### 2021 UPDATED INDEX

**COMMITTEE C (DENTAL EDUCATION, SCIENCE AND RELATED MATTERS)**

<table>
<thead>
<tr>
<th>Resolution/Report</th>
<th>Title</th>
<th>Sponsor</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>Amendment of Chapter IX, Section A of the Governance and Organizational Manual of the American Dental Association</td>
<td>Commission for Continuing Education Provider Recognition</td>
<td>4001</td>
</tr>
<tr>
<td>32</td>
<td>Amendment of the Policy: Review of ADA Definition: Continuing Competency</td>
<td>Council on Dental Education and Licensure</td>
<td>4005</td>
</tr>
<tr>
<td>CDEl Report 1</td>
<td>Response to Resolution 100H-2020: Special Needs Dentistry</td>
<td>Council on Dental Education and Licensure</td>
<td>4007</td>
</tr>
<tr>
<td>46</td>
<td>Special Care Dentistry Association</td>
<td>Council on Dental Education and Licensure</td>
<td>4057</td>
</tr>
<tr>
<td>CDEl Report 1</td>
<td>Continuing Education Market Research</td>
<td>Council on Dental Education and Licensure</td>
<td>4058</td>
</tr>
<tr>
<td>47</td>
<td>Developing Continuing Education Activities</td>
<td>Council on Dental Education and Licensure</td>
<td>4059</td>
</tr>
<tr>
<td>48</td>
<td>Proposed Policy: Patients With Special Needs</td>
<td>Council on Dental Education and Licensure</td>
<td>4060</td>
</tr>
<tr>
<td>CDEl Report 2</td>
<td>Response to Resolution 76-2020 – Elder Care Strategies on Increased Preparedness of Educational Institutions</td>
<td>Council on Dental Education and Licensure</td>
<td>4061</td>
</tr>
<tr>
<td>64</td>
<td>Amendment of the Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting</td>
<td>Council on Scientific Affairs</td>
<td>4065</td>
</tr>
<tr>
<td>65</td>
<td>Amendment of the Policy, Research Funds</td>
<td>Council on Scientific Affairs</td>
<td>4066</td>
</tr>
<tr>
<td>66</td>
<td>Rescission of the Policy, Comparative Effectiveness Research and Patient-Centered Outcomes Research</td>
<td>Council on Scientific Affairs</td>
<td>4069</td>
</tr>
<tr>
<td>CSA Report 1</td>
<td>Response to Resolution 21H-2020-Feasibility of Assessing the Role of Dental Health in the Management of Diseases and Medical Conditions</td>
<td>Council on Scientific Affairs</td>
<td>4072</td>
</tr>
<tr>
<td>CSA Report 2</td>
<td>Response to Resolution 72H-2020 - Modifying the Existing Medicare Dental Coverage: Statutory Dental Exclusion</td>
<td>Council on Scientific Affairs</td>
<td>4074</td>
</tr>
<tr>
<td>CSA Report 3</td>
<td>Response To Resolution 75-2020 - Elder Care Strategies on Research</td>
<td>Council on Scientific Affairs</td>
<td>4076</td>
</tr>
</tbody>
</table>

*Material Not Included in First Posting

**Newly Received (Received and Processed September 24; Posted September 30)

***Newly Received (Received and Processed September 22 – 28; Posted October 5)

++*See Highlighted Correction, Page 4110

++**See Highlighted Correction, Page 4101

#New Business–Majority Vote Received for Consideration (Posted October 13)
<table>
<thead>
<tr>
<th>Resolution/Report</th>
<th>Title</th>
<th>Sponsor</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Report 5</td>
<td>ADA Library and Archives Advisory Board Annual Report</td>
<td>Board of Trustees</td>
<td>4090</td>
</tr>
<tr>
<td>*80</td>
<td>Electronic Archiving of State and Component Dental Publications</td>
<td>Ninth District, Co-Sponsored by Districts Two and Thirteen</td>
<td>4099</td>
</tr>
<tr>
<td>+++*81</td>
<td>Report 8: Response to Resolution 74-2020 - Elder Care Work Group—Elder Care Strategies for Continuing Education</td>
<td>Board of Trustees</td>
<td>4101</td>
</tr>
<tr>
<td>**81S-1</td>
<td>Substitute Resolution</td>
<td>Third Trustee District</td>
<td>4102a</td>
</tr>
<tr>
<td>*92</td>
<td>Study Dental School Demographics: All Dental Schools Are Not Created Equal</td>
<td>Fourteenth District</td>
<td>4105</td>
</tr>
<tr>
<td>*96</td>
<td>The Practice of Dentistry and Cannabis</td>
<td>Fourteenth Trustee District</td>
<td>4108</td>
</tr>
<tr>
<td>**96S-1</td>
<td>Substitute Resolution</td>
<td>Third Trustee District</td>
<td>4109</td>
</tr>
<tr>
<td>*97</td>
<td>Development of Best Practices for the Inclusion of Research with Negative Findings and Failed Replications Studies</td>
<td>Fourteenth District</td>
<td>4107</td>
</tr>
<tr>
<td>+++*104</td>
<td>Financial Literacy Among New Dentists and Dental Students</td>
<td>Third Trustee District</td>
<td>4110</td>
</tr>
<tr>
<td>#108</td>
<td>NEW BUSINESS National Commission on Recognition of Dental Specialties and Certifying Boards Requirements for Recognition Review</td>
<td>Fifth and Sixteenth Trustee Districts</td>
<td>4111</td>
</tr>
</tbody>
</table>

*Material Not Included in First Posting
**Newly Received (Received and Processed September 24; Posted September 30)
***Newly Received (Received and Processed September 22 – 28; Posted October 5)
++See Highlighted Correction, Page 4110
++*See Highlighted Correction, Page 4101
#New Business—Majority Vote Received for Consideration (Posted October 13)
Resolution No. 31

Report: N/A

Date Submitted: June 2021

Submitted By: Commission for Continuing Education Provider Recognition

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None

Net Dues Impact:

Amount One-time

Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT OF CHAPTER IX, SECTION A OF THE GOVERNANCE AND ORGANIZATIONAL MANUAL OF THE AMERICAN DENTAL ASSOCIATION

Background: The American Association of Dental Boards (AADB), an organization which selects a member to serve on the Commission for Continuing Education Provider Recognition (CCEPR), pursuant to Chapter IX, Section A.3 of the Governance and Organizational Manual of the American Dental Association (the Governance Manual), has introduced a new program for accrediting continuing dental education activities, the Accredited Continuing Education (ACE) program.

The ACE program presents a competing business interest with the ADA Continuing Education Recognition Program (ADA CERP). As AADB is one of the organizations that appoints a member to CCEPR, the agency with oversight and administrative responsibility for ADA CERP, this has created a new potential for conflicts of interest.

To mitigate any real or perceived conflicts of interest that could arise from the appointment of a CCEPR member by an organization with a competing business interest, the Commission recommends that Chapter IX, Section A.3 of the Governance Manual be amended to eliminate the requirement that AADB appoint a member to CCEPR.

Chapter IX, Section A.3 of the Governance Manual states that, except for the six appointments mandated in that document, the Commission may establish the number and method of selecting and appointing its remaining members. The CCEPR Rules currently specify the selection and appointment of an additional 14 members, including one member appointed by each of the sponsoring organizations of the dental specialties recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards, one member appointed by the American Society of Constituent Dental Executives, and one public member appointed by the Commission.

To help ensure that the Commission continues to receive input from individuals with insights and experience in the regulatory community, the Commission proposes to amend its Rules and Policies and Procedures, to stipulate that the Commission shall appoint a member who is a member of a state dental board or jurisdictional dental agency. Draft revisions to the CCEPR Rules and Policies and Procedures conforming with the proposed amendment to the Governance Manual, and outlining the criteria for the appointment by the Commission of a dental board or jurisdictional dental agency member, are attached in Appendix 1. In the event that the proposed amendment to the Governance Manual is adopted, the Commission intends to make these conforming changes to the CCEPR Rules and Policies and Procedures.
Taking steps to minimize potential conflicts of interest that may arise by the appointment of a Commissioner by an organization with a competing business interest will help ensure that the Commission conducts its business in an unbiased manner, and will help minimize reputational risk to the ADA and CCEPR.

Accordingly, CCEPR recommends adoption of the following resolution to amend the Governance Manual by deleting the requirement that the American Association of Dental Boards select a member to serve on CCEPR.

Resolution

31. Resolved, that Chapter IX. Section A.3 of the Governance and Organizational Manual of the American Dental Association be amended as shown below (additions underscored; deletions stricken):

Commission for Continuing Education Provider Recognition. The number of and the method of selection of members of the Commission for Continuing Education Provider Recognition shall be governed by the Rules of the Commission for Continuing Education Provider Recognition, except that six (6) members shall be selected as follows:

a. Four (4) members who shall be appointed by the Board of Trustees from the names of active, life or retired members of this Association. None of the appointees shall be a faculty member of any dental education program working more than one day per week or a member of a state board of dental examiners or jurisdictional dental licensing agency. At least two (2) of the members appointed shall be general dentists.

b. One (1) member who is an active member of the American Association of Dental Boards and also, if eligible, an active, life or retired member of this Association shall be selected by the American Association of Dental Boards.

c. One (1) member who is an active member of the American Dental Education Association and also, if eligible, an active, life or retired member of this Association shall be selected by the American Dental Education Association.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
Section 2. COMPOSITION: The Board of Commissioners shall consist of:

Four (4) members who shall be appointed by the Board of Trustees from the names of active, life or retired members of this Association. None of the appointees shall be a faculty member of any dental education program working more than one day per week or a member of a state board of dental examiners or jurisdictional dental licensing agency. At least two (2) of members appointed shall be general dentists.

One (1) member who is an active member of the American Association of Dental Boards and also, if eligible, an active, life or retired member of this Association shall be selected by the American Association of Dental Boards.

One (1) member who is an active member of the American Dental Education Association and also, if eligible, an active, life or retired member of this Association shall be selected by the American Dental Education Association.

The remaining Commissioners shall be selected as follows: one (1) dentist who is board certified in the respective discipline-specific area of practice and is selected by each of the following organizations: American Academy of Oral and Maxillofacial Pathology, American Academy of Oral and Maxillofacial Radiology, American Academy of Oral Medicine, American Academy of Orofacial Pain, American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons, American Association of Orthodontists, American Association of Public Health Dentistry, American College of Prosthodontists; the American Society of Dentist Anesthesiologists; and one (1) member appointed by the American Society of Constituent Dental Executives. In addition, the Commission shall select and appoint (i) one (1) member who is also a member of a state dental board or jurisdictional dental licensing agency, and (ii) one (1) member of the public who is neither a dentist nor an allied dental personnel nor teaching in a dental or allied dental education institution, based on established and publicized criteria. In the event a Commission member sponsoring organization fails to select a Commissioner, it shall be the responsibility of the Commission to select an appropriate representative to serve as a Commissioner. The Director of the Commission shall be an ex-officio member of the Board without the right to vote.

The composition of the Commission for Continuing Education Provider Recognition, as established by the ADA Governance and Organizational Manual and the Commission’s Rules, includes one public member to be selected by the Commission, and one member who is a member of a state dental board or jurisdictional dental licensing agency to be selected by the Commission.

The public member may not be a dentist, an allied dental personnel, nor teaching in a dental or allied
dental education institution, and must meet the Criteria for Appointment to the Commission. The public
member shall be appointed to one (1) four (4) year term.

The jurisdictional licensing agency member may not (i) hold a leadership position for an entity that has a
certification or accreditation program for continuing dental education providers or courses, (ii) be involved
in the administration of a certification or accreditation program for continuing dental education providers
or courses, or (iii) work more than one day a week as a faculty member of any dental education program.
The jurisdictional licensing agency member shall be appointed to one (1) four (4) year term.

The Commission shall publicize an open positions for a public member and jurisdictional licensing agency
member by posting notices on the CCEPR website and and/or emailing notices to professional
organizations, state boards, and other interested parties and groups. Notices shall be sent at least 60
days before the deadline for applications. Applications will be submitted to CCEPR staff. Applications will
be reviewed by an ad hoc committee comprised of three members of the Board of Commissioners to be
appointed by the Chair. The Committee shall review applications and make recommendations to the
Board of Commissioners.

The Board of Commissioners will select and appoint the public member and jurisdictional licensing
agency member at a regularly scheduled meeting of the Commission, by conference call or by electronic
ballot.

CRITERIA FOR APPOINTMENT TO THE COMMISSION

All appointees to the Commission must meet the following criteria:

- Ability to commit to one (1) four (4) year term;
- Willingness to commit to ten (10) to twenty (20) days per year to Commission activities, including
  but not limited to training, comprehensive review of print and electronic materials, and
  participation in and travel to Commission meetings;
- Ability to evaluate a continuing dental education program objectively in terms defined by
  recognition standards;
- Stated willingness to comply with all Commission policies and procedures;
- Ability to conduct business through electronic means (email, Commission web sites);
- Active, life or retired member of the American Dental Association, where eligible.

Additional criteria for public member appointees:

- A commitment to bring the public/consumer perspective to the Commission’s deliberations. The
candidate should not have any formal or informal connection to the profession of dentistry; also,
the candidate should have an interest in, or knowledge of, health-related or accreditation issues.
In order to serve, the candidate must not be a:
  a. Dentist or member of an allied dental discipline;
  b. Instructor in a dental or allied dental education institution;
  c. Employee, member of the governing board, owner, or shareholder of, or independent
     consultant to a continuing dental education provider or a company that produces dental
     products or services;
  d. Member or employee of any professional trade association, licensing/regulatory agency
or membership organization related to, affiliated with or associated with the Commission, dental education, or dentistry; or
e. Spouse, parent, child or sibling of an individual identified in a-d above.

POLICY ON CHANGES TO THE COMPOSITION OF THE BOARD OF COMMISSIONERS

The Commission is composed of representatives and subject area experts from the dental education, dental licensure, organized dentistry, specialty and general dentistry practice communities, and the public at large. As the practice of dentistry and dental education continue to evolve, the Commission may considers a change in its composition, consistent with the Commission’s Rules and the American Dental Association’s Bylaws and Governance and Organizational Manual.
Resolution No. 32 ___________________________ New

Report: N/A _______________________________ Date Submitted: June 2021

Submitted By: Council on Dental Education and Licensure

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None Net Dues Impact: ______________________

Amount One-time ___________________ Amount On-going __________________

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY: REVIEW OF ADA DEFINITION: CONTINUING COMPETENCY

Background: In accord with Resolution 170H-2012, Regular Comprehensive Policy Review (Trans. 2012:370), the Council on Dental Education and Licensure (CDEL) has reviewed the definition Continuing Competency (Trans. 1999:939) for accuracy and currency.

CURRENT DEFINITION:

Continuing Competency (Trans. 1999:939)

Resolved, that the following definition of continuing competency be adopted.

Continuing Competency: The continuance of the appropriate knowledge and skills by the dentist in order to maintain and improve the oral health care of his or her patients in accordance with the ethical principles of dentistry.

The Council believes that an amendment should be considered to strengthen the definition and reflect language consistent with Standard 5-3 of the CODA Accreditation Standards for Dental Education Programs which states:

“...the dental school must conduct a formal system of continuous quality improvement for the patient care program that demonstrates evidence of:

c. an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of the care provided;”

Accordingly, the Council on Dental Education and Licensure has concluded that the current definition should be updated and recommends adoption of the following resolution:

Resolution

32. Resolved, that the ADA definition of Continuing Competency (Trans. 1999:939) be amended as follows (additions underscored; deletions stricken):

Continuing Competency: The continuance of the appropriate knowledge and skills...
maintain and improve the oral health care of his or her patients in accordance with the ethical principles of dentistry.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
Resolution No. 46-49  
New  
Report: CDEL Report 1  
Date Submitted: June 2021  
Submitted By: Council on Dental Education and Licensure  
Reference Committee: C (Dental Education, Science and Related Matters)  
Total Net Financial Implication: $42,500  
Net Dues Impact: $0.43  
Amount One-time $42,500  
Amount On-going  

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.  

How does this resolution increase member value: See Background

COUNCIL ON DENTAL EDUCATION AND LICENSURE REPORT 1 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 100H-2020: SPECIAL NEEDS DENTISTRY

Background: The Council on Dental Education and Licensure has considered Resolution 100H-2020:

100H-2020. Resolved, that the ADA Council on Dental Education and Licensure (CDEL) explore through a survey with other appropriate communities of interest, the feasibility of requesting the development of an accreditation process and accreditation standards for advanced education programs in special needs dentistry by the Commission on Dental Accreditation (CODA), and be it further

Resolved, that CDEL address actionable strategies to:

1. Enhance and expand pre-doctoral training;
2. Develop and promote continuing education programs for existing practitioners; and
3. Investigate advanced educational opportunities, and be it further

Resolved, that the feasibility study with any recommendations be provided to the 2021 ADA House of Delegates.

The Council took the following measures to address Resolution 100H-2020:

• Conducted a survey of the appropriate communities of interest to gather data on the current state of special needs dentistry education.

• In regard to strategies for enhancing and expanding pre-doctoral training, considered the results of the survey, reviewed the current Accreditation Standards for Dental Education Programs as they relate to special needs dentistry, and considered the scope and depth of didactic and clinical instruction provided to students in treating special needs patients.

• In regard to strategies for developing and promoting continuing education programs for existing practitioners, considered the survey results, conducted an environmental scan of current CE offerings on this topic and determined whether additional CE activities should be recommended for development, including financial implications.
In regard to investigating advanced educational opportunities, reviewed the current accreditation standards for advanced dental education programs in the relevant disciplines as they relate to special needs dentistry and determined whether the standards should be strengthened and/or the development of fellowship programs should be encouraged.

The Survey: The State of Special Needs Dentistry Education Survey was conducted from February 19 – March 26 to gather information from the special needs dentistry communities of interest, e.g., representatives/leaders of the Special Care Dentistry Association, representatives of the American Academy of Developmental Medicine & Dentistry, ADA Council on Advocacy for Access and Prevention, ADA Council on Dental Practice, leadership of the American Dental Education Association, directors of advanced dental education programs, directors of special needs dentistry programs and dental school deans. The survey instrument was designed to gather information and clarify the interest and understanding of the special needs dentistry practice and education communities in 1) developing an accreditation process and accreditation standards for advanced education programs in special needs dentistry in accord with the CODA Criteria (Policies and Procedures For Accreditation of Programs in a New Dental Education Area or Discipline) and 2) assessing whether current education offerings at the predoctoral, advanced dental and continuing education levels are adequate to support the needs of dentists and this patient population. The overall survey response rate was 29.25%. A summary of the results is provided in Appendix 1.

Research and Resources: In addition to the survey results, the following pertinent data was gathered and studied:

- Journal articles and curriculum resources available for dental and advanced dental education programs related to special needs dentistry/patients;
- CODA’s Accreditation Standards for Dental Education Programs and background information identifying when the standards were last revised in regards to the management and treatment of special needs patients;
- CODA’s Accreditation Standards for Advanced Dental Education Programs and background information identifying when the standards were last revised in regards to the management and treatment of special needs patients;
- CODA Frequency of Citings Reports identifying the number of dental education programs cited for noncompliance with standards pertaining to special needs dentistry/patients;
- CODA Frequency of Citings Reports identifying the number of advanced dental education programs cited for noncompliance with standards pertaining to special needs dentistry/patients;
- The 2018-19 Curriculum Survey of Dental Education Programs data related to special needs dentistry/patients;
- The 2019-20 Survey of Advanced Dental Education Report identifying advanced dental education programs not accredited by CODA that offer special care dentistry programs;
- Results of an environmental scan on current continuing education offerings related to special needs dentistry/patients;
- 2020 ADEA Senior Survey regarding seniors’ preparedness to treat patients with special needs.
Predoctoral Dental Education: The Accreditation Standards for Dental Education Programs was strengthened by CODA in August 2019 as a result of a request received by CODA in January 2018 from the National Council on Disability (NCD). The current Standard states:

2-25 Graduates must [emphasis in original] be competent in assessing and managing the treatment of patients with special needs.

Intent:
An appropriate patient pool should be available to provide experiences that may include patients whose medical, physical, psychological, or social situations make it necessary to consider a wide range of assessment and care options. As defined by the school, these individuals may include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. Clinical instruction and experience with the patients with special needs should include instruction in proper communication techniques including the use of respectful nomenclature, assessing the treatment needs compatible with the special need, and providing services or referral as appropriate.

Based on all of the information studied, the Council concluded that Standard 2-25 adequately addresses the scope and depth of predoctoral dental education related to special needs dentistry. Dental education programs are required to adhere to the Accreditation Standards which define Patients with Special Needs as “Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to consider a wide range of assessment and care options in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly.” Further, Standard 2-25 requires that “Graduates must [emphasis in original] be competent in assessing and managing the treatment of patients with special needs.” The Council will continue to monitor programs’ compliance with the standard via CODA’s annual Frequency of Citings Report for Predoctoral Dental Education. However, the Council believed that the intent statement which complements Standard 2-25 could be strengthened to ensure consistent interpretation and application of the standard by programs and accreditation site visitors. Accordingly, the Council transmitted written comment to CODA urging that that revision of the Standard 2-25 intent statement be considered to provide further clarification and additional guidance to programs and accreditation site visitors.

Advanced Dental Education: The Council reviewed the following information about the current scope and depth of special needs dentistry education provided to residents in the relevant advanced dental education programs: current definitions per CODA’s Accreditation Standards for Advanced Dental Education Programs; CODA accreditation standards for advanced education programs (general dentistry, general practice residency, dental anesthesiology, pediatric dentistry, periodontics dentistry, orthodontics and dentofacial orthopedics, orofacial pain, and clinical fellowship training programs in craniofacial and special care orthodontics) calling for students to receive training in managing and/or treating patients with special needs; and the 2019-20 Survey of Advanced Dental Education Report and State of Special Needs Dentistry Education survey results identifying advanced education providing instruction/experience in special needs dentistry. These definitions and standards also were reviewed and revised by CODA in 2019 as a result of a request from the Special Care Dentistry Association (SCDA) urging the Commission to consider the standardization of a definition for “Special Needs” across the various Accreditation Standards under the Commission’s purview. Some variation among the documents still exists. Depending on the document, residents may be required to achieve competency in assessing, diagnosing, and planning and/or managing and/or providing, and/or examining and/or treating patients with special needs and/or disabilities.

The Council believed that although the CODA Accreditation Standards for Advanced Dental Education Programs address special needs dentistry education, the Commission should consider further strengthening the standards to require all graduates to be competent in treating patients with special needs. Further, the Council believed that the Commission should consider strengthening the standards in
other areas such as curriculum, resident evaluation, facilities and patient care to better support the
special needs patient population. Accordingly, the Council transmitted written comment to CODA urging
further revision of the Accreditation Standards for Advanced Dental Education Programs to require
graduates to be competent in treating patients with special needs and to strengthen the standards in
other areas such as curriculum, resident evaluation, facilities and patient care to better support the
special needs patient population. The Council will continue to monitor advanced dental education
programs’ compliance with the standards via CODA’s annual Frequency of Citings Report for Advanced
Dental Education Programs.

**Special Care Dentistry:** Fifty-three respondents to the State of Special Needs Dentistry Education
survey indicated awareness of an association/organization/entity that may be interested in leading the
pursuit of CODA-accreditation for special needs dentistry programs, most often citing the Special Care
Dentistry Association as the organization that may be interested in taking the lead. As presented in
(Resolution 46), the Council recommends that the findings of this feasibility study be provided to the
Special Care Dentistry Association for its consideration in pursuing an accreditation process and
accreditation standards for advanced education programs in special needs dentistry by CODA and that
the Special Care Dentistry Association be urged to collaborate with advanced dental education programs
and their sponsoring institutions to enhance the current scope and depth of instruction related to special
needs dentistry and to encourage the establishment of more training programs in special needs dentistry.

**Continuing Education:** In regard to continuing education offerings in this subject area, survey
respondents indicated that general dentists and dental specialists need more continuing dental education
related to managing and treating special needs patients, e.g., people with developmental disabilities,
cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable
elderly. Many suggested topics that could be presented via CE activity were noted. An environmental
scan of current CE offerings related to special needs dentistry/patients also was reviewed. Given the
survey results and the current CE offerings on this subject, the Council concluded that market research
should be conducted to learn more about the continuing education interests of practicing dentists related
to special needs dentistry (Resolution 47) and that ADA should offer more continuing education programs
to increase knowledge and awareness of managing and providing oral health care to patients with special
needs. Such CE activities could include annual meeting courses, video-based on demand courses,
and/or a multi-modular online course. To begin, it is suggested that two webinars be conducted in 2022
and that asynchronous on-demand online CE courses be produced using the content of the webinars.
(Resolution 48).

**Proposed Policy:** The ADA has several policies addressing the special needs population and
supporting continuing education in general, but none specifically urging dentists to pursue continuing
education in this subject. The Council recommends that the House of Delegates adopt policy encouraging
dentists and dental specialists to pursue continuing education opportunities in this area and submits
(Resolution 49).

**Resolutions**

46. **Resolved**, that the findings of the feasibility study conducted by the Council on Dental
Education and Licensure be provided to the Special Care Dentistry Association for its
consideration in pursuing an accreditation process and accreditation standards for advanced
education programs in special needs dentistry by the Commission on Dental Accreditation, and
be if further

Resolved, that the Special Care Dentistry Association be urged to collaborate with advanced
dental education programs and their sponsoring institutions to enhance the current scope and
depth of instruction related to special needs dentistry and to encourage the establishment of more
training programs in special needs dentistry.
47. Resolved, that market research be conducted to learn more about the continuing education interests of practicing dentists related to managing and treating patients with special needs, i.e., people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly.

48. Resolved that a variety of continuing education activities related to special needs dentistry be developed by the appropriate ADA agency.

49. Resolved, that the following policy be adopted:

Patients with Special Needs

The dental profession’s continued ability to effectively provide dental care for America’s special needs population is dependent on sustaining a strong educational foundation in this area. The ADA encourages efforts to maintain and expand the availability of courses and programs at the predoctoral, advanced and continuing educational levels that support practitioners in providing dental treatment to patients whose medical, physical, psychological, cognitive or social situations make it necessary to consider a wide range of assessment and care options. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. The ADA encourages dental practitioners to regularly participate in continuing education in this area.

(Resolution 46:Worksheet:4057)
(Resolution 47:Worksheet:4058)
(Resolution 48:Worksheet:4059)
(Resolution 49:Worksheet:4060)

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
Q1 - Please indicate which of the following best describes you (select all that apply).

Survey Respondent Demographics

- National Level Association Officer
- National Level Association Council Member
- Dental School Dean
- Dean of Academic Affairs
- Dean for Clinical Affairs
- Director of Advanced Dental Education Program
- Director of Special Needs Dentistry Program
- Other

Q1 - Director of CODA Accredited Advanced Dental Education Program - Discipline:

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Dentistry</td>
<td>26</td>
</tr>
<tr>
<td>GPR</td>
<td>43</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>4</td>
</tr>
<tr>
<td>AEGD</td>
<td>19</td>
</tr>
<tr>
<td>Prosthodontics</td>
<td>6</td>
</tr>
<tr>
<td>DPH</td>
<td>2</td>
</tr>
<tr>
<td>Orofacial Pain Program</td>
<td>1</td>
</tr>
<tr>
<td>Endodontics</td>
<td>11</td>
</tr>
<tr>
<td>Periodontics</td>
<td>3</td>
</tr>
<tr>
<td>Craniofacial and Special Care Orthodontics</td>
<td>1</td>
</tr>
</tbody>
</table>
Orthodontics and Dentofacial Orthopedics (3)
Oral and Maxillofacial Surgery (10)
Dental Anesthesiology (5)
Oral Maxillofacial Radiology (1)

Q1 - Other; please describe:

Other:

Academic Program Coordinator
Section Chair of Geriatric and Special Patients. Chair of Dental Public Health and Pediatrics
Program Director Oral & Maxillofacial Surgery
Senior Attending Dentist, CODA accredited GPR AND PEDO training program.
Clinical Faculty for Special Patient Care Clinic
CDEL Member
Former Director of Special Needs and current Director of Geriatric Dentistry Masters and Certificate Program
Director of OMR Graduate Program
Director of a Graduate Periodontics Residency Program
Program Director
Division Director of Orthodontics
Chairman Department of Dental Medicine with CODA residency programs in General Practice, Pediatrics and Oral Surgery.
Faculty in special needs clinic
pediatric dentist
General dentist FOCUSING on pediatrics and special needs for 24+ years
Co-Director GPR program
Assistant Professor, Director of Community Dentistry (includes coursework and clinical experiences within special needs dentistry)
Former Dean
Private practice dentist whose practice focuses on treatment of Special Needs populations
Member local oral health coalition CSHCN workgroup
Director of CODA Accredited GPR
Hospital base GPR with a high focus on treating special needs populations.
<table>
<thead>
<tr>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faculty teaching special care to predoctoral students</td>
</tr>
<tr>
<td>Pediatric Dentistry Mentor for US Army's Advanced Education in Dentistry 2-Year Program</td>
</tr>
<tr>
<td>full time faculty dentist anesthesiologist</td>
</tr>
<tr>
<td>Council on Advocacy for Access and Prevention</td>
</tr>
<tr>
<td>course director Geriatrics/Special needs</td>
</tr>
<tr>
<td>Special Needs Dentistry Program Faculty/Attending Dentist</td>
</tr>
<tr>
<td>Dental School Faculty</td>
</tr>
<tr>
<td>Dentist who focuses on patients who have special needs</td>
</tr>
<tr>
<td>Program Director, OMFS</td>
</tr>
<tr>
<td>Associate Program Director and Immediate past-President of state dental organization.</td>
</tr>
<tr>
<td>Past Director of Special Needs Program for 18 years.</td>
</tr>
<tr>
<td>Dental Dean for Student Affairs</td>
</tr>
<tr>
<td>Residency Program Director</td>
</tr>
<tr>
<td>Department Chair, Pediatric Dentistry</td>
</tr>
</tbody>
</table>
Q2 - There is a body of established, evidence-based, substantive, scientific dental knowledge related to special needs dentistry to educate individuals in advanced education programs for a minimum of one 12-month full-time academic year in length.
Q3 - This knowledge in large part is distinct from, or more detailed than, special needs dentistry training taught in other advanced education programs already accredited by CODA (including, but not limited to, general practice residencies, advanced education in general dentistry programs, pediatric dentistry programs).
Q4 - There is a sufficient number of established programs with structured curriculum, qualified faculty and enrolled students to establish a peer-reviewed accreditation process for these programs.
List the advanced education programs that are one 12 month full academic year in length in special needs dentistry that currently exist. Please include their sponsoring university or hospital.

Q5 - List the advanced education programs that are one 12 month full academic year in length in special needs dentistry that currently exist. Please include their sponsoring university or hospital.

LSUSD University of the Pacific

Not sure I know of any that has a core curriculum devoted to 12 month training. Most programs focus on people with disabilities rather than complex medical conditions. Both NYU College of Dentistry's Oral Health Center for People with Disabilities and the University of Washington Department of Pediatric Dentistry and Seattle Childrens Hospital received special HRSA funding for expanding teaching to dental students last year. Many dental schools provide education through their hospital dentistry programs / clinics.

North Carolina Dental Program Targets Special Needs sponsored by: North Carolina Dental Society (NCDS)

University of Washington DECOD program

Craniofacial and Special Care Orthodontics 12-month fellowships are the only special need programs that I know of; UCLA, Univ. Mich., Case Western, UCSF

Stony Brook

University of Iowa Special Care and Geriatrics University of Washington Special Care Dentistry - 2nd year GPR USC Geriatric Dentistry Masters Program

OSF Saint Francis Medical Center General Practice Residency Illinois Masonic Dental Residency

University College London

Special needs dentistry is largely the prevue of GPR programs and this should be enhanced rather than separated out

Rancho Los Amigos National Rehabilitation Center +More complete list can be found on the Special Care Dentistry website

UOP AEGD, SF Lee Specialty Clinic, KY Rancho Los Amigos

Montefiore Medical Center, Dept. of Dentistry, Albert Einstein Medical College, Bronx, NY

Special Care GPR Programs self-identified and published on the SCDA website: https://www.scdaonline.org/page/GPRPrograms DECOD Program, University of Washington (option of second year) GPR in Dentistry at Wake Forest School of Medicine (option of 2 years)

Rose Fitzgerald Kennedy Center, Jacobi Medical Center, Bronx Oral Health Center for Patients with Disability, NYUCD
I think there is one at Stony Brook and one at Helen Hays, in NY. I don't understand this question. Why do you care if I know about these programs??

Rose F. Kennedy Stony Brook  Pacific Dental Services (PDS) Foundation Dentists for Special Needs clinic at NYUCD

Advanced Education-Special Needs Dentistry Fellowship - LSU

Yeshiva University, Rose. F. Kennedy Center fellowship in Special care Dentistry (Montefiore Medical Center) Special Care Fellowship Stonybrook University School of Dentistry Fellowship in Special Care Dentistry LSU School of Dentistry University of Tennessee Graduate School of Medicine Fellowship NYU AEGD ASDOH Site PGY2 year dedicated to Special Care The University of Iowa Fellowship In Geriatrics and Special Care

Rose F Kennedy Center - Albert Einstein College of Medicine/Montefiore Stonybrook university (I believe Helen Hayes just closed, which is a shame.) NYU school of dentistry has a special care center but I am not sure if they have a residency

Medical University of South Carolina, College of Dental Medicine 1 year AEGD and related Graduate/Post-Doctoral Programs. I serve as the Periodontics Residency Director and this population is served by us in both our outpatient and OR setting.

AEGD Texas A&M University College of Dentistry

ASDOH ATSU U of Pacific NYU Harvard U of Penn - I do not know of all the programs.

NYU Dentistry University of Washington School of Dentistry

University of Iowa LSU Washington UCSF Stonybrook

LSU

Stony Brook Dental School, NY Eastman Dental, Rochester, NY AT Still Dental School, Arizona Wake Forest Dental School, North Carolina University of Michigan Dental School, Michigan University Washington School of Dentistry, Washington

Rose F. Kennedy Program, UW DEOCOD program, Swedish Medical Center

Stony Brook University

Arizona- AEGD Tufts- GPR Washington- AEGD

NYU School of Dentistry UW School of Dentistry

OMFS AEGD GPR Pediatric Dentistry

SUNY Stony Brook - Special Care Dentistry fellowship program LSU - Special Care Fellowship Albert Einstein Medical Center (NY) - Special Care fellowship Texas A&M - Special Care fellowship program (relatively new) University of Tennessee- Operating Room fellowship (focus on special needs) Ohio State Univ - Community Based fellowship (with focus on special needs) Univ of WA - 2nd year GPR dedicated to special needs (linked with Leadership Education in Neurodevelopmental and related disabilities fellowship); Univ. of WA also offers short-term special care fellowships

GPR, University of Oklahoma, Childrens Hospital of Oklahoma

GPR Carilion Medical Center

St. Elizabeth's Hospital/ GPR Washington, DC
I am only aware of a program at Rutgers Dental School/and it may only be a part of the dental school curriculum

New York City is the only one I know of

AEGD and GPR programs really help with this for the adult population and Peds Dent covers both adult and peds dent.

Texas A&M University College of Dentistry, New York University, Univ. of PA School of Dental Medicine

Columbia College of Dental Medicine LSU Special Needs Fellowship

University of Washington DCODE program

Tufts University School of Dental Medicine GPR Program

Rutgers University Univ of Washington DECOD SUNY-Stony Brook University

Helen Hayes Hospital Rose F. Kennedy University of Tennessee

Advanced General and Special Needs Dentistry (Nova-) 1 yr Dental Operating Room Fellowship (U Tenn)- 1 yr Advanced Education- Special Needs Dentistry Fellowship (LSU)- 1 yr Special Care Dentistry GPR2 slot at Univ Washington GPR with DECOD – 1 yr Dental Care for the Developmentally Disabled (Stony Brook)- 1 yr Special Care Dentistry Fellowship Program at Rose F Kennedy Center (Albert Einstein Col of Med)- 1 yr Geriatric Dentistry (Harvard)- 2 yrs, 3 yrs with MMSc, 4 yr with DMS Interdisciplinary Geriatric Fellowship Program (U Rochester- Eastman)- 2yrs Geriatric Dental Medicine Residency (Boston U)- 1 yr Geriatric Dentistry (U Southern Calif_- 2 yr MS degree

UCLA University of Iowa

SUNY Stony Brook School of Dental Medicine

Stony Brook University School of Dental Medicine

The Lee Specialty Clinic- Louisville, KY - Dr. Henry Hood AT Still University- Dr. Maureen Perry I think one in New York? I also think one in Oregon? I also think one in San Francisco

Advanced Education in General Dentistry, Pacific Dugoni School of Dentistry

Iowa

Helen Hayes Rose F Kennedy Center pending: NYU Dentistry (HRSA Grant with Dr. Courtney Chinn as PI)

Kentucky, Lexington Tennessee: UT Washington State: UW New York/NYU

Rose F Kennedy Special Care Dentistry Fellowship Program Stony Brook School of Dental Medicine Dental Care for the Developmentally Disabled University of Washington School of Dentistry - 2nd year general practice residency track with emphasis in special care dentistry (in coordination with UW Dental Education in the Care of Persons with Disabilities DECOD Program) UMDNJ General Practice Residency with Second Year Concentration in Special Care Dentistry
Q6 - Do you believe established special needs dentistry programs and their sponsoring institutions would be interested in pursuing accreditation by the Commission on Dental Accreditation?
Q6.a - Please explain why.

<table>
<thead>
<tr>
<th>Please explain why.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think there is desperate need for this niche to be established.</td>
</tr>
<tr>
<td>CODA-accreditation would provide a mechanism for federal Graduate Medical Education (GME) funding</td>
</tr>
<tr>
<td>that would provide the financial resources needed to fund residents, attending staff, and the</td>
</tr>
<tr>
<td>infrastructure needed to provide sufficient care for the full spectrum of patients with intellectual</td>
</tr>
<tr>
<td>and developmental disabilities.</td>
</tr>
<tr>
<td>Because there is a need for this type of training. The more they are recognized the more people will</td>
</tr>
<tr>
<td>know about them and they will get recognition among other dental groups and the public in general.</td>
</tr>
<tr>
<td>It will make it easier for programs to go after HRSA grants</td>
</tr>
<tr>
<td>all programs wish to be CODA accredited whether it's justified or not</td>
</tr>
<tr>
<td>There is a training need. Is there a demand by the young dentists? If you build it, will they come?</td>
</tr>
<tr>
<td>Recognition of status</td>
</tr>
<tr>
<td>By being an accredited program, Hospitals would be much more receptive and cognizant of the program</td>
</tr>
<tr>
<td>needs. They would be more committed to financial support.</td>
</tr>
<tr>
<td>Accreditation lends value to a specialty and standardizes the programs to an extent that you can have an</td>
</tr>
<tr>
<td>expectation of the level the graduates achieve.</td>
</tr>
<tr>
<td>There is such a critical need for special needs adult populations and the margin of error is small with</td>
</tr>
<tr>
<td>treating that population. It warrants a program dedicated to special needs training for an entire year.</td>
</tr>
<tr>
<td>It is difficult for programs that are already doing other advanced dental concepts to adequately</td>
</tr>
<tr>
<td>train residents in one year the extensive skills required to treat special needs patients.</td>
</tr>
<tr>
<td>I think this would increase the level of interest of graduating students and would offer GME funding</td>
</tr>
<tr>
<td>that would help support these programs.</td>
</tr>
<tr>
<td>This is an area that could easily be expanded to promote more understanding in this so in need</td>
</tr>
<tr>
<td>population.</td>
</tr>
<tr>
<td>Why wouldn't they.  STATUS</td>
</tr>
<tr>
<td>Once it becomes a program offered by many institutions, those participating will seek accreditation</td>
</tr>
<tr>
<td>and validation of their time and effort</td>
</tr>
<tr>
<td>Potentially yes. I think that would be an important step to fully recognize these programs and expand</td>
</tr>
<tr>
<td>the knowledge and recognition to a greater level.</td>
</tr>
<tr>
<td>There is a specific niche of population that would benefit from specialty treatment regarding special</td>
</tr>
<tr>
<td>needs. Some of these patients are being seen by Dental Anesthesiologists. With the same logic, the</td>
</tr>
<tr>
<td>Special Needs advanced trained dentist, would seek establishing their own specialty.</td>
</tr>
<tr>
<td>I am not familiar with special needs dental programs but would assume they want to fulfill the highest</td>
</tr>
<tr>
<td>standards of accreditation for their patients and education for their trainees.</td>
</tr>
</tbody>
</table>
More and more Special Needs individuals are living into advancing ages and seeking dental care. This area of care needs a broader educational platform than can currently be provided in the pre-doctoral curriculum.

**Accreditation of a special needs dentistry program might entice more dentists to pursue this specialty.**

Accreditation will solidify credentials for eventual specialty status.

Having a specialty in Special Care improves the training and knowledge for all providers and training programs.

**Yes. To allow for CODA / ADA recognized certification**

I’ve mixed feelings on this. Let them tell you. Accreditation is a strong indicator of quality. The more programs are accredited, the more likely they would seek specialty status. However, the attending and staff time needed to devote to accreditation is daunting and continuous, and might dissuade programs from seeking accreditation.

See my previous comments

It will provide standardization and guidelines to be followed.

**Yes, either as a standalone residency or an advanced aspect of their curriculum portfolio**

Accreditation provides legitimacy to programs. However, I believe that special needs training should be focused on existing GPR programs as they are best equipped to meet the needs of this population with the hospital based services currently offered

To maintain the educational standard

Interested candidates will have a more focused experience; will hopefully expand access to care for this highly underserved population. Will also help structure and establish a SPHCN curriculum - that can potentially cross-over to pre-doctoral education.

Accreditation will help drive growing the programs and curriculum

At the behest of the requesters

**The need!!**

There is a need for programs which embody such patients’ needs, but will the dental community encourage new graduates to regard this as a legitimate and necessary area of specialization.

Brings a certain degree of credibility to the program and encourages potential applicants to seriously consider an accredited program.

It would establish the discipline as well as provide resources for the support of these training programs.

**Yes due to the increased number of special needs patients**

**Great unmet need public demand validation**

If a program exists, having an accreditation would provide support to that program.

**Good for programs to have an oversight and also gives credibility.**

self-evident

If education in special needs was a specialty that included an education from an accredited program, I believe more students would pursue it.
Having CODA accreditation would strengthen a program's reputation. However, it would also require specific program features, such as adequate patients to achieve competence. This may not be possible for all programs.

Because there is a great need

There was a needs assessment completed and published in the Journal of Special Care Dentistry by Hicks et al. that includes this information.

Accreditation gives programs structure and a framework to gear resident education, I don't see why any program would not want to be accredited, also accreditation for some institutions can open the door for GME funding and with so few special needs programs, I wonder if the lack of accreditation and GME funding is preventing more programs from arising and serving both patients with special needs and helping train providers who are motivated to do so.

I suspect they want to be acknowledged some day as a specialty.

Would improve standing of the program

I believe the proponents of these programs would welcome the legitimacy that accreditation would bring.

Accreditation does give the program since of respect and accountability

It would be a starting point for more programs.

Many would probably pursue a career in education or a hospital.

Creating a credential in Special Needs Dentistry would attract candidates who would like to become skilled in SND and have a program certificate or credential that would verify their education.

To create more uniformity in training and guidelines across programs

By having CODA approval, sponsoring institutions could apply for Graduate Medical Education funding. This would create another funding mechanism for some existing programs and a pathway to create additional programs.

I believe accreditation will help lead to GME funding which will make the programs more attractive to applicants.

It is an area that works better to be concentrated on and not diluted in order to give the learner better understanding and skills.

The treatment of patients with special needs has become much more complex than the traditional pediatric dental residency can manage. A new specialty dedicated to these patients would greatly enhance the care they receive. There is a tremendous need for more programs with a dedicated faculty providing a specific knowledge base. A specialty brings recognition. Who wouldn't want that?

I believe that the established special needs dentistry programs associated with dental schools may be interested in pursuing accreditation by CODA because it could conceivably cause the programs to receive more grants and would give their programs increased respect in the academic world. This and possible increased enrollment would increase the income of these institutions.

This is critical to the future of dentistry and these patients are not getting adequate care.

I think that these specialists would need to work in the hospital and that Accreditation would be integral to the practice. Accredited programs would absolutely need to have a must statement regarding hospital training and cases.
Our GPR curriculum and patient care experience is sufficient. Additional accreditation would be duplicative for this program and thus easier to obtain.

It would mean a different potential path to licensure.

The Commission on Dental Accreditation implements accreditation standards that promote quality and improvement of dental programs. Therefore, I assume special needs dentistry programs would be interested in pursuing the accreditation.

Accreditation leads to credibility as well as some standardization across programs.

To be recognized by their peers

Peer validation of the educational process

It is necessary and uncommon

These programs are run by individuals who incorporate a sensitivity to special populations and view their challenges to higher levels of oral health as a necessity not a burden

So that they are recognized with more skill for working with these special needs patients which require more time and effort to treat properly. This should also help in the reimbursement for insurance and billing purposes. Treating a regular patient and a special needs patient is not the same and should be compensated appropriately.

Every effort should be made to have the treatment of special needs in the DMD/DDS curriculum and in the residency programs for AEGD, GPR, and Pediatrics.

I think it would serve a purpose of achieving the same standards at all programs

Accreditation is, in my mind, always desirable and allows for standardization of outcomes expectations for the educational process as well as providing a standard of care for the providers and students.

It would help standardize the programs and raise their visibility.

Gives them more credibility

The demand for SN Dentistry is high and the access is low.

Program reputation GME funding of hospital-based programs

This will improve the quality of care and quantity of patients in the community that they could see due to promotion of these clinics

There should be reasonable standards set up that hold a Program to be accountable

There seems to be a lack of special needs care provided in the elderly population.

Because accreditation status is important in seeking hospital based positions.

the program needs standard and needs to meet standard

I think it would be helpful to have as a recognized specialty.

CODA accreditation provides universities/hospitals, faculty, residents, and the benefiting patients the assurance that a curriculum has been established in a systematic fashion. It establishes a set of goals and standards through which providers are held accountable for ensuring they provide the highest quality of care. In this scenario, patients with special health care needs require particular care and accommodations that otherwise healthy patients or patients with mild systemic disease may not require.
Graduating from an accredited institution would be more substantial than obtaining a certificate from a non-accredited institution.

To make sure that all Special Needs programs are following the same guidelines (methods may differ)

There is a demand on the local and state levels for creation of programs to provide care for individuals with intellectual and developmental disabilities. Access for this population is limited, and creation of these programs will increase access and train providers to care for this population. In addition, these training programs are needed to increase faculty at dental schools to meet the CODA standards.

Establishing a structured agreed-upon body of knowledge to pass on to others will help with recruiting additional individuals interested in working with the patient population.

Would be recognized by GME funding

Gives them academic credibility.

There is a tremendous unmet need

There is not enough training on special needs dental care.

There is an overwhelming need that has long been ignored. Providers would jump at the chance for accreditation.

Almost every body of dentistry wants recognition for the work they do.... the easiest method for recognition for accreditation.

Due to the unique set of skills necessary to provide care to special needs in both out-patient and hospital-based settings. Advance knowledge in oral medicine, anesthesiology, and behavioral management is necessary as the ability to provide dental care in compromised settings.

CODA accreditation would raise the profile of these programs helping them to attract greater numbers of qualified applicants. I have seen this happen in my 35 years of involvement with dental resident education in Dental Anesthesiology.

From what I gather in classes and meetings, people who are involved in the special needs industry, whether in a volunteer or career capacity, are ALWAYS saying they need more dentists to see and feel comfortable seeing special needs patients. Their institutions should be happy to have the accreditation, I’m my opinion.

For many, ability to compete for graduate medical education support (Medicare IMD/DME) from their local partner hospital.

So many persons with special needs cannot find well trained professionals to provide the care they need. I believe it's the desire of many of us in the field to promote the field to Specialty status. The recognition of the body of knowledge and specialized skills by CODA would promote greater interest in the field and help to increase the number of professionals serving this vastly underserved population. It also would make clear that serving this group requires specialized training and consequently better reimbursement for services. Better reimbursement would also attract more professionals to treat this vastly underserved population.

Programs that already established should be recognized. However in the Stony Brook program all the dental students and residents have interactions with our established program.

This is an area that requires training in proper patient management, use of sedation methods, knowledge of appropriate diagnosis and treatment planning and should be regulated.

Perhaps with accreditation they can establish GME funding and increase enrollment rates.
<table>
<thead>
<tr>
<th>Increases the availability of GME funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding - I think this would also increase the number of programs that exist which is what is desperately needed.</td>
</tr>
<tr>
<td>Population is aging and changing making it more critical that oral health care providers of appropriately educated</td>
</tr>
<tr>
<td>Professional recognition</td>
</tr>
<tr>
<td>This would allow better standardization and sharing of resources.</td>
</tr>
<tr>
<td>it would be better for them</td>
</tr>
<tr>
<td>This is an area that is lacking care providers and they follow to pediatric dentists to take care of, but once they have adult needs it becomes difficult.</td>
</tr>
<tr>
<td>Credibility Funding</td>
</tr>
<tr>
<td>Residents attending CODA accredited programs know with more certainty what didactic and clinical educational experiences to expect. CODA Accredited programs must comply with the standards developed for the program.</td>
</tr>
<tr>
<td>If given the opportunity, I would believe any high quality educational institution would appreciate accreditation to show it maintains high standards.</td>
</tr>
<tr>
<td>I do not feel I can speak on behalf of these programs. I do not know their situations in detail to know what the pros and cons of this would be for them and their staff. This is a yes/ no question, I would select n/a.</td>
</tr>
<tr>
<td>Because advanced training is needed in this field to meet the needs of our most vulnerable populations. While many people with disabilities and other special health care needs can access dental care in traditional dental office, many need access to providers with advanced skills. These are not traditionally obtained in GPR/AEGD residency programs and the work-around of having a yearlong fellowship or 2nd year AEGD/GPR track is not sufficient to have a standardized education in this field. We need our own standards.</td>
</tr>
<tr>
<td>there is a great need to establish such programs with credible educational standards</td>
</tr>
<tr>
<td>Because of the huge unmet need out in the community, the need for more trainees to complete this type of program, and the fact that accreditation could help programs attract the best residents into their programs.</td>
</tr>
<tr>
<td>They feel it is unique enough to be a specialty.</td>
</tr>
</tbody>
</table>
Q6.b - Please explain why not.

<table>
<thead>
<tr>
<th>Please explain why not.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The amount of training is not sufficient to support a 12 month program.</td>
</tr>
<tr>
<td>Should already be covered in existing programs</td>
</tr>
<tr>
<td>I'm not familiar with any Advanced Education programs that are centered on treating special-needs patients.</td>
</tr>
<tr>
<td>Most GPR and AEGD programs already include didactic and clinical education on the treatment of Patients with Special Needs.</td>
</tr>
<tr>
<td>Most special needs individuals can be treated by generalists IF dental curriculum includes such education. CODA standards have moved in that direction. Having a Specialty will dis-incentivize generalists from &quot;taking care&quot; of those they should.</td>
</tr>
<tr>
<td>There is a lack of foundational knowledge to assist in establishing criteria for accreditation</td>
</tr>
<tr>
<td>Pediatric dentist and Hospital Dentistry cover this topic with OMS very well</td>
</tr>
<tr>
<td>Patient population, in terms of numbers, does not merit dental subspecialty recognition</td>
</tr>
<tr>
<td>Accreditation by CODA then facilitates the ability to apply for Graduate Medical Education funding to support the training of residents and advanced post-doctoral trainees. This is essential in designing a successful and sustainable program.</td>
</tr>
<tr>
<td>Sadly, no market for it...meaning not enough funding to sustain a business model. Our Pedodontists and GPR get special needs training as part of their programs so they can incorporate it into their own practices to fill that need the best they can.</td>
</tr>
<tr>
<td>Because we already have more paperwork than we need to be accredited as it is. I believe this is part of pediatric dentistry.</td>
</tr>
<tr>
<td>Reimbursement is often challenging with insurances and there is a routine loss of time due to coordination of travel especially during COVID. The Special needs community needs support financially, this is only one area of concern. Even designated areas are often back-logged with numbers.</td>
</tr>
<tr>
<td>It is intensive with a lot of faculty needed to cover all aspects of the program. You would in addition to regular faculty but also faculty in dental anesthesiology which is currently in a shortage.</td>
</tr>
<tr>
<td>Not immediately...need to have multiple programs that exhibit a standard that can be emulated by others...then seek accreditation</td>
</tr>
<tr>
<td>It is part of our care already.</td>
</tr>
<tr>
<td>Training is already an integral part of the CODA accredited programs</td>
</tr>
<tr>
<td>&quot;I don't know&quot; is a more appropriate response.</td>
</tr>
<tr>
<td>Economically challenging in the private practice setting</td>
</tr>
<tr>
<td>We have too many specialties</td>
</tr>
<tr>
<td>Accreditation is laborious</td>
</tr>
</tbody>
</table>
The patient population is too limited and would only be of interest to academic practitioners. Nearly impossible to make a living in our state based on the poor reimbursement for services. Well-staffed GPR programs generally provide services for this population as a result.

It’s going to be a lot of work.

I don’t know of any so I can’t comment on it

Many of the special care dentistry training programs are closely aligned with general dentistry and pediatric dentistry programs and may not have the resources to be accredited independent of the other programs.

Administrative burden

Possibly, but I think it is better to have rotating GPRs than a standalone program

It is a headache to do the special needs in the OR prior doing the case (H&P, consent, conservator paperwork). Spend a lot of time and resources blocking out time to do the case in the OR for a very small amount of money. Major institutions get dumped on with these cases, because no one else wants to do them. Need to incentivize offices to do these cases

I believe this can be taken care of in most GPR or AEGD programs.

I'm unsure of the benefit.

Lack of interest in the bureaucracy that accompanies the CODA accreditation process.

We need to educate dentists and specialists to manage children and adults with special needs and FUND them to provide care of individuals with special needs. Even if you establish a specialty without funding it will not work.

Needs already being met by Pediatric and OMS

Too small of a focus for establishment of a specialty

The terminology of special care is too broad.

Too much bureaucracy would be created. Burdensome levels of paperwork would not benefit people with special needs. I think it only serve to dissuade dentists from becoming more involved.

This is a component of several GPR programs that allow exposure and some expertise in the area. I believe it could detract from programs and remove a resource some program residents would find helpful and educational without it being a devoted special needs program.

Not a specialty or certificate program

Extra cost

There would be no advantage to the individuals who finish. The accreditation process is not worth the effort for them.

In our case, we already have an established GPR program and having accreditation in this area would not change the types of patients we see as our work already centers around this.

There is no need for a subspecialty. This population of patients is well cared for by those trained in pediatric, AEGD/GPR programs, and oral and maxillofacial surgery programs. Any lack of access is generally due to poor reimbursement or aging out of Medicaid, not a lack of provider experience.

It depends on the obstacles that would be involved in the process. Most of these clinics and programs are encumbered with limitations of effort, money, resources and community support. More paperwork, expense and administrative needs would be a serious deterrent.
<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>It is too onerous of a process.</td>
</tr>
<tr>
<td>Current GPR and AEGD programs provide training and clinical experience in special care dentistry</td>
</tr>
<tr>
<td>The same happens for all of the unanswered short response questions</td>
</tr>
</tbody>
</table>
Q7 - An association/organization/entity that may be interested in leading the pursuit of CODA-accreditation for special needs dentistry programs is:

<table>
<thead>
<tr>
<th>Association/Organization/Entity</th>
<th>Name and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Care Dentistry Association</td>
<td>53</td>
</tr>
<tr>
<td>American Academy of Pediatric Dentistry</td>
<td>5</td>
</tr>
<tr>
<td>American Dental Association</td>
<td>3</td>
</tr>
<tr>
<td>Academy of General Dentistry</td>
<td>2</td>
</tr>
<tr>
<td>Hospital Based Dentistry</td>
<td>2</td>
</tr>
<tr>
<td>American Society of Hospital Dentists and the Organization of Special Care in Dentistry</td>
<td></td>
</tr>
<tr>
<td>GPR programs</td>
<td></td>
</tr>
<tr>
<td>General Practice Residency Cleveland Dental Institute St. Vincent's Charity Medical Center Suite 136 11201 Shaker Blvd. Cleveland, Ohio 44104</td>
<td></td>
</tr>
<tr>
<td>Rancho Los Amigos National Rehabilitation Center</td>
<td></td>
</tr>
<tr>
<td>American Association of Orthodontists</td>
<td></td>
</tr>
<tr>
<td>American Academy of Developmental Medicine and Dentistry (possible interest)</td>
<td></td>
</tr>
<tr>
<td>ACLU, AAPH, Special Olympics</td>
<td></td>
</tr>
<tr>
<td>Dental School</td>
<td></td>
</tr>
<tr>
<td>American Dental Education Association</td>
<td></td>
</tr>
<tr>
<td>ATSU Missouri School of Dentistry and Oprah Health ATSU Arizona School of Dentistry and Oral Health</td>
<td></td>
</tr>
<tr>
<td>I assume the hospital dentistry group would, but it is important to distinguish between adult and pediatric care.</td>
<td></td>
</tr>
<tr>
<td>Herman Ostrow School of Dentistry</td>
<td></td>
</tr>
<tr>
<td>American Association of Public Health Dentistry</td>
<td></td>
</tr>
<tr>
<td>UConn in Farmington, CT or St. Francis Hospital in Hartford, CT</td>
<td></td>
</tr>
<tr>
<td>CODA should lead this</td>
<td></td>
</tr>
<tr>
<td>Pediatric Dentistry and Oral Maxillofacial Surgery likely receive the most comprehensive training in management of patients with special health care needs. The difficulty that specialists in these fields face is that, as patients with special health care needs age, their dental needs also change. These dental needs cannot always be satisfied in a comprehensive manner due to lack of skill set on the part of the pediatric dentist or oral surgeon. For example, pediatric dentists are not typically proficient in performing root canal therapies on permanent teeth, or managing complex prosthodontic needs for these patients. Almost all pediatric residency programs as well as most geriatric programs.</td>
<td></td>
</tr>
<tr>
<td>The Ohio State University, Arkansas Children's Hospital, Wake Forest University</td>
<td></td>
</tr>
<tr>
<td>Tufts University School of Dental Medicine / Tufts Dental Facilities Program for Individuals with Special Needs</td>
<td></td>
</tr>
<tr>
<td>American College of Prosthodontists (ACP)</td>
<td></td>
</tr>
<tr>
<td>American Academy of Developmental medicine and dentistry</td>
<td></td>
</tr>
<tr>
<td>SPCA</td>
<td></td>
</tr>
<tr>
<td>Autism Speaks/ Autism Society of Minnesota (AuSM MN) Special Olympics United Cerebral Palsy ARC</td>
<td></td>
</tr>
<tr>
<td>American Board of Special Care Dentistry</td>
<td></td>
</tr>
</tbody>
</table>
Q8 - Accredited advanced education programs in special needs dentistry will increase access to care for this patient population.
Q9 - There is evidence of need and support from the public and professional communities to sustain advanced education programs in special needs dentistry, e.g., there is evidence that program graduates will obtain employment and practice the discipline.
Q10 - There is evidence that undergraduates trained more specifically in special needs dentistry would expand their treatment options to include special needs patients into their general practice.
Q11 - Please add a list of special needs conditions which are currently not addressed by students in your program and which are routinely referred to external facilities for treatment. This information will enable the Council to better assess the needs and the focus for an advanced dental education program.

Please add a list of special needs conditions which are currently not addressed by students in your program and which are routinely referred to external facilities for treatment. This information will enable the Council to better assess the needs and the focus for an advanced dental education program.

my program is able to treat IDD patients

Severe developmental conditions Some Cerebral Palsy cases Moderate to Severe Intellectual Disabilities Epidermolysis Bullosa Severe Down Syndrome Severe Autism Uncontrolled epilepsy/seizures

Special needs children go to the pediatric dentist; along with some special needs adults. TBI impacted patients often go to GPR along with complicated medical patients. PTSD patients may wind up in the GPR or AEGD clinic depending on comfort of patients.

Any syndrome or condition that causes a cognitive disability where conventional treatment is not possible: Down Syndrome Various Trisomies Cerebral Palsy Autism TBI Asperger's Syndrome Stroke Dementia Alzheimer's Sensory Processing Disorders

We have a large and diverse special needs population. We address most needs but need to refer for more complex surgical procedures. Also, because of the limited number of programs available with access to sedation we are overwhelmed with patient volumes and need to refer many patients out of our service area.

We treat special needs patients

Oncology patient, hematologic patient, patient with pain control issues

Down Syndrome CB

Severely medical compromised patients. Patients with behavior problems Patients with severe physical limitations

Autism (pediatric)

We have a Special Needs Clinic that has been in existence for over 30 years. We treat all people with Special Needs including those requiring sedation. Those who have unstable medical conditions are referred to hospital settings.

Comprehensive care under IV sedation

Our Special Care and Geriatrics Program treats all patients with special health care needs. The only referral to outside providers is related to the limited availability of a dental anesthesiologist.

Home-bound Many institutionalized large gurneys/chairs motion disorders (flailing, severe Parkinson's, etc) severe cognitive disability

Care in long-term care facilities
We are fortunate to be able to offer a wide range of procedures within the scope of our dental service, including special needs patient's, however it would be beneficial for there to be a standard accreditation minimum that would support the program and legitimize our offerings while further providing the resident with a governing body sanctioning that training and documentation for their portfolio.

Our program offers comprehensive care to all special needs individuals. The limitation is not in training but rather in financial resources available to these individuals and their families. Current undergraduate training is at best insufficient and at worst harmful to these populations as it promotes dentistry that is lower than the standard of care.

We manage most Pts with Special Needs within our AEGD Residency. Our school also has a Special Care Clinic, and a small hospital-based GPR Residency, which is able to manage most Pts with Special Needs that we are not able to treat in a traditional dental clinic setting; they have the ability to take Pts with Special Needs to the OR when indicated.

Patients with complex medical problems. Patients with history of stem cells transplant and organ transplant etc.

For many years, Rancho has only treated individuals with physical and/or neurodevelopmental disabilities within LA County Dept of Health Services and private practice dental clinics in Southern California. We refer out very few cases each year (1-2/yr) - all of them general anesthesia cases. While Rancho performs dental treatment in the OR quite frequently, every once in a while, we refer out patients who are very fragile medically. For those cases, we refer them to our level 1 trauma hospitals as they have more robust emergency services compared to our hospital.

Patients with complex medical problems. Patients with history of stem cells transplant and organ transplant etc.

the transitioning adult population of IDD/ DD as well as physically and medically compromised... The paradigm of screening out patients due to "we don't have faculty to oversee" needs to be relooked.. We should have faculty help train younger, less experienced faculty to be able to teach and oversee care... We should not seek the lowest common denominator...but prepare the clinicians for moderately challenging cases... Studies suggests that with minor modification, a special needs patient can be seen in over 80% of offices. That is not to say there is not a significant population that can benefit from true "advanced cases"... but a lot of that is behavioral management, occupational therapy techniques and understanding the pathophysiology of the disease or syndrome.

The hospital-based GPR program with an affiliated dental school site provide the majority of care for complex patients with special healthcare needs. Patients with multiple diagnoses who experience functional challenges with mobility, cooperation and medical co-morbidities that require a higher level of management and/or modification are seen outside of a dental school/trainee, pre-doctoral dental or dental hygiene setting. This website provides a generic reference for multiple conditions that are often included in the scope of special needs: [https://dental.washington.edu/dept-oral-med/special-needs/patients-with-special-needs/](https://dental.washington.edu/dept-oral-med/special-needs/patients-with-special-needs/)

This program does extend and accept special needs patients but there are limitations in terms of space, equipment and training.

None - we take special needs patients of all kinds up to the OR for dentistry.

Firstly doctors won't treat if they are uncomfortable. But more importantly, they won't treat if they cannot make a living doing it. Make it profitable, and doctors will pursue the education that they need. We are a capitalist society. Doctors won't see special needs patients if it takes twice as long to earn less money. I feel that this is a wasted effort. Get insurance companies to pay for autistic kids to be seen in the OR. Start with the basics. We only refer endo, we will see any special needs patient. There are trained doctors, they just need to financial incentives.
Our patients vary—we have a few that are deaf, many are Autistic, a couple that are developmentally slow, some born with syndromes—i.e. fetal alcohol, or Downs. The institution has a hard time with capture of reimbursable codes, follow-up care, and points of contact especially when it comes to foster care, group home or adult home facilities.

Wheel chair bound patients, adults with intellectual challenges, institutionalized adults, homeless populations, refugee populations, older adults with complex medical conditions, disabled veterans who cannot access VA care.

Understanding the medical complexities of patients with IDD is challenging and can be elusive. The is impacted by the many layers of people and entities involved with the support of this patient population particularly if they reside in a group setting with caregivers, house managers, fiduciaries, etc. Access to medical care is similarly limited particularly influenced by the cooperation of the patient which can limit the medical history obtained. Regardless of the primary diagnosis (Down Syndrome, ASD, CP, etc.), the level of mental function is what is most impacting. The more severe this presentation is for a patient, the more limited is the ability to obtain appropriate medical and dental information. This type of assessment and evaluation is beyond the capacity of dental students. This involves intensive and specialized education and training that is best achieved through residency training. Even in the AEGD or GPR settings, this is not typically addressed at the appropriate level. Working for the past several years (20+) with AEGD residents at several institutions, I find there is limited capacity for these residents to properly and appropriately treat this patient population. It requires more focused training and education that would be best accomplished in a directed and specific residency training program.

In our Institution we do have a specialty care facility and all special needs patients are seen there

Autism, Developmental disability.

children and adults with cognitive/behavioral issues currently require Operating Room sedation in order to accomplish lengthy/involved endodontic procedures

Patients that test high on the autism spectrum Special needs patients that require extensive dental treatment and need to be sedated.

We attempt to manage all we can for all patients of need, especially in the realm of emergencies through creative approaches as needed

We do not refer patients from our Center. We have a well-trained faculty many of whom are fellows in Special Care as well as Diplomates. We have D3, D4, and PGY1 and PGY2 residents who treat our patients.

we are fortunate to collaborate with the Rose F Kennedy Center for special care dentistry. we send patients with a whole range of physical and psychological/developmental/neurological conditions such as cerebral palsy, autism, developmental delay, ADHD, epilepsy and a variety of genetic conditions for care at RFK

Patients who need sedation or General Anesthesia are currently not treated by our students, but we are developing programs to address these issues.

We provide comprehensive oral health care for all infants, children, and adolescents, including those with special healthcare needs. No family is referred away because of their special healthcare need.

We are able to take care of all our needs related to special needs patients Multi specialty approach drive by GPs

Almost all are referred to the residency program. Before we had a program students learned to work on special needs patients in the school.
as we are a military based practice, many special needs are not seen within our program, for medically complex and patients with dental anxiety...we are able to see in our program

We are that eternal facility. We are 3 community hospitals. Our catchment area has 1.1 million people. We receive many referrals for: 1. special needs patients with complex medical conditions requiring dental treatment 2. Special needs patients that require moderate, deep and general anesthesia 3. Special needs patients that have to be admitted to the hospital to manage their medical conditions in order to provide dental treatment 4. Special needs patients that require multidiscipline care coordination. If CODA approved such programs, our sponsoring organization would definitely seek to establish a CODA approved Advanced Education Program in Special Needs Thank you.

Patients presenting with advanced airway complications, patients requiring sedation/general anesthesia, patients with severe cognitive conditions (including Alzheimer's and dementia), medically frail patients presenting with long lists of medications and/or medical conditions

As the Director of a GPR program that services the special needs patients in our area, we feel that well trained Doctors who graduate will continue to treat these patients in their private practices and will have the training to take these patients into the OR.

OR cases are handled by the resident

We do not refer any patients to any other facility. Advocate Aurora Illinois Masonic Medical Center has a 9-resident GPR and 2-resident Dental Anesthesia residency. We have an established Special Patient Care program, but there is not a dedicated 12-months of education in only special needs dentistry. The combination of the GPR with the DA residency means we can treat anybody without referring them. We routinely receive referrals from the University of Illinois College of Dentistry for patients they cannot or will not treat.

I am not associated with a special needs program; however, my wife and I had a special needs child for 14 years with severe disabilities. She was nonverbal, could not walk and could not feed herself. It was during that time and since that time I have come to realize that there is a critical deficit of private practitioners willing to learn how to care for special needs patients of all ages. Practitioners being uncomfortable around those with special needs is a major roadblock to treating them. I was self-taught and my compassion for this sector of our population overcame my fear and intimidation. Treating special needs patients carries with it elevated risks to the patient and dentist. I am unsure if many will want to accept the challenge. Special needs conditions that must be addressed are autism, cerebral palsy, severe cognitive disorders, metabolic disorders, and multiple disorders in the same patient.

patients who cannot safely or appropriately be treated by predoctoral (DMD) students are not referred externally, but rather are referred internally to residents in the general dentistry training programs there are many existing general dentistry (AEGD and GPR) and pediatric dentistry residency programs that provide significant training and experience in the management of patients with special needs

None - we see all persons with any degree of special needs.

Any condition requiring sedation/operating room treatment.

Adults with special healthcare needs; we treat individuals who are aged 20 years and below. The state of Tennessee does not extend Medicaid dental benefits to individuals who "age out" of the system at 20. Adults with special healthcare needs are woefully underserved; however, I am not sure that a specialty program will be able to improve access to care for these individuals without additional insurance coverage policies. Thus, all adults with these special healthcare needs: Cardiac (particularly individuals with congenital heart defects who have extended lifespans like Tetrology of Fallot) Cancer patients (xerostomia and radiation to the head and neck) Down syndrome Autistic/Developmental Delay Cerebral Palsy Spina Bifida Liver disease/failure Kidney disease/failure Epilepsy Osteoporosis/Bone disease Respiratory (cystic fibrosis, persistent asthma) GERD Celiac/Crohns Craniofacial anomalies/syndromes (Crouzon, Apert, Goldenhar, etc).
We are a VA program so we do not get an opportunity to treat many children with special needs, only adults whose special needs were a result of their military service.

Autism Multiple sclerosis Trisomy 21

I am a private practitioner. A GPR I teach at only addresses challenging patients whom require general anesthesia for care due to combative behavior, with basic dental care covered by Medicaid and not reconstructive care prosthetic etc.

Autism Developmental Delays

The main problem is treating the special needs patient that requires general anesthesia in an operating room setting. Often there is no funding / insurance.

My program is a Veterans hospital so there is exposure to special needs patients

We provide most dental services to our special needs patients including or care but due to the small number of attending staff that feel comfortable overseeing the care there are very long wait lists to be seen. Also pediatric dentists, who are most comfortable with patient management, are often not comfortable with adult and geriatric special needs patients. We are unable to provide any prosthodontic services to this patient population.

It is impossible to list them all here. In general, dental students do not have much meaningful education, either didactic or clinical, related to the treatment of this patient population.

Downs syndrome Mental disabilities

Our program is the final stopping point for SN people is our city and surrounding states. We receive referrals from GP's. Pedo, Endo, OS and Perio doctors to take care of these type of patients. Students are NOT taught how to handle SN populations. Many local dentists do not even try to see these people in their offices, they just tell them to go to the University. We need to educate the dentist (both older and new practitioners) on how to provide care in their offices. Students do not learn: patient management, how to access if they need to go to the OR, how to examine a patient with SN and get as much info as possible, sedation techniques, restraint techniques, etc. Health history reviews and pre-operative evaluations are not addressed in schools. Post-operative follow up and care is also not taught.

Patients with behaviors necessitating general anesthesia

Patient with severe disabilities Patients that require special equipment to be treated Patients with behavior disorders

We are basically "Black or White" in our Program. If a patient cannot be treated here in the clinic (mentally, medically, physically or behaviorally), then we treat them in the O.R.

N/A- we take on the special needs cases that everyone else does not want to do.

Special needs dentistry should be part of primary care dentistry, just as special needs populations are part of primary care medicine and pediatrics. Can you imagine having to take you child to a "special" pediatrician just because he/she had a developmental disorder? To remove special needs dentistry and classify it as its own specialty is just giving general dentists a pass to only see uncomplicated, easy, short visit, high reimbursement patients, and pushing off more complicated patients that end up with less reimbursement for their time to other (and fewer) dental professionals - and would result in an overall decrease in access to care in this already disenfranchised population. The ADA should follow the lead of the AMA, and make caring for all populations as part of a primary general practice.

There is a shortage of information for how to treat patients with autism.

My program affords me the opportunity to collaborate with all dental specialists to provide comprehensive dental care for patients with special health care needs. My limitations occur in the
setting of this dental care in an outpatient facility. If the patient requires sedation or general anesthesia, my hospital (which is not a level 1 facility) is not equipped to support patients with some ASA III and ASA IV status, and I am forced to find them a dental home somewhere else that can support their medical and dental treatment needs. This is not always an easy task, particularly in a military setting, where families may be limited by finances or transportation to a military treatment facility that can support them.

<table>
<thead>
<tr>
<th>Cerebral Palsy</th>
<th>Autism</th>
<th>Down Syndrome</th>
<th>Severe mental health issues</th>
</tr>
</thead>
</table>

Medically complex Autistic adults Anxious adults

Autism Patients with behavior issues, students and residents are not currently getting the training in behavior management to successfully treat these patients in traditional clinical settings. The patients get referred automatically and are treated under anesthesia. There is a continuum of care that is missing from the student and resident curriculum.

Severely medically compromised individuals. Due to Covid and budget cuts, we no longer offer general anesthesia. Due to Covid and budget cuts, we no longer have the services of an oral surgeon.

This is about a concept, the list needs to be developed by those that embark on this road, which is very much needed

Cerebral palsy Paralysis
developmental disabilities cognitive impairment complex medical problems significant physical limitations vulnerable elderly

Cognitive disorders, seizure disorders

I am program director of a hospital based Dental Anesthesiology residency program - NYU Langone Brooklyn. My residents get extensive experience in the Main Operating Room Suite. Special Needs dental patients are reserved Block Time in the OR schedule one full day every week. Special Needs cases that cannot be treated elsewhere are routinely referred to this facility. Conditions requiring these referrals include: combative adults, involved medical histories, extensive treatment needs requiring general anesthesia.

Psychological

From DDS education "student" perspective, there is limited interaction with geriatric and intellectually/developmentally disabled patients and those with complex health needs. Even before COVID, the faculty in the dental school did not feel "comfortable" treating the special needs patients in student clinics. There is no nitrous oxide available for analgesia use in clinics. Sedation techniques only exist in pediatric dentistry, OMFS and Periodontics at graduate student levels. There is a 1 week "rotation" of DDS3-4 to our "special care/geriatric clinic" that has been hampered by COVID. This has been the "special needs" clinical experience. Some students have taken an "elective" with one of our now retired pediatric dentists on managing the developmentally disabled in a clinic setting. Our DDS3-4 extramural rotations to community sites and to hospitals were dramatically reduced in the past 5-10 years so our historical 4 week hospital dentistry rotation is no longer required of students and few opportunities exist for learning how to work in this setting and with these more complicated patients treated in an interprofessional care setting. This past summer, with retirement of our Public Health focused director of extramural programs, administration folded this experience into clinical education services as a mode of obtaining more routine dental experiences off site from the school as a few focused community health collaborators. Thus the "special needs" experience of the extramural rotation program was essentially eliminated. In defense of the school, the hospital extramural rotation partners administrators also over this time period became increasingly worried about their clinic's financial bottom line, removing as much time/focus on education as possible to focus on faster care provision by their hired dentists.
Any patient that requires IV sedation or general anesthesia is referred to external facilities. This tends to include many moderate to severely uncooperative patients.

There needs to be better reimbursement if we are to expect a group of students would specialize in this field. Having a designated SN specialty would just allow dentists to punt their moral responsibility to treat patients to a group that still would be unable to meet the demand both due to time and money.

We treat all patients in our program. There is no one else to refer to.

Cases that require hospital procedures and OR treatment are routinely referred to the Special Needs Program at the School of Dental Medicine

### Adult dentistry Treatment of older adults with special needs

We are the place that takes everyone - But I feel people need more education in Aspiration risks and respiratory problems Conditions that effect swallowing Treating people in wheelchairs Treating people in hospital beds Interdisciplinary collaboration with MDs Consent issues for dependent adults Behavior management adults Behavior management dementia Protective Medical stabilization Movement disorders Sensory stimulation and creating a low sensory environment Hospital dentistry Sedation Seizure disorders

Cerebral palsy  Severe autism

Those that require General Anesthesia and post op monitoring

When adult special needs patient have endodontic needs. We are also booked out for patients that need treatment in the OR.

None. The special needs program sponsored by the GPR that I am affiliated with as Program Director receives referrals from a multi-state region.

We do not have a craniofacial/cleft palate focused team here at Hennepin Healthcare so any young children are referred to the University of Minnesota for the early intervention. We do see these patients as adolescents/adults in our clinic. The pediatric dental residency here performs some orthodontic care, but refers the complex cases that would affect some of these populations to the University of Minnesota or to practitioners in the community who are willing to care for them, when appropriate. All other populations defined by this survey can be cared for here.

My program is not a GPR, but I would think that a GPR covers more in depth these special need patients. I wonder how much overlap there would be between these two programs; however, I'm not in a position to determine that.

In our Pediatric Dentistry program we treat many patients with SHCNs and do not need to refer out fortunately. We are able to provide treatment with non-pharmacologic and pharmacologic (sedation and general anesthesia) behavior guidance for our patients. We address all conditions in clinic and/or in our didactic courses.

We have a GPR, oral surgery residency, pediatric dentistry residency and all special needs patient are cared for within this group without need for external referrals.

Our teaching will address all aspects of treating persons with disabilities providing appropriate accommodations needed to successfully treat persons with disabilities.
We are the program that people refer to. Our patients with Down syndrome, autism, intellectual disability, cerebral palsy, and traumatic brain injury have particular difficulties with access and often report being sent away from multiple dental offices before finding us; however, it is not always correlated with diagnosis or even the severity of the diagnosis but how that individual is affected in their ability to tolerate dental care, follow instructions for dental care, their medical complexity, behavioral complexity, etc.

Cerebral palsy patients, severe autism patients, patients with chronic advanced stage disabling diseases (Parkinson, ALS, MS etc.) vulnerable elderly with dementia

<table>
<thead>
<tr>
<th>All special needs population patients are treated at the hospital which serves as a referral base for the region.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adults with developmental disabilities being treated in the operating room or outpatient environment—our dental students could not possibly be competent at the time of graduation—advanced training would be necessary.</td>
</tr>
<tr>
<td>2. Those on the severe end of the autism spectrum.</td>
</tr>
<tr>
<td>3. Vulnerable elderly in nursing homes.</td>
</tr>
<tr>
<td>4. Some medically complex/medically unstable patients best treated in a hospital setting, or whose dental treatment must be completed very efficiently, for example pre-transplant, pre-cardiac surgery, pre-radiation therapy for head and neck cancer.</td>
</tr>
<tr>
<td>5. Those with dental fear requiring medication and/or behavioral interventions.</td>
</tr>
</tbody>
</table>
Q12 - Graduates of DDS/DMD programs must be competent in assessing and managing the treatment of patients with special needs.
Q13 - Graduates of Advanced Education in General Dentistry Programs must be able to assess, diagnose and plan for the provision of multidisciplinary oral health care for a wide variety of patients including patients with special needs.
Q14 - Graduates of General Practice Residency Programs must be able to assess, diagnose, and plan for the provision of multidisciplinary oral health care for a wide variety of patients including patients with special needs.
Q15 - Graduates of Dental Anesthesiology Residencies must be competent in providing comprehensive anesthesia care using pharmacologic and non-pharmacologic methods to manage anxiety and pain in adult and child dental patients, including patients with special needs.
Q16 - Graduates of Pediatric Dentistry Residencies must be competent in providing both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs.
Q17 - Graduates of Pediatric Dentistry Residencies must be competent in diagnosis and treatment planning for infants, children, adolescents and those with special health care needs.
Q18 - Graduates of Pediatric Dentistry Residencies must be competent in the provision of comprehensive dental care to infants, children, adolescents and those with special health care needs in a manner consistent with the dental home.
Q19 - Graduates of Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics must be competent to treat patients with congenital and acquired deformities of the integument and its underlying musculoskeletal system within the maxillofacial area and associated structures and patients with special needs including disabilities and medically compromised patients who require comprehensive treatment.
Q20 - General dentists need more continuing dental education offerings on the subject of managing and treating special needs patients.
Q21 - Dental specialists need more continuing dental education offerings on the subject of managing and treating special needs patients.
Q22 - My dental colleagues plan to take a continuing dental education course on managing and treating special needs patients in the next 12 months.
Q23 - Please indicate which topics you believe should be covered in a continuing dental education course on managing and treating special needs patients (select all that apply).
All these topics are really important and I consider that we need to be updating them on a regular basis.

Emphasis should be placed in providing dental care for intellectually challenged or patients with complex medical histories at the same level as provided for all patients. Most patients in this category are often relegated to merely urgent care with minimal consideration of aesthetics and function. Physically and intellectually challenged patients should have the same opportunities for the best dental care as our patients.

**Business Plan**

Teledentistry is new but I feel should become part of the curriculum. We are starting to utilize for nursing home patients and find it very effective.

Cognitive impairment; rare developmental diseases, the unique qualities of older adults and those with physical and cognitive impairments. (The word elderly is out of favor).

Proper Informed Consent and Legal Guardianship Analysis for this sub group population

Sedation and General Anesthesia

Caries Risk Assessment and prevention program

Ergonomics

PTSD

Of course. There is never too much training. You might want to add behavior management

Empathy

Medicaid billing, CDT coding, third party payer issues, medical billing codes

Health care disparities endured by patients with special needs Social aspects of care, working with families and caregivers Understand the system of care, group homes, assisted living Medicare, Medicaid, social service agencies.

Understanding Medicaid, advocating for special needs patients with Medicaid, and understanding how to make positives changes in Medicaid that directly impact patient care and a dental practice.

Cancer patients undergoing RT and/or chemo or post-RT/chemo patients.

Compassion exploration and development

Please note the previous questions regarding pediatric dentistry did not specify whether the special needs component is limited to infancy through adolescence, or adults. I responded as if adults were excluded. I would have responded differently if adults were included. I do not know what was intended or what other respondents assumed the question was asking.

behavior management techniques

Triage for various modalities of restraint Medical Ethics Intricacies of consent legally and assent when applicable
All of these are critical for proper training.

If the patient needs sedation, the practitioner should be able to have this option available and know how to refer or provide this service.

Alzheimer and geriatric patients

Treatment planning based on reality of the patient's ability

Interfacing with Special Needs Caregivers - especially in managing the communication divide between family members and daily institutional caregivers of SN Patients.

Financial issues- barriers to care

reimbursement issues consent/healthcare proxy issues legal issues

Recognition of Patients that cannot be treated in a conventional Dental Setting and the ability to refer these patient to a special care facility that can accommodate these patients and give them care

Traumatic brain injuries

Private practice colleagues generally want to know about billing/ reimbursement/ compensation.

Assessing capacity to consent; differentiating between capacity and competency to consent; resolving ethical/legal challenges when capacity and competency do not align, especially for adults with cognitive and intellectual disabilities Communication disorders Autonomy and the role of caregivers and guardians Oral manifestations associated with specific disabilities/conditions Social determinants of health for people requiring special care dentistry The emotional experience of people living with disabilities, understanding patient perspectives Interdisciplinary care Spinal cord injury Disability language Cultural humility related to disability Legal issues related to disabilities Advocacy The Americans with Disabilities Act Institutionalized care and deinstitutionalization Other living settings, such as group homes Facilitation techniques in special care dentistry

How to get paid for the care. This is a major barrier to dentists participating in this type of care. How to get hospital privileges. Advocacy at the local and state level.
Resolution No. 46

Report: CDEL Report 1

Date Submitted: June 2021

Submitted By: Council on Dental Education and Licensure

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None

Net Dues Impact: 

Amount One-time 

Amount On-going 

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

SPECIAL CARE DENTISTRY ASSOCIATION

Background: In its report to the 2021 House of Delegates, the Council on Dental Education and Licensure has offered several actions in response to Resolution 100H-2020 (Worksheet:4013). The Council has recommended that the Special Care Dentistry Association be provided with the Council’s feasibility study for consideration on the development of an accreditation process and accreditation standards for advanced education programs in special needs dentistry by the Commission on Dental Accreditation. Further, the Council recommends that the House of Delegates urge the Special Care Dentistry Association to collaborate with advanced dental education programs and their sponsoring institutions to enhance the current scope and depth of instruction related to special needs dentistry and encourage the establishment of more training programs in special needs dentistry.

Therefore, the Council on Dental Education and Licensure presents Resolution 46:

Resolution

46. Resolved, that the findings of the feasibility study conducted by the Council on Dental Education and Licensure be provided to the Special Care Dentistry Association for its consideration in pursuing an accreditation process and accreditation standards for advanced education programs in special needs dentistry by the Commission on Dental Accreditation, and be if further

Resolved, that the Special Care Dentistry Association be urged to collaborate with advanced dental education programs and their sponsoring institutions to enhance the current scope and depth of instruction related to special needs dentistry and to encourage the establishment of more training programs in special needs dentistry.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
Resolution No. 47

Report: CDEL Report 1

Date Submitted: June 2021

Submitted By: Council on Dental Education and Licensure

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: $35,000

Net Dues Impact: $0.35

Amount One-time $35,000

Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

CONTINUING EDUCATION MARKET RESEARCH

Background: In its report to the 2021 House of Delegates, the Council on Dental Education and Licensure has offered several actions in response to Resolution 100H-2020 (Worksheet:4014). Respondents to the State of Special Needs Dentistry Education Survey conducted by the Council indicated that general dentists and dental specialists need more continuing dental education related to managing and treating special needs patients, e.g., people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. Many suggested topics that could be presented via CE activity were noted. An environmental scan of current CE offerings related to special needs dentistry/patients also was reviewed. Given the survey results and the current CE offerings on this subject, the Council concluded that market research should be conducted by the appropriate ADA agency to learn more about the continuing education interests of practicing dentists related to the general and specific subject areas of special needs dentistry.

The Council on Dental Education and Licensure recommends adoption of the following resolution:

Resolution

47. Resolved, that market research be conducted to learn more about the continuing education interests of practicing dentists related to managing and treating patients with special needs, i.e., people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
Resolution No. 48

Report: CDEL Report 1

Date Submitted: June 2021

Submitted By: Council on Dental Education and Licensure

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: $7,500

Net Dues Impact: $0.08

Amount One-time $7,500

Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

DEVELOPING CONTINUING EDUCATION ACTIVITIES

Background: In its report to the 2021 House of Delegates, the Council on Dental Education and Licensure has offered several actions in response to Resolution 100H-2020 (Worksheet:4014). Respondents to the State of Special Needs Dentistry Education Survey conducted by the Council indicated that general dentists and dental specialists need more continuing dental education related to managing and treating special needs patients, e.g., people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. Many suggested topics that could be presented via CE activity were noted. An environmental scan of current CE offerings related to special needs dentistry/patients also was reviewed. Given the survey results and the current CE offerings on this subject, the Council concluded that the ADA should offer more continuing education programs to increase knowledge and awareness of managing and providing oral health care to patients with special needs. Over time, such CE activities could include annual meeting courses, video-based on demand courses, and/or a multi-modular online course. To begin, it is suggested that two webinars be conducted in 2022 and that asynchronous on-demand online CE courses be produced using the content of the webinars.

Therefore, the Council on Dental Education and Licensure recommends adoption of the following resolution:

48. Resolved that a variety of continuing education activities related to special needs dentistry be developed by the appropriate ADA agency.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
PROPOSED POLICY: PATIENTS WITH SPECIAL NEEDS

Background: In its report to the 2021 House of Delegates, the Council on Dental Education and Licensure has offered several actions in response to Resolution 100H-2020 Special Needs Dentistry (Worksheet:4014).

In regard to ADA policy, the Council noted several policies addressing the special needs population and supporting continuing education in general. However, there is no policy specifically urging dentists to pursue continuing education in this subject. Accordingly, the Council recommends that the 2021 House of Delegates adopt the following resolution:

Resolution

49. Resolved, that the following policy be adopted:

Patients with Special Needs

The dental profession’s continued ability to effectively provide dental care for America’s special needs population is dependent on sustaining a strong educational foundation in this area. The ADA encourages efforts to maintain and expand the availability of courses and programs at the predoctoral, advanced and continuing educational levels that support practitioners in providing dental treatment to patients whose medical, physical, psychological, cognitive or social situations make it necessary to consider a wide range of assessment and care options. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. The ADA encourages dental practitioners to regularly participate in continuing education in this area.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
Resolution No.  N/A  New
Report:  CDEL Report 2  Date Submitted:  June 2021
Submitted By:  Council on Dental Education and Licensure
Reference Committee:  C (Dental Education, Science and Related Matters)
Total Net Financial Implication:  None  Net Dues Impact:  
Amount One-time  Amount On-going
ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

COUNCIL ON DENTAL EDUCATION AND LICENSURE REPORT 2 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 76-2020 – ELDER CARE STRATEGIES ON INCREASED PREPAREDNESS OF EDUCATIONAL INSTITUTIONS

Background: In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar, which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each Referred Resolution, Resolution 76-2020 was reviewed by the Council on Dental Education and Licensure (CDEL). Resolution 76-2020 is appended to this report.

The Council has considered Resolution 76-2020 and elected not to re-offer it to the 2021 House of Delegates for the following reasons.

In regard to advocating for geriatric fellowship programs, the Council has taken action by requesting that the Council on Government Affairs (CGA) and Council on Advocacy for Access and Prevention (CAAP) increase advocacy for the HRSA Geriatrics Workforce Enhancement Program and in conjunction with the Council on Dental Practice (CDP), enhance communications with ADA members regarding current funding opportunities for geriatric programs and fellowships. In addition, per the House directive, the Council has transmitted its 2019 report, Council on Dental Education and Licensure Response to Resolution 83-2018: Geriatric Dentistry (Trans.2019:281), to the Special Care Dentistry Association for its consideration in pursuing an accreditation process and accreditation standards for advanced education programs in geriatric dentistry by the Commission on Dental Accreditation.

In regard to geriatric curriculum for dental and advanced dental education programs, the Council reviewed numerous reports and documents (examples below) and concluded that curriculum and resources exist:

- White Paper on Dental Care Needs of Aging U.S. Populations, 2004 Supplement to Annual Reports and Resolutions Excerpt, Volume 1, Report 4101
- Oral Health for Independent Older Adults: ADEA/GSK Predoctoral Curriculum Resource Guide
- 2018-2019 Curriculum Survey of Dental Education Programs (DDS/DMD), Excerpts
- CDEL Response to Resolution 83-2018: Geriatric Dentistry
- Report of the Elder Care Workgroup in Response to Resolution 33H-2018: Presidentially-
appointed Elder Care Workgroup
• Excerpt of 2020 Unofficial Actions of the House of Delegates
• Literature Search related to Elder Care/Geriatric Dentistry Curriculum

While the Council appreciates the strategies suggested in Resolution 76-2020, the Council believes matters related specifically to elder care/geriatric dentistry education have been and are being addressed. A number of non-accredited geriatric/elder care fellowship-level programs currently offered by universities and the Department of Veterans Affairs have been identified. Increasing advocacy in collaboration with CGA, CAAP and CDP for these programs via the HRSA Geriatrics Workforce Enhancement Program also may provide incentive for the development of more training programs. Further, the Special Care Dentistry Association has been urged to consider pursuing an accreditation process and accreditation standards for advanced education programs in geriatric dentistry by the Commission on Dental Accreditation. Finally, the curriculum presented in accredited dental and advanced dental education programs currently includes competencies in the management and treatment of geriatric patients.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
WORKSHEET ADDENDUM

2020 RESOLUTION 76—ELDER CARE WORKGROUP—ELDER CARE STRATEGIES ON INCREASED PREPAREDNESS OF EDUCATIONAL INSTITUTIONS

76-2020. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder care strategies on increased preparedness of Educational Institutions as priority projects, and be it further

Resolved, increase preparedness of educational institutions to train dentists and specialists in elder care by:

1. advocating for geriatric fellowship programs; and encourage universities, the Department of Veterans’ Affairs (VA), and hospitals to develop these; the fellows will play an important role in both the delivery of care, and the education of dental students.
2. advocating for the inclusion of treating the elderly population, including complex cases, for pre-doctoral and relevant specialties in school curriculum.
3. working with other relevant associations to develop curriculum guidelines for inter-professional education on both the oral-systemic connection and the dental management of the medically complex older adult.
Resolution No. 64

Report: N/A

Date Submitted: June 2021

Submitted By: Council on Scientific Affairs

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

**AMENDMENT OF THE POLICY STATEMENT ON INTRAORAL/PERIORAL PIERCING AND TONGUE SPLITTING**

**Background:** In accordance with House Resolution 170H-2012, Regular Comprehensive Policy Review (Trans.2012:370), the Council on Scientific Affairs (Council) reviews Association policies on a broad range of scientific issues every five years, and proposes policy revisions or other recommendations as appropriate.


**Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting**

Resolved, that the American Dental Association advises against the practices of cosmetic intraoral/perioral piercing and tongue splitting, and views these as invasive procedures with negative health sequelae that outweigh any potential benefit.

The Council considered this policy review alongside Resolution 109-2020, which was assigned to the Council following the 2020 House of Delegates (HOD) meeting.

The Council reviewed existing resources on this subject, which included a recently-updated Oral Health Topics (OHT) page on Oral Piercing/Jewelry. This OHT page also presented information on the use of tooth gems and oral jewelry, which corresponded with the charge given to the CSA under Resolution 109-2020.

Following review, the Council determined that considerations regarding tooth gems and oral jewelry have a fair degree of overlap with the current ADA Policy on Intraoral/Perioral Piercing and Tongue Splitting. Wearing oral piercings or tooth gems/jewelry (as well as tongue splitting) can be associated with various adverse effects (e.g., plaque accumulation, enamel damage, erosion, or potential aspiration of jewels, labrets or gems). However, it also noted a lack of data in this area, and that the use of tooth gems and jewelry has both historical and current cultural applications that should be considered alongside potential clinical concerns.
Resolution 64


ADA Policy Statement on Intraoral/Perioral Piercing, Tooth Gems/Jewelry and Tongue Splitting

Resolved, that the American Dental Association advises against the practices of cosmetic intraoral/perioral piercing, tooth gems/jewelry, and tongue splitting, and views these as invasive procedures due to the increased risk of negative health outcomes, sequelae that outweigh any potential benefit.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
NOTES
AMENDMENT OF THE POLICY, RESEARCH FUNDS

Background: In accordance with Resolution 170H-2012 (Trans.2012:370), Regular Comprehensive Policy Review, the Council on Scientific Affairs (Council) reviewed the ADA Policy titled Research Funds (Trans.1984:519; 1999:974; 2016:302). The ADA policy statement reads as follows:

Research Funds

Resolved, that the ADA urges appropriate external agencies and organizations to provide funding for basic and clinical research that advances the scientific basis of dentistry and the oral and craniofacial health sciences.

The Council reviewed the Current Policy on Research Funds in June 2021 and recommended that the policy be amended to focus more directly on research funding advocacy, a role the ADA has pursued for many years on behalf of member dentists and the entire profession.

In addition to revisions made to the existing resolved clause, a second resolve clause was added to reflect the need for—and importance of—ADA advocacy to support the diversification efforts in the oral health sciences. The recommended revisions are intended to articulate the urgent need for sustained, robust funding support from appropriate external agencies and organizations in oral health research. The Council believes that the proposed revisions to this policy statement are timely, appropriate, and present a clear public stance for the ADA on diversity and equity in the research workforce.

The Council recommends the following resolution be adopted:

Resolution

65. Resolved, that the ADA Policy Statement on Research Funds (Trans.1984:519; 1999:974; 2016:302) be amended as follows (additions underscored; deletions stricken):

Policy Statement on Research Fundings Advocacy

Resolved, that the ADA urges appropriate external agencies and organizations to provide advocate for sustained, robust funding for in basic, translational and clinical oral and craniofacial health research for the improvement of health outcomes in diverse populations across the lifespan advances the scientific basis of dentistry and the oral and craniofacial health sciences, and be it further
Resolved, that the ADA advocate for research funding to enhance gender, racial and
ethnic diversity and equity across the research workforce in the oral and craniofacial
health sciences.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO
BOARD DISCUSSION)
Resolution 66

Resolution No.  66   New

Report:   N/A    Date Submitted:   June 2021

Submitted By:   Council on Scientific Affairs

Reference Committee:   C (Dental Education, Science and Related Matters)

Total Net Financial Implication:   None   Net Dues Impact:   

Amount One-time   

Amount On-going   

ADA Strategic Plan Objective:   Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value:  See Background

RESCISSION OF THE POLICY, COMPARATIVE EFFECTIVENESS RESEARCH AND PATIENT-CENTERED OUTCOMES RESEARCH

Background: The ADA Policy Statement on Comparative Effectiveness Research and Patient-Centered Outcomes Research (Trans.2011:457; 2016:302) was adopted in 2011 and last reviewed by the Council on Scientific Affairs (Council) in 2016 as part of its regular review process. This policy urges the Patient-Centered Outcomes Research Institute (PCORI) or other comparative effectiveness research and patient-centered outcomes research (CER and PCOR) entities to consider several key principles when evaluating diagnostic or treatment modalities pertaining to the provision of oral health care.

The full text of the policy is provided in the worksheet addendum.

The Council’s review of the 2016 policy noted the following considerations:

- The policy statement is outdated and of limited utility. The PCORI was established in 2010 as a non-profit institute created through the 2010 Patient Protection and Affordable Care Act. Feedback from ADA Government Affairs division confirmed that the 2016 ADA policy statement has not been directly referenced or cited in ADA research advocacy efforts for some time (the last known advocacy-related correspondence presenting this policy statement is from March 2012).

- The policy statement is redundant. The ADA Policy Statement on Evidence-Based Dentistry (Trans.2001:462; 2012:469; 2017:275) provides a mechanism and framework for ADA advocacy for patient-centered outcome research and comparative effectiveness research. This is underscored by the current ADA Strategic Plan, Common Ground 2025, which indicates that being “science/evidence-based” is a core value for the Association.

- The policy has limited impact. The policy statement presents a general overview of recommendations or characteristics of CER supported by the ADA, as originally developed by the CSA (e.g., research on dental and oral conditions, diseases and therapies; participation of organized dentistry in the scientific and clinical aspects of comparative effectiveness studies). However, these recommendations and statements of principle have had relatively little impact on CER studies related to dental interventions.
The policy is imprecise. The policy includes some imprecise phrasings regarding CER and PCOR. As an example, the policy does not clearly delineate between the concepts of CER and PCOR, which are partially overlapping but distinct fields of study (the terms are also not fully synonymous). CER studies typically evaluate the comparative effectiveness of medications, devices, or other treatment interventions, but a CER study does not necessarily need to include an evaluation of patient-centered outcomes. Additionally, a PCOR study may not include a head-to-head comparative clinical evaluation of treatments and/or their impact on patient-important outcomes.

The Council determined that the 2016 ADA policy has fulfilled its intent of outlining desired components/attributes within CER studies on clinical issues related to dentistry, and that its currency and utility as ADA policy is no longer particularly strong (e.g., since PCORI’s establishment in 2010, dental CER studies have received relatively little research funding).

The Council also noted that its recommendation to amend the 2016 ADA Research Funds policy (see Resolution 65), which proposes amendments that focus more directly on research funding advocacy, would sufficiently provide for ADA advocacy for translational research, CER and PCOR. The Subcommittee considered this to be sufficient to address any future dental research considerations regarding these areas of study.

The Council recommends the following resolution be adopted:

Resolution


The American Dental Association (ADA) has a long history of identifying and supporting scientific advances in dentistry. Through rigorous scientific inquiry and knowledge sharing, the ADA supports advancements in dental research that improve the health of all Americans.

As an organization with a strong commitment to evidence-based dentistry and improving patient outcomes, the ADA supports comparative effectiveness research and patient-centered outcomes research (CER and PCOR) as methodologies that can lead to improved clinical outcomes, more cost-effective and personalized treatments, and increased patient satisfaction. Concurrently, such research should be designed to address important variables that may impact outcomes, such as patient subgroups to help address biological variability and individual patient needs.

Through the 2010 Patient Protection and Affordable Care Act, Congress has established an independent, non-profit organization to conduct comparative effectiveness research and patient-centered outcomes research. This organization, the Patient-Centered Outcomes Research Institute (PCORI), seeks public input and feedback prior to adoption of priorities, agendas, methodological standards, peer review processes and dissemination strategies.

Therefore, the ADA urges PCORI or other CER/PCOR entities to incorporate the following principles when evaluating diagnostic or treatment modalities pertaining to the provision of oral health care.

1. CER/PCOR Must Be Well Designed.

Objective, independent researchers should conduct thorough, rigorous and scientifically valid research with specific outcome measures. The researchers’ and sponsors’ actual potential and perceived conflicts of interest must be disclosed.

Protocols must be developed to ensure sound, reliable and reproducible research. Additionally, all efforts must be made to reduce bias in research protocols, literature reviews and clinical summaries.

Patient safety, confidentiality of personal health information and data security must be assured. Institutional review boards (IRBs) must be used to consider whether any risk to patients is balanced by potential research gains. Informed consent must be obtained from patients participating in CER and PCOR studies.

CER and PCOR must adequately consider specific populations by race, gender, ethnicity, age, economic status, geography or any other relevant variable to assure the applicability of the study. Long-term and short-term studies should be performed and adequately funded. Periodic reevaluation must be done to determine the efficacy of oral health related to CER/PCOR.

2. CER PCOR Process Must Be Open and Transparent.

Setting research priorities, developing research techniques and selecting investigators must be accomplished following an equitable, transparent process that emphasizes engagement with patients and openness to ideas from individuals across the health care community.

3. CER/PCOR Should Not Limit Innovative Treatments or Diagnostics.
CER/PCOR should not act to limit the continued development of innovative therapeutic or diagnostic modalities.

4. The Doctor/Patient Relationship Must Be Maintained.

The unique dentist/patient relationship and patient autonomy are overriding principles that must be included when assessing CER/PCOR information. Results from CER/PCOR studies should not be used to mandate or predetermine a course of treatment for an individual patient, nor should it be used to determine a standard of care.

5. CER/PCOR Should Be Widely Disseminated.

Balanced, clear, accurate, effective and timely communication of results, written with the audience in mind, should be made. PCORI or other CER/PCOR research entities should work with the ADA to disseminate results that are relevant to oral health care providers.

6. CER/PCOR Should Not Be Payment Driven.

PCORI or other CER/PCOR entities should not make recommendations on payment or coverage decisions. The primary focus of research designed and/or supported by PCORI or other CER and PCOR entities should be to improve patient outcomes, quality of care and/or quality of life.

7. CER/PCOR Should Address Dental Treatment Outcomes.

The dental profession needs PCOR and CER for improved evaluation of health outcomes in clinical practice. This includes independent evaluation of the effectiveness of specific treatments in dental practice.
COUNCIL ON SCIENTIFIC AFFAIRS REPORT 1 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 21H-2020—FEASIBILITY OF ASSESSING THE ROLE OF DENTAL HEALTH IN THE MANAGEMENT OF DISEASES AND MEDICAL CONDITIONS

Background: In October 2020, the Council on Scientific Affairs (Council) introduced proposed policy under Resolution 86H-2016, Proposal to Convene Three Expert Panels to Address Optimizing Dental Health Prior to Surgical/Medical Procedures and Treatment. The proposed policy was amended and ultimately adopted by the ADA House of Delegates (HOD) as Resolution 21H-2020, Proposed ADA Statement on Optimizing Dental Health Prior to Surgical/Medical Procedures and Treatments. The final adopted policy statement, as amended by the House of Delegates, reads as follows:

ADA Statement on Optimizing Dental Health Prior to Surgical/Medical Procedures and Treatments

The ADA believes that optimizing dental health prior to the performance of complex medical and surgical procedures can be an important component of clinical care. Inter-professional communication and collaboration are crucial to identifying pre-existing or underlying oral health concerns that may impact post-medical/surgical complications or healing time, particularly for patients who are immunocompromised or otherwise at greater risk of adverse medical outcomes because of underlying health problems. Direct communication with patients and their medical teams regarding the need for, and ability to obtain, a dental examination, as well as a consultation and treatment, when appropriate, prior to initiation of complex surgical and medical treatments is especially recommended.

and be it further,

Resolved, that the appropriate ADA agency consider the feasibility of assessing the role of dental health in the management of diseases and medical conditions and report back to the 2021 House of Delegates.

With the adoption of Resolution 21H-2020, the House of Delegates established new Association policy on Optimizing Dental Health Prior to Surgical/Medical Procedures and Treatments, and requested a report on the feasibility of assessing the role of dental health in the management of diseases and medical conditions. Following the 2020 HOD meeting, the policy was assigned to the Council as lead agency.
The Council considered the request within the context of work completed to date pertaining to Resolution 86H-2016, which included evidence-based reviews on optimizing oral health prior to the performance of complex medical and surgical procedures. To date, the Council has overseen work with respect to a previous House Resolution, 86H-2016, including evaluations of the effect of dental treatment before:

(a) cardiac valve surgery (published in September 2019) and (b) radiotherapy for head and neck cancer (pending completion in Q4 2021).

During its research efforts addressing Resolution 86H-2016, the Council determined that there is very limited evidence supporting oral health strategies, interventions, or treatments in the management of diseases and medical conditions. Similarly, it determined that there are few (if any) randomized clinical trials and observational studies addressing this very broad topic, and the evidence base is insufficient for conducting meta-analyses or systematic reviews, or drawing evidence-based statements and recommendations.

At its January 2021 meeting, the Council determined that there currently is insufficient evidence to support the development of an evidence-based deliverable addressing the role of dental health in the management of diseases and medical conditions.

Conclusion

Given these findings, the Council determined that at this time, while an important and clinically valuable area of study, there is insufficient high-quality research evidence to produce a viable evidence-based document or deliverable, including any type of review to support policy and inform practice.

Resolution

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
COUNCIL ON SCIENTIFIC AFFAIRS REPORT 2 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 72H-2020—MODIFYING THE EXISTING MEDICARE DENTAL COVERAGE: STATUTORY DENTAL EXCLUSION

Background: In October 2020, the ADA House of Delegates adopted Resolution 72H-2020 “Modifying the Existing Medicare Dental Coverage: Statutory Dental Exclusion” as part of a series of proposed resolutions introduced by the Eldercare Workgroup. This resolution was referred to the Council on Scientific Affairs (Council) in November 2020. The resolution reads as follows:

Resolved, that the appropriate ADA agencies should consider conducting a review of the current scientific evidence that would support expanding the oral health services provided to medically frail recipients prior to major medical or surgical treatments available through Medicare in order to determine next steps for modifying the Medicare statutory exclusion, with the recommendation that the review include but not be limited to the following:

- head and neck radiation therapies
- osteoclast inhibitor therapy
- organ transplants
- cancer chemotherapy including hematopoietic cell transplantation
- joint replacement
- cardiac valve replacement

Following a review of the resolution, and based on recent efforts and existing resources developed under Resolution 86H-2016, including investigations into dental treatment prior to cardiac valve surgery (JADA, Sept. 2019) and head and neck cancer treatments (publication forthcoming), the Council has concluded that the supporting research evidence on the above topic areas is sparse, and thus evidence-based reviews on the topic areas cited in the resolution would very likely lack the scientific basis to support any significant clinical conclusion or recommendation.

Additionally, the Council expressed concerns about the significant staff resources required to support such a request, as those resources have already been dedicated to existing projects and priorities.

While it concedes that Eldercare is an important topic, and that the areas put forth by the resolution are of clinical importance, based on the above considerations, the Council recommends against conducting a review of the current scientific evidence to support expanding the oral health services provided to medically frail recipients prior to major medical or surgical treatments available through Medicare.
Resolution

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
COUNCIL ON SCIENTIFIC AFFAIRS REPORT 3 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 75-2020—ELDER CARE STRATEGIES ON RESEARCH

Background: Resolution 75-2020, “Elder Care Strategies on Research,” was introduced to the ADA House of Delegates in October 2020 as part of a series of proposed resolutions introduced by the Eldercare Workgroup. In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar, which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each Referred Resolution, Resolution 75-2020 was reviewed by the Council on Scientific Affairs (Council), with support from the Council on Dental Practice (CDP), in November 2020. Resolution 75-2020 is appended to this report.

In response to this request, the Council considered the current research landscape with regard to integrating the five elder care strategies on research as priority projects, and reviewed a summary of current or forthcoming ADA resources targeting elder oral health care (Appendix 1), and elder care considerations in past and current systematic reviews and clinical practice guideline projects (e.g., development of guidelines on caries management and the management of acute dental pain).

The Council also considered its Intramural Research Priorities, which have been established through 2022 (with committed resources), but specifically note that the priority area of “Oral Diseases/Conditions” include the consideration of “specific patient sub-populations (e.g., pediatric, geriatric, pregnant patients) where relevant and appropriate” (Appendix 2). Furthermore, the Council’s Extramural Research Priorities (also established through 2022), which identify priority areas for external organizations to consider when conducting or funding research, similarly identify the need for extramural research addressing prevention, assessment and management of oral diseases and conditions “across a patient’s lifespan within diverse population groups” (Appendix 3).

The Council also noted that, in its consideration of a separate House resolution (21H-2020), relatively little research was identified that addressed oral health treatments/interventions on “optimizing oral health prior to the performance of complex medical and surgical procedures.” And noted that while data in this area are limited, the Council, in accordance with its stated priorities and initiatives, remains committed to consideration of older patient populations in its clinical resources, where feasible and appropriate.

At this time, given the above considerations, the Council recommends against pursuing development of any specific translatable research study on the oral health treatment of geriatric populations, including medically, functionally or cognitively impaired complex patients, to assist in establishing the linkage

How does this resolution increase member value: See Background
between oral health care and overall health. Accordingly, the council has decided not to re-offer the resolution for consideration.

Resolution

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
WORKSHEET ADDENDUM

2020 RESOLUTION 75—COUNCIL ON SCIENTIFIC AFFAIRS—ELDER CARE STRATEGIES ON RESEARCH

Resolution

75-2020. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder care strategies on research as priority projects, and be it further

Resolved, focus research by:

1. pursuing translatable research on the oral health treatment of geriatric populations including medically, functionally or cognitively impaired complex patients to establish the linkage between oral health care and overall health
2. leading in the collection and dissemination of evidence-based recommendations on the oral systemic health connection
3. studying states with dual eligible Medicare and Medicaid beneficiaries to determine the financial savings, health outcomes and costs of the programs
4. studying cost savings and health outcomes from dental benefit plans
5. promoting the implementation of new treatment approaches, such as Silver Diamine Fluoride or other minimally invasive interventions, and determining the beneficial effects of the treatments on older adult patients in terms of quality of life and cost effectiveness
Overview of ADA Resources Related to Resolution 75-2020--Elder Care Strategies on Research for Oral-Systemic Health and Translatable Research on the Oral Health Treatment of Older Individuals

Oral Diseases in the Growing Elderly Population: The Council recognizes that the burden of oral disease commonly increases with age, and that poor oral health can have a significant impact on overall health and quality of life. Caries and periodontal disease are the most prevalent oral diseases, particularly among older populations. Research from the National Center for Health Statistics has found that 20 percent of adults over age 65 have untreated tooth decay, and 25 percent of adults over 75 are edentulous. Epidemiologic studies, using data from the SEER database, have also shown that life-threatening conditions such as oral cancer affect older adults more commonly.

The ADA and CSA have developed a number of resources in the last few years to address this growing need. The following is an overview of recent CSA systematic reviews, guidelines and resources with information pertaining to elder oral health care and translatable research on the oral health treatment of older individuals (publication dates included parenthetically).

- Non-restorative Caries Management Meta-analysis; Systematic Review and Meta-analysis (Journal of Dental Research, January 2019), and Clinical Practice Guideline on Non-restorative Treatments for Carious Lesions (October 2018 JADA) [both articles present recommendations for older adults with root caries, including use of silver diamine fluoride];
- Systematic review on the effect of dental treatment before cardiac valve surgery: systematic review and meta-analysis (published in September 2019 issue of JADA);
- Forthcoming new draft guidelines on caries prevention and restorative caries treatment (both to include recommendations for adults 18-65 years of age and the elderly);
- Forthcoming new systematic review addressing the effect of dental intervention on subsequent development of osteoradionecrosis in people undergoing radiotherapy for head and neck cancer (to be submitted for publication in 2021).

Additional guideline projects that will be conducted over next two years (e.g., dental radiographic exams, sedation and general anesthesia) will also include clinical recommendations specific to older patients.

Enhancing the Relevance of ADA Evidence-based Clinical Practice Guidelines for Specific Subpopulations: The Council’s clinical practice guideline projects have consistently integrated considerations pertaining to specific patient subpopulations (e.g., children, adolescents, pregnant women, cancer patients under active treatment, the elderly, and patients with multiple comorbidities). The Council’s development of evidence-based guidelines has also presented opportunities for identifying future research needs and priorities on key clinical topics, such as oral cancer screening. The Council also works with the ADA Government and Public Affairs Division to advocate for support of oral health across the lifespan.

Additional Resources Addressing Elder Oral Health Care and Age-Related Oral-Systemic Health Considerations: The ADA publishes scientific information on a variety of topics via its Oral Health Topics (OHT) pages on ADA.org, for some of which the Council’s Clinical Excellence Subcommittee provides advisory oversight. The OHT pages address a range of elder oral health care and oral-systemic health considerations, including:

(a) Aging and Dental Health
(b) Oral-Systemic Health
(c) Hypertension (High Blood Pressure)
(d) Xerostomia (Dry Mouth)
(e) Diabetes
(f) Sjögren disease
Additional OHT pages address oral disease considerations for older individuals (e.g., a new OHT on silver diamine fluoride (SDF) presents evidence on the use of SDF for treating root caries).

The ADA also has several resources on dental therapeutics for various patient populations, including older individuals and the elderly, through the CSA’s guideline projects (e.g., caries management); and publications, including the ADA Dental Drug Handbook: A Quick Reference. An updated version of the ADA Dental Drug Handbook will be issued later in 2021, and will include a new chapter titled “The Elderly and Medication Considerations.”

The ADA has also developed a resource titled “Dentistry in Long-Term Care: Why It’s Important,” which addresses the importance of oral health care for the elderly in long-term facilities (e.g., to reduce risk for aspiration pneumonia).

“For the Patient” Pages Addressing Elder Oral Health Care: The ADA also publishes “For the Patient” pages in JADA to help dentists communicate with patients regarding oral health care and treatment. Recent “For the Patient” pages addressing elder oral health care considerations include the following: Oral Care During Cancer Treatment (January 2019); Oral and Throat Cancer (April 2019); Oral Health Tips for Caregivers (May 2019); The Changing Oral Health Care Needs of Older Adults (June 2020); Preventing Tooth Loss (September 2020); Is Your Mouth Always Dry? (October 2020). Another JADA “For the Patient” page (scheduled for publication in spring 2021) will address “Replacing Missing Teeth” (e.g., bridges, implants).
ADA Council on Scientific Affairs
Recommended Intramural Scientific Research Priorities
(2020-2022)

Background/Purpose

As America’s premier voice for oral health, the ADA advocates for strong investment in scientific research for the advancement of dental care and improvement of patient and population health outcomes. Beginning in 2020, and every three years thereafter, the ADA Council on Scientific Affairs (CSA) has a responsibility (in accordance with the ADA Governance and Organizational Manual) to identify intramural and extramural research priorities for the organization.

In 2018, the CSA chair created the Research Priorities Subcommittee to identify and propose intramural and extramural research priorities for CSA consideration. Priorities identified by CSA are intended to be practical and clinically relevant to practicing dentists and aimed at improving the safety and effectiveness of existing dental procedures, techniques, treatments, and products; as well as promoting the development and evaluation of novel treatments, techniques, and products that are most likely to impact dental practice in the near future. More specifically, these priorities provide recommendations to ADA Science and Research Institute (ADASRI) staff in their efforts to (1) synthesize, translate, and disseminate scientific content to inform clinical decisions; and (2) evaluate/test dental products and technologies relevant to practicing dentists.

The Council emphasizes that these priorities are not exhaustive, but rather address important scientific issues and research needs that are directly related to patient care, are actionable, and are most likely to significantly impact the practice of dentistry. The identified priorities reflect interests of ADA members reflected in environmental scans, as well as input from CSA members and ADA staff. Periodic review of these priorities will help ensure that the identified priorities accurately reflect the immediate interests and needs of practicing dentists. Once approved, these priorities will be submitted to ADA senior leadership, the ADA House of Delegates, and to the ADASRI Board to help coordinate the ADA and ADASRI scientific research portfolios.

CSA Recommended Intramural Research Priorities (2020-2022)

The CSA recommends that the ADA support scientific research in the following categories for 2020-2022 (listed in alphabetical order):

- **Dental Equipment and Instruments**
  - CAD/CAM
  - Curing units
  - Dental radiographs and computed tomography
  - Handpieces and instruments

- **Dental Pharmacology**
  - Antibiotic stewardship
  - Management of acute dental pain (including patient expectations of pain)

- **Innovations and Assessment of Biomaterials/Dental Materials**
  Note: Where relevant and appropriate, the characteristics of the materials as they interact with the oral environment and tissues should be addressed.
- Bonding agents
- Ceramics
- Composites
- Corrosion of dental materials

- **Oral Diseases/Conditions**
  *Note: Where relevant and appropriate, the needs of specific patient sub-populations (e.g., pediatric, geriatric, pregnant patients) should be addressed.*
  - Caries
  - Dental acid erosion
  - Dental considerations for medically-complex patients (Resolution 86H-2016)
  - Oral and oropharyngeal cancer
  - Periodontal disease
  - Xerostomia/hyposalivation

- **Oral Hygiene Products**
  - OTC products
  - Professionally-applied products
  - Professionally-dispensed products

- **Orthodontic aligners**

- **Tobacco, Nicotine, and Marijuana Products**
  - Cannabis and cannabidiol products (Resolution 79H-2019)
  - Vaping and electronic cigarettes (Resolution 84H-2019)
ADA Council on Scientific Affairs
Recommended Extramural Research Priorities for Oral Health: Addressing the Needs of Practicing Dentists in the United States (2020-2022)

Background/Purpose

As America’s premier voice for oral health, the ADA advocates for strong investment in scientific research for the advancement of dental care and improvement of patient and population health outcomes. Beginning in 2020, and every three years thereafter, the ADA Council on Scientific Affairs (CSA) has a duty to define intramural and extramural research priorities that are practical and clinically relevant to practicing dentists. Priorities are aimed at improving the safety and effectiveness of existing dental procedures, techniques, treatments, and products; as well as promoting the development and evaluation of novel treatments, techniques, and products that are most likely to impact dental practice in the near future.

In 2018, the CSA chair created the Research Priorities Subcommittee to identify and propose intramural and extramural research priorities for CSA consideration. Extramural priorities are intended to provide list of key research priorities for the Association. The ADA Extramural Research Priorities are shared with external organizations, dental schools and funding agencies to promote further study and external financial support for these priorities. Triennial updates help ensure that the document addresses existing and emerging research needs and priorities in dentistry, with input from ADA members and other critical stakeholders.

As America’s leading advocate for oral health, the ADA strongly supports the dental research enterprise, and takes a leading role in promoting, conducting and critically reviewing research on topics related to dentistry and its relationship to the overall health of individuals and populations. The ADA will continue to serve as a facilitator of the national dental research effort, identify priority topics for research, and help ensure the timely dissemination of information to the profession.

CSA Recommended Extramural Research Priorities (2020-2022)

Priority 1: Strengthen the Nation’s Investment in the Oral Health Research Infrastructure

1. Expand the oral health research infrastructure across the research continuum to facilitate research conduct and scholarly activity.
2. Invest in training to improve diversity and inclusivity within the oral health research workforce.
3. Support “big data” and health services research, including use of the dental practice-based research network and/or large clinical databases, to improve oral health surveillance and oral disease monitoring.

Priority 2: Integrate Dental and Medical Aspects of Dental and Craniofacial Research to Improve Patient Care

1. Examine the relevance of oral health to the overall well-being and health of individuals and populations, and promote resulting evidence of these relationships.
2. Promote the integration of oral diseases and oral health quality-of-life outcomes into health studies and initiatives.
3. Explore the impact of environmental, behavioral, and social determinants on oral health outcomes across a patient's lifespan within diverse population groups.

4. Examine the complexity of the human oral microbiome and its interactions with other human ecosystems.

5. Promote the integration of principles and practices of evidence-based dentistry within the rapidly changing scientific foundation of precision health care, and seek inclusion of dentistry in this scientific foundation, such as within the auspices of the Precision Medicine Initiative.

6. Expand funding to support integration of dental electronic health record systems with medical systems, with the goal of promoting the integration of oral health care within the overall health care system.

7. Support oral health research funding opportunities to enable more multidisciplinary and interprofessional longitudinal studies.

Priority 3: Improve Prevention of Oral Diseases and Conditions across a Patient’s Lifespan within Diverse Population Groups

1. Support studies on the etiology and prevention of oral diseases and conditions. Diseases and conditions of interest include (in alphabetical order):
   - Caries
   - Dental acid erosion
   - Oral and oropharyngeal cancer
   - Peri-implant conditions
   - Periodontal disease
   - Xerostomia/hyposalivation

2. Support the development of evidence-based clinical practice guidelines for the prevention of oral diseases and conditions. Diseases and conditions of interest include (in alphabetical order):
   - Caries
   - Oral and oropharyngeal cancer
   - Periodontal disease

3. Support research on the role of tobacco, nicotine, and marijuana products in oral disease (including vaping and e-cigarettes).

Priority 4: Improve the Assessment and Management of Oral Diseases and Conditions Across a Patient’s Lifespan within Diverse Population Groups

1. Support studies on the pathogenesis and pathophysiology of oral diseases and conditions, including diagnostic, prognostic and risk assessment tools to advance precision dentistry and establish foundational knowledge for improved therapies. Diseases and conditions of interest include (in alphabetical order):

*Diverse population groups include, but are not limited to: geriatric individuals (e.g., focus on root caries and patients with hyposalivation), children and adolescents; pregnant and medically-complex patients; and vulnerable populations (e.g., disabilities, etc.). Diversity considerations also include research into gender-specific responses to preventive and therapeutic strategies used to address oral diseases and conditions.
2. Support the development of evidence-based clinical practice guidelines to address the management of (in alphabetical order):

- Acute dental pain
- Caries
- Oral and oropharyngeal cancer
- Periodontal disease

3. Explore the mechanisms of pain and management of acute and chronic dental pain (including patient expectations and perceptions of pain).

4. Expand the understanding of the underpinnings of inflammatory responses associated with oral diseases and conditions to include the innate immune response, neuro-inflammatory pathways and epithelial barrier functions, with the goal of developing applications for individual and population health.

5. Support and promote research for the development, testing, and use of safe, novel restorative materials and biomimetic materials for oral and craniofacial health care, including the restoration and regeneration of hard and soft tissues affected by trauma, disease and developmental defects.

**Priority 5: Encourage the Dissemination and Implementation of New Evidence-Based Technologies, Tools, and Strategies to Improve Oral Health Outcomes**

1. Support research on the adoption and use of evidence-based strategies, including clinical practice guidelines, risk assessment protocols, and other clinical decision support tools, to enhance the prevention and management of common oral diseases and conditions, including acute dental pain, caries, periodontal disease, and oral cancer.

2. Support research on the effectiveness of tele-dentistry and other virtual consultation applications to improve patient health outcomes.

3. Identify barriers to the:
   - diffusion of new knowledge in oral health;
   - implementation of effective oral health treatments; and
   - identification and de-implementation of ineffective oral health treatments.

**Priority 6: Encourage Effective and Holistic Infectious Disease Response Research**

*Note: This priority is derived from, but not limited to, response items related to COVID-19, and is intended to address the needs of dentists and patients stemming from similar public health emergencies.*

1. Support research to develop patient treatment protocols and decision support tools to enhance dental response to pandemics and other public health emergencies. This includes:
• Research into the risks of disease transmission in the dental clinic, with emphasis on aerosolized and airborne infectious agents;
• Development of new practice paradigms;
• Triage of care;
• Emergency treatment needs and criteria;
• Occupational health and safety of dental teams; and
• Protection and safety of patients during treatment.

2. Advance the understanding of anxiety and other mental health conditions that impact dental treatment during a public health emergency; this includes mental health research aimed at both dental teams and patients.

3. Support studies for the development of safe and effective infection control procedures and protocols for use in dental treatment environments; this includes research to address:
   • Risk of disease transmission within dental settings;
   • Personal protective equipment; and
   • Disease monitoring to protect the health of patients and the dental team.
COUNCIL ON SCIENTIFIC AFFAIRS REPORT 4 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 109-2020: ADA POLICY ON TOOTH GEMS AND JEWELRY

Background: Resolution 109-2020, “ADA Policy on Tooth Gems and Jewelry,” was submitted by the Fourteenth District for consideration by the 2020 House of Delegates (HOD). This resolution was included on the 2020 HOD referral consent calendar.

In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar, which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each Referred Resolution, Resolution 109-2020 was reviewed by the Council on Scientific Affairs (Council). In October 2020, the Council chair assigned Resolution 109-2020 to its Clinical Excellence Subcommittee (Subcommittee). Resolution 109-2020 is appended to this report.

Update: In an audit of existing resources on this subject, the Subcommittee noted that a recently-updated Oral Health Topics (OHT) page on Oral Piercing/Jewelry presented information on the use of tooth gems and oral jewelry.

Tooth gems are a type of tooth jewelry, and practices of oral ornamentation (decoration with jewels, crystals, gold, rhinestone or other gems/stones) are associated with various cultures worldwide. In contemporary society, tooth gems using diamonds or precious stones have become used as forms of oral body art and self-expression. Other forms of oral jewelry are also available to consumers, including dental grills (also called “grillz” or “fronts”), or ornamental gold crowns worn on anterior teeth (usually an incisor). The Council notes that research articles on tooth gems and jewelry are relatively scarce, and no systematic reviews on the topic are available at present.

In addition to the OHT page, an existing ADA policy was identified as a potentially appropriate vehicle for efficiently addressing the request of a new ADA policy on tooth gems. The existing ADA Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting is as follows:


Resolved, that the American Dental Association advises against the practices of cosmetic intraoral/perioral piercing and tongue splitting, and views these as invasive procedures with negative health sequelae that outweigh any potential benefit.
This policy was identified for regular review by the Council in 2021 pursuant to Resolution 170H-2012, Regular Comprehensive Policy Review (Trans.2012:370), which requires review of ADA policies on a five-year cycle. At its January 2021 meeting, the Council, following the recommendation of the Subcommittee, concluded that considerations regarding tooth gems and oral jewelry have a fair degree of overlap with the current ADA Policy on Intraoral/Perioral Piercing and Tongue Splitting and that a revision of existing policy may be a more appropriate vehicle to address Resolution 109-2020.

Given these findings, the Council does not recommend creation of new policy on tooth gems. In response to Resolution 109-2020, a proposed revision of existing ADA policy on oral piercings and tongue splitting is recommended in a separate report.

Resolution

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
WORKSHEET ADDENDUM

2020 RESOLUTION 109—FOURTEENTH TRUSTEE DISTRICT—ADA POLICY ON TOOTH GEMS AND JEWELRY

Resolution

109-2020. Resolved, that the appropriate ADA agencies recommend a policy on tooth gems and jewelry to the 2021 House of Delegates.
Resolution No.  None N/A

Report:  Board Report 5 Date Submitted:  August 2021

Submitted By:  Board of Trustees

Reference Committee:  C (Dental Education, Science and Related Matters)

Total Net Financial Implication:  None Net Dues Impact:  

Amount One-time  Amount On-going  

ADA Strategic Plan Objective: Membership Obj-3: Maintain an overall retention rate of 94%.

How does this resolution increase member value: See Background

REPORT 5 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ADA LIBRARY AND ARCHIVES ADVISORY BOARD ANNUAL REPORT

Background: In November 2013, the ADA House of Delegates approved the ADA Library and Archives Transition Plan, including the establishment of a volunteer board to oversee operations of the ADA Library and Archives. An engaged and functioning advisory board is considered a best practice for library management. The ADA Library and Archives Advisory Board serves in an advisory capacity to the Board of Trustees.

At its September 2021 meeting, the Board of Trustees approved the appended Annual Report of the ADA Library Archives Advisory Board for transmittal to the 2021 House of Delegates.

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
Appendix 1

ADA Library & Archives Advisory Board

Harrington, Jr., John F., 2021, Board of Trustees, 5th District (chair)
Liddell, Rudolph, 2021, Board of Trustees, 17th District
Dionne, Raymond, 2021, North Carolina, Council on Scientific Affairs
Lefebvre, Carol A., 2021, Georgia, Council on Scientific Affairs
Niessen, Linda, 2021, Texas, Council on Dental Education and Licensure
Lim, Jun, 2021, Illinois, Council on Dental Education and Licensure
Masters, Antonette, 2021, California, at-large member
Jhaveri, Viren, 2021, New York, at-large member
Nevius, Amanda, 2021, public member, special/dental librarian
Nickisch Duggan, Heidi, director, ADA Library & Archives
Fleming, Anna, electronic resources & research services librarian, ADA Library & Archives
Matlak, Andrea, archivist & metadata librarian, ADA Library & Archives
O’Brien, Kelly, informationist, ADA Library & Archives
Pontillo, Laura, coordinator, ADA Library & Archives
Strayhorn, Nicole, data informationist, ADA Library & Archives

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

The areas of responsibility for the ADA Library & Archives Advisory Board (LAAB) are as follows:

- Creating and developing the mission and strategic plan of the ADA Library & Archives.
- Ensuring that the ADA Library & Archives remain relevant to the ADA strategic plan.
- Providing input during the annual ADA budgeting process on library funding, priorities and needs.
- Adopting policies and rules regarding library governance, assets and use; developing, approving, and codifying all policies, based on input from the library staff; also delegating procedural work to the library staff.
- Regularly planning and evaluating the library’s service program.
- Evaluating the library facility to ensure that it continues to meet ADA member and ADA staff needs.
- Launching a marketing plan for the promotion of the ADA Library & Archives to ADA members; ADA component and constituent societies; the local dental and medical communities; and affiliated dental organizations.
- Conducting the business of the library in an open and ethical manner in compliance with all applicable laws and regulations and with respect for the association, staff and public.

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

Objective 1: Grow Active, Full Dues Paying Membership

Initiative/Program: Scientific Support/Utilization of Library Content

Success Measure: Achieve a 10% variance in the number of user searches via electronic resources from prior year by December 2020.
Target: 109,026 (Regular and automated searches)

Range: 98,123 – 119,929

Outcome: Exceeded, 131,744

Usage statistics show continued increased use of the Library’s electronic resources (journals, databases, e-books, clinical resources). ADA members and staff conducted approximately 21% more regular and automated searches in 2020 over 2019’s 79,142 regular and automated searches.

Table 1: Database Searches, Regular* and Automated**, 2020

<table>
<thead>
<tr>
<th>Target</th>
<th>Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>109,026</td>
<td>131,744</td>
</tr>
<tr>
<td></td>
<td>21%</td>
</tr>
</tbody>
</table>

*Regular Searches refers to the number of times a user searches a database, where they have actively chosen that database from a list of options OR there is only one database available to search.

**Automated Searches refers to the number of times a user searches a database, where they have not actively chosen that database from a list of options. That is, Searches Automated is recorded when the platform offers a search across multiple databases by default, and the user has not elected to limit their search to a subset of those databases.

Table 2: Top 5 Subscribed Databases by Regular & Automated Searches, 2020

<table>
<thead>
<tr>
<th>Database</th>
<th>Searches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentistry &amp; Oral Sciences Source</td>
<td>6,731</td>
</tr>
<tr>
<td>MEDLINE Complete</td>
<td>6,522</td>
</tr>
<tr>
<td>Health Business Elite</td>
<td>5,016</td>
</tr>
<tr>
<td>CINAHL Complete</td>
<td>4,986</td>
</tr>
<tr>
<td>DynaMed</td>
<td>4,687</td>
</tr>
</tbody>
</table>
DynaMed, an evidence-based resource of drug information and clinical summaries intended to reduce time-to-answer, is available through the ADA Library & Archives website. DynaMed incorporated enhancements such as CE in 2020. The library does not yet have data on how many ADA members are claiming CE for their learning. There is no additional cost to ADA members to access this valuable resource.

*Regular Searches refers to the number of times a user searches a database, where they have actively chosen that database from a list of options OR there is only one database available to search.

**Automated Searches refers to the number of times a user searches a database, where they have not actively chosen that database from a list of options. That is, Searches Automated is recorded when the platform offers a search across multiple databases by default, and the user has not elected to limit their search to a subset of those databases.

Table 3. DynaMed Searches

<table>
<thead>
<tr>
<th>Year</th>
<th>Regular Searches</th>
<th>Automated Searches</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>556</td>
<td>2,819</td>
</tr>
<tr>
<td>2018</td>
<td>386</td>
<td>4,404</td>
</tr>
<tr>
<td>2019</td>
<td>421</td>
<td>6,073</td>
</tr>
<tr>
<td>2020</td>
<td>276</td>
<td>4406</td>
</tr>
<tr>
<td>2021 Q1</td>
<td>52</td>
<td>716</td>
</tr>
</tbody>
</table>

Objective 2: Grow Active, Full Dues Paying Membership

Initiative/Program: Scientific Support/Utilization of Library Content

Success Measure: Achieve a 10% variance in the number of unique item investigations and full-text downloads via electronic resources from prior year by December 2020.

Target: 22,111

Range: 19,900 – 24,322

Outcome: Exceeded, 25,229

Downloads and unique item investigations (the number of unique content items (e.g. chapters) investigated by a user) are more difficult to predict because ADA staff and members tend to search for known items and ask for staff assistance when conducting more open research, for instance, to answer a clinical question. As a result, ADA Library & Archives staff search more broadly, thus increasing the total search numbers but selecting fewer and more focused full-text downloads than the typical user might. ADA Library & Archives service goals influence sending only the most relevant full-text downloads combined with abstracts and citations to prompt user evaluation.
### Table 4: Downloads & Unique Item Investigations, 2020

<table>
<thead>
<tr>
<th>Year</th>
<th>Target</th>
<th>Diff</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>22,111</td>
<td>25,229</td>
<td>14%</td>
</tr>
</tbody>
</table>

### Table 5: Top 10 Journals by Article Downloads, 2020

<table>
<thead>
<tr>
<th>Rank</th>
<th>Title</th>
<th>Downloads</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>JADA</td>
<td>4,114</td>
</tr>
<tr>
<td>2</td>
<td>Journal of Esthetic and Restorative Dentistry</td>
<td>1,185</td>
</tr>
<tr>
<td>3</td>
<td>Journal of Prosthetic Dentistry</td>
<td>1,173</td>
</tr>
<tr>
<td>4</td>
<td>American Journal of Orthodontics and Dentofacial Orthopedics</td>
<td>1,034</td>
</tr>
<tr>
<td>5</td>
<td>Dental Clinics of North America</td>
<td>1,024</td>
</tr>
<tr>
<td>6</td>
<td>JAMA Otolaryngology Head &amp; Neck Surgery</td>
<td>937</td>
</tr>
<tr>
<td>7</td>
<td>British Dental Journal</td>
<td>857</td>
</tr>
<tr>
<td>8</td>
<td>Dental Abstracts</td>
<td>841</td>
</tr>
<tr>
<td>9</td>
<td>Oral and Maxillofacial Surgery Clinics of North America</td>
<td>830</td>
</tr>
<tr>
<td>10</td>
<td>Dental Clinics of North America</td>
<td>822</td>
</tr>
</tbody>
</table>

### Table 6. Top 10 eBook Title Usage, 2020

<table>
<thead>
<tr>
<th>Title</th>
<th>Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohen's Pathways of the Pulp Expert Consult</td>
<td>25</td>
</tr>
<tr>
<td>Craig's Restorative Dental Materials</td>
<td>19</td>
</tr>
<tr>
<td>Dental Implant Prosthetics</td>
<td>17</td>
</tr>
<tr>
<td>Distraction Osteogenesis of the Facial Skeleton</td>
<td>16</td>
</tr>
<tr>
<td>Dental Implants (Dental Clinics of North America)</td>
<td>12</td>
</tr>
<tr>
<td>Wheeler's Dental Anatomy, Physiology, and Occlusion</td>
<td>11</td>
</tr>
<tr>
<td>McDonald and Avery's Dentistry for the Child and...</td>
<td>11</td>
</tr>
<tr>
<td>Mosby's Dental Dictionary</td>
<td>10</td>
</tr>
<tr>
<td>Global Diagnosis: A New Vision of Dental Diagnosis...</td>
<td>10</td>
</tr>
<tr>
<td>Handbook of Nitrous Oxide and Oxygen Sedation.</td>
<td>8</td>
</tr>
</tbody>
</table>
**Emerging Issues and Trends**

Libraries continue to maximize resources through the expanded use of digital and electronic means to convey information to their patrons. The ADA Library & Archives continually reviews these rapid changes in order to remain relevant to ADA Members and the profession. The LAAB is committed to:

**World-wide Remote Access**

Providing efficient searching using current eResources and making the Library & Archives a 24/7 knowledge center. This is partially accomplished by the implementation of DISCOVERY and OpenAthens, an identity access management tool that allows members to access subscribed electronic content 24/7, and augmented by document delivery and interlibrary loan services.

---

### Table 7. OpenAthens Usage

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021 Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts</td>
<td>759</td>
<td>853</td>
<td>884</td>
<td>756</td>
</tr>
<tr>
<td>Accesses</td>
<td></td>
<td>5,234</td>
<td>5,040</td>
<td>5,591</td>
</tr>
</tbody>
</table>

*On-site (ADA building at 211 E. Chicago) usage is not reflected in these statistics; complete resource use is much higher and includes staff use, in-house research, etc. Coming fall 2021 in the new Digital Members Experience, all library traffic will be pushed through OpenAthens.

---

### Table 8. Open Athens Users by Country

<table>
<thead>
<tr>
<th>Country</th>
<th>2019</th>
<th>2020</th>
<th>2021 Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts</td>
<td>759</td>
<td>853</td>
<td>884</td>
</tr>
<tr>
<td>Accesses</td>
<td>5,234</td>
<td>5,040</td>
<td>5,591</td>
</tr>
</tbody>
</table>

*On-site (ADA building at 211 E. Chicago) usage is not reflected in these statistics; complete resource use is much higher and includes staff use, in-house research, etc. Coming fall 2021 in the new Digital Members Experience, all library traffic will be pushed through OpenAthens.

---

Interlibrary loan (ILL) services provide ADA Staff and members with scholarly articles not held in the collections of the ADA Library & Archives (borrowing) and provide those same services to outside researchers via other libraries (lending). In 2020, the ADA Library & Archives fulfilled 49% of ILL requests from outside libraries. Outside libraries fulfilled 94% of the ILL requests from ADA members and staff.
Like many university and public libraries, COVID-19 restrictions limited access to the print collection of books and journals. Library staff are adept at leveraging existing library networks to obtain articles and books for members and staff. Additionally, a catalog maintenance project prior to and during the pandemic ensured ADA Library holdings were accurate in the global library catalog that is visible to other libraries.

**Information Services**

The current staff roles allow for faster, more robust reference assistance and user education, expert searching, and new means of engaging with members. In addition to multiple daily rapid reference questions, library staff addressed over 300 complex literature searches and clinical queries for ADA staff and members.

Continuous support of various information needs of ADA Science and Research Institute (ADASRI). Informationist Kelly O’Brien actively engages in expert searching for clinical practice guideline development and systematic reviews, provides education and access to evidence-based clinical tools and drug information, and provides expert support for initiatives such as the ADA/FDA joint statement on The...
Selection of Patients for Dental Radiographic Examinations, and ADA COVID-19 Interim Recommendation & Guidance. Coordinator Laura Pontillo has retrieved and uploaded well over 1,000 full-text articles into DistillerSR, an important systematic review and literature review software tool used by ADASRI.

**ADA Archives and Dental History**

Provide expert reference and research assistance to ADA staff, members, and other dental organizations and institutions, searching for information on ADA history, history of dentistry and biographical information on individuals involved in the profession. This year in spite of the COVID-19 lockdown, remote work, and isolation from the archival collections, ADA Archivist Andrea Matlak answered daily queries from ADA staff and members as well as members of the public on a variety of different topics including ADA / dental profession response to the 1918 "Spanish" influenza pandemic, dental instrument sterilization history, ADA tracking of dentists mortality. Moreover, Ms. Matlak provided information on the history of women in dentistry to the writer/editor of an article on the topic that was published in the May 2020 Bulletin of The Second District Dental Society of New York. She also updated the ADA history timeline on ADA.org (https://www.ada.org/en/about-the-ada/ada-history-and-presidents-of-the-ada), adding entries for 2015-2020.

**Data Visualization Services**

Providing expertise in data visualization to drive policy, planning, and other decision making in support of ADA initiatives, publications, and strategic goals. Informationist Nicole Strayhorn continues to create and enhance data dashboards such as the National Dashboard in collaboration with the Membership Data and Reporting Team (MDAR) by incorporating more visualizations related to member acquisitions, retention, and conversion. ADA staff members continue to use this dashboard daily to improve data-driven decision making for membership growth, perform membership outreach to state societies and associations, and eliminate paper reports.

Ms. Strayhorn also re-designed the Dental Licensure dashboard to incorporate Continuing Education information and COVID-19 related information to help established dentists and dentists working across state lines navigate continuously changing information and upcoming deadlines on requirements from all states. Finally, in collaboration with the former ADA Center for Professional Success (CPS), Ms. Strayhorn designed and launched the ADA Practice Location Tool for Dentists (https://www.ada.org/en/member-center/member-benefits/practice-resources/ada-practice-state-map-for-dentists) utilizing Tableau to enable dentists to make more informed decisions on where to start a dental practice or relocate a practice, and capitalize on untapped business opportunities using spatial information.

**COVID-19 Response**

Leveraging expertise to support COVID-19 efforts at the ADA. The staff created an FAQ Site for COVID-19-related questions and answers to assist the Member Service Center and other Association staff, volunteers, and the Board of Trustees in finding accurate, up-to-date information to reflect and supplement the ADA.org/virus webpages. The FAQ site had more than 500 entries at its height (370 currently). The ADA Archives has archived the items that no longer are current.

Ms. Pontillo continues to engage with Science, Dental Practice, Membership, and others departments and divisions to ensure a continuously-updated COVID-19 repository that is accessible to all ADA Board of Trustees, state societies and association staff, and ADA staff. Mrs. Nickisch Duggan served as the Scrum Master for the Education & Licensure COVID-19 Rapid Response Team and as a member of the ADA’s COVID-19 Rapid Response Team. Ms. O’Brien provided expert searching for the ADA COVID-19 Interim Recommendation & Guidance and other toolkits. She has also developed an alert system for ADASRI to stay on top of new literature regarding COVID-19 infection control with new variants & COVID-19 long term vaccination response.
Ms. Strayhorn collaborated with the COVID-19 Rapid Response Team and Member & Client Services Division to develop three dashboards:

- COVID-19 State Mandates and Recommendations (over 500,000 views) - 

- COVID-19 Vaccine Regulations for Dentists Map (over 111,000 views) - 

- Clinical Laboratory Improvement Amendments (CLIA) State Information for Dentists (over 4,000 views) - 

Professional Contributions/Education

Contributing to professional activities and remaining active in the library and archive community-at-large by participating in professional organization committees and building partnerships. All library & archives staff members engage in professional development via professional association conferences and other learning opportunities.

Ms. O’Brien served as a reviewer for the peer-reviewed publication Journal of the Medical Library Association (JMLA).

Ms. Strayhorn became Tableau certified after taking the Tableau Desktop Specialist Exam to enhance her skills as an effective leader in Tableau, a powerful data-visualization tool.

Ms. Pontillo earned her Masters of Library and Information Science (MLIS) degree from the University of Illinois at Urbana-Champaign in December 2020.

Ms. Fleming served as Chair of the Medical Library Association’s Donald A. B. Lindberg Research Fellowship Jury. The fellowship funds research linking the information services provided by librarians to improved health care and advances in biomedical research.

Ms. Matlak collaborated with the Sindecuse Museum of Dentistry at the University of Michigan School of Dentistry in the loan of a tooth fairy themed electric toothbrush from the Archives Artifacts Collection (Object 83.2) for use in its Tooth Fairy Exhibit. View the item in situ in the exhibit: https://www.flickr.com/photos/dentalmuseum/47698713702/in/album-72157706865199851/. The item was donated to the ADA Library & Archives in 1983 by Dr. Rosemary Wells, an Illinois dentist who was an expert on dental folklore and operated a tooth fairy museum from her home during her lifetime.

Ms. Nickisch Duggan served as a Special Emphasis Panel (SEP) member for the National Institutes of Health, National Library of Medicine: Regional Medical Libraries for the National Network of the National Library of Medicine (UG4) and Network of the National Library of Medicine Evaluation Center (U24). She continues to serve as a reviewer and panel member for Institutional Review Boards (IRBs) at Northwestern University, Ann & Robert H. Lurie Children’s Hospital of Chicago, and the ADA.

Policy Review


Resolved, that the ADA donate its excess library materials to organizations in need of these materials, and be it further

Resolved, that the ADA encourage its allied dental organizations to also donate their excess materials.

The policy was a directive that became moot once the task to Donation of ADA Library Materials (Trans.1993:684; 2012:512) was completed. Accordingly, the Speaker directed that the policy not be published in future editions of Current Policies.
Resolution No. 80

Report: N/A

Date Submitted: August 26, 2021

Submitted By: Ninth District, Co-Sponsored by Districts Two and Thirteen

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: $5,000

Net Dues Impact: $0.05

Amount One-time $5,000

Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: See Background

ELECTRONIC ARCHIVING OF STATE AND COMPONENT DENTAL PUBLICATIONS

Background: For many years, the ADA library was the repository and archivist for almost every dental publication in the world. Dental editors from around the globe would mail each issue of their respective publication to the ADA Library where it would be catalogued and stored for both reference and historical purposes. Maintaining this archive was discontinued by the ADA and much of the historical content has been lost. For a time, the National Library of Medicine (NLM) accepted dental publications through an agreement with the ADA. NLM index is given to articles that can be searched through PubMed. Up until 2017, many if not all, state journals were included in PubMed listings. Since that time, to be consistent with their mission, PubMed will only archive professional journals that meet rigid criteria that exclude most dental publications. Many tripartite publications publish peer-reviewed clinical and scientific articles, however, they also present promotional and news content on the activities of their professional organization. Because this blended content is not viewed to be consistent with NLM and PubMed’s inclusion criteria, most state and local dental publications are not accepted.

State and local journals rank among the most read by dental professionals. Many authors choose not to publish in journals not indexed by PubMed. The result is that valuable clinical information is not archived and not available to the profession through our blended journals, diminishing awareness of and access to the evolving literature. This is a loss to the dental profession.

During the COVID-19 Pandemic, ADA Executive Director Kathleen O’Loughlin called on the profession to document and archive the issues they face in dealing with this event. It was that sentiment that drove the creation of the ADA’s JADA+COVIDE-19 monograph – a digital collection of stories, reflections and accounts intended to archive dentistry’s response to the pandemic.

We believe it is appropriate for the American Dental Association, the Voice of the profession, to reestablish itself as the repository and archive for all U.S. dental state and component publications in a searchable electronic format. Dentistry is defined by its professional literature. The progress and history of our tripartite must be preserved to guide the advancement of the profession and lend historical perspective. Digital publishing is currently offered across the dental community. These digital efficiencies offer the most reasonable and financially feasible way to accomplish archiving our profession’s literature.

Resolution

80. Resolved, that the appropriate ADA agencies explore creating or facilitating a searchable digital archive for tripartite publications and report back to the 2022 House of Delegates.
BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO
BOARD DISCUSSION)
NOTES
Resolution No. 81 — New

Report: Board Report 8 — Date Submitted: August 2021

Submitted By: Board of Trustees

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: $10,000

Net Dues Impact: 

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

BOARD REPORT 8 TO THE HOUSE OF DELEGATES: RESOLUTION 74-2020—ELDER CARE WORK GROUP—ELDER CARE STRATEGIES FOR CONTINUING EDUCATION

Background: In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar, which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each Referred Resolution, Resolution 74-2020, Elder Care Strategies for Continuing Education, was reviewed by the Advisory Committee on Annual Meetings (in collaboration with the Council on Dental Practice). Resolution 74-2020 is appended to this report.

At its September meeting, the Board of Trustees considered the review of Resolution 74-2020 by the Advisory Committee and is proposing a modified version of the resolution presented in 2020 by removing the education of the public as well as clarifying some of the language of the second resolved based on the following:

- Continuing education developers throughout the ADA agencies provide CE opportunities for the profession and do not provide education for the public. References to the public have been removed from the second resolved.
- Items one and two under the second resolved have been combined to cover the elevation of both the oral-systemic connection and the dental management of the medically complex older adult through the delivery of education and continuing education granting opportunities via all ADA delivery channels.
- Item three has been removed because the ADA is always seeking out the most qualified speakers and subject matter experts to present continuing education for all delivery modalities and currently maintains a database of scouted speakers which includes elder care. The mechanism for this work is already in place and is ongoing.
- Item four remains as is.

Therefore, the Board of Trustees proposes the following resolution (additions underscored; deletions stricken):

Resolution

81. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder care strategies on both the oral-systemic connection and the dental management of the medically complex older adult as priority projects, and be it further

...
Resolved, elevate the importance of both the oral-systemic connection and the dental management of the medically complex older adult to members and the public the dental community, as appropriate, by:

1. providing educational opportunities for the profession on the oral-systemic connection.
2. promoting dental continuing education on treating the medically, functionally or cognitively complex patients through the Annual Meeting or other ADA meetings.
3. developing and maintaining a roster of qualified speakers both the oral-systemic connection and the dental management of the medically complex older adult.
4. developing and delivering dental continuing education on both the oral-systemic connection and the dental management of the medically complex older adult through ADA online CE, SmileCon programs, and other ADA meetings, publications and programming as appropriate.
5. developing presentations on both the oral-systemic connection and the dental management of the medically complex older adult for use by member state or local dental societies, and to be shared with other Associations and other Health Care Professionals

BOARD RECOMMENDATION: Vote Yes.
BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
WORKSHEET ADDENDUM

2020 RESOLUTION 74—ELDER CARE WORK GROUP—ELDER CARE STRATEGIES FOR CONTINUING EDUCATION

74-2020. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder care strategies on both the oral-systemic connection and the dental management of the medically complex older adult as priority projects, and be it further

Resolved, elevate the importance of both the oral-systemic connection and the dental management of the medically complex older adult to members and the public, as appropriate, by:

1. providing educational opportunities for the profession on the oral-systemic connection.
2. promoting dental continuing education on treating the medically, functionally or cognitively complex patients through the Annual Meeting or other ADA meetings.
3. developing and maintaining a roster of qualified speakers both the oral-systemic connection and the dental management of the medically complex older adult.
4. developing presentations on both the oral-systemic connection and the dental management of the medically complex older adult for use by member state or local dental societies, and to be shared with other Associations and other Health Care Professionals.
Resolution No. 81S-1 Amendment

Report: N/A Date Submitted: September 2021

Submitted By: Third Trustee District

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: $10,000 Net Dues Impact: 

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

ELDER CARE STRATEGIES FOR CONTINUING EDUCATION

The following amendment to Resolution 81 (Worksheet: 4101) was submitted by the Third Trustee District and transmitted on September 24, 2021 by Mr. Ward Blackwell, executive director, Pennsylvania Dental Association.

Background: The Third District supports the objectives of Resolution 81. However, medically complex older adults who also happen to be institutionalized, home-bound or in similar long-term care settings may pose a particular challenge when it comes to the maintenance of good oral health and the delivery of care. Accordingly, the Third District would offer the following amendment to Resolution 81 that includes an additional program objective that explicitly addresses this area of particular need. (Additions are double underscored; deletions are double stricken.)

Resolution 81S-1. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder care strategies on both the oral-systemic connection and the dental management of the medically complex older adult as priority projects, and be it further

Resolved, elevate the importance of both the oral-systemic connection and the dental management of the medically complex older adult to members and the public the dental community, as appropriate, by:

1. providing educational opportunities for the profession on the oral-systemic connection.
2. promoting dental continuing education on treating the medically, functionally or cognitively complex patients through the Annual Meeting or other ADA meetings.
3. developing and maintaining a roster of qualified speakers both the oral-systemic connection and the dental management of the medically complex older adult.
4. developing and delivering dental continuing education on both the oral-systemic connection and the dental management of the medically complex older adult through ADA online CE, SmileCon programs, and other ADA meetings, publications and programming as appropriate.
4.2. developing presentations on both the oral-systemic connection and the dental management of the medically complex older adult for use by member state or local dental societies, and to be shared with other Associations and other Health Care Professionals.
3. the development of educational curricula for the delivery of preventive and quality of life dental care for institutional, long-term care and home-bound individuals to allow for greater access in their respective environments.
1 BOARD COMMENT: Received after the September 2021 Board of Trustees Meeting.
NOTES
STUDY DENTAL SCHOOL DEMOGRAPHICS: ALL DENTAL SCHOOLS ARE NOT CREATED EQUAL

The following was submitted by the Submitted by the Fourteenth Trustee District and transmitted on August 31, 2021, by Dr. Julius N. Manz.

Background: It is incumbent upon the ADA to provide information that allows pre-dental students to make an informed decision concerning their future dental education along with an adequate understanding of what sort of return they should expect on their investment 5, 10- and 20-years post-graduation.

When considering law degrees, schools are ranked on the quality of the education they provide. If you are fortunate enough to go to a quality law school, it is not unreasonable to expect a higher return on your academic efforts and financial investment. It has become apparent the cost of a dental education has gotten out of control while the quality of dental education is questionable.

Aspiring dental students typically don’t have comprehensive ways to find the answers to many of the most important questions related to choosing a dental school. We believe that the ADA with all of its resources can and should provide ethical and trustworthy guidance for these young individuals who have their entire life hanging in the balance.

Approximately 25 years prior, dental schools were closing across the country mostly due to costly expenses suffered by the sponsoring institution. Now however, it is apparent that dental education seems to a profitable venture. But at whose expense?

Most CODA approved dental schools across the country appear to lack sufficient faculty, especially in the ADA approved specialties.

Some members of the ADA, have expressed confusion and frustration with the ability to evaluate the current status of, and activities going on within, dental education and the Commission on Dental Accreditation.

New dentists accept that being part of a large group practice is the new norm, and whether large group or private practice, existing owners of those practices expect a reasonable level of competency from a new dentist they intend to hire.
92. Resolved, the ADA form a task force that establishes metrics to compare the dental school educational experience and financial implications across CODA accredited dental schools to assist prospective dental students in making choices to include but not limited to the following:

1. Evaluates the value of new dentists’ education experience 1, 5 and 10 years after graduation.
2. Evaluates Student: Teacher ratios at dental schools.
3. Evaluates the cost of education and breakdown of expenses.
4. Compiles a data bank of the number and type of procedures performed by each student prior to graduation.
5. Evaluates Student: Specialist-Teacher ratios at dental schools.
6. Evaluates the feasibility of using ADA resources to provide guidance for pre-dental students on selecting a dental school.

and be it further

Resolved, that this task force report back to the 2022 House of Delegates with their findings.

BOARD COMMENT: Delivered to the House of Delegates absent Board of Trustees evaluation, recommendation or comment due to inadequate process time of resolution.
DEVELOPMENT OF BEST PRACTICES FOR THE INCLUSION OF RESEARCH WITH NEGATIVE FINDINGS AND FAILED REPlications STUDIES

The following was submitted by the Submitted by the Fourteenth Trustee District and transmitted on August 31, 2021, by Dr. Julius N. Manz.

Background: In the world of peer-reviewed scientific research, negative experimental findings (those not validating a hypothesis) and failed replication studies are a valuable component of the pool of scientific knowledge because they force a critical re-evaluation of current theories and understandings of how the world works. However, there is currently an overwhelming publication bias in scientific literature (including dental and medical journals) making it extremely difficult to communicate these negative results. Papers are far less likely to be published and cited if they report results which do not validate a hypothesis (negative results) and many researchers are therefore choosing not to proceed with “non-significant” findings that yield less scientific interest and fewer citations. Consequently, the amount of data reported and published which contains these “non-significant” findings is progressively declining, and as a direct result of this, it has been noticed, in what few recent replication studies are available, that there is a large quantity of basic clinical findings which cannot in fact be reproduced. These studies often continue to remain in scientific journals creating a false scientific reality which directly shows the necessity and importance of being able to recognize and minimize positive-result skewed publication biases.

A prominent example of the real-world effect of such bias is seen in the publication by Dr. Andrew Wakefield, who, together with 12 co-authors, published the radical finding that child vaccinations (specifically the MMR vaccine) increases the incidence of autism in young adults. Although there were numerous replication studies yielding dissenting results between the time of the Wakefield article’s publication and its retraction, these studies failed to gain the same level of attention as the original paper yielding serious long-term health consequences. Specifically, the failure to promptly publish dissenting replication results led to a hallmark period of time where the morbidity and mortality of preventable diseases like measles, mumps and rubella was unusually high. In medicine, and dentistry especially, the consequences of failing to publish and circulate information challenging the findings of a previous paper aren’t just academic, they have real, impactful repercussions. That is why it is so important to recognize the value of negative results and the findings of replication studies, they are vital to helping maintain balance and correct previous literature and by reporting instances in which replication of research has failed.
In 2018 a retrospective assessment of publication bias in dental research journals\textsuperscript{1} found that articles with positive results are easier to publish compared to articles with negative results. This publication bias toward positive results may therefore skew the information and results obtained from systematic reviews and meta-analysis. Creation of best practices would create an awareness of the potential problems resulting from positive publication bias and provide the tools needed to overcome it. The quality of the research done rather than the result of the study in publishing the article should be the prime criteria.

\textbf{Resolution}

\textit{97. Resolved,} that the appropriate ADA agency is urged to participate and work with the Editors of professional dental publications and the American Association of Dental Editors and Journalists (AADEJ) to develop best practices for the inclusion of, and publication of, dental research with negative findings as well as failed replication studies and report back to the 2022 ADA HOD.

\textbf{BOARD COMMENT:} Delivered to the House of Delegates absent Board of Trustees evaluation, recommendation or comment due to inadequate process time of resolution.

NOTES
THE PRACTICE OF DENTISTRY AND CANNABIS

The following was submitted by the Fourteenth Trustee District and transmitted on August 31, 2021, by Dr. Julius N. Manz.

Background: With the federal government considering decriminalization of cannabis use and sales, and most of the states with some level of legalization of cannabis, additional research should be conducted regarding how dentists approach working and using anesthesia on patients who use cannabis. Also, medical legal issues may present daunting challenges to our treatment including obtaining informed consent from patients or parents of minor patients who are under the influence.

Although the ADA has resources and information regarding Cannabis on its website, further research and guidelines are needed.

https://disa.com/map-of-marijuana-legality-by-state

Resolution

96. Resolved, that the ADA encourage research and develop best practices for the management of patients who are under the influence of cannabis including the administration of all forms of anesthesia and the continuum of sedation.

BOARD COMMENT: Delivered to the House of Delegates absent Board of Trustees evaluation, recommendation or comment due to inadequate process time of resolution.
THE PRACTICE OF DENTISTRY AND CANNABIS

The following amendment to Resolution 96 (Worksheet: 3025) was submitted by the Third Trustee District and transmitted on September 24, 2021 by Mr. Ward Blackwell, executive director, Pennsylvania Dental Association.

**Background:** There is little doubt that the number of patients entering dental offices under the influence of cannabis, whether used for medical or recreational purposes, will continue to increase. The Third District concurs with the Fourteenth that there is a need to develop best practices for management of such patients. However, we could contend that such management by definition includes the use of sedation and anesthesia. So, specifying such in the resolution is superfluous.

However, this increased usage is unlikely to be confined to patients, and dentists could benefit from having guidance for managing patients’ families and even staff (who may require cannabis for medical purposes) as well.

Furthermore, the expanding role of cannabis as a treatment modality suggests there is merit to assessing its value, if any, to the practice of dentistry. Accordingly, the Third District respectfully offers the following amendment to Resolution 96. (Additions are underscored; deletions are stricken.)

**Resolution**

96S-1. **Resolved,** that the ADA encourage research and develop best practices for the management of patients, patients’ families and employees who are under the influence of cannabis including the administration of all forms of anesthesia and the continuum of sedation, and be it further

Resolved, that the appropriate ADA agencies research the usefulness, if any, of prescribing CBD and medical marijuana in the practice of dentistry, and that the results be reported to the 2022 House of Delegates.

**BOARD COMMENT:** Received after the September 2021 Board of Trustees Meeting.
FINANCIAL LITERACY AMONG NEW DENTISTS AND DENTAL STUDENTS

The following substitute resolution was submitted by the Third Trustee District and transmitted on September 24, 2021 by Mr. Ward Blackwell, executive director, Pennsylvania Dental Association.

Background: In response to the report of the Task Force to Study Alternate Student Loan Repayment Strategies, we recognize that there is a notable lack of development with respect to financial literacy for dental students and practicing dentists to carry them through their professional lives. Therefore, the Third District offers the following:

Resolution

104. Resolved, that the appropriate ADA agency be tasked with: 1) a thorough review of existing financial literacy resources within the ADA for practicing dentists to compile an easily accessible and navigable database; 2) development of new resources to provide dentists with an increased understanding of how to manage debt and wealth where members express a remaining need; and 3) creation of a robust marketing strategy to highlight its efforts for this purpose to our membership.

BOARD COMMENT: Received after the September 2021 Board of Trustees Meeting.
NEW BUSINESS-MAJORITY VOTE RECEIVED FOR CONSIDERATION

Resolution No. 108

Report: N/A

Date Submitted: October 2021

Submitted By: Co-Sponsored by Fifth Trustee District and Sixteenth Trustee District

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None

Net Dues Impact: 

Amount One-time 

Amount On-going 

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

NATIONAL COMMISSION ON RECOGNITION OF DENTAL SPECIALTIES AND CERTIFYING
BOARDS REQUIREMENTS FOR RECOGNITION REVIEW

The following resolution was submitted and transmitted on October 13, 2021 by Ms. Michele Huebner, secretary, Alabama Dental Association.

Background: The National Commission on Recognition of Dental Specialties and Certifying Boards (National Commission) is to be commended for its work as it reviews applications for dental specialty recognition from organizations wishing to become a recognized dental specialty. The National Commission has been judicious in adhering to the current criteria of Requirements for Recognition that applicants for specialty recognition must satisfy as a part of the application process.

Since this dental specialty recognition process is relatively new, it is a wise course to have the requirements for specialty recognition reviewed periodically by the ADA agency with governance responsibilities for the Requirements, the Council on Dental Education and Licensure (CDEL). The National Commission has already completed three reviews and has requested that CDEL provide additional guidance on the intent of several of the criteria. For this reason, it would be beneficial to request CDEL to begin the full criteria review in 2022.

Resolution

108. Resolved, that the Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists, currently used by the National Commission on Recognition of Dental Specialties and Certifying Boards, be reviewed by the ADA Council on Dental Education and Licensure in 2022, rather than 2023, and be it further

Resolved, that CDEL report its findings and any proposed revisions to the Requirements for Recognition to the National Commission and to the 2022 ADA House of Delegates.

BOARD COMMENT: Received after the deadline for New Business submission of September 28.
NOTES