a particular activity is prohibited or permitted under the Campaign Rules, the following procedures shall be followed: 	

		<p>a. Any declared candidate or campaign representative may submit a question directly to the Election Commission without the need for prior discussion with other candidates.</p> <p>b. Any communications from a candidate to the Election Commission regarding these Campaign Rules shall be submitted to the chair of the Election Commission via email addressed to electioncommission@ada.org or by such other means as the Election Commission may from time-to-time specify. All declared candidates will receive a copy of all communications. Such copies shall be provided within three (3) business days of receipt by the Chair.</p> <p>c. Other candidates may provide their input within three (3) business days. The Election Commission shall issue a written opinion within five (5) business days of the close of the candidate input period and provide it to all declared candidates. All opinions shall be posted in the House of Delegates Library on ADA Connect. Opinions shall not disqualify any candidate from continued campaigning or appearing on the ballot. Final authority regarding any consequences rests with the House of Delegates.</p> <p>2. Each year, a copy of the current Campaign Rules shall be distributed, signed and acknowledged by all ADA trustees and elective officers with the agenda and organizational material provided at the first meeting of the Board of Trustees following adjournment of the House of Delegates. It is the responsibility of each candidate to inform their campaign committee members, the constituent Executive Directors within their trustee districts and other constituent staff within their trustee districts who are assisting the campaign of these Campaign Rules within fourteen (14) days of the candidate's formation of a campaign committee or announcement of candidacy, whichever first occurs.</p> <p>The current Campaign Rules shall also be made available to all members via ADA Connect and www.ada.org to support transparency.</p> <p style="text-align: center;">Agreements Between Candidates</p> <p>3. Candidates may engage in good-faith coordination regarding campaign schedules, shared forums, and travel logistics, provided that such</p>	
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		<p>agreements do not restrict access to campaign activities, reduce public communications, or create private advantages unavailable to other candidates. Agreements that would narrow or waive campaign rights outlined in these Rules shall be nonbinding and unenforceable. All candidates are encouraged to disclose any formal coordination to the Election Commission to preserve procedural fairness.</p> <p>The Election Commission shall not facilitate or enforce private agreements among candidates and reserves the right to disregard agreements that impair the fairness, transparency, or neutrality of the election process.</p> <p style="text-align: center;">Announcing Candidacy</p> <p>4. Candidates for any elected position may formally announce their intent to run for office on the final day of the annual session immediately preceding their candidacy, or any time after. A formal announcement shall include, at a minimum, the name of the candidate and an identification of the office being sought. Prior to this formal announcement, candidates may freely campaign within their own trustee districts. Campaign activities outside a candidate's own trustee district shall begin only after the official announcement. Once declared to the Election Commission in writing, candidates are permitted to campaign without geographic restrictions. All nominating speeches shall be posted on ADA.org.</p> <p>5. Announcements of candidacies for the offices of Treasurer and Speaker of the House of Delegates shall follow the procedures outlined in Chapter VI, Sections B.2. and B.3. of the Governance Manual. These candidates shall also be subject to the same transparency and disclosure requirements as other declared candidates under these rules.</p> <p style="text-align: center;">Travel and Meeting Attendance</p> <p>6. Candidates shall limit their campaign travel to attending state and/or district annual meetings and/or leadership conferences and annual session district caucus meetings to which all candidates ,for the same office, have been invited.</p>	
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		<p>Candidates may also accept invitations from other recognized ADA-affiliated or professional organizations, provided that such invitations are extended to all declared candidates for the same office.</p> <p>a. Candidates may attend such events if all declared candidates are given equal opportunity to participate. Coordination among campaigns is encouraged but not required for acceptance.</p> <p>b. Invitations for campaign appearances shall be sent directly and simultaneously to all declared candidates of the same office and their campaign managers, with a copy provided to the Office of the Executive Director for coordination and recordkeeping.</p> <p>c. Candidates are encouraged to coordinate their schedules in good faith and respond directly to the inviting organizations. In the event that a candidate is unable to attend a district or caucus event due to a religious holiday, scheduling conflict, or last-minute emergency, they shall have the option to participate virtually through audio or audiovisual means, or to submit pre-recorded remarks. The format and duration of such participation shall be comparable to what is provided to other candidates, as determined by the host organization. The remaining candidates may proceed with the event as planned.</p> <p>7. To encourage fiscal responsibility, all candidates may use virtual audio or audiovisual means to campaign and answer questions at any time to any extent after their candidacy announcement. Virtual campaign appearances, interviews, or forums by all candidates may also be hosted by any organization, provided all declared candidates for the office in question are given equal notice and opportunity to participate. Invitations for virtual campaign appearances shall be sent directly to all declared candidates of the same office and their campaign managers, with a copy provided to the Office of the Executive Director for coordination and recordkeeping. Candidates may respond directly to invitations for virtual events. Coordination is encouraged but shall not be required. After a virtual candidate forum that is intended for all candidates, has been accepted by a candidate, if a situation arises that requires the candidate to cancel their attendance, the remaining candidates may participate as planned. Any candidate is free to decline any invitation and may submit a pre-recorded message with permission from the host. Hosts are encouraged to accept</p>	
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		<p>pre-recorded messages when a candidate cannot attend live, as long as the same option is offered to all candidates.</p> <p>8. Caucuses and state meetings are requested to provide an appropriate opportunity for the candidates to meet with their members. It is recommended that such forums be structured to allow:</p> <ol style="list-style-type: none"> a. All candidates to make presentations; b. Caucuses freedom to assess candidates; and c. Each candidate to respond to questions. <p>9. Notwithstanding any of these Campaign Rules, nothing in these Rules shall prevent a candidate from traveling on a personal basis or attending a meeting, conference or other event as an official ADA representative. Campaigning while personally traveling or attending events as an ADA representative is strictly prohibited. When traveling personally or as an ADA representative, candidates shall notify other candidates of such travel as soon as possible once the travel has been scheduled.</p> <p>10. Candidates shall not use campaign-sponsored social functions or hospitality suite/meeting rooms on behalf of their candidacy at any regional, national or annual meeting. (This is not intended, however, to limit candidates from holding campaign meetings for the purpose of strategizing.) Campaign receptions are not to be held at the ADA Annual Session. Additionally, a district that hosts a reception during the ADA annual session and is sponsoring a candidate in a contested election shall not host the reception prior to the officer elections; a reception may be held after the election. Prior to the election, candidates shall not attend events in or visit district hospitality suites. This prohibition shall not apply to a candidate visiting his or her own district's hospitality suite or attending events hosted by their own district exclusively for the district's members. Districts and caucuses are encouraged to fully utilize virtual appearances before the Annual Session to allow delegates to ask questions and get to know the candidates. All declared candidates in each race should be invited to participate. This approach promotes equal access while helping limit costs and support fiscal responsibility.</p> <p style="text-align: center;">Publications and Media</p>	
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		<p>11. Candidates may participate in news articles or interviews published in print or online journals provided that equal opportunity is extended to all candidates upon request. Hosts are encouraged to document in writing that all declared candidates were offered the same opportunity; candidates shall retain that documentation for review by ADA staff if questions arise.</p> <p>12. Candidates shall disclose their candidacy to any organizations or groups to which they belong and may request such groups not campaign on their behalf unless equal access is provided to all other candidates for that office.</p> <p>13. Candidates may participate in interviews and publications provided the subject matter is relevant to their professional expertise and not used for campaign messaging. National appearances, publications, or speaker engagements must not include endorsements or campaign solicitations. Campaign-related media must be disclosed to the Election Commission and other candidates when scheduled, and equal access must be offered to others upon request.</p> <p style="text-align: center;">Use of Social Media</p> <p>14. Candidates may use campaign-specific social media pages, podcasts, or online platforms to communicate with delegates and alternate delegates, provided access is offered equitably to all declared candidates and campaign-related content complies with the ADA Code of Ethics and these Rules. This approach promotes equal access and expanded exposure while helping limit costs and support fiscal responsibility.</p> <ul style="list-style-type: none"> a. Candidates shall notify the Election Commission of the digital platforms they intend to use for campaign communications and agree to maintain basic content moderation to ensure compliance with ADA rules. b. Candidates may invite certified delegates, alternate delegates, campaign staff, and ADA observers to their campaign platforms. c. Within 14 days of candidate declaration, the ADA shall provide candidates with a current delegate and alternate delegate list. 	
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		<p>Candidates may use this list to distribute digital invitations to their campaign platforms.</p> <ul style="list-style-type: none"> d. A second invitation may be sent using the most current official delegate list available from ADA staff, no later than 21 days prior to the House of Delegates session. If a more updated list becomes available within that period, campaigns are encouraged to send it again. e. Candidates are responsible for ensuring that campaign-related content is accurate, relevant, and not defamatory. Campaign platforms must designate a moderator and comply with ADA Code of Ethics provisions on fairness and veracity. f. Candidates shall not conduct surveys, polls, or vote-solicitation campaigns through their campaign platforms unless such tools are offered identically to all candidates by ADA. g. Interactions on declared digital campaign platforms shall not count toward contact limits, but must remain public and viewable to all members of that platform. h. Candidates may participate in interviews, podcasts, livestreams, forums, or digital communications hosted by independent platforms not affiliated with the ADA, including professional publications, podcasts, Facebook groups, or dental community pages. Participation in such media shall not require the consent of other candidates. A candidate's refusal to participate shall not prohibit others from accepting the same invitation. Prior to publication or broadcast, the host or moderator of any independent media appearance must send a written confirmation (such as an email) to the Office of the Executive Director, affirming that the opportunity to participate was extended to all declared candidates for the applicable race. All content must comply with the ADA Code of Ethics, including the principles of fairness and veracity. <p>15. The Election Commission shall not restrict participation in independent platforms, provided ADA rules and candidate ethics are upheld.</p>	
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		<p>provide the information to the Election Commission members and staff. Candidates may also publicize the telephonic town halls they sponsor on any media.</p> <p>26. The agenda for a candidate's telephonic town hall meeting(s) shall be the prerogative of the candidate, with the candidates being permitted to provide opening and closing statements and whether follow-up questions are permitted. The length of the telephonic town hall event is also discretionary with the candidate.</p> <p>27. Candidates are expected to maintain a respectful tone during town halls and may use a moderator to manage questions and content. Offensive or defamatory comments are discouraged, but candidates shall not be held responsible for unscripted audience remarks beyond their control.</p> <p style="text-align: center;">Contributions</p> <p>28. Contributions (including money and in-kind services) may only be accepted from individual dentists, family members, and ADA constituent or component dental societies (including study clubs and branches recognized by a constituent society). Contributions from any other source are not permissible. No candidate shall knowingly accept any contribution that creates the appearance of a conflict of interest as defined in the ADA Bylaws. Total contributions from any individual donor (including family members, friends, or colleagues) shall not exceed \$2,500 per election cycle. Total contributions from any ADA constituent or component society shall not exceed \$10,000 per candidate. All contributions over \$500, including self-funding and in-kind support, must be disclosed to the Election Commission within 10 business days of receipt. Because contributions from constituent and component societies may come from membership dues, all such support must be transparently reported and made accessible to ADA members through appropriate posting on ADA Connect and the candidate's campaign website, if applicable.</p> <p>29. The sending of a brief note acknowledging a financial contribution or thanking a host of a campaign event to those contributors or hosts outside of the candidate's district is permitted, as long as no additional campaign message is included. Such thank you notes may be sent on campaign letterhead or a notecard containing the campaign logo; envelopes for the</p>	
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		<p>between the candidates, shall report those violations to the House of Delegates. The report will be given orally by the Election Commission chair (or a designee of the Election Commission if the chair is absent from the House of Delegates session) at the first meeting of the House. If violations occur after that meeting, and before the election, then a report of such violations shall be read to each caucus by a designee of the Election Commission. The candidate shall also be offered an opportunity to respond orally or in writing prior to or during the same session in which the violation is reported.</p> <p>34. Should an allegation of a Campaign Rules violation against an individual or entity not affiliated with a campaign be made, the Election Commission shall review the allegation and determine if a violation has occurred. If so, the campaign and candidate affected by the infraction will be notified, and shall be responsible for contacting the individual or entity involved and using their best efforts to curtail the violation.</p> <p>35. In addition to the foregoing notifications of violations, all violations of the Campaign Rules that occur shall be reported orally at the House of Delegates meeting by the Election Commission. The ADA encourages all delegates to review reported violations and candidate responses when casting votes, as ethical campaign conduct reflects integrity in leadership.</p> <p>and be it further</p> <p>Resolved, that the <i>Governance and Organizational Manual</i>, Chapter VI. ELECTIVE OFFICERS OF THE ASSOCIATION, Sections B.2. and B.3., be amended as follows (additions <u>underscored</u>, deletions stricken through):</p> <p>B. Nominations</p> <p style="text-align: center;">* * *</p> <p>2. Treasurer. The search for Treasurer shall be announced in an official publication of the Association in November of the final year of the incumbent Treasurer's term, together with the recommended qualifications for that position as provided in the <i>Bylaws</i>. Candidates for the office of Treasurer shall apply by submitting a standardized Treasurer <i>Curriculum Vitae</i> form to the Executive Director at least one hundred twenty (120) days prior to the convening of the House of Delegates. Each candidate's application shall be reviewed by the Board of Trustees. At least sixty (60) days prior to the convening of the House of Delegates the</p>	
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		<p>established by the Speaker of the House of Delegates. Seconding a nomination is not permitted. If there are no candidates for the office of Speaker of the House nominated when the House of Delegates meets, the term of the incumbent Speaker of the House shall be extended by one (1) year. Should the incumbent Speaker of the House be unwilling or unable to serve an additional one (1) year term, the office of Speaker of the House shall be filled in accordance with the vacancy provisions of this chapter of the <i>Governance Manual</i>. Under these circumstances, former Speakers of the House not otherwise eligible to serve as Speaker due to term limits will be eligible to serve as Speaker until the House of Delegates can elect a Speaker of the House.</p>	
509	<p>Referred to the appropriate ADA agency for further study and report to the 2026 House of Delegates</p>	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 509—Fully Funded ADA Advocacy Realigned with Dentist Priorities Through State-Focused Investment and National Collaboration</p> <p>Resolved, that the American Dental Association urges the Board of Trustees to protect and maintain all existing advocacy funding, including but not limited to the Government Affairs and State Public Affairs (SPA) budgets, contracted advocacy services, and staff positions directly supporting advocacy functions, and to increase such funding annually by at least the Consumer Price Index (CPI) or comparable inflationary measure, and to target an annual advocacy investment of at least \$25 million within five years of the adoption of this resolution, unless an extension is authorized by the House of Delegates through a resolution submitted by the Finance Committee, and be it further</p> <p>Resolved, that the appropriate ADA agencies shall publish an annual advocacy performance report detailing state and federal policy outcomes, use of SPA funds, key member-facing wins (including but not limited to legislative or regulatory outcomes that directly benefit dentists or their patients), and the Association’s progress toward its advocacy investment target, and that this report shall be made publicly available to demonstrate the value of ADA advocacy to members and prospective members alike, and be it further</p> <p>Resolved, that the Board of Trustees be urged to fully fund the Government Affairs Division at levels sufficient to support both federal and state initiatives, and redirect no less than 80% of the Government Affairs budget including but not limited to staff, contracts, consultant services, travel, lobby day expenditures, policy development, media campaigns, and research, toward supporting state-led legislative efforts that address issues specific to each state’s needs and priorities, and shall structure SPA grants and other state-level funding support based on strategic alignment with mission-based legislative objectives, with documentation of planning, execution, and measurable outcomes required as a condition of future disbursements, and be it further</p>	

		<p>Resolved, that the Board of Trustees be urged to prioritize insurance reform as a core component of its advocacy strategy, and dedicate no less than 30% of its total advocacy budget annually to supporting state and federal efforts that address insurance-related legislation, including but not limited to network leasing abuses, third-party payment practices, lack of fee transparency, and advancing meaningful dental loss ratio reform aligned with House of Delegates policy, as well as other member-identified insurance concerns.</p>	
510	<p>Referred to the appropriate ADA agency for further study and report to the 2026 House of Delegates</p>	<p>Board of Trustees Resolution 510B in lieu of Seventeenth Trustee District Resolution 510—Policy on Authority of State Dental Associations in Legislative Actions</p> <p>Resolved, that the following policy titled “Authority <u>and Scope of</u> State Dental Associations in Legislative Actions” be adopted (additions <u>underlined</u>, deletions stricken through):</p> <p>Resolved, that State Dental Associations shall have primary authority in determining responses to state-level legislative actions. The ADA shall provide guidance, expertise, and resources to State Dental Associations upon request, and be it further</p> <p>Resolved, that the ADA shall not take unilateral action in state legislative affairs without the express consent of the respective State Dental Association. Any advocacy efforts at the state level shall be conducted in alignment with the priorities established by the State Dental Association. The ADA shall not lobby in opposition to a state’s position on a particular matter, <u>and be it further</u></p> <p>Resolved, that constituent and component dental societies shall recognize the <u>primacy of the American Dental Association in setting federal policy positions and acknowledge the American Dental Association as the governing body for federal advocacy positions. No constituent or component society shall lobby against, or otherwise advocate in conflict with, positions taken by the ADA at the federal level.</u></p> <p>and be it further</p> <p>Resolved, that the policy titled Legislative Assistance by the Association (<i>Trans.</i> 1977:948; 1986:530; 2019:310) be rescinded.</p>	

511	Referred to the appropriate ADA agency for further study and report to the 2026 House of Delegates	<p>Twelfth Trustee District Resolution 511—Proposed Amendments to the ADA Policy on Legislative Assistance by the Association</p> <p>Resolved, that the ADA Policy on Legislative Assistance (<i>Trans.</i>1977:948; 1986:530; 2019:310) be amended as follows (additions are <u>underlined</u>, deletions are stricken through):</p> <p>Resolved, that the American Dental Association shall not assist, <u>communicate with or interact with in any fashion</u> any organization, agency, group, <u>legislator</u> or individual who is attempting to alter, <u>evaluate or study</u> the laws of a state <u>or licensing jurisdiction</u> without the <u>written</u> consent and approval of the constituent society, and be it further</p> <p>Resolved, that when the American Dental Association is aware of pending legislation within a state which is in opposition to existing Association policy or is otherwise detrimental to the best interests of the public, the Association shall inform the constituent society of the implications of such legislation, urge the constituent society to take appropriate action and offer assistance <u>upon request to only the constituent society</u> in addressing the issue.</p>	
512H	Adopted—Consent Calendar Action	<p>Council on Ethics, Bylaws, and Judicial Affairs Resolution 512—Amendment to Section 3.E. of the ADA <i>Principles of Ethics and Code of Professional Conduct</i></p> <p>Resolved, that the following revisions to Section 3.E. of the ADA <i>Principles of Ethics and Code of Professional Conduct</i> (additions <u>underscored</u> and deletions stricken through) be adopted:</p> <p>SECTION 3.E. ABUSE AND NEGLECT.</p> <p>Dentists shall be obliged to become familiar with the signs of abuse, and neglect <u>and human trafficking and</u> to report suspected cases to the proper authorities, consistent with state laws.</p>	
513H	Adopted—Consent Calendar Action	<p>Council on Ethics, Bylaws, and Judicial Affairs Resolution 513—Amendment to Section 5 of the ADA <i>Principles of Ethics and Code of Professional Conduct</i></p> <p>Resolved, that the following revisions to Section 5 of the ADA <i>Principles of Ethics and Code of Professional Conduct</i> (deletions stricken through) be adopted:</p> <p>SECTION 5. PRINCIPLE: VERACITY (“truthfulness”).</p>	

		The dentist has a duty to communicate truthfully. This principle expresses the concept that professionals have a duty to be honest and trustworthy in their dealings with people . Under this principle, the dentist's primary obligations include respecting the position of trust inherent in the dentist-patient relationship, communicating truthfully and without deception, and maintaining intellectual integrity.	
514H	Adopted— Consent Calendar Action	<p>Council on Ethics, Bylaws, and Judicial Affairs Resolution 514—Amendment to Chapter VIII., Section G. of the <i>Governance Manual</i></p> <p>Resolved, that Chapter VIII., Section G. of the <i>Governance Manual of the American Dental Association</i> be amended as follows (additions are <u>underscored</u>, deletions are stricken through):</p> <p>G. Meetings may be held in the Headquarters Building Offices, the Washington Office other locations where the Association or its subsidiaries or affiliates <u>maintain offices</u>, or from multiple remote locations through the use of a conference telephone or other communications equipment by means of which all members can communicate with each other. <u>Except for the Council on Government Affairs meeting in ADA facilities in Washington, D.C., any in-person council meeting in a location other than the Headquarters Offices must be approved in advance by the Executive Director.</u></p>	
515H	Adopted	<p>Reference Committee D Resolution 515RC in lieu of Campaign Rules Task Force Resolution 515—Amendment of the Election Commission and Campaign Rules Pursuant to Resolution 518-H-2024</p> <p>Resolved, that the current Election Commission and Campaign Rules found in the <i>Manual of the House of Delegates</i> be rescinded, and be it further</p> <p>Resolved, that the Election Commission and Campaign Rules appended to the Report of the Campaign Rules Task Force as Appendix 1 be adopted and take effect immediately upon adoption.</p> <p><i>Note: 515H-2025 Appendix 1 appears on pages 163-172.</i></p>	
516	UNASSIGNED		
517	Referred to the appropriate ADA agency for further study and report to the 2026 House	<p>Dr. Spencer Bloom, delegate, Illinois, Resolution 517—Amendment to ADA Policy on Medical (Dental) Loss Ratio</p> <p>Resolved, that the policy titled “Medical (Dental) Loss Ratio” (<i>Trans.</i>2015:244; 2019:262; 2024:XXX) be amended as follows (additions <u>underlined</u>, deletions stricken through):</p>	

	<p>of Delegates— Consent Calendar Action</p>	<p>Resolved, that the ADA supports the concept of a “Medical Loss Ratio” for dental plans defined as the proportion of premium revenues that is spent on clinical services, specifically:</p> <ul style="list-style-type: none"> (A) The numerator is the sum of (1) the amount paid for clinical dental services provided to enrollees and (2) the amount paid to providers on activities that improve oral health through clinical services for plan enrollees. (B) The denominator is the total amount of premium revenue, excluding only (1) federal and state taxes, (2) licensing and regulatory fees paid, and (3) any other payments required by federal law, <p>and be it further</p> <p>Resolved, that states pursuing MLR, refer to the definitions of each of the amounts referenced in the numerator and denominator within the ADA’s Glossary of Dental Administrative Terms maintained by the ADA Council on Dental Benefit Programs (CDBP), and be it further</p> <p>Resolved, that dental plans, both for profit and nonprofit should be required to make information available to the general public and to publicize in their marketing materials to plan purchasers and in written communications to their beneficiaries the percentage of premiums that fund treatment and the percentage of premiums that go to administrative costs, promotion, marketing and profit, or in the case of nonprofit entities, reserves, and be it further</p> <p>Resolved, that the ADA support legislative efforts to require dental benefit plans to file a comprehensive MLR report annually, which contains the same information required in the 2013 federal MLR Annual Report Form (CMS-10418) along with number of enrollees, the plan cost-sharing and deductible amounts, the annual maximum coverage limit and the number of enrollees who meet or exceed the annual coverage limit and to establish a specific loss ratio for dental plans in each state, and be it further</p> <p>Resolved, that a “specific loss ratio” be calculated by each state as the average dental loss ratio for each market segment (large group and small/individual groups as defined within the state). If the average loss ratio is less than 85% for large group plans and 83% for small/individual groups, then states should aspire to establish a mechanism to have MLR improved to at least this benchmark over time. For those carriers reporting MLR above 85%, such carriers should be required to maintain operations at that level, and be it further</p>	
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Resolved, that the ADA shall adopt the following principles as negotiation framework for any future development, negotiation, endorsement, or support of model dental loss ratio legislation in collaboration with external organizations:

(A) Loss ratio benchmarks must apply to individual insured dental plans (not to market-wide averages), and implementation models such as “Rising Tide,” which apply only to statistical outliers or rely on multi-year rolling averages, shall be considered non-compliant with ADA policy.

(B) Loss ratio targets shall be set at a minimum of 85% for large group plans and 83% for small or individual plans, and insurers whose plans fail to meet these thresholds must issue rebates or premium credits to purchasers. Such rebates must be returned within a defined timeframe, with the return method (check or credit) clearly disclosed.

(C) Loss ratio calculations must exclude charitable contributions, broker commissions, and non-clinical quality improvement programs from any part of the numerator or denominator.

(D) Insurers must submit publicly accessible annual financial statements, broken down by line of business and plan, and itemized to show spending on direct patient care, administrative expenses, broker fees, charitable giving, and surplus.

(E) Insurers with excessive surplus (e.g., a risk-based capital ratio above 700%) must be subject to public financial review and required to explain the need for the excessive surplus, or how the excessive surplus will be reassigned to refund patients or benefit patients.

(F) Annual administrative cost increases must be limited to the percentage increase in the dental services Consumer Price Index (CPI), and any rate filings that exceed this threshold may be presumptively disapproved by state regulators, followed by hearings to justify the need for increases above the dental services CPI.

(G) State regulatory agencies must retain full authority to disapprove rate filings that are excessive, inadequate, discriminatory, or not actuarially justified, and shall do so within a clearly defined public review timeline with a right to appeal.

		<p><u>(H) States should establish mechanisms to improve plan-level loss ratios to meet or exceed the applicable 85% or 83% benchmarks over a defined period of time.</u></p> <p><u>and be it further</u></p> <p>Resolved, that the ADA shall develop and distribute model statutory language and implementation guidance for use by state dental societies seeking to strengthen existing dental loss ratio laws or correct previous legislative compromises that do not align with ADA policy as amended, and be it further</p> <p>Resolved, that when a carrier fails to meet the MLR, the carrier be required to issue rebates to plan purchasers, and be it further</p> <p>Resolved, that instituting an MLR should not result in premium rate increases in excess of the percentage increase of the latest dental services Consumer Price Index as reported through the US Bureau of Labor Statistics.</p>	
518	Declared Moot	Strategic Forecasting Committee Resolution 518—Amendments to the Charter Language of the Strategic Forecasting Committee	
519	Referred to the appropriate ADA agency for further study and report to the 2026 House of Delegates	<p>Reference Committee D Resolution 519RC in lieu of Resolutions Dr. Steven Saxe, delegate, Nevada Resolution 519, Board of Trustees Resolution 519B and Fifth Trustee District Resolution 530—Enable Member Participation in Governance by Allowing Resolution Submission by ADA Members</p> <p>Resolved, that the Standing Rules of the House of Delegates, section titled “Items of Business” in the <i>Manual of the House of Delegates</i> be amended as follows:</p> <p><i>Items of Business</i></p> <p>An item of business becomes the property of the House of Delegates and is subject to House action in accordance with the appropriate order of business and agenda schedule when such item is received in writing by the American Dental Association Executive Director (Secretary of the House) subject to the following conditions:</p> <ol style="list-style-type: none"> 1. Reports and resolutions from Association agencies, constituent and component societies, individual delegates, and trustee districts are governed by the Association Bylaws and the Manual of the House of Delegates. 	

		<p>2. Constituent and component societies, <u>individual delegates</u>, trustee districts, American Student Dental Association (ASDA), and ADA agencies shall have the authority to submit resolutions to the Association. Constituent and component societies, and trustee districts must collaborate with their individual delegates on resolutions submitted to the Association. Individual delegates may collaborate with members in good standing to develop resolutions that must be submitted to a constituent, component society, and/or a trustee district.</p> <p>3. Resolutions from dental agencies not part of the American Dental Association may become items of business at the discretion of the House if received in writing by the Executive Director (Secretary of the House) at least 15 days in advance of a session.</p> <p>and be it further</p> <p>Resolved, that the Board of Trustees is urged to establish guidance and proper protocols for submitting resolutions to the House of Delegates, in order to facilitate and promote member engagement.</p>	
520	Not Adopted— Consent Calendar Action	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 520—Strengthening ADA Transparency to Grow and Retain Membership Through Majority and Minority Board Reports</p> <p>Resolved, that the American Dental Association <i>Bylaws</i>, Chapter V. BOARD OF TRUSTEES, Section 80. DUTIES, be amended by adding a new duty S. to read as follows (additions <u>underlined</u>):</p> <p><u>S. prepare and publish a written majority report and, where applicable, a minority report for every vote falling into any of the following categories:</u></p> <p><u>(a) Votes to recommend, establish, amend, or rescind ADA policy;</u> <u>(b) Votes addressing insurance reform, dental benefit plans, or third-party payer relations;</u> <u>(c) Votes to authorize or take a position on interstate compacts or licensure reciprocity agreements;</u> <u>(d) Votes involving legislative or regulatory advocacy at the federal or state level;</u> <u>(e) Votes committing the Association to a contractual or financial transaction exceeding two hundred fifty thousand dollars;</u> <u>(f) Votes that alter the structure, authority, or duties of the House of Delegates, Board of Trustees, or any standing committee.</u></p>	

		<p><u>For all other Board votes, such a report shall be prepared and published upon the written request of any active, life, retired, or student member of the Association, made to the Executive Director within 60 days of the vote. The Board shall prepare and publish the report within 30 days of the vote or of receiving a valid request. The report shall be made available to members in the ADA.org member area and released to the public.</u></p>	
521H	Adopted as amended	<p>Board of Trustees Resolution 521—as amended—Proposal to Modify Timeline for the Next ADA Governance Study in lieu of Ninth Trustee District Resolution 521S-1</p> <p>Resolved, that the next ADA governance study be delivered to the 2026 House of Delegates Board of Trustees be urged to retain a qualified outside firm to conduct a comprehensive governance and organizational health evaluation, and be it further</p> <p>Resolved, that any evaluation should include, but not be limited to, review of the governance structure, internal controls, leadership and management culture, accountability expectations and a causal analysis of the challenges the ADA continues to experience in operations, finances and leadership accountability, and be it further</p> <p>Resolved, that should the Board retain an outside consultant, the firm will create a detailed plan to ensure immediate financial sustainability including long term viable governance and operational structure recommendations with sound processes, controls and clear Board and management accountability, and be it further</p> <p>Resolved, that the Board and its Governance Committee be urged to ensure the outside consultant considers input from the following stakeholders before and during any governance and organizational health evaluation to ensure a balanced blend of innovation, experience, and diverse perspectives:</p> <ol style="list-style-type: none"> 1. <u>Early-career dentists</u> 2. <u>Past ADA leaders and/or past presidents</u> 3. <u>State executive directors</u> 4. <u>Members of the ADA House of Delegates</u> 5. <u>State dental leaders</u> <p>and be it further</p> <p>Resolved, that an interim progress report be provided electronically to the House of Delegates within six months of the close of the 2025 ADA House, and be it further</p>	

		<p><u>Resolved, that the Board be urged to adopt the turnaround plan and evaluation plans be submitted to the 2026 House of Delegates for information and any required action, and be it further</u></p> <p>Resolved, that Resolution 504H-2023, Proposal to Postpone the ADA Governance Study to Account for Strategic Forecasting (<i>Trans.2023:XXX</i>), be rescinded.</p>	
522H	<p>Adopted— Consent Calendar Action</p>	<p>Board of Trustees Resolution 522B in lieu of Dr. Spencer Bloom, delegate, Illinois Resolution 522—Transparency in Dental Practice Ownership, Management and Outside Investors</p> <p>Resolved, that the ADA the policy on Transparency in Dental Practice Ownership, Management, and Outside Investors be adopted as follows (additions <u>underlined</u>, deletions stricken through):</p> <p style="padding-left: 40px;">The American Dental Association encourages all state dental boards societies and constituents to advocate for laws to require state dental boards to require clear and accessible disclosure of dental practice ownership and financial control for the benefit of patients, including:</p> <ol style="list-style-type: none"> (1) the name(s) of the registered owner and licensed dentist(s) legally responsible for patient care at each location, and (2) if applicable, the name of any Dental Service Organization, management firm, business, or investor with controlling interest, and (3) such information shall be posted visibly from the patient side of the front desk, published on the practice website, included in all public-facing marketing materials (including digital directories and online platforms), and placed on office signage, stationery, and patient communications, <p>and be it further</p> <p>Resolved, that the ADA constituents encourage all state dental boards and relevant authorities to adopt these transparency requirements, and that the ADA publish sample language and layout recommendations for signage and disclosures to support practices in implementing these measures effectively.</p>	

523H	Adopted— Consent Calendar Action	<p>Special Committee on ERISA Resolution 523—Report of the Special Committee on ERISA</p> <p>Resolved, that the 2025 ADA House of Delegates reauthorize the Special Committee on ERISA for an additional year to oversee the implementation of the proposed strategy and continue its legal and legislative program for members, and be it further</p> <p>Resolved, that the President be urged to reappoint as many existing members of the Special Committee as possible for the sake of continuity, and be it further</p> <p>Resolved, that the Special Committee on ERISA report back to the 2026 House of Delegates on the progress made on ERISA reform and member education.</p>	
524H	Adopted	<p>Seventeenth Trustee District Resolution 524—as amended—Structured Debate Format for ADA Elected Positions</p> <p>Resolved, that a presidential appointed task force work in concert with the Election Commission to develop and implement a structured debate style candidate forum similar to the format of the national presidential debate, for all ADA elected offices, at each House of Delegates beginning in 2026, utilizing the existing conference facilities as available, with the optional for individual visits to trustee districts during caucuses at the House of Delegates at the invitation and discretion of each individual caucus.</p>	
525	Referred to the appropriate ADA agency for further study and report to the 2026 House of Delegates	<p>Council on Government Affairs Resolution 525—Amendment to the Policy, Legislative Assistance by the Association</p> <p>Resolved, that the policy titled Legislative Assistance by the Association (<i>Trans.</i>1977:948; 1986:530; 2019:310) be amended as follows (additions are <u>underscored</u>; deletions are stricken):</p> <p>Resolved, that the American Dental Association shall not assist <u>provide financial, legal, logistical, or promotional support to</u> any organization, agency, group, or individual attempting to alter the laws of a state without the <u>prior written</u> consent and approval of the constituent society of that state, and be it further</p> <p>Resolved, that when the American Dental Association is aware of pending legislation within a state which is in opposition to existing Association policy or is otherwise detrimental to the best interests of the public, the Association shall inform the constituent society of the implications of such legislation, urge the constituent society to take appropriate action and offer assistance in addressing the issue.</p>	

526	WITHDRAWN		
527	Not Adopted— Consent Calendar Action	<p>Dr. Steven Saxe, delegate, Nevada, Resolution 527—Coordinating Dental Advocacy Through a National Task Force for Greater Unity and Impact</p> <p>Resolved, that the ADA shall convene a Dental Advocacy Alignment Task Force to evaluate opportunities for greater coordination, collaboration, and resource alignment among dental organizations engaged in advocacy, with the goal of reducing duplication, strengthening impact, and better addressing the profession’s shared legislative priorities, and be it further</p> <p>Resolved, that the Task Force shall include representatives from the ADA, ADEA, AGD, AAOMS, state dental societies, other recognized specialty organizations, and other dental organizations engaged in federal and state advocacy that are aligned with improving the profession, and shall include at least one representative who is within ten years of dental school graduation, selected in consultation with the New Dentist Committee, and that the Task Force may meet virtually or in person as needed, with a target composition of no more than 15 members, and be it further</p> <p>Resolved, that the Task Force shall report its findings and recommendations to the House of Delegates no later than the 2026 Annual Session.</p>	
528H	Adopted— Consent Calendar Action	<p>Dr. Scott Hansen, delegate, Oregon, Resolution 528—Preservation of Rights of ADA Members Serving the ADA House of Delegates</p> <p>Resolved, that the ADA urge all districts, constituents, and components to rescind all policies and rules which restrict the rights of ADA delegates that are outlined in the ADA <i>Manual of the House of Delegates</i> and the parliamentary authority of the ADA House of Delegates, and be it further</p> <p>Resolved, that the Speaker is urged to amend the subsection, <i>Conduct of Hearings</i>, in the section, <i>General Procedures for Reference Committees</i>, of the <i>2025 Manual of the House of Delegates</i> as follows (additions <u>underscored</u>, deletions stricken through):</p> <p style="text-align: center;">Conduct of Hearings</p> <p style="text-align: center;">* * *</p> <p>Prior to beginning the reference committee hearing, each chair is requested to read the following statement:</p>	

		<p>All members of the American Dental Association have the right to attend and participate in the reference committee hearing, whether or not they are members of the House of Delegates. <u>This member right of open testimony may not be removed or compromised by constituent or trustee district rules.</u> However, nonmembers of the Association may participate in the discussion at this hearing with the consent of a majority of the reference committee. Members of this Association who are not members of the House of Delegates and nonmembers of the Association have been provided the opportunity to submit written testimony. Any written testimony submitted by the October 2 deadline is posted in the House of Delegates community on ADA Connect. At this time, I respectfully request that all members of the media and other nonmembers, excluding component, constituent and ADA staff, to identify themselves.</p> <p>American Dental Association staff members are available at this hearing to provide information requested by members of the reference committee or through the chair by those participating in the discussion.</p> <p>In accordance with the ADA Disclosure Policy, at the appropriate time anyone present at this meeting is obligated to disclose any personal, professional or business relationship that they or their immediate family may have with a company, professional organization or individual doing business with the ADA, when such company, professional organization or person is being discussed. This includes, but is not limited to insurance companies, sponsors, exhibitors, vendors and contractors.</p> <p>At this hearing, you must first identify those relationships before speaking on an issue related to such conflict of interest.</p>	
529	WITHDRAWN		
530	Not Adopted—See Resolution 519H	<p>Fifth Trustee District Resolution 530—Limit to Number of Resolutions That Can be Submitted to the House</p> <p>Resolved, that the <i>Standing Rules of the House of Delegates</i>, published in the <i>Manual of the House of Delegates</i>, section titled “Items of Business”, be amended by addition of a new item #2, and the renumbering of existing condition “#2: as “#3”, so the amended section reads as follows (new language <u>underscored</u>, deletions stricken through):</p> <p style="text-align: center;">Items of Business</p>	

		<p>An item of business becomes the property of the House of Delegates and subject to House action in accordance with the appropriate order of business and agenda schedule when such item is received in writing by the American Dental Association Executive Director (Secretary of the House) subject to the following conditions:</p> <ol style="list-style-type: none"> 1. Reports and resolutions from Association agencies, constituent and component societies, trustee districts and individual delegates are governed by the Association Bylaws and the Manual of the House of Delegates. 2. <u>A delegate may not submit more than two resolutions without constituent or district endorsement.</u> 2.3. Resolutions from dental agencies not part of the American Dental Association may become items of business at the discretion of the House if received in writing by the Executive Director (Secretary of the House) at least 15 days in advance of a session. 	
531	<p>Not Adopted— Failed to receive a 2/3 affirmative vote</p>	<p>Third Trustee District Resolution 531—Addressing Apparent Inaccuracies in the 2026-2029 Delegate Allocation</p> <p>Resolved, that the delegate reallocation scheduled to be implemented in 2026 pursuant to section B. of the portion of the Manual of the House of Delegates entitled “Representation of Constituents and Periodic Reapportionment of Delegates and Alternate Delegates” be postponed for one year provision in the Manual of the House of Delegates stipulating reallocation of delegates should next take effect for the 2026 House of Delegates be suspended for one year, with the allocations for the 2025 House remaining in effect for the following year, and be it further</p> <p>Resolved, that the four-year schedule for reallocation of delegates re-start after this one-year suspension with the next reallocation to take effect for the 2027 House of Delegates and commence a new four-year cycle thereafter, and be it further</p> <p>Resolved, that the introductory paragraph to Section B. Delegate Allocation Methodology, of <i>Representation of Constituent and Periodic Reapportionment of Delegates and Alternate Delegates</i>, as published in the <i>Manual of the House of Delegates</i>, be amended by addition (new language <u>underscored</u>):</p> <p>B. Delegate Allocation Methodology.</p> <p>Commencing in 2014, based on the representational requirements and goals set forth in this <i>Manual</i> and in the <i>Governance Manual</i>, delegates shall be allocated</p>	

		<p>according to the allocation methodology set forth below. Thereafter, to account for membership fluctuations, delegate allocations shall be reviewed and delegates shall be reallocated by the Secretary of the House of Delegates every four (4)* years among the Association's constituents, the five (5) federal dental services and the American Student Dental Association in accordance with that same methodology. Delegate allocations shall be based on the Association's year-end membership records for the second calendar year preceding the year in which the delegate allocations become effective. The review of delegates shall take place as soon as possible after the membership numbers on which the delegate allocations are based are available. The Secretary of the House of shall publish the new delegate allocations expeditiously thereafter to the constituent dental societies, the five (5) federal dental services and the American Student Dental Association. The delegate allocations shall also be published in this Manual. The delegate allocation methodology is as follows:</p> <p><u>* To accommodate the Association's transition of the new CRMS/AMS software, CMS/AMS platforms, the delegate reallocation scheduled to be implemented in the Year 2026 is postponed to the Year 2027. With this one-year postponement, the four-year schedule for reallocation of delegates shall re-start in 2027 and commence a new four-year cycle thereafter.</u></p>	
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1 **Appendix 1: Proposed Revisions to the ADA *Guidelines for the Use of Sedation and General Anesthesia***
2 ***by Dentists***

3 **I. Introduction**

4 The administration of local anesthesia, sedation and general anesthesia is an integral part of dental practice. The
5 American Dental Association is committed to the safe and effective use of these modalities by appropriately
6 educated and trained dentists. The purpose of these guidelines is to assist dentists in the delivery of safe and
7 effective sedation and anesthesia.

8 Dentists must comply with their state laws, rules and/or regulations when providing sedation and anesthesia and
9 will only be subject to Section III. Educational Requirements as required by those state laws, rules and/or
10 regulations. Dental office-based sedation or general anesthesia may be administered by a qualified dentist or
11 another independently qualified anesthesia healthcare provider, and in accordance with state laws, rules and/or
12 regulations for the benefit of patient safety should ensure that sedation and general anesthesia guidelines are
13 consistently applied for all providers in the dental office setting.

14 Level of sedation is entirely independent of the route of administration. Moderate and deep sedation or general
15 anesthesia may be achieved via any route of administration and thus an appropriately consistent level of training
16 must be established.

17 For children, the American Dental Association supports the use of the American Academy of Pediatrics/American
18 Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After
19 Sedation for Diagnostic and Therapeutic Procedures and the American Dental Association's Council on Dental
20 Education and Licensure's Guidelines for Teaching Pediatric Pain Control and Sedation to Dentists and Dental
21 Students. The American Dental Association further recognizes that other disciplines of dentistry may provide
22 sedation/anesthesia care to children in accordance with their respective guidelines, Commission on Dental
23 Accreditation Standards for anesthesia education and training, and state laws, rules and/or regulations.

24 Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual
25 patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to
26 diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes
27 deeper than initially intended.¹

28 For all levels of sedation, the qualified dentist must have the training, skills, drugs and equipment to identify and
29 manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to
30 the intended level of sedation without airway or cardiovascular complications.

31 **II. Definitions**

32 **Methods of Anxiety and Pain Control**

33 **minimal sedation (previously known as anxiolysis)** - a minimally depressed level of consciousness, produced
34 by a pharmacological method, that retains the patient's normal response to verbal command. ~~ability to~~
35 ~~independently and continuously maintain an airway and respond normally to tactile stimulation and verbal~~
36 ~~command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular~~
37 ~~functions are unaffected.¹⁻¹~~

38 ~~Patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a~~
39 ~~state of minimal sedation.~~

40 They will also retain the ability to independently and continuously maintain an airway. Although cognitive function
41 and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.

42 The following definitions apply to administration of minimal sedation:

1 *maximum recommended dose (MRD)* - maximum FDA-recommended dose of a drug, as printed in FDA-approved
2 labeling for unmonitored home use.

3 *dosing for minimal sedation via the enteral route* – minimal sedation may be achieved by the administration of a
4 drug, either singly or in divided doses, by the enteral route to achieve the desired clinical effect, not to exceed the
5 maximum recommended dose (MRD).

6 The administration of an enteral drug for unmonitored home use exceeding the maximum recommended dose is
7 considered to be moderate sedation and the moderate sedation guidelines apply.

8 Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep
9 sedation or general anesthesia.

10 ~~If more than one enteral drug is administered to achieve the desired sedation effect, with or without the~~
11 ~~concomitant use of nitrous oxide, the guidelines for moderate sedation must apply. The administration of an~~
12 ~~enteral drug for unmonitored home use exceeding the maximum recommended dose is considered to be~~
13 ~~moderate sedation and the moderate sedation guidelines apply.~~

14 *Note:* In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety
15 wide enough never to render unintended loss of consciousness. The use of the MRD to guide dosing for minimal
16 sedation is intended to create this margin of safety.

17 **moderate sedation** - a drug-induced depression of consciousness during which patients respond *purposefully* to
18 verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to
19 maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually
20 maintained.¹

21 *Note:* In accord with this particular definition, the drugs and/or techniques used should carry a margin of
22 safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent
23 before the effects of previous dosing can be fully appreciated may result in a greater alteration of the
24 state of consciousness than is the intent of the dentist. ~~During a moderate sedation anesthetic procedure, if~~
25 ~~any airway intervention such as a head tilt/chin lift is required, this is beyond moderate sedation.~~ Further,
26 a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a
27 state of moderate sedation.

28 The following definition applies to the administration of moderate or ~~greater~~ deeper levels of sedation:
F

29 *titration* - administration of incremental doses of an intravenous or inhalation drug until a desired effect is reached.
30 Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation.
31 Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate
32 sedation one must know whether the previous dose has taken full effect before administering an additional drug
33 increment.

34 **deep sedation** - a drug-induced depression of consciousness during which patients cannot be easily aroused but
35 respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory
36 function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous
37 ventilation may be inadequate. Cardiovascular function is usually maintained.¹

38 **general anesthesia** - a drug-induced loss of consciousness during which patients are not arousable, even by
39 painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often
40 require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of
41 depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular
42 function may be impaired.

1 ~~Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual~~
2 ~~patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to~~
3 ~~diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes~~
4 ~~deeper than initially intended.⁴~~

5 ~~For all levels of sedation, the qualified dentist must have the training, skills, drugs and equipment to identify and~~
6 ~~manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to~~
7 ~~the intended level of sedation without airway or cardiovascular complications.~~

8 **Routes of Administration**

9 *enteral* - any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract
10 or oral mucosa [i.e., oral, rectal, sublingual].

11 *parenteral* - a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e.,
12 intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous
13 (IO)].

14 *transdermal* - a technique of administration in which the drug is administered by patch or iontophoresis
15 through skin.

16 *transmucosal* - a technique of administration in which the drug is administered across mucosa such as
17 intranasal, sublingual, or rectal.

18 *inhalation* - a technique of administration in which a gaseous or volatile agent is introduced into the lungs and
19 whose primary effect is due to absorption through the gas/blood interface.

20 **Terms**

21 *analgesia* – the diminution or elimination of pain.

22 *local anesthesia* - the elimination of sensation, especially pain, in one part of the body by the topical
23 application or regional injection of a drug.

24 *Note:* Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record
25 of safety, dentists must be aware of the maximum, safe dosage limits for each patient. Large doses of local
26 anesthetics in themselves may result in central nervous system depression, especially in combination with
27 sedative agents.

28 *qualified dentist* - a dentist providing sedation and anesthesia in compliance with their state rules and/or
29 regulations.

30 *operating dentist* – dentist with primary responsibility for providing operative dental care while a qualified
31 dentist or independently practicing qualified anesthesia healthcare provider administers minimal, moderate or
32 deep sedation or general anesthesia.

33 *competency* - while performing independently, displaying special skill or knowledge derived from training and
34 experience.

35 *must/shall* - indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

36 *should* - indicates the recommended manner to obtain the standard; highly desirable.

37 *may* - indicates freedom or liberty to follow a reasonable alternative.

38 *continual* - repeated regularly and frequently in a steady succession.

1 *continuous* - prolonged without any interruption at any time.

2 *time-oriented anesthesia record* - documentation at appropriate time intervals of drugs, doses
 3 and physiologic data obtained during patient monitoring.

4 *immediately available* – on site in the facility and available for immediate use.

5 **American Society of Anesthesiologists (ASA) Patient Physical Status Classification²**

ASA PS Classification	Definition	Adult Examples, including, but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): <u>e</u> Current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): <u>p</u> Poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, <u>**</u> ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Examples include (but not limited to): <u>r</u> Recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or <u>**</u> ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Examples include (but not limited to): <u>r</u> Ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	

**The addition of “E” denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)

6 **American Society of Anesthesiologists Fasting Recommendations*Guidelines³**

Ingested Material	Minimum Fasting Period[†]
Clear liquids [‡]	2 hours
Breast milk	4 hours
Infant formula	6 hours
Nonhuman milk [§]	6 hours
Light meal ^{**}	6 hours

Fried foods, Fatty meal, or meat	Additional fasting time (e.g. 8 or more hours) may be needed
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1 Modifications to the above should be considered for patients with physiologic conditions or taking medications
2 that delay gastric emptying (i.e., GLP-1 agonists).

3 * These recommendations apply to healthy patients who are undergoing elective procedures. They are not
4 intended for women in labor. Following the guidelines does not guarantee complete gastric emptying.

5 †The fasting periods noted above apply to all ages.

6 ‡Examples of clear liquids include water, fruit juices without pulp, carbonated beverages, clear tea, and black
7 coffee.

8 §Since nonhuman milk is similar to solids in gastric emptying time, the amount ingested must be considered
9 when determining an appropriate fasting period.

10 **A light meal typically consists of toast and clear liquids. Meals that include fried or fatty foods or meat may
11 prolong gastric emptying time. Additional fasting time (e.g., 8 or more hours) may be needed in these cases.
12 Both the amount and type of foods ingested must be considered when determining an appropriate fasting
13 period.

14 **III. Educational Requirements**

15 **A. Minimal Sedation**

16 1. To administer minimal sedation, the dentist must ~~demonstrate competency by having successfully completed~~
17 be competent, as demonstrated by successful completion of:

18 a. training in minimal sedation consistent with that prescribed in the ADA *Guidelines for Teaching Pain*
19 *Control and Sedation to Dentists and Dental Students,*

20 *or*

21 b. comprehensive training in moderate sedation that satisfies the requirements described in the Moderate
22 Sedation section of the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental*
23 *Students* at the time training was commenced,

24 *or*

25 c. an advanced education program accredited by the Commission on Dental Accreditation that affords
26 comprehensive and appropriate training necessary to administer and manage minimal sedation
27 commensurate with these guidelines;

28 *and*

29 d. a current certification in Basic Life Support ~~for Healthcare Providers.~~

1 2. Administration of minimal sedation by another qualified dentist or independently practicing qualified anesthesia
2 healthcare provider requires the operating dentist and ~~their his/her~~ clinical staff to maintain current certification in
3 Basic Life Support ~~for Healthcare Providers~~.

4 **B. Moderate Sedation**

5 1. To administer ~~minimal~~ moderate sedation, the dentist must ~~demonstrate competency by having successfully~~
6 ~~completed~~ be competent, as demonstrated by successful completion of:

7 a. a comprehensive training program in moderate sedation that satisfies the requirements described in the
8 Moderate Sedation section of the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and*
9 *Dental Students* at the time training was commenced,

10 *or*

11 b. an advanced education program accredited by the Commission on Dental Accreditation that affords
12 comprehensive and appropriate training necessary to administer and manage moderate sedation
13 commensurate with these guidelines;

14 *and*

15 c. 1) A current certification in Basic Life Support ~~for Healthcare Providers~~ and
16 2) ~~Either~~ Current certification in Advanced Cardiac Life Support (ACLS or equivalent), or Current
17 certification in Pediatric Advanced Life Support (PALS) is required for treating age-appropriate patients
18 ~~completion of an appropriate dental sedation/anesthesia emergency management course on the same~~
19 ~~recertification cycle that is required for ACLS.~~

20 2. Administration of moderate sedation by another qualified dentist or independently practicing qualified
21 anesthesia healthcare provider requires the operating dentist and ~~their his/her~~ clinical staff to maintain current
22 certification in Basic Life Support ~~for Healthcare Providers~~.

23 **C. Deep Sedation or General Anesthesia**

24 1. To administer ~~minimal~~ deep sedation or general anesthesia, the dentist must ~~demonstrate competency by~~
25 ~~having successfully completed~~ be competent, as demonstrated by successful completion of:

26 a. An advanced education program accredited by the Commission on Dental Accreditation that affords
27 comprehensive and appropriate training necessary to administer and manage deep sedation or general
28 anesthesia, commensurate with Part IV.C of these guidelines;

29 *and*

30 b. 1) A current certification in Basic Life Support ~~for Healthcare Providers~~ and
31 2) ~~either~~ Current certification in Advanced Cardiac Life Support (ACLS or equivalent), and Current
32 certification in Pediatric Advanced Life Support (PALS) is required for treating age-appropriate patients.

33 2. Administration of deep sedation or general anesthesia by another qualified dentist or independently practicing
34 qualified anesthesia healthcare provider requires the operating dentist and ~~their his/her~~ clinical staff to maintain
35 current certification in Basic Life Support (BLS) ~~Course for the Healthcare Provider~~.

36 **IV. Clinical Guidelines**

37 **A. Minimal sedation**

38 1. Patient History and Evaluation

1 Patients considered for minimal sedation must be suitably evaluated prior to the start of any sedative procedure.
2 In healthy or medically stable individuals (ASA I, II) this should consist of a review of their current medical
3 history and medication use. In addition, patients with significant medical considerations (ASA III, IV) may require
4 consultation with their primary care physician or consulting medical specialist.

5 2. Pre-Operative Evaluation and Preparation

- 6 • The patient, parent, legal guardian and/or care giver must be advised regarding the procedure
7 associated with the delivery of any sedative agents and informed consent for the proposed sedation
8 must be obtained.
- 9 • Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive
10 pressure must be completed.
- 11 • An appropriate focused physical evaluation should be performed.
- 12 • Baseline vital signs including body weight, height, BMI, blood pressure, pulse rate, and respiration rate
13 must be obtained unless invalidated by the nature of the patient, procedure or equipment. Body
14 temperature should be measured when clinically indicated.
- 15 • Preoperative dietary restrictions must be considered based on the sedative technique prescribed.
- 16 • Pre-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian
17 and/or care giver.

18 3. Personnel and Equipment Requirements

19 Personnel:

- 20 • At least one additional person trained in Basic Life Support ~~for Healthcare Providers~~ must be present
21 in addition to the dentist.

22 Equipment:

- 23 • A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately
24 available. At minimum, the following must be available: This includes but is not limited to bag-valve-
25 mask with multiple mask sizes, portable oxygen tank with regulator and key, and oral pharyngeal
26 airways.
- 27 • Documentation of compliance with manufacturers' recommended maintenance of monitors,
28 anesthesia delivery systems, and other anesthesia-related equipment should be maintained. A pre-
29 procedural check of equipment for each administration of sedation must be performed.
- 30 • When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and
31 calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of
32 less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with
33 audible alarm.
- 34 • An appropriate scavenging system must be available if gases other than oxygen or air are used.

35 4. Monitoring and Documentation

36 Monitoring: A qualified dentist, or at the dentist's direction, an appropriately trained individual, must remain in
37 the operatory during active dental treatment to monitor the patient continuously until the patient meets ~~the~~
38 criteria for discharge to the recovery area. The appropriately trained individual must be familiar with
39 monitoring techniques and equipment. Monitoring must include:

- 40 • Consciousness:
 - 41 ▪ Level of sedation (e.g., responsiveness to verbal commands) must be continually assessed.
- 42 • Oxygenation:
 - 43 ▪ Oxygen saturation by pulse oximetry. ~~may be clinically useful and should be considered.~~
- 44 • Ventilation:
 - 45 ▪ The qualified dentist and/or appropriately trained individual must observe chest excursions.
 - 46 ▪ The qualified dentist and/or appropriately trained individual must verify respirations.

- 1 • Circulation:
2 ▪ Blood pressure and heart rate should be evaluated pre-operatively, post-operatively and
3 intraoperatively as necessary (unless the patient is unable to tolerate such monitoring).

4 Documentation: An appropriate sedative record must be maintained, including the names of all drugs
5 administered, time administered and route of administration, including local anesthetics, dosages, and
6 monitored physiological parameters.

7 5. Recovery and Discharge

- 8 • Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
9 • The qualified dentist or appropriately trained clinical staff must monitor the patient during recovery
10 until the patient is ready for discharge by the dentist.
11 • The qualified dentist must determine and document that level of consciousness, oxygenation,
12 ventilation and circulation are satisfactory prior to discharge.
13 • Post-operative verbal and written instructions must be given to the patient, parent, escort, legal
14 guardian or care giver.

15 6. Emergency Management

- 16 • If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must
17 stop the dental procedure until the patient returns ~~is returned~~ to the intended level of sedation.
18 • The qualified dentist is responsible for the sedative management, adequacy of the facility and staff,
19 diagnosis and treatment of emergencies related to the administration of minimal sedation and
20 providing the equipment and protocols for patient rescue.
21 • All providers and offices must have written emergency protocols.
22 • Documented training sessions, including rehearsed emergency drills, must be developed and
23 rehearsed, at minimum, every six months. It is the responsibility of the qualified dentist to ensure
24 training occurs as presented.

25 B. Moderate Sedation

26 1. Patient History and Evaluation

27 Patients considered for moderate sedation must undergo an evaluation prior to the administration of any
28 sedative. This should consist of at least a review at an appropriate time of their medical history and medication
29 use and NPO (nothing by mouth) status. In addition, patients with significant medical considerations (e.g., ASA
30 III, IV) should also require consultation with their primary care physician or consulting medical specialist.
31 Assessment of Body Mass Index (BMI)⁴ should be considered part of a pre-procedural workup. Patients with
32 elevated BMI may be at increased risk for airway associated morbidity, particularly if in association with other
33 factors such as obstructive sleep apnea.

34 2. Pre-operative Evaluation and Preparation

- 35 • The patient, parent, legal guardian and/or care giver must be advised regarding the procedure
36 associated with the delivery of any sedative agents and informed consent for the proposed sedation
37 must be obtained.
38 • Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive
39 pressure must be completed.
40 • An appropriate focused physical evaluation must be performed.
41 • Baseline vital signs including body weight, height, BMI, blood pressure, pulse rate, respiration rate,
42 and blood oxygen saturation by pulse oximetry must be obtained unless precluded by the nature of
43 the patient, procedure or equipment. Body temperature should be measured when clinically indicated.
44 • Pre-operative verbal and/or written instructions must be given to the patient, parent, escort, legal
45 guardian or care giver, including pre-operative fasting instructions based on the ASA Summary of
46 Fasting and Pharmacologic Recommendations.³

1 3. Personnel and Equipment Requirements

2 Personnel:

- 3 • At least one additional person trained in Basic Life Support for Healthcare Providers must be present
4 in addition to the dentist.

5 Equipment:

- 6 • A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately
7 available. At minimum, the following must be available: This includes but is not limited to bag-valve-
8 mask with multiple mask sizes, portable oxygen tank with regulator and key, oral pharyngeal airways,
9 and supraglottic airways.
- 10 • Documentation of compliance with manufacturers' recommended maintenance of monitors,
11 anesthesia delivery systems, and other anesthesia-related equipment should be maintained. A pre-
12 procedural check of equipment for each administration of sedation must be performed.
- 13 • When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and
14 calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of
15 less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with
16 audible alarm.
- 17 • The equipment necessary for monitoring end-tidal CO₂ and auscultation of breath sounds must be
18 immediately available.
- 19 • An appropriate scavenging system must be available if gases other than oxygen or air are used.
- 20 • The equipment necessary to establish intravascular or intraosseous access should be available until
21 the patient meets discharge criteria.
- 22 • The patient should be on supplemental oxygen throughout the procedure, as determined by the
23 treating dentist, unless precluded by the nature of the patient, procedure (e.g., fire risk), or equipment.

24 4. Monitoring and Documentation

25 Monitoring: A qualified dentist administering moderate sedation must remain in the operatory room to monitor
26 the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and
27 the patient recovers to a minimally sedated level a qualified allied team member auxiliary may be directed by
28 the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are
29 discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for
30 discharge and is discharged from the facility. Monitoring must include:

- 31 • Consciousness:
32 ▪ Level of sedation (e.g., responsiveness to verbal command) must be continually assessed.
- 33 • Oxygenation:
34 ▪ Oxygen saturation must be evaluated by pulse oximetry continuously.
- 35 • Ventilation:
36 ▪ The dentist must observe chest excursions continually.
37 ▪ The dentist must monitor ventilation and/or breathing by monitoring end-tidal CO₂ unless
38 precluded or invalidated by the nature of the patient, procedure or equipment. In addition,
39 ventilation should be monitored by continual observation of qualitative signs, including
40 auscultation of breath sounds with a precordial or pretracheal stethoscope.
41 ▪ Respiratory rate must be continually monitored and evaluated.
- 42 • Circulation:
43 ▪ The dentist must continually evaluate blood pressure and heart rate unless invalidated by the
44 nature of the patient, procedure or equipment and this is noted in the time-oriented anesthesia
45 record.

- 1 ▪ ~~Continuous ECG monitoring of patients with significant cardiovascular disease should be~~
2 ~~considered unless precluded or invalidated by the nature of the patient, procedure (e.g. fire~~
3 ~~risk), or equipment.~~

4 Documentation:

- 5 • Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs,
6 dosages (in weight, i.e., mg or mcg) and their administration times, including local anesthetics,
7 dosages and monitored physiological parameters.
8 • Pulse oximetry, heart rate, respiratory rate, blood pressure and level of consciousness must be
9 recorded continually.

10 5. Recovery and Discharge

- 11 • Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
12 • The qualified dentist or appropriately trained clinical staff must continually monitor the patient's blood
13 pressure, heart rate, oxygenation and level of consciousness.
14 • The qualified dentist must determine and document that level of consciousness; oxygenation,
15 ventilation and circulation are satisfactory for discharge.
16 • Post-operative verbal and written instructions must be given to the patient, parent, escort, legal
17 guardian and/or care giver.
18 • If a pharmacological reversal agent is administered before discharge criteria have been met, the
19 patient must be monitored for a longer period than usual before discharge, since re-sedation may
20 occur once the effects of the reversal agent have waned.

21 22
23 6. Emergency Management

- 24 • If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must
25 stop the dental procedure until the patient ~~returns~~ is returned to the intended level of sedation.
26 • The qualified dentist is responsible for the sedative management, adequacy of the facility and staff,
27 diagnosis and treatment of emergencies related to the administration of moderate sedation and
28 providing the equipment, drugs and protocol for patient rescue.
29 • All providers and offices must have written emergency protocols. Documented training sessions,
30 including rehearsed emergency drills.
31 • must be developed and rehearsed, at minimum, every six months. It is the responsibility of the
32 qualified dentist to ensure training occurs as presented.
33

34 **C. Deep Sedation or General Anesthesia**

35 1. Patient History and Evaluation

36 Patients considered for deep sedation or general anesthesia must undergo an evaluation prior to the
37 administration of any sedative. This must consist of at least a review of their medical history and medication
38 use and NPO (nothing by mouth) status. In addition, patients with significant medical considerations (e.g., ASA
39 III, IV) ~~must have~~ should also require consultation with their primary care physician or consulting medical
40 specialist. Assessment of Body Mass Index (BMI)⁴ should be considered part of a pre-procedural workup.
41 Patients with elevated BMI may be at increased risk for airway associated morbidity, particularly if in
42 association with other factors such as obstructive sleep apnea.

43 2. Pre-operative Evaluation and Preparation

- 44 • The patient, parent, legal guardian and/or care giver must be advised regarding the procedure
45 associated with the delivery of any sedative or anesthetic agents and informed consent for the
46 proposed sedation/anesthesia must be obtained.

- 1 • Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive
2 pressure must be completed.
- 3 • ~~A focused physical evaluation must be performed as deemed appropriate. An appropriate focused~~
4 physical evaluation must be performed.
- 5 • Baseline vital signs including body weight, height, BMI, blood pressure, pulse rate, respiration rate,
6 and blood oxygen saturation by pulse oximetry must be obtained unless invalidated by the patient,
7 procedure or equipment. In addition, body temperature should be measured when clinically
8 appropriate.
- 9 • Pre-operative verbal and written instructions must be given to the patient, parent, escort, legal
10 guardian and/or care giver, including pre-operative fasting instructions based on the ASA Summary of
11 Fasting and Pharmacologic Recommendations.³
- 12 • An intravenous (IV) line should be established and secured for the duration of the procedure, as
13 needed.
 - 14 ○ In certain cases, deep sedation or general anesthesia may be administered without first
15 establishing an indwelling intravenous line. These exceptions may apply to very short
16 procedures or situations where intravenous access is delayed until after sedation or anesthesia
17 is initiated, such as with uncooperative patients.
- 18 • ~~An intravenous line, which is secured throughout the procedure, must should be established as~~
19 needed, except as provided in part IV. C.6. Special Needs Patients.
 - 20 ○ ~~In selected circumstances, deep sedation or general anesthesia may be utilized without~~
21 ~~establishing an indwelling intravenous line. These selected circumstances may include very~~
22 ~~brief procedures or periods of time, which, for example, may occur in some patients; or the~~
23 ~~establishment of intravenous access after deep sedation or general anesthesia has been~~
24 ~~induced because of poor patient cooperation.~~

25 3. Personnel and Equipment Requirements

26 Personnel: A minimum of three (3) individuals must be present.

- 27 • A dentist qualified in accordance with part III. C. of these Guidelines to administer the deep sedation
28 or general anesthesia.
- 29 • Two additional individuals who have current certification in Basic Life Support (BLS) ~~course for the~~
30 ~~Healthcare Provider.~~
- 31 • When the same individual administering the deep sedation or general anesthesia is performing the
32 dental procedure, one of the additional appropriately trained team members must be designated for
33 patient monitoring.

34 Equipment:

- 35 • A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately
36 available At minimum, the following must be available: This includes but is not limited to bag-valve-
37 mask with multiple mask sizes, portable oxygen tank with regulator and key, oral pharyngeal airways,
38 and supraglottic airways.
- 39 • Documentation of compliance with manufacturers' recommended maintenance of monitors,
40 anesthesia delivery systems, and other anesthesia-related equipment should be maintained. A pre-
41 procedural check of equipment for each administration must be performed.
- 42 • When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and
43 calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of
44 less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with
45 audible alarm.
- 46 • An appropriate scavenging system must be available if gases other than oxygen or air are used.
- 47 • The equipment necessary to establish intravenous access must be available.
- 48 • Equipment and drugs necessary to provide advanced airway management, and advanced cardiac life
49 support must be immediately available.

- The equipment necessary for monitoring end-tidal CO₂ and auscultation of breath sounds must be immediately available.
- Resuscitation medications and an appropriate defibrillator must be immediately available.
- The patient must be on supplemental oxygen throughout the procedure, as determined by the treating dentist, unless precluded by the nature of the patient, procedure (e.g., fire risk), or equipment.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

- Oxygenation:
 - Oxygenation saturation must be evaluated continuously by pulse oximetry.
- Ventilation:
 - Intubated patient: End-tidal CO₂ must be continuously monitored and evaluated.
 - Non-intubated patient: End-tidal CO₂ must be continually monitored and evaluated unless precluded or invalidated by the nature of the patient, procedure, or equipment. In addition, ventilation should be monitored and evaluated by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope.
 - ~~Respiratory~~ Respiration rate must be continually monitored and evaluated.
- Circulation:
 - The dentist must continuously evaluate heart rate and rhythm via ECG throughout the procedure, as well as pulse rate via pulse oximetry.
 - The dentist must continually evaluate blood pressure.
- Temperature:
 - A device capable of measuring body temperature must be readily available during the administration of deep sedation or general anesthesia.
 - The equipment to continuously monitor body temperature should be available and must be performed whenever triggering agents associated with malignant hyperthermia are administered.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages (in weight, i.e., mg or mcg) and their administration times, including local anesthetics and monitored physiological parameters.
- Pulse oximetry and end-tidal CO₂ measurements (if taken), heart rate, respiratory rate and blood pressure must be recorded continually.

6. ~~Special Needs Patients~~ Patients with Special Healthcare Needs

~~Because many dental patients undergoing deep sedation or general anesthesia are mentally and/or physically challenged have mental and/or physical special healthcare needs, it is not always possible to have a comprehensive physical examination or appropriate laboratory tests prior to administering care. When these situations occur, the dentist responsible for administering the deep sedation or general anesthesia should document the reasons preventing the recommended preoperative management.~~

~~In selected circumstances, deep sedation or general anesthesia may be utilized without establishing an indwelling intravenous line. These selected circumstances may include very brief procedures or periods of time, which, for example, may occur in some patients; or the establishment of intravenous access after deep sedation or general anesthesia has been induced because of poor patient cooperation.~~

7. Emergency Management

- 1 • The qualified dentist is responsible for sedative/anesthetic management, adequacy of the facility and
2 staff, diagnosis and treatment of emergencies related to the administration of deep sedation or
3 general anesthesia and providing the equipment, drugs and protocols for patient rescue.
- 4 • All providers and offices must have written emergency protocols.
- 5 • Documented training sessions, including rehearsed emergency drills, must be developed and
6 rehearsed, at minimum, every six months. It is the responsibility of the qualified dentist to ensure
7 training occurs as presented.

8 Endnotes

- 9 1. Excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of
10 Sedation/Analgesia, 2024, of the American Society of Anesthesiologists. A copy of the full text can be obtained
11 from ASA, 1061 American Lane Schaumburg, IL 60173-4973 or online at www.asahq.org.
- 12 2. Excerpted from Standards and Practice Parameters: Statement on ASA Physical Status Classification System,
13 2020, of the American Society of Anesthesiologists. A copy of the full text can be obtained from ASA, 1061
14 American Lane Schaumburg, IL 60173-4973 or online at www.asahq.org.
- 15 3. Excerpted from American Society of Anesthesiologists: Practice Guidelines for preoperative fasting and the use
16 of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing
17 elective procedures. Anesthesiology, 2017. A copy of the full text can be obtained from ASA, 1061 American Lane
18 Schaumburg, IL 60173-4973 or online at www.asahq.org.
- 19 4. Standardized BMI category definitions can be obtained from the Centers for Disease Control and Prevention or
20 the American Society of Anesthesiologists.

2 **Appendix 1: Proposed Revisions to the Guidelines for Teaching Pain Control and Sedation to Dentists**
3 **and Dental Students**

4 **I. Introduction**

5 The administration of local anesthesia, sedation and general anesthesia is an integral part of the practice of
6 dentistry. The American Dental Association is committed to the safe and effective use of these modalities by
7 appropriately educated and trained dentists.

8 Anxiety and pain control can be defined as the application of various physical, chemical and psychological
9 modalities to the prevention and treatment of preoperative, operative and postoperative patient anxiety and pain
10 to allow dental treatment to occur in a safe and effective manner. It involves all disciplines of dentistry and, as
11 such, is one of the most important aspects of dental education. The intent of these *Guidelines* is to provide
12 direction for the teaching of pain control and sedation to dentists and can be applied at all levels of dental
13 education from predoctoral through continuing education. They are designed to teach initial competency in pain
14 control and minimal and moderate sedation techniques.

15 These *Guidelines* recognize that many dentists have acquired a high degree of competency in the use of anxiety
16 and pain control techniques through a combination of instruction and experience. It is assumed that this has
17 enabled these teachers and practitioners to meet the educational criteria described in this document.

18 It is not the intent of the *Guidelines* to fit every program into the same rigid educational mold. This is neither
19 possible nor desirable. There must always be room for innovation and improvement. They do, however, provide a
20 reasonable measure of program acceptability, applicable to all institutions and agencies engaged in predoctoral
21 and continuing education.

22 The curriculum in anxiety and pain control is a continuum of educational experiences that will extend over several
23 years of the predoctoral program. It should provide the dental student with the knowledge and skills necessary to
24 provide minimal sedation to alleviate anxiety and control pain without inducing detrimental physiological or
25 psychological side effects. Dental schools whose goal is to have predoctoral students achieve competency in
26 techniques such as local anesthesia and nitrous oxide inhalation and minimal sedation must meet all of the goals,
27 prerequisites, didactic content, clinical experiences, faculty and facilities, as described in these *Guidelines*.

28 Techniques for the control of anxiety and pain in dentistry should include both psychological and pharmacological
29 modalities. Psychological strategies should include simple relaxation techniques for the anxious patient and more
30 comprehensive behavioral techniques to control pain. Pharmacological strategies should include not only local
31 anesthetics but also sedatives, analgesics and other useful agents. Dentists should learn indications and
32 techniques for administering these drugs enterally, parenterally and by inhalation as supplements to local
33 anesthesia.

34 The predoctoral curriculum should provide instruction, exposure and/or experience in anxiety and pain control,
35 including minimal and moderate sedation. The predoctoral program must also provide the knowledge and skill to
36 enable students to recognize and manage any emergencies that might arise as a consequence of treatment.
37 Predoctoral dental students must complete a course in Basic Life Support for the Healthcare Provider. Though
38 Basic Life Support courses are available online, any course taken online should be followed up with a hands-on
39 component and be approved by the American Heart Association or the American Red Cross.

40 Local anesthesia is the foundation of pain control in dentistry. Although the use of local anesthetics in dentistry
41 has a long record of safety, dentists must be aware of the maximum safe dosage limit for each patient, since large
42 doses of local anesthetics may increase the level of central nervous system depression with sedation. The use of
43 minimal and moderate sedation requires an understanding of local anesthesia and the physiologic and
44 pharmacologic implications of the local anesthetic agents when combined with the sedative agents.

1

2 Level of sedation is entirely independent of the route of administration. Moderate and deep sedation or general
3 anesthesia may be achieved via any route of administration and thus an appropriately consistent level of training
4 must be established.

5 For children, the American Dental Association supports the use of the American Academy of Pediatrics/American
6 Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After
7 Sedation for Diagnostic and Therapeutic Procedures and the American Dental Association's Council on Dental
8 Education and Licensure's Guidelines for Teaching Pediatric Pain Control and Sedation to Dentists and Dental
9 Students. The American Dental Association further recognizes that other disciplines of dentistry may provide
10 sedation/anesthesia care to children in accordance with their respective guidelines, Commission on Dental
11 Accreditation Standards for anesthesia education and training, and state laws, rules and/or regulations.

12 The knowledge, skill and clinical experience required for the safe administration of deep sedation and/or general
13 anesthesia are beyond the scope of predoctoral and continuing education programs. Advanced education
14 programs that teach deep sedation and/or general anesthesia to competency have specific teaching requirements
15 described in the Commission on Dental Accreditation requirements for those advanced programs and represent
16 the educational and clinical requirements for teaching deep sedation and/or general anesthesia in dentistry.

17 The objective of educating dentists to utilize pain control, sedation and general anesthesia is to enhance their
18 ability to provide oral health care. The American Dental Association urges dentists to participate regularly in
19 continuing education update courses in these modalities in order to remain current.

20 All areas in which local anesthesia and sedation are being used must be properly equipped with written
21 emergency protocols, suction, physiologic monitoring equipment, a positive pressure oxygen delivery system
22 suitable for the patient being treated and emergency drugs. Training sessions, including simulation, should be
23 developed and rehearsed frequently. Protocols for the management of emergencies must be developed and
24 training programs held at frequent intervals.

25 Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual
26 patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to
27 diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes
28 deeper than initially intended.¹

29 For all levels of sedation, the qualified dentist must have the training, skills, drugs and equipment to identify and
30 manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to
31 the intended level of sedation without airway or cardiovascular complications.

32

II. Definitions

33 **Methods of Anxiety and Pain Control**

34 **minimal sedation (previously known as anxiolysis)** - a minimally depressed level of consciousness, produced
35 by a pharmacological method, that retains the patient's *normal* response to verbal command.

36 They will also retain the ability to independently and continuously maintain an airway ~~and respond normally to~~
37 ~~tactile stimulation and verbal command~~. Although cognitive function and coordination may be modestly impaired,
38 ventilatory and cardiovascular functions are unaffected.¹

39 ~~Patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a~~
40 ~~state of minimal sedation.~~

1 The following definitions apply to administration of minimal sedation:

2 *maximum recommended dose (MRD)* - maximum FDA-recommended dose of a drug, as printed in FDA-approved
3 labeling for unmonitored home use.

4 *dosing for minimal sedation via the enteral route* – minimal sedation may be achieved by the administration of a
5 drug, either singly or in divided doses, by the enteral route to achieve the desired clinical effect, not to exceed the
6 maximum recommended dose (MRD).

7 ~~The administration of an enteral drug exceeding the maximum recommended dose for unmonitored home use~~
8 ~~during a single appointment is considered to be moderate sedation and the moderate sedation guidelines apply.~~

9 ~~The administration of an enteral drug for unmonitored home use exceeding the maximum recommended dose is~~
10 ~~considered to be moderate sedation and the moderate sedation guidelines apply.~~

11 Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep
12 sedation or general anesthesia.

13 If more than one enteral drug is administered to achieve the desired sedation effect, with or without the
14 concomitant use of nitrous oxide, the guidelines for moderate sedation must apply.

15 *Note:* In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety
16 wide enough never to render unintended loss of consciousness. The use of the MRD to guide dosing for minimal
17 sedation is intended to create this margin of safety.

18 **moderate sedation** - a drug-induced depression of consciousness during which patients respond *purposefully* to
19 verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to
20 maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually
21 maintained.¹

22 *Note:* In accord with this particular definition, the drugs and/or techniques used should carry a margin of
23 safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent
24 before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of
25 consciousness than is the intent of the dentist. ~~During a moderate sedation anesthetic procedure, if any~~
26 ~~airway intervention such as a head tilt/chin lift is required, this is beyond moderate sedation.~~ Further, a
27 patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of
28 moderate sedation.

29 The following definition applies to administration of moderate and deeper levels of sedation:

30 *titration* - administration of incremental doses of an intravenous or inhalation drug until a desired effect is reached.
31 Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation.
32 Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate
33 sedation one must know whether the previous dose has taken full effect before administering an additional drug
34 increment.

35 **deep sedation** - a drug-induced depression of consciousness during which patients cannot be easily aroused but
36 respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory
37 function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous
38 ventilation may be inadequate. Cardiovascular function is usually maintained.¹

39 **general anesthesia** – a drug-induced loss of consciousness during which patients are not arousable, even by
40 painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often
41 require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of
42 depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular
43 function may be impaired.¹

44 **Routes of Administration**

1 *enteral* - any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract
2 or oral mucosa [i.e., oral, rectal, sublingual].

3 *parenteral* - a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e.,
4 intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous
5 (IO)].

6 *transdermal* - a technique of administration in which the drug is administered by patch or iontophoresis
7 through skin.

8 *transmucosal* – a technique of administration in which the drug is administered across mucosa such as
9 intranasal, sublingual, or rectal.

10 *inhalation* - a technique of administration in which a gaseous or volatile agent is introduced into the lungs and
11 whose primary effect is due to absorption through the gas/blood interface.

12 **Terms**

13 *analgesia* – the diminution or elimination of pain.

14 *local anesthesia* - the elimination of sensation, especially pain, in one part of the body by the topical
15 application or regional injection of a drug.

16 *Note:* Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record
17 of safety, dentists must always be aware of the maximum, safe dosage limits for each patient. Large doses
18 of local anesthetics in themselves may result in central nervous system depression especially in combination
19 with sedative agents.

20 *qualified dentist* – a dentist providing sedation and anesthesia in compliance with their state rules and/or
21 regulations.

22 *must/shall* - indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

23 *should* - indicates the recommended manner to obtain the standard; highly desirable.

24 *may* - indicates freedom or liberty to follow a reasonable alternative.

25 *continual* - repeated regularly and frequently in a steady succession.

26 *continuous* - prolonged without any interruption at any time.

27 *time-oriented anesthesia record* - documentation at appropriate time intervals of drugs, doses and
28 physiologic data obtained during patient monitoring.

29 *immediately available* – on site in the facility and available for immediate use.

30 **Levels of Knowledge**

31 *familiarity* - a simplified knowledge for the purpose of orientation and recognition of general principles.

32 *in-depth* - a thorough knowledge of concepts and theories for the purpose of critical analysis and the
33 synthesis of more complete understanding (highest level of knowledge).

34 **Levels of Skill**

35 *exposed* - the level of skill attained by observation of or participation in a particular activity.

36 *competent* - while performing independently, displaying special skill or knowledge derived from training and
37 experience.

1

American Society of Anesthesiologists (ASA) Patient Physical Status Classification²

ASA PS Classification	Definition	Adult Examples, including, but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): <u>e</u> Current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): <u>p</u> Poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, <u>**</u> ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Examples include (but not limited to): <u>r</u> Recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or <u>**</u> ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Examples include (but not limited to): <u>r</u> Ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	
<p><u>**</u>The addition of "E" denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)</p>		

2 **American Society of Anesthesiologists Fasting Recommendations^{*Guidelines³}**

Ingested Material	Minimum Fasting Period[±]
Clear liquids [±]	2 hours
Breast milk	4 hours
Infant formula	6 hours
Nonhuman milk [§]	6 hours
Light meal ^{**}	6 hours

Fried foods, Fatty meal, or meat	Additional fasting time (e.g. 8 or more hours) may be needed
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1 Modifications to the above should be considered for patients with physiologic conditions or taking medications that
2 delay gastric emptying (i.e., GLP-1 agonists).

3 *These recommendations apply to healthy patients who are undergoing elective procedures. They are not
4 intended for women in labor. Following the guidelines does not guarantee complete gastric emptying.

5 †The fasting periods noted above apply to all ages.

6 ‡Examples of clear liquids include water, fruit juices without pulp, carbonated beverages, clear tea, and black
7 coffee.

8 §Since nonhuman milk is similar to solids in gastric emptying time, the amount ingested must be considered when
9 determining an appropriate fasting period.

10 **A light meal typically consists of toast and clear liquids. Meals that include fried or fatty foods or meat may
11 prolong gastric emptying time. Additional fasting time (e.g., 8 or more hours) may be needed in these cases. Both
12 the amount and type of foods ingested must be considered when determining an appropriate fasting period.

13 **Education Courses**

14 Education may be offered at different levels (competency, update, survey courses and advanced education
15 programs). A description of these different levels follows:

16 **1. Competency Courses** are designed to meet the needs of dentists who wish to become competent in the safe
17 and effective administration of local anesthesia, minimal and moderate sedation. They consist of lectures,
18 demonstrations and sufficient clinical participation to assure the faculty that the dentist understands the
19 procedures taught and can safely and effectively apply them so that mastery of the subject is achieved. Faculty
20 must assess and document the dentist's competency upon successful completion of such training. To maintain
21 competency, periodic update courses must be completed.

22 **2. Update Courses** are designed for persons with previous training. They are intended to provide a review of the
23 subject and an introduction to recent advances in the field. They should be designed didactically and clinically to
24 meet the specific needs of the participants. Participants must have completed previous competency training
25 (equivalent, at a minimum, to the competency course described in this document) and have current experience to
26 be eligible for enrollment in an update course.

27 **3. Survey Courses** are designed to provide general information about subjects related to pain control and
28 sedation. Such courses should be didactic and not clinical in nature, since they are not intended to develop
29 clinical competency.

30 **4. Advanced Education Courses** are a component of an advanced dental education program, accredited by the
31 Commission on Dental Accreditation in accord with the *Accreditation Standards* for advanced dental education
32 programs. These courses are designed to prepare the graduate dentist or postdoctoral student in the most
33 comprehensive manner to be competent in the safe and effective administration of minimal, moderate and deep
34 sedation and general anesthesia.

35 **III. Teaching Pain Control**

36 These *Guidelines* present a basic overview of the recommendations for teaching pain control.

37 **A. General Objectives:** Upon completion of a predoctoral curriculum in pain control the dentist must:

- 1 1. have an in-depth knowledge of those aspects of anatomy, physiology, pharmacology and psychology
2 involved in the use of various anxiety and pain control methods;
- 3 2. be competent in evaluating the psychological and physical status of the patient, as well as the magnitude
4 of the operative procedure, in order to select the proper regimen;
- 5 3. be competent in monitoring vital functions;
- 6 4. be competent in prevention, recognition and management of related complications;
- 7 5. have in-depth knowledge of the appropriateness of and the indications for medical consultation or
8 referral;
- 9 6. be competent in the maintenance of proper records with accurate chart entries recording medical history,
10 physical examination, vital signs, drugs administered and patient response.

11 **B. Pain Control Curriculum Content:**

- 12 1. Philosophy of anxiety and pain control and patient management, including the nature and purpose of
13 pain
- 14 2. Review of physiologic and psychologic aspects of anxiety and pain
- 15 3. Review of airway anatomy and physiology
- 16 4. Physiologic monitoring
 - 17 a. Observation
 - 18 (1) Central nervous system
 - 19 (2) Respiratory system
 - 20 a. Oxygenation
 - 21 b. Ventilation
 - 22 (3) Cardiovascular system
 - 23 b. Monitoring equipment
- 24 5. Pharmacologic aspects of anxiety and pain control
 - 25 a. Routes of drug administration
 - 26 b. Sedatives and anxiolytics
 - 27 c. Local anesthetics
 - 28 d. Analgesics and antagonists
 - 29 e. Adverse side effects
 - 30 f. Drug interactions
 - 31 g. Drug abuse
- 32 6. Control of preoperative and operative anxiety and pain
 - 33 a. Patient evaluation
 - 34 (1) Psychological status
 - 35 (2) ASA physical status
 - 36 (3) Type and extent of operative procedure

- 1 b. Nonpharmacologic methods
- 2 (1) Psychological and behavioral methods
- 3 a. Anxiety management
- 4 b. Relaxation techniques
- 5 c. Systematic desensitization
- 6 (2) Interpersonal strategies of patient management
- 7 (3) Hypnosis
- 8 ~~(4) Electronic dental anesthesia~~
- 9 (5) Acupuncture/Acupressure
- 10 ~~(6) Other~~
- 11 c. Local anesthesia
- 12 (1) Review of related anatomy, and physiology
- 13 (2) Pharmacology
- 14 a. Dosing
- 15 b. Toxicity
- 16 c. Selection of agents
- 17 (3) Techniques of administration
- 18 a. Topical
- 19 b. Infiltration (supraperiosteal)
- 20 c. Nerve block – maxilla-to include:
- 21 (aa) Posterior superior alveolar
- 22 (bb) Infraorbital
- 23 (cc) Nasopalatine
- 24 (dd) Greater palatine
- 25 ee. Maxillary (2nd division)
- 26 ff. Other blocks
- 27 d. Nerve block – mandible-to include:
- 28 (aa) Inferior alveolar-lingual
- 29 (bb) Mental-incisive
- 30 (cc) Buccal
- 31 (dd) Gow-Gates
- 32 (ee) Closed mouth
- 33 e. Alternative injections-to include:
- 34 (aa) Periodontal ligament
- 35 (bb) Intraosseous
- 36 d. Prevention, recognition and management of complications and emergencies

1 **C. Sequence of Pain Control Didactic and Clinical Instruction:** Beyond the basic didactic instruction in local
2 anesthesia, additional time should be provided for demonstrations and clinical practice of the injection techniques.
3 The teaching of other methods of anxiety and pain control, such as the use of analgesics and enteral, inhalation
4 and parenteral sedation, should be coordinated with a course in pharmacology. By this time the student also will
5 have developed a better understanding of patient evaluation and the problems related to prior patient care. As
6 part of this instruction, the student should be taught the techniques of venipuncture and physiologic monitoring.
7 Time should be included for demonstration of minimal and moderate sedation techniques.

8 Following didactic instruction in minimal and moderate sedation, the student must receive sufficient clinical
9 experience to demonstrate competency in those techniques in which the student is to be certified. It is understood
10 that not all institutions may be able to provide instruction to the level of clinical competence in pharmacologic
11 sedation modalities to all students. The amount of clinical experience required to achieve competency will vary
12 according to student ability, teaching methods and the anxiety and pain control modality taught.

13 Clinical experience in minimal and moderate sedation techniques should be related to various disciplines of
14 dentistry and not solely limited to surgical cases. Typically, such experience will be provided in managing healthy
15 adult patients.

16 Throughout both didactic and clinical instruction in anxiety and pain control, psychological management of the
17 patient should also be stressed. Instruction should emphasize that the need for sedative techniques is directly
18 related to the patient's level of anxiety, cooperation, medical condition and the planned procedures.

19 **D. Faculty:** Instruction must be provided by qualified faculty for whom anxiety and pain control are areas of major
20 proficiency, interest and concern.

21 **E. Facilities:** Competency courses must be presented where adequate facilities are available for proper patient
22 care, including drugs and equipment for the management of emergencies.

23 **IV. Teaching Administration of Minimal Sedation**

24 The faculty responsible for curriculum in minimal sedation techniques must be familiar with the ADA Policy
25 Statement: *Guidelines for the Use of Sedation and General Anesthesia by Dentists*, and the Commission on
26 Dental Accreditation's *Accreditation Standards* for dental education programs.

27 These *Guidelines* present a basic overview of the recommendations for teaching minimal sedation. These include
28 courses in nitrous oxide/oxygen sedation, enteral sedation, and combined inhalation/enteral techniques.

29 **General Objectives:** Upon completion of a competency course in minimal sedation, the dentist must be able to:

- 30 1. Describe the adult anatomy and physiology of the respiratory, cardiovascular and central nervous
31 systems, as they relate to the above techniques.
- 32 2. Describe the pharmacological effects of drugs.
- 33 3. Describe the methods of obtaining a medical history and conduct an appropriate physical examination.
- 34 4. Apply these methods clinically in order to obtain an accurate evaluation.
- 35 5. Use this information clinically for ASA classification risk assessment and pre-procedure fasting
36 instructions.
- 37 6. Choose the most appropriate technique for the individual patient.
- 38 7. Use appropriate physiologic monitoring equipment.
- 39 8. Describe the physiologic responses that are consistent with minimal sedation.
- 40 9. Understand the sedation/general anesthesia continuum.

- 1 10. Demonstrate the ability to diagnose and treat emergencies related to the next deeper level of anesthesia
2 than intended.

3 **Inhalation Sedation (Nitrous Oxide/Oxygen)**

4 **A. Inhalation Sedation Course Objectives:** Upon completion of a competency course in inhalation sedation
5 techniques, the dentist must be able to:

- 6 1. Describe the basic components of inhalation sedation equipment.
7 2. Discuss the function of each of these components.
8 3. List and discuss the advantages and disadvantages of inhalation sedation.
9 4. List and discuss the indications and contraindications of inhalation sedation.
10 5. List the complications associated with inhalation sedation.
11 6. Discuss the prevention, recognition and management of these complications.
12 7. Administer inhalation sedation to patients in a clinical setting in a safe and effective manner.
13 8. Discuss the abuse potential, occupational hazards and other untoward effects of inhalation agents.

14 **B. Inhalation Sedation Course Content:**

- 15 1. Historical, philosophical and psychological aspects of anxiety and pain control.
16 2. Patient evaluation and selection through review of medical history taking, physical diagnosis and
17 psychological considerations.
18 3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
19 4. Description of the stages of drug-induced central nervous system depression through all levels of
20 consciousness and unconsciousness, with special emphasis on the distinction between the conscious
21 and the unconscious state.
22 5. Review of adult respiratory and circulatory physiology and related anatomy.
23 6. Pharmacology of agents used in inhalation sedation, including drug interactions and incompatibilities.
24 7. Indications and contraindications for use of inhalation sedation.
25 8. Review of dental procedures possible under inhalation sedation.
26 9. Patient monitoring using observation and monitoring equipment (i.e., pulse oximetry), with particular
27 attention to vital signs and reflexes related to pharmacology of nitrous oxide.
28 10. Importance of maintaining proper records with accurate chart entries recording medical history, physical
29 examination, vital signs, drugs and doses administered and patient response.
30 11. Prevention, recognition and management of complications and life-threatening situations.
31 12. Administration of local anesthesia in conjunction with inhalation sedation techniques.
32 13. Description, maintenance and use of inhalation sedation equipment.
33 14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting
34 occupational exposure.

1 15. Discussion of abuse potential.

2 **C. Inhalation Sedation Course Duration:** While length of a course is only one of the many factors to be
3 considered in determining the quality of an educational program, the course should be a minimum of *14 hours*
4 plus management of clinical dental cases, during which clinical competency in inhalation sedation technique is
5 achieved. The inhalation sedation course most often is completed as a part of the predoctoral dental education
6 program. However, the course may be completed in a postdoctoral continuing education competency course.

7 **D. Participant Evaluation and Documentation of Inhalation Sedation Instruction:** Competency courses in
8 inhalation sedation techniques must afford participants with sufficient clinical experience to enable them to
9 achieve competency. This experience must be provided under the supervision of qualified faculty and must be
10 evaluated. The course director must certify the competency of participants upon satisfactory completion of
11 training. Records of the didactic instruction and clinical experience, including the number of patients treated by
12 each participant must be maintained and available.

13 **E. Faculty:** The course should be directed by a dentist or physician qualified by experience and training. This
14 individual should possess an active permit or license to administer moderate sedation in at least one state, have
15 had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain
16 control. In addition, the participation of highly qualified individuals in related fields, ~~such as anesthesiologists,~~
17 ~~pharmacologists, internists, and cardiologists and psychologists,~~ should be encouraged.

18 A participant-faculty ratio of not more than ten-to-one when inhalation sedation is being used allows for adequate
19 supervision during the clinical phase of instruction; a one-to-one ratio is recommended during the early state of
20 participation.

21 The faculty should provide a mechanism whereby the participant can evaluate the performance of those
22 individuals who present the course material.

23 **F. Facilities:** Competency courses must be presented where adequate facilities are available for proper patient
24 care, including drugs and equipment for the management of emergencies.

25 **Enteral and/or Combination Inhalation-Enteral Minimal Sedation**

26 **A. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Objectives:** Upon completion of
27 a competency course in enteral and/or combination inhalation-enteral minimal sedation techniques, the dentist
28 must be able to:

- 29 1. Describe the basic components of inhalation sedation equipment.
- 30 2. Discuss the function of each of these components.
- 31 3. List and discuss the advantages and disadvantages of enteral and/or combination inhalation-enteral
32 minimal sedation (combined minimal sedation).
- 33 4. List and discuss the indications and contraindications for the use of enteral and/or combination
34 inhalation-enteral minimal sedation (combined minimal sedation).
- 35 5. List the complications associated with enteral and/or combination inhalation-enteral minimal sedation
36 (combined minimal sedation).
- 37 6. Discuss the prevention, recognition and management of these complications.
- 38 7. Administer enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation)
39 to patients in a clinical setting in a safe and effective manner.
- 40 8. Discuss the abuse potential, occupational hazards and other effects of enteral and inhalation agents.
- 41 9. Discuss the pharmacology of the enteral and inhalation drugs selected for administration.

- 1 10. Discuss the precautions, contraindications and adverse reactions associated with the enteral and
2 inhalation drugs selected.
- 3 11. Describe a protocol for management of emergencies in the dental office and list and discuss the
4 emergency drugs and equipment required for management of life-threatening situations.
- 5 12. Demonstrate the ability to manage life-threatening emergency situations, including current certification in
6 Basic Life Support for Healthcare Providers.
- 7 13. Discuss the pharmacological effects of combined drug therapy, their implications and their management.
8 Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate,
9 deep sedation or general anesthesia.

10 **B. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Content:**

- 11 1. Historical, philosophical and psychological aspects of anxiety and pain control.
- 12 2. Patient evaluation and selection through review of medical history taking, physical diagnosis and
13 psychological profiling.
- 14 3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
- 15 4. Description of the stages of drug-induced central nervous system depression through all levels of
16 consciousness and unconsciousness, with special emphasis on the distinction between the conscious
17 and the unconscious state.
- 18 5. Review of adult respiratory and circulatory physiology and related anatomy.
- 19 6. Pharmacology of agents used in enteral and/or combination inhalation-enteral minimal sedation,
20 including drug interactions and incompatibilities.
- 21 7. Indications and contraindications for use of enteral and/or combination inhalation-enteral minimal
22 sedation (combined minimal sedation).
- 23 8. Review of dental procedures possible under enteral and/or combination inhalation-enteral minimal
24 sedation).
- 25 9. Patient monitoring using observation, monitoring equipment, with particular attention to vital signs and
26 reflexes related to consciousness.
- 27 10. Maintaining proper records with accurate chart entries recording medical history, physical examination,
28 informed consent, time-oriented anesthesia record, including the names of all drugs administered
29 including local anesthetics, doses, and monitored physiological parameters.
- 30 11. Prevention, recognition and management of complications and life-threatening situations.
- 31 12. Administration of local anesthesia in conjunction with enteral and/or combination inhalation-enteral
32 minimal sedation techniques.
- 33 13. Description, maintenance and use of inhalation sedation equipment.
- 34 14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting
35 occupational exposure.
- 36 15. Discussion of abuse potential.

37 **C. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Duration:** Participants must be
38 able to document current certification in Basic Life Support for Healthcare Providers and have completed a nitrous

1 oxide competency course to be eligible for enrollment in this course. While length of a course is only one of the
2 many factors to be considered in determining the quality of an educational program, the course should include a
3 minimum of *16 hours*, plus clinically-oriented experiences during which competency in enteral and/or combined
4 inhalation-enteral minimal sedation techniques is demonstrated. Clinically-oriented experiences may include
5 simulation, group observations on patients undergoing enteral and/or combination inhalation-enteral minimal
6 sedation. Clinical experience or simulation training in ~~managing a compromised~~ airway management is critical to
7 the prevention of life-threatening emergencies and must be included in the course. The faculty should schedule
8 participants to return for additional clinical experience if competency has not been achieved in the time allotted.
9 The educational course may be completed in a predoctoral dental education curriculum or a postdoctoral
10 continuing education competency course.

11 **D. Participant Evaluation and Documentation of Instruction:** Competency courses in combination inhalation-
12 enteral minimal sedation techniques must afford participants with sufficient clinical understanding to enable them
13 to achieve competency. The course director must certify the competency of participants upon satisfactory
14 completion of the course. Records of the course instruction must be maintained and available.

15 **E. Faculty:** The course should be directed by a dentist or physician qualified by experience and training. This
16 individual should possess a current permit or license to administer moderate sedation in at least one state, have
17 had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain
18 control. Dental faculty with broad clinical experience in the particular aspect of the subject under consideration
19 should participate. In addition, the participation of highly qualified individuals in related fields, ~~such as~~
20 ~~anesthesiologists, pharmacologists, internists, and cardiologists and psychologists,~~ should be encouraged. The
21 faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals
22 who present the course material.

23 **F. Facilities:** Competency courses must be presented where adequate facilities are available for proper patient
24 care, including drugs and equipment for the management of emergencies.

25 **V. Teaching Administration of Moderate Sedation**

26 These *Guidelines* present a basic overview of the requirements for a competency course in moderate sedation.
27 These include courses in enteral and parenteral moderate sedation. The teaching guidelines contained in this
28 section on moderate sedation ~~differ slightly from documents in medicine to reflect the differences in delivery~~
29 ~~methodologies and practice environment in dentistry.~~

30 Completion of a pre-requisite nitrous oxide-oxygen competency course is required for participants combining
31 moderate sedation with nitrous oxide-oxygen.

32 **A. Course Objectives:** Upon completion of a course in moderate sedation, the dentist must be able to:

- 33 1. List and discuss the advantages and disadvantages of moderate sedation.
- 34 2. Discuss the prevention, recognition and management of complications associated with moderate
35 sedation.
- 36 3. Administer moderate sedation to patients in a clinical setting in a safe and effective manner.
- 37 4. Discuss the abuse potential, occupational hazards and other untoward effects of the agents utilized to
38 achieve moderate sedation.
- 39 5. Describe and demonstrate the technique of intravenous access, intramuscular injection and other
40 parenteral techniques.
- 41 6. Discuss the pharmacology of the drug(s) selected for administration.
- 42 7. Discuss the precautions, indications, contraindications and adverse reactions associated with the drug(s)
43 selected.

- 1 8. Administer the selected drug(s) to dental patients in a clinical setting in a safe and effective manner.
- 2 9. List the complications associated with techniques of moderate sedation.
- 3 10. Describe a protocol for management of emergencies in the dental office and list and discuss the
4 emergency drugs and equipment required for the prevention and management of emergency situations.
- 5 11. Discuss principles of advanced cardiac life support or an appropriate dental sedation/anesthesia
6 emergency course equivalent.
- 7 12. Demonstrate the ability to manage emergency situations.
- 8 13. Demonstrate the ability to diagnose and treat emergencies related to the next deeper level of anesthesia
9 than intended.

10 **B. Moderate Sedation Course Content:**

- 11 1. Historical, philosophical and psychological aspects of anxiety and pain control.
- 12 2. Patient evaluation and selection through review of medical history taking, physical diagnosis and
13 psychological considerations.
- 14 3. Use of patient history and examination for ASA classification, risk assessment and pre-procedure fasting
15 instructions.
- 16 4. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
- 17 5. Description of the sedation anesthesia continuum, with special emphasis on the distinction between the
18 conscious and the unconscious state.
- 19 6. Review of adult respiratory and circulatory physiology and related anatomy.
- 20 7. Pharmacology of local anesthetics and agents used in moderate sedation, including drug interactions
21 and contraindications.
- 22 8. Indications and contraindications for use of moderate sedation.
- 23 9. Review of dental procedures possible under moderate sedation.
- 24 10. Patient monitoring using observation and monitoring equipment, with particular attention to vital signs,
25 ventilation/breathing and reflexes related to consciousness.
- 26 11. Maintaining proper records with accurate chart entries recording medical history, physical examination,
27 informed consent, time-oriented anesthesia record, including the names of all drugs administered
28 including local anesthetics, doses, and monitored physiological parameters.
- 29 12. Prevention, recognition and management of complications and emergencies.
- 30 13. Description, maintenance and use of moderate sedation monitors and equipment.
- 31 14. Discussion of abuse potential.
- 32 15. Intravenous access: anatomy, equipment and technique.
- 33 16. Prevention, recognition and management of complications of venipuncture and other parenteral
34 techniques.
- 35 17. Description and rationale for the technique to be employed.

1 18. Prevention, recognition and management of systemic complications of moderate sedation, with particular
2 attention to airway maintenance and support of the respiratory and cardiovascular systems.

3 **Moderate Sedation Course Duration and Documentation:**

4 The Course must include:

- 5 • A minimum of 60 hours of instruction ~~plus administration of sedation for at least 20 individually managed~~
6 ~~patients.~~
- 7 • Supervised individual administration of moderate sedation for at least twenty (20) dental patients receiving
8 moderate sedation.
- 9 • Certification of competence in moderate sedation technique(s).
- 10 • Certification of competence in rescuing patients from a deeper level of sedation than intended including
11 managing the airway, intravascular or intraosseous access, and reversal medications.
- 12 • Provision by course director or faculty of additional clinical experience if participant competency has not
13 been achieved in time allotted.
- 14 • Records of instruction and clinical experiences (i.e., number of patients managed by each participant in
15 each modality/route) that are maintained and available for participant review.

16 **D. Documentation of Instruction:** The course director must certify the competency of participants upon
17 satisfactory completion of training in each moderate sedation technique, including instruction, clinical experience,
18 managing the airway, intravascular/intraosseous access, and reversal medications.

19 **E. Faculty:** The course ~~should~~ ~~must~~ be directed by a dentist or physician qualified by experience and training.
20 This individual ~~should~~ shall possess a current permit or license to administer moderate or deep sedation and
21 general anesthesia in at least one state, have had at least three years of experience, including formal
22 postdoctoral training in anxiety and pain control. Dental faculty with broad clinical experience in the particular
23 aspect of the subject under consideration should participate. In addition, the participation of highly qualified
24 individuals in related fields, ~~such as anesthesiologists, pharmacologists, internists, cardiologists and~~
25 ~~psychologists,~~ should be encouraged.

26 A participant-faculty ratio of not more than four-to-one when moderate sedation is being taught allows for
27 adequate supervision during the clinical phase of instruction. A one-to-one ratio is recommended during the early
28 stage of participation.

29 The faculty should provide a mechanism whereby the participant can evaluate the performance of those
30 individuals who present the course material.

31 **F. Facilities:** Competency courses in moderate sedation must be presented where adequate facilities are
32 available for proper patient care, including drugs and equipment for the management of emergencies. These
33 facilities may include dental and medical schools/offices, hospitals and surgical centers.

34 Endnotes

35 1. Excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of
36 Sedation/Analgesia, 2024, of the American Society of Anesthesiologists. A copy of the full text can be obtained
37 from ASA, 1061 American Lane Schaumburg, IL 60173-4973 or online at www.asahq.org.

38 2. Excerpted from Standards and Practice Parameters: Statement on ASA Physical Status Classification System,
39 2020, of the American Society of Anesthesiologists. A copy of the full text can be obtained from ASA, 1061
40 American Lane Schaumburg, IL 60173-4973 or online at www.asahq.org.

- 1 3. Excerpted from American Society of Anesthesiologists: Practice Guidelines for preoperative fasting and the use
- 2 of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing
- 3 elective procedures. Anesthesiology, 2017. A copy of the full text can be obtained from ASA, 1061 American Lane
- 4 Schaumburg, IL 60173-4973 or online at www.asahq.org.

Resolution 515H-2025

Appendix 1

Election Commission and Campaign Rules

The Election Commission is composed of three members: the immediate past President, and the chair and vice chair of the Council on Ethics, Bylaws and Judicial Affairs (CEBJA). The chair of CEBJA serves as the Election Commission chair. The Speaker and the President-elect’s campaign manager or appointee will serve as consultants to the Election Commission, each without the right to vote. Except as provided below, in the event that one of the members is unavailable, a replacement member will be selected by the chair of the Election Commission in consultation with the Election Commission. In the event that the chair is unavailable due to a conflict with a candidate, the vice chair of CEBJA shall serve as chair and shall appoint a replacement member in consultation with the Election Commission. In the event that both the chair and vice chair of CEBJA are unavailable due to conflicts with a candidate, the senior class of CEBJA shall select replacement members and the chair of the Election Commission.

The Election Commission is charged with (1) overseeing and adjudicating contested issues arising under the Election Commission Rules Governing the Conduct of Campaigns for all ADA Elective Offices (the Campaign Rules); (2) informing anyone identified as being under a disciplinary sentence of suspension or probation for violating their duties to the constituent society within whose jurisdiction the member practices or to this Association that they are ineligible to seek elective or appointive office while under that disciplinary sentence; (3) referring any dispute of eligibility to CEBJA; (4) informing the House of any violation of the Campaign Rules; (5) reviewing and proposing revisions to the Campaign Rules as required; and (6) receiving summaries of campaign revenues and expenses from candidates for all ADA elective offices.

The following Campaign Rules govern the announcement and conduct of all campaigns for ADA elective office. All candidates for elective office are required to abide by the Campaign Rules.

Election Commission Rules Governing the Conduct of Campaigns for all ADA Elective Offices

I. General Campaign Principles

A. Every candidate for elective office shall conduct their campaign in the most positive, professional, honest and ethical manner possible and will adhere to the General Principles enumerated below. Candidates will also follow the rules and guidelines contained in these Campaign Rules. Every candidate for elective office shall be responsible and accountable for their campaign team conducting themselves in the same positive, professional, honest and ethical manner and their campaign’s adherence to the General Principles enumerated below, and the other rules and guidelines contained in these Campaign Rules.

B. General Principles.

1. Every candidate for elective office and their campaigns should be focused on the candidate and the candidate’s leadership qualifications, proposed solutions to perceived issues, and future plans for the ADA if elected.
2. Every candidate for elective office and their campaigns shall refrain from making negative comments concerning any other candidate and refrain from comparing or contrasting themselves with any other candidate or candidates for elective office.
3. No statements or communications by the candidates and their campaigns that are predicated or rely on the existence of a fact or facts shall be made unless the fact or facts can be objectively verified.
4. Should any communication or message from or on behalf of a candidate be found to contain any erroneous facts or misinformation, it is the candidate’s duty and responsibility to remove or correct the communication or message as soon as possible after becoming aware of the error.

1 **II. Announcing Candidacy for Elective Office**

2 A. Announcements of Candidacy for President elect and Second Vice President Made During the Candidate
3 Announcement Period.

4 1. Candidates for President-elect and Second Vice President may formally announce their intent to run for
5 office during the period commencing at the third meeting of the annual session of the House of Delegates and
6 ending on December 31st of that same year (“the Candidate Announcement Period”).

7 2. Candidates intending to announce their candidacy for President-elect or Second Vice President at the
8 third meeting of the House of Delegates should provide notice of that intent to the Office of the
9 Executive Director and Secretary of the House of Delegates no later than the evening before the third
10 meeting of the House of Delegates to facilitate scheduling the announcements.

11 3. Announcements of candidates running for elective office made during the third meeting of the
12 annual session of the House of Delegates will be by the Speaker of the House of Delegates from the
13 Speaker’s podium.

14 4. Notification of candidacy after the close of the House of Delegates during the remainder of the
15 Candidate Announcement Period will be via email to the ADA executive director and secretary of the
16 House of Delegates. At a minimum, that notification must include the name of the candidate and an
17 identification of the office being sought. The Office of the Executive Director and Secretary of the House
18 of Delegates will publish a candidate roster on the candidate information page of ADA.org listing all
19 candidates from whom notices have been received.*

20 B. Individuals Intending to be Nominated for President-elect and Second Vice President but not Announcing
21 their Candidacies During the Candidate Announcement Period Preceding the Election.

22 1. Individuals not announcing their candidacy during the Candidate Announcement Period preceding the
23 election can be nominated for the office of President-elect or Second Vice President at the first meeting
24 of the annual session of the House of Delegates pursuant to Chapter VI., Section B.1. of the *Governance
25 and Organizational Manual of the American Dental Association (Governance Manual)*. Such candidates:

- 26 a. Are not permitted to campaign outside their own trustee districts before they are nominated;
- 27 b. Must notify the executive director and secretary of the House of Delegates of that intent at least
28 sixty (60) days prior to the date of the first meeting of the House of Delegates. Such notice should
29 include the name of the prospective candidate and the office for which that individual intends to be
30 nominated. This timetable is needed to allow planning for and accommodation of candidate speeches
31 during the first session of the House and provides time for notifying the district caucuses of all
32 candidates for elective office; and
- 33 c. Are permitted to campaign at the annual session following their nomination pursuant to the
34 Campaign Rules below.

35 2. Candidates who fail to notify the executive director and secretary of the House of Delegates of their
36 intent to be nominated for the office of President-elect or Second Vice President at least sixty (60) days
37 before the first meeting of the House of Delegates:

* The task force understands that in recent years candidates for President-elect are invited to attend meetings of the Board of Trustees after signing a nondisclosure agreement and that last year the candidates were permitted to attend both regular and closed sessions (excluding attorney-client sessions). The task force encourages the Board of Trustees to continue that practice, and extend the practice to inviting Second Vice President, Treasurer and Speaker of the House candidates to the last regular Board of Trustees meeting that precedes the House of Delegates meeting.

1 a. Forfeit their right to appear at district caucus meetings convened during the annual session of the
2 House of Delegates, unless specifically invited by a District Caucus;

3 b. Forfeit their right to appear at or participate in any other campaign events held during the annual
4 session of the House of Delegates, unless specifically invited by the event sponsor.

5 C. Candidates for Treasurer and Speaker of the House of Delegates. Announcements of candidacies for the
6 offices of Treasurer and Speaker of the House of Delegates will be as stated in Chapter VI. Sections B.2. and
7 B.3., respectively, of the Governance Manual.

8 D. Caucus Notification. The names of all President-elect and Second Vice President candidates who have
9 notified the Executive Director and Secretary of the House of Delegates of their intent to be nominated for
10 office and the names of candidates for Treasurer and Speaker of the House of Delegates will be forwarded
11 by the Office of the Executive Director and Secretary of the House of Delegates to the chairs of the district
12 caucuses at least forty-five (45) days prior to the commencement of the House of Delegates session to allow
13 caucuses to plan for potential in-person caucus visits by candidates during the annual session.

14 E. Conflict of Interest Review.

15 1. Candidates announcing during the Candidate Announcement Period will provide a completed conflict
16 of interest statement and current curriculum vitae to the Office of the Executive Director and Secretary of
17 the House of Delegates when they provide notice of their candidacies. Candidates for Treasurer and
18 Speaker of the House shall provide a completed conflict of interest statement to the Office of the
19 Executive Director and Secretary of the House of Delegates when submitting the material supporting their
20 candidacies required by Chapter VI., Section B.2. or B.3., respectively, of the Governance Manual. Any
21 individual who did not announce their candidacy during the Candidate Announcement Period but intends
22 to be nominated for President-elect or Second Vice President at the first meeting of the House of
23 Delegates shall forward a completed conflict of interest statement and a current curriculum vitae when
24 they submit their notification of intent to be nominated for elective office to the Office of the Executive
25 Director and Secretary of the House of Delegates pursuant to Article II., Section B.1.b. of these
26 Campaign Rules.

27 2. When received, the curriculum vitae and completed conflict of interest statements of the announced
28 candidates and individuals intending to be nominated for elective office will be reviewed. Candidates and
29 individuals will be notified of any conflict of interest issues that would arise if they were to be elected.

30 **III. Commencement and Conduct of Campaign Activity by Candidates for President-elect**

31 A. Before the Close of Candidate Announcement Period. Prior to close of the Candidate Announcement
32 Period, candidates for President-elect are prohibited from campaigning outside their own trustee districts.

33 B. Campaign Activity Following the Close of the Candidate Announcement Period and Before the Annual
34 Session. Candidates for President-elect who announced their candidacies during the Candidate
35 Announcement Period may campaign outside their own trustee districts from the conclusion of the Candidate
36 Announcement Period to the start of the House of Delegates as follows:

37 1. A trustee district may invite candidates for President-elect to attend one (1) campaign-related event
38 or leadership conference held or sponsored by a constituent society within the trustee district or the
39 district caucus that is scheduled to be held prior to the annual session of the House of Delegates.

40 a. All announced President-elect candidates must be invited to the campaign event.

41 b. For efficiency and economic purposes, virtual campaign events via videoconference platforms are
42 strongly encouraged.

1 c. Constituent societies and district caucuses are urged to collaborate to develop and hold campaign
2 events sponsored by multiple societies or caucuses, for example, regionally based campaign forums. It
3 is recommended that such events be structured to allow:

4 i. Each candidate to make a presentation of a prescribed length;

5 ii. Members the freedom to ask questions; and

6 iii. Each candidate to respond to questions presented.

7 d. Organizers of campaign events are strongly encouraged to cooperate in scheduling, so an efficient
8 campaign schedule is achieved, and conflicts are minimized.

9 e. Campaign event invitations should be forwarded to the Office of the ADA Executive Director and
10 Secretary of the House of Delegates who will distribute invitations to the campaign managers of the
11 announced candidates.

12 2. Campaign activity by announced President-elect candidates before the annual meeting of the House
13 of Delegates shall be limited to the following:

14 a. Prior to the annual session of the House of Delegates, candidates will limit their campaign activity
15 to attending one (1) event per constituent society and/or district caucus to which all announced
16 candidates have been invited.

17 b. After a district caucus or constituent society invitation is received, representatives of the
18 announced President-elect candidates should confer and negotiate a mutually agreeable schedule.

19 c. It is the responsibility of the candidates and/or the campaign managers, through coordination
20 among the campaigns, to determine the candidates' availability and respond directly to the inviting
21 organizations.

22 d. Except for conflicts due to a religious holiday observed by one or more of the candidates,
23 candidates should vote on whether to accept an invitation, with a majority vote needed to accept. A
24 tie vote will result in accepting the invitation.

25 e. If the date of an invitation falls on a religious holiday observed by one of the candidates and that
26 candidate votes to reject that invitation, the invitation will be declined by all the candidates because of
27 the religious holiday conflict.

28 f. For events requiring personal attendance, candidates who have scheduling conflicts prohibiting their
29 personal attendance may, at their option and with the consent of the event organizer or sponsor,
30 participate in the event via a mutually available videoconference platform.

31 g. After an invitation has been accepted, if an emergency arises and a candidate must cancel their
32 attendance, the remaining candidates may attend as planned. Candidates who cancel their attendance
33 at an in-person event due to an emergency may, at their option and with the consent of the event
34 organizer or sponsor, participate in the event via a videoconference platform available to both the
35 candidate and the event's sponsor.

36 **IV. Pre-Annual Session Campaign Activity by Candidates for Second Vice President, Treasurer and**
37 **Speaker of the House of Delegates**

38 A. Candidates for Second Vice President, Treasurer and Speaker of the House of Delegates are not permitted
39 to travel to campaign events prior to the commencement of House of Delegates annual session.

40 B. District caucuses and constituent societies are permitted to organize and hold virtual candidate events with
41 announced candidates for Second Vice President, Treasurer and Speaker of the House of Delegates ("virtual

1 candidate events”) during the two-month period immediately preceding the commencement of the House of
2 Delegates annual session. The virtual candidate events may be held via a videoconference platform.

3 C. Invitations for virtual candidate events must be issued to all announced candidates running for the
4 particular elective office(s) for which virtual candidate event(s) are desired; the invitations should specify the
5 type of event that will be held (one-on-one, candidate forum, etc.). District caucuses and constituent
6 societies are urged to collaborate on the dates and times for the virtual candidate events so that scheduling
7 conflicts are avoided if possible.

8 D. Announced candidates for the offices of Second Vice President, Treasurer and Speaker of the House of
9 Delegates may accept and attend any such virtual campaign event to which they have been invited to
10 participate, but only if all announced candidates for the particular elective office involved have been invited.
11 It is the responsibility of the candidates and/or the campaign managers, through coordination among the
12 campaigns, to determine the candidates’ availability to participate in the virtual candidate events and
13 respond directly to the inviting organizations.

14 E. Except for conflicts due to a religious holiday observed by one or more of the candidates, candidates
15 should vote on whether to accept an invitation to participate in a virtual campaign event, with a majority
16 vote needed to accept. A tie vote will result in accepting the invitation.

17 F. If the date of a virtual campaign event to which candidates have been invited to participate falls on a
18 religious holiday observed by one of the candidates and results in a vote to reject that invitation by that
19 candidate, the invitation will be declined by all the candidates because of that conflict.

20 G. After a virtual candidate event has been accepted by a candidate, if a situation arises that requires the
21 candidate to cancel their participation in the event, the remaining candidates may participate as planned.

22 **V. Campaign Activity by Candidates for Elective Office at the Annual Session of the House of** 23 **Delegates**

24 A. District caucuses may, at their option, invite all candidates for one or more elective office to appear in
25 person and address the caucus during the annual session. Candidates who do not provide notice of their
26 intent to seek elective office at least sixty (60) days before the first meeting of the House of Delegates
27 should not be invited to such events.

28 B. Invitations to address a district caucus should be distributed by the caucus directly to all eligible
29 candidates for the particular elective office or offices of interest to the caucus. A copy of each invitation
30 issued should be distributed to the Office of the Executive Director and Secretary of the House of Delegates.

31 C. Responses to invitations received by candidates for elective office should be sent by the candidate or the
32 candidate’s campaign to the issuing caucus.

33 D. Organizers of the district caucus campaign visits are strongly encouraged to cooperate with one another
34 in scheduling campaign visits, so an efficient campaign visitation schedule is achieved, the time of the
35 candidates is used effectively and travel between caucuses by candidates is minimized. Upon a request by a
36 majority of the district caucuses made at least thirty (30) days before the start of the annual session, the
37 ADA will assist the caucuses in developing an efficient campaign visitation schedule.

38 **VI. Provisions Applicable to All Elective Campaigns**

39 A. Nothing in these Campaign Rules shall prevent a candidate from traveling on a personal basis or
40 attending a meeting, conference or other event in their official ADA capacity. When traveling personally or as
41 an ADA representative, candidates must notify other candidates of such travel as soon as possible once the
42 travel has been scheduled.

43 B. Campaigning while personally traveling or attending events as an ADA representative is prohibited.

1 C. Candidates shall not use campaign-sponsored social functions or district caucus hospitality suite/meeting
2 rooms for campaigning at any regional, national or annual meeting. Candidates can hold campaign strategy
3 meetings in their district’s hospitality suite. Except as permitted in the Campaign Rules, campaign receptions
4 are not to be held at the House of Delegates annual session. A district that hosts a reception during the
5 House of Delegates annual session and has a candidate from its district in a contested election shall not host
6 the reception prior to the officer elections; a reception may be held after the election. Prior to the election,
7 candidates shall not attend events in or visit any district hospitality suites, except that candidates may visit
8 the hospitality suite of their own district to attend district-only events or to hold campaign meetings with
9 their campaign teams.

10 **VII. Campaign Communications**

11 A. Articles and Interviews.

- 12 1. Candidates are encouraged to participate in interviews via digital and/or print media platforms and
13 should provide delegates and alternate delegates with links or citations to such interviews whenever
14 possible.
- 15 2. Candidates for elective office may be interviewed or consent to an article being written about them
16 subject to the interview or article conforming to the General Principles stated in Article I. of these
17 Campaign Rules. Articles and interviews concerning why one person would make a better elective officer
18 will be considered a comparison of candidates and are not permissible.
- 19 3. Except for a candidate’s constituent and component dental society, candidates will notify all
20 organizations and groups to which they belong of their candidacies and request that they refrain from
21 distributing or publishing any information or material referencing the campaign or the candidate’s
22 candidacy.
- 23 4. Scholarly articles written by a candidate and appearing in a peer-reviewed publication and educational
24 seminars, webinars and presentations by a candidate are permitted so long as there is no reference to the
25 candidate running for elective office and no mention of the candidate’s campaign is made.

26 B. Social Media.

- 27 1. Candidates and/or their campaigns may maintain accounts or sites on any social media platform that
28 allows the account holder or site owner to prohibit the direct reposting of site contents and prohibits the
29 posting of comments on the site.
- 30 2. Any campaign-related site or account that is controlled or maintained by candidates or their
31 campaigns must prohibit the posting of comments to the site. The site shall also prohibit the reposting of
32 site contents.
- 33 3. Shortly after the close of the Candidate Announcement Period, the ADA will provide the known email
34 addresses of delegates and alternate delegates to each announced candidate. Using that list, candidates
35 may notify delegates and alternate delegates of the social media accounts maintained by the candidate or
36 their campaign. This notification should only contain a listing of the candidate’s social media accounts and
37 no other information and therefore will not count toward the number of interactions allowed between a
38 candidate and an individual delegate or alternate delegate
- 39 4. Following the compilation of the list of certified delegates and alternate delegates who will attend the
40 House of Delegates session at which the election will occur, the ADA will send the candidate an updated list
41 of certified delegates and alternate delegates. The candidate can use the updated list to send a notification
42 of campaign-related social media accounts. This notification should only contain a listing of the candidate’s
43 social media accounts and no other information, and therefore will not count toward the number of
44 interactions allowed between a candidate and an individual delegate or alternate delegate.

1 5. Each candidate who maintains any campaign-related social media site will provide a list of all such
2 sites to the Election Commission.

3 6. Only material that is relevant to the campaign shall be posted on candidates' campaign-related social
4 media sites. All content posted to campaign related social media sites shall adhere to the General Principles
5 stated in Article I. of these Campaign Rules.

6 7. No surveys or polls shall be used or conducted via a candidate's campaign-related social media sites.

7 8. Personal, non-campaign use of social media by candidates during the campaign for elective office is
8 permitted but must conform to the General Principles stated in Article I. of these Campaign Rules.

9 C. Campaign Material.

10 1. No printed campaign-related material may be distributed on the floor of the House of Delegates or to
11 delegates and alternate delegates.

12 2. Candidates may provide the ADA with a hyperlink that directs a user to campaign material of the
13 candidate. The ADA will provide the hyperlink on the candidate information page on ADA.org. Any
14 material accessed via the hyperlink will adhere to General Principles stated in Article I. of these Campaign
15 Rules.

16 3. Any campaign material of a candidate that includes photographs or likenesses of or mentions any
17 non-familial third parties shall be submitted to the ADA Office of the Executive Director and Secretary of
18 the House of Delegates for review and approval prior to being made accessible to delegates. When
19 submitting campaign material for review, candidates should indicate whether third party permissions to
20 use their likenesses have been obtained. The written permissions should be retained by the candidates
21 and submitted to the ADA only if requested.

22 4. In order to avoid the appearance of an endorsement or sponsorship, campaign material shall not
23 include any photograph, likeness or mention of any other current officer of the ADA or current member of
24 the ADA Board of Trustees.

25 D. Individual Communications with Delegates and Alternate Delegates.

26 1. After certified delegate and alternate delegate contact information is received, each candidate is
27 permitted to individually communicate with each delegate and alternate delegate a single time via an
28 electronic communication (i.e., email) for the purpose of campaigning, electioneering and soliciting votes.
29 A third-party vendor may be used to send such electronic communications so long as the privacy of the
30 email addresses and identities of the recipients are maintained and preserved and there is no ability to
31 reply to all the recipients of the electronic communication. The candidate's electronic communication may
32 contain campaign material, either by embedding or attaching the material to the electronic
33 communication or by providing a hyperlink or hyperlinks that connects to the location of the material. A
34 brief note of thanks for a campaign contribution or for acting as a host at an event will not be considered
35 as a communication under this paragraph.

36 2. Each campaign is permitted to individually initiate a telephonic (phone call or text) communication with
37 each delegate and alternate delegate a single time for the purpose of campaigning, electioneering
38 and soliciting votes following the receipt from the ADA of the list of certified delegate and alternate
39 delegate contact information.

40 3. Nothing in these Campaign Rules prevents a candidate from communicating regarding matters within
41 the specific duties of the candidate's position as an ADA officer, member of the Board of Trustees, task

1 force or work group, as long as the communication is strictly related to such responsibilities, does not
2 mention the candidate’s campaign, and is not used for campaigning, electioneering or soliciting votes.

3 E. Telephonic and Videoconference Events.

4 1. Candidates may each schedule up to three (3) telephone or video conference forums or town hall
5 events during the campaign. The schedule of any such event shall be communicated to the ADA, together
6 with the instructions and contact information necessary for delegates and alternate delegates to
7 participate. The ADA will announce the schedule and telephone or video conference information for the
8 event to delegates and alternate delegates via ADA Connect and provide the information to the Election
9 Commission members and staff. Candidates may also publicize the forums or town halls via their campaign
10 social media sites.

11 2. The agenda, format and length of any telephonic or videoconference town hall or forum shall be at the
12 discretion of the candidate sponsoring the event.

13 3. The event should be conducted pursuant to the General Principles stated in Article I. of the Campaign
14 Rules. Candidates shall be responsible for ensuring that a screening mechanism is employed during the
15 event so that broadcasting participant comments or questions that violate this provision is avoided.

16 **VIII. Contributions**

17 A. Contributions (including money and in-kind services) are acceptable only from individual dentists, family
18 members and ADA constituent and component dental societies, which includes component branches and
19 study clubs recognized as part of the constituent society. Contributions from any other sources are not
20 permissible. No candidate will knowingly accept campaign contributions which create the appearance of
21 conflict of interest as reflected in the ADA *Bylaws*.

22 B. Any contribution source that could be interpreted to be a conflict of interest or creates the appearance of a
23 conflict of interest must be reported to the Election Commission. In the event a contribution source is deemed
24 to be a conflict of interest or creates the appearance of a conflict of interest, the candidates will be required to
25 return the contribution.

26 C. Not less than thirty (30) days prior to the start of the annual session, each candidate for elective office will
27 notify the Office of the Executive Director and Secretary of the House of Delegates of (1) the total aggregate
28 dollar amount of campaign contributions that have been raised or received to date by the campaign, and (2)
29 the total expenditures of the campaign to date, broken into the categories of (i) travel, (ii) consulting services,
30 (iii) marketing and campaign material design and production, and (iv) other. Each campaign’s contribution and
31 expense information will be posted on the candidate information page of ADA.org.

32 D. Candidates for all ADA elective offices should submit a summary of campaign contributions and expenses
33 to the Election Commission at the end of the campaign.

34 **IX. Agreements between Candidates**

35 A. All candidates for a particular elective office can negotiate and enter into an agreement concerning the
36 conduct of a campaign for that elective office that does not contravene and is not in conflict with the Campaign
37 Rules.

38 B. Agreements between all candidates for a particular elective office that (a) narrows any of the provisions of
39 the Campaign Rules or (b) foregoes any of the campaign activities permitted under these Campaign Rules are
40 permissible.

41 **X. Contacting the Election Commission**

1 Any communications from a candidate or campaign to the Election Commission regarding these Campaign Rules
2 will be submitted to the chair of the Election Commission via email addressed to electioncommission@ada.org or
3 by such other means as the Election Commission may from time-to-time specify.

4 **XI. Interpretation of the Campaign Rules**

5 A. If one or more candidates for elective office has a question concerning the interpretation of the Campaign
6 Rules or whether a particular activity is prohibited or permitted under the Campaign Rules, the following
7 procedures shall be followed:

8 1. Prior to contacting the Election Commission concerning the question or interpretation, all candidates
9 for that elective office and/or their campaign managers shall communicate and attempt in good faith to
10 reach a consensus on the question.

11 2. If a consensus cannot be reached:

12 a. The campaign that raised the issue shall contact the Election Commission (copying the other
13 candidates for that elective office and their campaign managers) via a brief and succinct email, state
14 the question or interpretation that has arisen, aver that the campaigns were unable to reach a
15 consensus on the issue and provide the campaign's position on the issue presented.

16 b. Within three business days of the receipt of the email referenced in Paragraph 2.a., above, any
17 other campaign for that same elective office desiring to do so shall send the Election Commission a
18 brief and succinct email setting forth that campaign's position on the question or interpretation
19 presented to the Election Commission.

20 c. After the time for receiving statements of position has expired, the Election Commission will
21 consider and decide the issue as promptly as possible and will email the decision to the campaigns
22 involved. Rulings by the Election Commission are final and non-appealable.

23 **XII. Violations**

24 A. In the event a violation of the Campaign Rules is determined by the Election Commission to have occurred
25 more than fourteen (14) days prior to the House of Delegates convening, then the Election Commission, if it
26 cannot resolve the violation between the candidates, shall post a report of the violation in the House of
27 Delegates section on ADA Connect. In addition, an email reporting on any such violations will be sent by the
28 Election Commission to each certified delegates and alternate delegates with a working email address on file
29 with the ADA on or about fourteen (14) days prior to the convening of the House of Delegates.

30 B. In the event a violation of the Campaign Rules is determined by the Election Commission to have occurred
31 in the period from fourteen (14) days prior to the convening of the House of Delegates through the elections
32 of elective officers, then the Election Commission, if it cannot resolve the violation between the candidates,
33 shall report those violations to the House of Delegates. The report will be given orally by the Election
34 Commission chair (or a designee of the Election Commission if the chair is absent from the House of
35 Delegates session) at the first meeting of the House. If violations occur after that meeting, and before the
36 election, then a report of such violations shall be read to each caucus by a designee of the Election
37 Commission.

38 C. Should an allegation of a Campaign Rules violation against an individual or entity not affiliated with a
39 campaign be made, the Election Commission shall review the allegation and determine if a violation has
40 occurred. If so, the campaign and candidate affected by the infraction will be notified and shall be responsible
41 for contacting the individual or entity involved and using their best efforts to curtail the violation.

42 **XIII. Distribution of the Campaign Rules**

- 1 A. To Candidates and Campaigns.
- 2 1. A copy of the current Campaign Rules will be distributed to each candidate as soon as possible
- 3 following receipt of their notification of candidacy.
- 4 2. It is each's candidate's responsibility to inform their campaign committee members, and the
- 5 constituent executive directors within their trustee districts of these Campaign Rules.
- 6 3. A written acknowledgment of the receipt and distribution of these Campaign Rules must be returned
- 7 by a current or prospective candidate to the Election Commission within fourteen (14) days of receiving
- 8 the copy of the Campaign Rules.
- 9 B. To Delegates and Alternate Delegates.
- 10 1. A current copy of the Campaign Rules will be posted each year in the House of Delegates library on
- 11 ADA Connect.
- 12 2. A succinct summary of the most important portions of the current Campaign Rules will also be posted
- 13 each year in the House of Delegates library on ADA Connect.