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++*Second Set Material Posted August 29

++Second Set Material Posted October 3

++*Second Set Material Posted October 10

++***Newly Received (Received and Processed September 3–October 6; Posted October 15)

#Newly Received (Received and Processed September 15–October 16; Posted October 21)

#*Newly Received (Received and Processed September 3–October 17; Posted October 23)

***New Business – Majority Vote Received (Received and Posted October 25)

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***Material Posted July 22

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***Material Posted July 22

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- #**New Business – Majority Vote Received (Received and Posted October 25)

1 **Vote: Resolution 304**

BERG	Yes	DOWD	Yes	KNAPP	Yes	STUEFEN	Yes
BOYLE	Yes	GRAHAM	Yes	MANN	Yes	TULAK-GORECKI	Yes
BROWN	Yes	HISEL	Yes	MARKARIAN	Yes	WANAMAKER	Yes
CAMMARATA	Yes	HOWARD	Yes	MERCER	Yes		
CHOPRA	Yes	IRANI	Yes	REAVIS	Absent		
DEL VALLE-SEPÚLVEDA	Yes	KAHL	Yes	ROSATO	Yes		

1 improve patient care access, support its members, and grow membership by delivering services not
2 readily available elsewhere.

3 Provisional credentialing is already widely used in the medical field. For example, UnitedHealthcare
4 allows provisional credentialing of physicians in underserved areas within 14 days of receiving a complete
5 application, evident in multiple states in the following document ([use the search function for “provisional”](#)
6 [in *UnitedHealthcare Credentialing Plan – State and Federal Regulatory Addendum*](#)).

7 Hospital systems and physician networks also routinely use provisional privileging to ensure continuity of
8 care during credentialing ([LinkedIn article: *Medical Credentialing Process: Improving Efficiency with AI –*](#)
9 [Neolytix](#)).

10 This resolution proposes a similar approach for dentistry: allowing licensed and insured dentists to begin
11 treating patients at in-network rates while full credentialing is completed. This proposal is not intended to
12 interfere with pricing agreements, network participation decisions, or any antitrust-sensitive matters. All
13 recommendations will be voluntary and non-binding. This initiative aligns with the ADA Strategic Plan
14 2020–2025, Objective 10, page 6.

15 **Resolution**

16 **305. Resolved**, That the American Dental Association create a task force, appointed for up to one
17 year or until its work is completed, charged with developing a model framework for provisional
18 insurance credentialing of licensed, malpractice-insured dentists actively applying to join a network,
19 allowing such dentists to treat patients at in-network rates while full credentialing is completed, and
20 be it further

21 **Resolved**, that the task force be charged with the following responsibilities:

- 22 1. Work with third-party payers, regulatory stakeholders, and subject matter experts to create a
23 system that protects patients, verifies licensure and liability insurance, and maintains payer
24 integrity;
- 25 2. Evaluate artificial intelligence (AI)-based credentialing platforms, including but not limited to
26 LightSpun and CAQH ProView, to determine which features can support—but not replace—
27 provisional credentialing workflows and whether any systems can meaningfully reduce
28 administrative lag;
- 29 3. Review credentialing standards already in use in the medical field, and consider best
30 practices for dental-specific provisional credentialing guidelines, such as a 15-day eligibility
31 window with completion within 60 days; and
- 32 4. Explore whether the ADA can create or facilitate credentialing support services—such as
33 background checks, licensure and liability insurance verification, or pre-submission data
34 screening—to assist both payers and ADA members, and whether such a program could
35 serve as a meaningful membership benefit, especially for younger dentists and for practice
36 owners seeking to streamline onboarding of new associates.

37 and be it further

38 **Resolved**, that the Council on Dental Benefit Programs review the work of the task force and, if
39 appropriate, draft a resolution for submission to the 2026 House of Delegates for adoption as ADA
40 policy, and in the interim, consider using the framework to guide voluntary engagement and
41 advocacy efforts with third-party payers, and be it further

1 **Resolved**, that the task force be composed of up to seven members, including at least one early-
 2 career dentist, one member with expertise in dental benefits or credentialing, and one member of the
 3 Council on Dental Benefit Programs, and be it further

4 **Resolved**, that if in-person meetings are required, funding shall be provided in accordance with
 5 existing ADA policy, and be it further

6 **Resolved**, that the ADA ensure all activities under this resolution, including engagement with
 7 insurance carriers, remain voluntary, non-binding, and fully compliant with applicable federal and
 8 state antitrust laws.

9 **BOARD COMMENT:** The Board appreciates the sentiments expressed in Resolution 305. The Board
 10 believes that the ADA’s Council on Dental Benefit Programs (CDBP) has the expertise on this matter, is
 11 more cost effective, and can certainly engage other stakeholders as needed to evaluate the issues
 12 around provisional credentialing without the need to establish a new taskforce. The Board respectfully
 13 suggests that the matters referenced in Resolution 305 be referred to the appropriate ADA agencies and
 14 the Board urges the assigned ADA agencies to not only evaluate but to also take the necessary steps to
 15 address the need to expedite the credentialing process.

16 **BOARD RECOMMENDATION: Vote Yes on Referral.**

17 **Vote: Resolution 305**

BERG	Yes	DOWD	Yes	KNAPP	Yes	STUEFEN	Yes
BOYLE	Abstain	GRAHAM	Yes	MANN	Yes	TULAK-GORECKI	Yes
BROWN	Yes	HISEL	Yes	MARKARIAN	Yes	WANAMAKER	Yes
CAMMARATA	Yes	HOWARD	Yes	MERCER	Yes		
CHOPRA	Yes	IRANI	Yes	REAVIS	Yes		
DEL VALLE-SEPÚLVEDA	Yes	KAHL	Yes	ROSATO	Yes		

18

1 10. If the bulk payment amount on the EOB reflects the final amount paid to the dentist, taking
2 into account any secondary plan payment, then the individual claim amounts should also
3 be adjusted appropriately to avoid discrepancy between the individual claim amounts
4 listed on the EOB and the bulk payment amount.

5 and be it further

6 **Resolved**, that third party payers should not withhold funds from current bulk benefit payments
7 as a means of settling disputes over prior claims experience with the dentist or another dental
8 office and that state dental societies be encouraged to seek legislation to resolve this problem,
9 and be it further

10 **Resolved**, that bulk payments should be issued to dentists at intervals of not longer than every
11 ten business days, and be it further

12 **Resolved**, that the Council on Dental Benefit Programs work with the insurance industry and third
13 party payers to incorporate this policy into their administrative procedures.

14 **BOARD RECOMMENDATION: Vote Yes.**

15 **BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)**

Resolution No. 307 New

Report: N/A Date Submitted: August 2025

Submitted By: Council on Dental Benefit Programs

Reference Committee: B (Dental Benefits, Practice, Science, Health and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time: _____ Amount On-going: _____

ADA Strategic Forecast Outcome: Public Profession: Increase and improve dental coverage and access.

1 **AMENDMENT OF POLICY, MAXIMUM FEES FOR NON-COVERED SERVICES**

2 **Background:** In accordance with Resolution 170H-2012, Regular Comprehensive Policy Review
3 (*Trans.*2012:370), the Council on Dental Benefit Programs (CDBP) reviewed the Association policy
4 addressing maximum fees for non-covered services.

5 The Council believes that the policy should be clarified to state that a covered service should not include
6 any procedures or services not paid by the plan, nor should any payer use contractual language to
7 impose a “de-minimis” or insignificant reimbursement that the insurance company provides for a service
8 that is not fully covered that still qualifies as a covered service under the plan’s terms. Further, any denial
9 or exclusion of coverage from a benefit policy should not be conflated with a finding of medical necessity
10 for those services.

11 The Council recommends that the following amendments be adopted.

12 **Resolution**

13 **307. Resolved**, that the policy titled, Maximum Fees for Non-Covered Services (*Trans.*2010:616;
14 2020:317) be amended as follows (additions are underscored; deletions are ~~stricken~~).

15 **~~Maximum Fees for Non-Covered Services~~ Reimbursement**

16 **Resolved**, that the Association opposes any third-party contract provisions that establish limits on
17 dentists’ charges for services that are not “covered services,” and be it further

18 **Resolved**, that “covered service” is defined as any service for which reimbursement is actually
19 provided on a given claim. A “covered service” should not include procedures or services not paid
20 for by the dental benefit plan on a given claim for reasons including but not limited to benefit
21 limitations (e.g., waiting periods, frequency limits) or the patient having exceeded the annual
22 maximum, and be it further

23 **Resolved**, that the ADA opposes any contractual language that prohibits a dentist from charging
24 their full fee to a patient for a procedure or service not paid for by the benefit plan or imposing a
25 de-minimis payment, and be it further

26 **Resolved**, that denials for non-covered services are not a determination of medical necessity and
27 should not be communicated to a patient as such, and be it further

28 **Resolved**, that the ADA opposes any mandates for fee discounts for procedures for which the
29 plan pays no benefit, and be it further

1 **Resolved**, that the carrier provides payment for the covered services under the patient's policy in
2 an amount that reflects the costs of the services rendered by using the current year's averaged
3 fee from similar geographic areas and adjusts such amounts every year to reflect inflation.

4 **BOARD RECOMMENDATION: Vote Yes.**

5 **BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)**

- 1 • Provide their name, degree, license number and direct phone number to the treating
- 2 dental office
- 3 • ~~Request~~ Seek consultations from specialists for ~~certain~~ specialty-related cases, when
- 4 necessary
- 5 • Provide advice to third-party payers regarding the merit and value of dental benefits plan
- 6 designs
- 7 • Educate plan purchasers regarding the impact alternative, less costly treatment may
- 8 have on the life of a tooth, overall oral health, etc.
- 9 • Alert third-party payers when dentists' treatment patterns are changed by cost
- 10 containment strategies to the detriment of the patients
- 11 • Provide guidance to third-party payers regarding the importance of the dentist/patient
- 12 relationship
- 13 • Inform third-party payers, plan sponsors and subscribers about the availability and value
- 14 of the profession's peer review system
- 15 • Initiate dialogue with organized dentistry regarding ~~questionable~~ emerging treatment
- 16 modalities
- 17 • Inform the dental profession of those treatment procedures on which questions of
- 18 judgment between the dentist and the dental consultant are most likely to result in areas
- 19 of disagreement
- 20 • Discuss treatment decisions with dentists on a professional level
- 21 • Explain clearly to practicing dentists the provisions of particular contracts and the benefit
- 22 limitations of those contracts
- 23 • Demonstrate knowledge of contract interpretation, and laws and regulations governing
- 24 dental practice in those jurisdictions affected by their consulting activities, as well as
- 25 accepted standards of administrative procedure within the dental benefits industry
- 26 • Dentists reviewing claims submissions must be licensed in the United States, ~~preferably~~
- 27 and within the jurisdiction of the dentist treating the patient in accordance with applicable
- 28 state law

29 Dentists have a fundamental obligation to serve the best interests of the public and their
30 profession. This obligation can never be abrogated for any reason. In order to maintain
31 independent thought and judgment regarding dental matters, dental consultants should be
32 competent with regard to current clinical procedures and practice through such mechanisms as
33 continuing education, or have been in practice for a minimum of ten years immediately preceding
34 employment as a dental consultant, and remain involved in the continuing dental education
35 process in order to stay current with clinical procedures and changing technology.

36 It is strongly recommended that dental consultants be members of the American Dental
37 Association and adhere to the ADA's Code of Ethics.

38 and be it further

39 **Resolved**, that when a third-party payer such as a Health Maintenance Organization (HMO),
40 capitation program, or Preferred Provider Organization (PPO) denies a claim for treatment or
41 tests required for treatment it considers dentally or medically unnecessary, the denial should be
42 subject to automatic review by independent qualified dental consultant within the state of the
43 treating dentist, and be it further

44 **Resolved**, that the American Dental Association distribute copies of this Statement to all third-
45 party payers following any revisions or at least every 5 years, and be it further

46 **Resolved**, that third-party payers, including dental consultants to payers, should not exceed their
47 legitimate role in the processing of dental benefit claims, and specifically, third-party payers and
48 dental consultants should not:

- 1 • Change code numbers as submitted without written permission of the ~~attending~~treating
- 2 dentist
- 3 • Redefine code numbers, nomenclatures or descriptors except as provided for in their
- 4 CDT license agreements
- 5 • Disapprove complex cases without seeking the advice of appropriately trained
- 6 consultants

7 and be it further

8 **Resolved**, that the ADA urge third-party payers and administrators to identify dental consultants
9 by name in any correspondence to ~~attending~~treating dentists.

10 **BOARD RECOMMENDATION: Vote Yes.**

11 **BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)**

Resolution No. 308S-1 Amendment

Report: N/A Date Submitted: 09/25/2025

Submitted By: Ninth District

Reference Committee: B (Dental Benefits, Practice, Science, Health and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time: _____ Amount Ongoing: _____

ADA Strategic Forecast Outcome: Public Profession: Support a healthy, well-distributed, skilled and scoped workforce.

1 **AMENDMENT OF POLICY, STATEMENT ON DENTAL CONSULTANTS**

2 The following resolution was submitted on Thursday, September 25, 2025, by Michelle Nichols-Cruz,
3 governance manager, Michigan Dental Association on behalf of the Ninth District.

4 **Background:** The 9th District recognizes the intent of Resolution 308 to assert the need for clinical
5 experience to serve as a consultant and the housekeeping nature of this resolution. Furthermore, we see
6 an opportunity to offer alternative wording that preserves the intent and avoids unintended consequences.
7

8 The assertion that 10 years of practice experience automatically qualifies a clinician to serve as a
9 consultant lacks evidence-based support. Establishing an ADA policy that implies dentists with fewer
10 practice years have inferior clinical judgment unfairly disparages new practitioners and may create
11 unintended consequences for member recruitment and retention, and areas where these practitioners
12 must defend their clinical judgment.
13

14 Competence is not defined by years of service, regardless of the threshold. Therefore, the Ninth District
15 recommends the following alternative language:
16

17 **Resolution**

18 **308S-1. Resolved,** that the policy titled, Statement on Dental Consultants (*Trans.2010:555*) be
19 amended as follows (additions are double underscored; deletions are ~~double stricken through~~).

20 **Statement on Dental Consultants**

21 Third-party payers and plan purchasers have used dental consultants in order to streamline the
22 claims review process for many years.

23 The American Dental Association initially saw a positive potential in the use of dental consultants
24 by third-party payers as a means of receiving professional advice on certain aspects of dental
25 benefits plans. While the ADA still believes that there is value to third-party payers' use of dental
26 consultants, it also believes that some clear distinctions must be made between dental
27 consultants and dental claims reviewers.

28 Dental claims reviewers work under supervision. They do not necessarily have, or need, clinical
29 dental or dental practice background, and are trained specifically by the third-party payer to
30 review dental claims that are uncomplicated and require straightforward processing.

1 Dental consultants are licensed dentists who, even if not currently practicing, have ~~at least many~~
2 ~~ten years of sufficient clinical practice~~ experience ~~to in practice and can and should:~~

- 3 • Offer a professional opinion regarding complicated dental treatment
- 4 • Provide their name, degree, license number and direct phone number to the treating
- 5 dental office
- 6 • ~~Request~~ Seek consultations from specialists for ~~certain~~ specialty-related cases, when
- 7 necessary
- 8 • Provide advice to third-party payers regarding the merit and value of dental benefits plan
- 9 designs
- 10 • Educate plan purchasers regarding the impact alternative, less costly treatment may
- 11 have on the life of a tooth, overall oral health, etc.
- 12 • Alert third-party payers when dentists' treatment patterns are changed by cost
- 13 containment strategies to the detriment of the patients
- 14 • Provide guidance to third-party payers regarding the importance of the dentist/patient
- 15 relationship
- 16 • Inform third-party payers, plan sponsors and subscribers about the availability and value
- 17 of the profession's peer review system
- 18 • Initiate dialogue with organized dentistry regarding ~~questionable~~ emerging treatment
- 19 modalities
- 20 • Inform the dental profession of those treatment procedures on which questions of
- 21 judgment between the dentist and the dental consultant are most likely to result in areas
- 22 of disagreement
- 23 • Discuss treatment decisions with dentists on a professional level
- 24 • Explain clearly to practicing dentists the provisions of particular contracts and the benefit
- 25 limitations of those contracts
- 26 • Demonstrate knowledge of contract interpretation, and laws and regulations governing
- 27 dental practice in those jurisdictions affected by their consulting activities, as well as
- 28 accepted standards of administrative procedure within the dental benefits industry
- 29 • Dentists reviewing claims submissions must be licensed in the United States, ~~preferably~~
- 30 and within the jurisdiction of the dentist treating the patient in accordance with applicable
- 31 state law

32 Dentists have a fundamental obligation to serve the best interests of the public and their
33 profession. This obligation can never be abrogated for any reason. In order to maintain
34 independent thought and judgment regarding dental matters, dental consultants should be
35 competent with regard to current clinical procedures and practice through such mechanisms as
36 continuing education, or have ~~been in practice for a minimum of ten years immediately~~ sufficient
37 practice experience preceding employment as a dental consultant, and remain involved in the
38 continuing dental education process in order to stay current with clinical procedures and changing
39 technology.

40 It is strongly recommended that dental consultants be members of the American Dental
41 Association and adhere to the ADA's Code of Ethics.

42 and be it further

43 **Resolved,** that when a third-party payer such as a Health Maintenance Organization (HMO),
44 capitation program, or Preferred Provider Organization (PPO) denies a claim for treatment or
45 tests required for treatment it considers dentally or medically unnecessary, the denial should be
46 subject to automatic review by independent qualified dental consultant within the state of the
47 treating dentist, and be it further

1 **Resolved**, that the American Dental Association distribute copies of this Statement to all third-
2 party payers following any revisions or at least every 5 years, and be it further

3 **Resolved**, that third-party payers, including dental consultants to payers, should not exceed their
4 legitimate role in the processing of dental benefit claims, and specifically, third-party payers and
5 dental consultants should not:

- 6 • Change code numbers as submitted without written permission of the attending treating
7 dentist
- 8 • Redefine code numbers, nomenclatures or descriptors except as provided for in their
9 CDT license agreements
- 10 • Disapprove complex cases without seeking the advice of appropriately trained
11 consultants

12 and be it further

13 **Resolved**, that the ADA urge third-party payers and administrators to identify dental consultants
14 by name in any correspondence to attending treating dentists.

15 **Board Recommendation: Received after the August 2025 Board of Trustees Meeting.**

<p>Arkansas</p>	<p>23-86-404. Optional health benefit plans</p>	<p>(a) A health maintenance organization may offer and issue health benefit plans that reimburse or arrange for covered healthcare services to covered persons through a limited network plan if:</p> <p>(4) Under the optional health benefit plan or point-of-service plan, the rate of reimbursement for healthcare providers out of the network shall be no higher than the normal and usual and customary rate charged by those out-of-network providers on a regular basis, provided that copayment, coinsurance, and other cost-sharing features may be different for out-of-network providers and in-network providers.</p>
<p>Georgia</p>	<p>§ 33-30-23. Standards; payments or reimbursement for noncontracting provider of covered services; filing requirements for unlicensed entities; provision for payment solely to provider</p>	<p>(c)(1) Notwithstanding the provisions of paragraphs (3) and (4) of subsection (b) of this Code section, health benefit plans providing incentives for covered persons to use pharmaceutical or dental services of preferred providers shall contain a provision which clearly identifies that the payment or reimbursement for a noncontracting provider of covered pharmaceutical or dental services shall be the same as the payment or reimbursement for a preferred provider of covered pharmaceutical or dental services; provided, however, the health benefit plan shall not be required to make payment or reimbursement in an amount which is greater than the actual fee charged by the provider for the dental or pharmaceutical services rendered.</p>
	<p>§ 33-51-6. Incentives for preferred providers</p>	<p>Notwithstanding the provisions of paragraphs (2) and (3) of Code Section 33-51-5, health benefit plans providing incentives for covered persons to use pharmaceutical or dental services of preferred providers shall provide, and clearly indicate, that the payment or reimbursement for a noncontracting provider of covered pharmaceutical or dental services shall be the same as the payment or reimbursement for a preferred provider of covered pharmaceutical or dental services; provided, however, that the health benefit plan shall not be required to make payment or reimbursement in an amount which is greater than the actual fee charged by the provider for such dental or pharmaceutical services.</p>
<p>Louisiana</p>	<p>§ 22:1154. Freedom of choice of dentist in health plans.</p>	<p>(b) The payment or reimbursement for a noncontracting provider dentist shall be the same as or greater than the payment or reimbursement for a contracting provider dentist; however, the health insurance policy or the employee benefit plan shall not be required to make payment or reimbursement in an amount that is greater than the amount so specified in the policy or plan or that is greater than the fee charged by the providing dentist for the dental care services rendered.</p>

<p>Mississippi</p>	<p>83-51-5. Disclosure requirements; payments to non-contracting providers</p>	<p>Payment or reimbursement for a non-contracting provider dentist shall be the same as the payment or reimbursement for a contracting provider dentist; provided, however, that the health insurance policy or the employee benefit plan shall not be required to make payment or reimbursement in an amount which is greater than the amount specified or which is greater than the fee charged by the providing dentist for the dental care services rendered.</p> <p>HISTORY: SOURCES: Laws, 1985, ch. 369, § 3, eff</p>
<p>Texas</p>	<p>Sec. 1451.206. Payment or Reimbursement of Dentist.</p>	<p>(a) The employee benefit plan or health insurance policy shall provide:</p> <p>(1) that payment or reimbursement for a noncontracting provider dentist shall be the same as payment or reimbursement for a contracting provider dentist</p>
<p>Tennessee</p>	<p>56-7-2365. Health insurance coverage related to clinical trials.</p>	<p>56-7-2365. Health insurance coverage related to clinical trials.</p> <p>(e) In the case of health care services provided by a participating provider, the payment rate shall be at the network negotiated rate, based on the member's plan design. In the case of a non-participating provider, the payment shall be at the rate that the member's plan would otherwise pay to a non-participating provider for the same services, less any applicable copayments and deductibles.</p>

1 The Council recommends revising the policy to "Assignment of Benefits" to reflect common dental
 2 industry terminology usage.

3 The Council is aware of ongoing issues concerning repricing dental services when provided by a non-
 4 contracted provider. Repricing occurs when insurance companies adjust the amount they pay for dental
 5 procedures, often resulting in a lower payment than the dentist's original charge. The Council believes the
 6 proposed additions to the policy will provide a stronger position for the Association as it pursues
 7 legislative relief on repricing issues.

8 The Council also discussed the differentiation between "dentist" and "dental provider" as appropriate
 9 terminology in this policy. The Council recognizes that ADA policy titled "Preferred Professional
 10 Terminology" (*Trans.* 1977:914; 1997:661) encourages the use of the title "dentist" rather than "provider"
 11 whenever possible. However, the Council notes that use of dental provider is more appropriate when
 12 addressing the administration of dental benefits and reimbursement/payment issues applicable to the
 13 *practice*, citing the Social Security Act §1861(u) defines a "provider of services" as "a hospital, critical
 14 access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health
 15 agency, or hospice program which has in effect an agreement to participate in Medicare."

16 The Council recommends that the following amendments be adopted.

17 **Resolution**

18 **309. Resolved**, that the policy titled, Authorization of Benefits (*Trans.* 1994:665; 2013:306; 2017:264)
 19 be amended as follows (additions are underscoring; deletions are ~~stricken~~).

1 **Authorization Assignment of Benefits**

2 **Resolved**, that the American Dental Association supports the right of each dentist dental provider
3 to accept or reject assignment of benefits ~~from any dental benefits plan~~, and be it further

4 **Resolved**, that the Association supports the right of every patient to assign their benefits to the
5 treating dentist-provider and to have the assignment honored by the third-party payer, and be it
6 further

7 **Resolved**, that the insurer providing coverage under a dental benefit plan should honor a written
8 assignment of benefit that is made by a patient to a provider, for services provided to the patient,
9 and that is signed by the covered person, until a written termination notice is received directly
10 from the patient, and be it further

11 **Resolved**, that upon meeting the requirements of assignment of benefits, the insurer should
12 make payments for covered services directly to the provider regardless of their network status,
13 and be it further.

14 **Resolved**, that the non-contracting provider retains the right to request the remaining balance of
15 the provider's full fee directly from the patient, and be it further

16 **Resolved**, that the ADA opposes the use of third-party repricing practices or any other methods
17 that restrict beneficiaries from seeking care from any providers of their choice, especially those to
18 whom they have assigned the right to payment or reimbursement, and be it further

19 **Resolved**, the ADA is opposed to any practice that misrepresents a patient's financial
20 responsibility when benefits are assigned, and be it further

21 **Resolved**, that when a third-party payer ~~submits~~ sends payment directly to the patient, contrary
22 to the patient's authorized preference, the dentist provider has the right to request payment
23 directly from the patient. If the patient declines, then it is the third-party payer's responsibility to
24 ~~submit~~ send the correct payment to the dentist provider within fifteen (10) days of being notified of
25 the incorrect payment, and to ~~submit~~ send the payment to the dentist provider whether or not the
26 third-party payer has received reimbursement from the patient, and be it further

27 **Resolved**, that in those states where ~~dentists~~ providers are not notified of the rescission of a prior
28 assignment of benefits, the Association encourages state dental societies to seek legislative
29 relief.

30 **BOARD RECOMMENDATION: Vote Yes.**

31 **BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)**

Resolution No. 309S-1 New

Report: NA Date Submitted: 10/15/2025

Submitted By: Seventeenth Trustee District

Reference Committee: B (Dental Benefits, Practice, Science, Health and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time: _____ Amount On-going: _____

ADA Strategic Forecast Outcome: Public Profession: Increase and improve dental coverage and access.

1 **AMENDMENT OF RESOLUTION 309: AMENDMENT OF POLICY, AUTHORIZATION OF BENEFITS**

2 The following substitute resolution was submitted on Wednesday, October 15, 2025, by Lianne Bell,
3 leadership affairs manager, Florida Dental Association on behalf of the Seventeenth District.

4 **Background:** This amendment is proposed to correct a grammatical error in the original resolution text.
5 The change does not alter the intent or substance of the resolution but ensures clarity and correct
6 structure.

7 **Resolution**

8 **309S-1. Resolved,** that the policy titled, Authorization of Benefits (*Trans.*1994:665; 2013:306;
9 2017:264) be amended as follows (additions are double underscored; deletions are ~~double stricken~~).

10 **Authorization-Assignment of Benefits**

11 **Resolved,** that the American Dental Association supports the right of each ~~dentist~~ dental provider
12 to accept or reject assignment of benefits ~~from any dental benefits plan~~, and be it further

13 **Resolved,** that the Association supports the right of every patient to assign their benefits to the
14 ~~treating dentist~~ provider and to have the assignment honored by the third-party payer, and be it
15 further

16 **Resolved,** that the insurer providing coverage under a dental benefit plan should honor a written
17 assignment of benefit that is made by a patient to a provider, for services provided to the patient,
18 and that is signed by the covered person, until a written termination notice is received directly
19 from the patient, and be it further

20 **Resolved,** that upon meeting the requirements of assignment of benefits, the insurer should
21 make payments for covered services directly to the provider regardless of their network status,
22 and be it further.

23 **Resolved,** that the non-contracting provider retains the right to request the remaining balance of
24 the provider's full fee directly from the patient, and be it further

25 **Resolved,** that the ADA opposes the use of third-party repricing practices or any other methods
26 that restrict beneficiaries from seeking care from any providers of their choice, especially those to
27 whom they have assigned the right to payment or reimbursement, and be it further

1 **Resolved**, the ADA is opposed to any practice that misrepresents a patient's financial
2 responsibility when benefits are assigned, and be it further

3 **Resolved**, that when a third-party payer ~~submits~~ sends payment directly to the patient, contrary
4 to the patient's authorized preference, the ~~dentist~~ provider has the right to request payment
5 directly from the patient. If the patient declines, then it is the third-party payer's responsibility to
6 ~~submit~~ send the correct payment to the ~~dentist~~ provider within ~~fifteen~~ ten (10) days of being
7 notified of the incorrect payment, and to ~~submit~~ send the payment to the ~~dentist~~ provider whether
8 or not the third-party payer has received reimbursement from the patient, and be it further

9 **Resolved**, that in those states where ~~dentists~~ providers are not notified of the rescission of a prior
10 assignment of benefits, the Association encourages state dental societies to seek legislative
11 relief.

12 **BOARD RECOMMENDATION: Received after the August Board of Trustees meeting.**

1 transfer (EFT) payments or any other payment options as the only payment option without an
2 opportunity to choose a paper check.

3 ~~Virtual credit cards may apply processing fees, and these fees can be much higher than the fees~~
4 ~~agreed upon by the dentist when signing the original merchant credit service agreement credit~~
5 ~~card agreement.~~

6 ~~While EFT improves efficiency for the payers and may, in the long term, be beneficial for dental~~
7 ~~practices, there are some dental offices that may incur problems due to their current patient~~
8 ~~management systems not being fully equipped to handle end-to-end electronic claims processing,~~
9 ~~in particular bulk claim payments. Under current circumstances, dentists are simply left with~~
10 ~~having to deal with bank charges levied to adopt EFT or paying to get upgraded to new software~~
11 ~~simply to handle EFT and electronic remittance advice (ERA) transactions seamlessly. This~~
12 ~~results in little to no improvement in practice efficiency.~~

13 **Resolved,** In addition, that the ADA believes all dental claims should be reimbursed within fifteen
14 (15) ten (10) business days from receipt of the claim by the third-party payer, and be it further

15 **Resolved,** that when initiating or changing payments to a health care provider using electronic
16 funds transfer payments, or virtual credit card payments, insurers must notify the health care
17 provider of all fees associated with a particular payment method, advise the provider of all
18 available methods of payment, and provide clear instructions to the health care provider as to
19 how to select or change an alternative payment method, and be it further

20 **Resolved,** that when initiating or changing payments to a health care provider, the carrier should
21 present opt-in selections for payment remittance, and be it further

22 **Resolved,** the ADA is opposed to any carrier policy or third-party contractor that uses opt-out for
23 provider payment remittance method selection. Should opt-out be used by a carrier or third-party
24 contractor, the provider's selection should be honored unless the provider changes their election.

25 **BOARD RECOMMENDATION: Vote Yes.**

26 **BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)**

- 1 • should not retroactively deny, adjust, or seek recoupment or refund of a paid claim for
- 2 dental care expenses after the expiration of six months from the date of the initial claim
- 3 submission
- 4 • should not place withholds on future payments for alleged overpayments but instead
- 5 should seek a refund from the provider after providing information about why the alleged
- 6 refund is due, including the name of the patient, service provided, date of service and the
- 7 reason for the recoupment
- 8 • should allow six months to contest the refund request from the date of proper notice of
- 9 recoupment from the payer,

10 and be it further

11 **Resolved,** that the ADA is opposed to the inclusion of hold-harmless clauses favoring the carrier

12 in third-party payer contracts, and be it further

13 **Resolved,** that third party payers, administering self-funded and fully-insured plans, be urged to

14 adopt these guidelines as an industry-wide standard for alleged overpayment of benefits to

15 dentists.

16 ~~**Resolved,** that the American Dental Association shall and its constituent societies are urged to~~

17 ~~seek or support legislation to prevent third-party payers from withholding assigned benefits or~~

18 ~~recouping payment when a payment made in error has been made on behalf of a different patient~~

19 ~~covered by the same third-party payer or because of an alleged overpayment to a different~~

20 ~~dentist, and be it further.~~

21 ~~**Resolved,** that dental plans should not retroactively deny, adjust, or seek recoupment or refund~~

22 ~~of a paid claim for dental care expenses submitted by a provider for any reason, other than fraud~~

23 ~~or for duplicate payments on claims received from the same plan for the same service from a~~

24 ~~provider, after the expiration of six months from the date that the initial claim was paid. The plan~~

25 ~~must provide information about why a refund is due, including the name of the patient, date of~~

26 ~~service and service provided along with the reason for the overpayment and allow the provider six~~

27 ~~months before the refund must be paid. The provider should be allowed 30 days to contest the~~

28 ~~refund request, and be it further~~

29 ~~**Resolved,** that dental plans, representing self-funded and fully insured plans, be urged to adopt~~

30 ~~these guidelines as an industry wide standard for alleged overpayment of benefits to dentists.~~

31 **BOARD RECOMMENDATION: Vote Yes.**

32 **BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)**

1 A research letter titled, [Availability of Dental Benefits Within Medicare Advantage Plans by Enrollment](#)
2 [and County](#), was published in the Journal of the American Medical Association, found “a total of 5485
3 plans (86.6%) offered a dental benefit, but only 460 (8.4%) offered a comprehensive benefit”, and that
4 only “(4.1%) were enrolled in a plan with a comprehensive dental benefit.”

5 The Council on Dental Benefit Programs recognizes dentists' and patients' concerns regarding the
6 administration of these plans, the benefits provided, and the potential misrepresentation of supplemental
7 dental benefits in marketing materials created by carriers. The Council saw the need for ADA policy
8 related to the administration of supplemental dental benefits in Medicare Advantage plans. The Council
9 reviewed issues such as loss ratios, utilization and costs, plan design transparency, marketing, waiver of
10 liability, and provider participation.

11 A notable concern was the process of determining the applicability of federal and state insurance law to
12 the supplemental benefits of MA plans. Based on a review of the CMS regulations, e.g., CFR, manuals,
13 the Council understands that the federal preemption applies to supplemental benefits except for state
14 licensure or solvency standards. Therefore, it was determined that ADA policy should not focus on state-
15 based insurance laws regarding supplemental dental benefits.

16 The Council also believes that the federal regulations for Medicare Part A and B should not apply, so as
17 not to create undue regulatory burden on those providers who wish to participate in Medicare Advantage
18 supplemental dental benefit networks. For example, when payment is denied by the plan, any appeal
19 process for Part C plans requires the provider to waive liability and hold the patient harmless if the claim
20 is denied for medical necessity even if the provider is not in-network for the plan. The regulations are
21 currently being applied to supplemental benefits, including dental benefits.

22 Based on these discussions, CDBP proposes to establish a policy that addresses the administration of
23 supplemental dental benefit within Medicare Advantage plans.

24 **Resolution**

25 **312. Resolved**, that the proposed policy titled, “Administrative Principles of Supplemental Dental
26 Benefits in Medicare Advantage Plans” be adopted.

27 **Administrative Principles of Supplemental Dental Benefits in Medicare Advantage Plans**

28 **Resolved**, that the American Dental Association is supportive of dental plans offered as
29 supplemental benefits by Medicare Advantage (MA) plans consistent with the following
30 principles:

- 31 • Medicare Advantage plan reporting of MLR should clearly distinguish dental from medical
32 services, requiring that 85% of the premium or equivalent dollars allocated to provide
33 supplemental dental benefits be spent on dental care, as required for medical services
34 during Medicare Advantage reporting periods by federal statute.
- 35 • Centers for Medicare and Medicaid Services (CMS) should collect and publicly report
36 standardized utilization and cost data for MA dental benefits, including enrollee out-of-
37 pocket spending, plan spending, network participation, and service utilization.
- 38 • Supplemental benefits should not be subject to any regulations applicable to Part A and
39 Part B covered services offered within a Part C plan
- 40 • MA plans should not be allowed to reduce dental benefits after initial enrollment in a way
41 that misleads enrollees. Plans should be required to disclose benefit changes clearly
42 before the annual enrollment period.

- 1 • Purchasers should be provided with a summary of benefits information available in
2 formats that are easy to understand and compare plans prior to purchase.

- 3 • Marketing materials for MA dental benefits should clearly specify which services are
4 covered, cost-sharing obligations, and network limitations.

- 5 • Standardized benefit categories should be clearly defined to allow for easy comparison
6 across plans. Options should include combinations of plan designs that:
 - 7 ○ Offer both freedom of choice and network-based plans although network-based plans
8 should not lower the available benefit when a patient chooses to go out of network.
 - 9 ○ Offer both annual maximum limited benefit products and true insurance products (i.e.
10 with no annual maximum) with out-of-pocket maximum protections

- 11 • MA supplemental dental networks should not automatically include providers from
12 commercial dental networks.

- 13 • Providers must have a separate opt-in process to join an MA network, with clear terms
14 and reimbursement structures.

- 15 • If a provider explicitly consents, they may participate in both networks, but participation in
16 one should not imply participation in the other.

- 17 Providers who have opted-in to participation in an MA network must be given the opportunity to
18 change their election annually or upon contract amendments.

19 **BOARD RECOMMENDATION: Vote Yes.**

20 **BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)**

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**WORKSHEET ADDENDUM
ADA POLICY TO BE RESCINDED**

3 **Policy on Fluoridation of Water Supplies** (*Trans.*1950:244; 2015:274)

4 **Resolved**, that in the interest of public health, the American Dental Association recommends the
5 fluoridation of community water systems in accordance with the standards established by the appropriate
6 authority, and be it further

7 **Resolved**, that the American Dental Association supports ongoing research on the safety and
8 effectiveness of community water fluoridation.

1 and be it further

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

- 3 • ADA Policy on the Aged, Blind and Disabled (*Trans.*2002:390; 2012:455)
4 • Dental Care in Institutional and Homebound Settings (*Trans.*1986:518; 2013:341)

5 **BOARD RECOMMENDATION: Vote Yes.**

6 **BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)**

7

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

- 2 • Guidelines for Hospital Dental Privileges (*Trans.*2015:274)
3 • Hospital Medical Staff Membership (*Trans.*1999:923)

4 **BOARD RECOMMENDATION: Vote Yes.**

5 **BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)**

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**WORKSHEET ADDENDUM
POLICIES TO BE RESCINDED**

Guidelines for Hospital Dental Privileges (*Trans.2015:274*)

Resolved, the American Dental Association believes that all dentists who practice in hospitals should be eligible for privileges that should include performance of history and physical examinations, diagnosis, treatment and admission in accordance with their education, training and current competencies, consistent with the protocols and guidelines of the hospital where they have privileges.

Hospital Medical Staff Membership (*Trans.1999:923*)

Resolved, that the American Dental Association supports active hospital medical staff membership for qualified dentists that request such appointment, and be it further

Resolved, active medical staff membership for these dentists conveys upon them all appropriate rights and privileges of any other active medical staff member, including but not limited to: the right to vote, hold office, apply for clinical privileges and if necessary, the right to a fair hearing and appellate review, and be it further

Resolved, that the process and general criteria for medical staff membership and privileges for dentists should be the same as for any other medical staff member, and be it further

Resolved, that dentists who receive such membership be encouraged to be active in the hospital and in its related committees in order to raise the profile of dentists as contributing medical staff members, and be it further

Resolved, that should cases of national significance concerning denial or revocation of privileges for qualified dentists be brought to the attention of the Association, the Board of Trustees be urged to take appropriate action, including legal action.

1 ~~professionals about groundwater sectors and water systems with~~ local fluoride levels that exceed
2 2.0 parts per million so that parents and caregivers of young children receive appropriate
3 counseling to reduce the risk of severe dental fluorosis in permanent teeth.

4 **BOARD RECOMMENDATION: Vote Yes.**

5 **BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)**

1 **Resolved**, ~~that 5. The~~ the Association supports the following actions to maintain the quality of the
2 nation's national community water fluoridation and its infrastructure:

- 3 • performance of periodic assessments of community water fluoridation infrastructure
4 needs by appropriate state agencies;
- 5 • allocation of needed resources to or by appropriate state agencies to upgrade and
6 maintain the fluoridation infrastructure; and
- 7 • observance of the standards established by the appropriate municipal authorities and
8 state agencies related to engineering and administrative recommendations for water
9 fluoridation, ~~in accordance with guidance issued by the Centers for Disease Control and~~
10 ~~Prevention and be it further~~

11 **Resolved**, that the Association encourages for communities to receive a minimum 90-day
12 notification to any proposed implementation, cessation, or change in community water fluoridation
13 status.

14 **BOARD RECOMMENDATION: Vote Yes.**

15 **BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)**

Resolution No. 318S-1 Substitute

Report: N/A Date Submitted: 10/13/2025

Submitted By: Sixteenth Trustee District

Reference Committee: B (Dental Benefits, Practice, Science, Health and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time: _____ Amount On-going: _____

ADA Strategic Forecast Outcome: Public Profession: Drive evidence-based, ethical quality care.

1 **AMENDMENT OF RESOLUTION 318: AMENDMENT OF POLICY, OPERATIONAL POLICIES AND**
2 **RECOMMENDATIONS REGARDING COMMUNITY WATER FLUORIDATION**

3 The following resolution was submitted by on Monday, October 13, 2025, by Phil Latham, executive
4 director, South Carolina Dental Association on behalf of the Sixteenth Trustee District.

5 **Background:** The 16th District recognizes the intent of Resolution 318 to modernize and establish a
6 more comprehensive policy on community water fluoridation. However, with the proposed rescission of
7 the Policy on Fluoridation of Water Supplies (*Trans.*1950:244; 2015:274), we are concerned that the
8 ADA’s documented support for ongoing research on the safety and effectiveness of community water
9 fluoridation would be lost.

10 While it is well established that community water fluoridation is safe at recommended levels, the ADA
11 must remain transparent and continue to communicate its commitment to science-based decision-making.
12 Therefore, the 16th District recommends incorporating the second resolving clause from the Policy on
13 Fluoridation of Water Supplies (*Trans.*1950:244; 2015:274)—which is proposed to be rescinded by
14 Resolution 313—into Resolution 318 as follows:

15 **Resolution**

16 **318S-1. Resolved**, that the policy titled Operational Policies and Recommendations Regarding
17 Community Water Fluoridation (*Trans.*1997:673; 2015:273) be amended to read as follows
18 (additions are double underscored).

19 **Operational Policies and Recommendations Regarding Community Water Fluoridation**

20 **Resolved**, that 1. The ~~the~~ Association endorses community water fluoridation as a beneficial, safe,
21 socially equitable, and cost saving ~~safe, beneficial and cost effective and socially equitable public health~~
22 measure for preventing dental caries in children and adults, and be it further

23 **Resolved**, that 2. The ~~the~~ Association supports the fluoridation of community water systems as
24 recommended by the 2015 U.S. Public Health Service Recommendation, the Centers for Disease
25 Control and Prevention, Healthy People 2030, and the 2022 World Health Organization global oral
26 health status report, and be it further

27 **Resolved**, that the Association supports ongoing research on the safety and effectiveness of
28 community water fluoridation, and be it further

1 **Resolved, ~~that 3. The~~ the Association ~~urges~~ encourages individual dentists and dental societies**
2 to exercise collaborative leadership in all phases of activity ~~which that~~ lead to the initiation and
3 continuation of community water fluoridation, ~~including by~~ making scientific knowledge and
4 resources available to relevant communities of interest, ~~the community and collaborating with~~
5 state and local agencies and be it further

6 **Resolved, ~~that 4. The~~ the Association encourages governmental, philanthropic and other entities**
7 to make funding available to communities seeking to initiate and/or maintain community water
8 fluoridation, and be it further

9 **Resolved, ~~that 5. The~~ the Association supports the following actions to maintain the quality of the**
10 nation's national community water fluoridation and its infrastructure:

- 11 • performance of periodic assessments of community water fluoridation infrastructure
- 12 needs by appropriate state agencies;
- 13 • allocation of needed resources to or by appropriate state agencies to upgrade and
- 14 maintain the fluoridation infrastructure; and
- 15 • observance of the standards established by the appropriate municipal authorities and
- 16 state agencies related to engineering and administrative recommendations for water
- 17 fluoridation, ~~in accordance with guidance issued by the Centers for Disease Control and~~
- 18 Prevention and be it further

19 **Resolved, that the Association encourages for communities to receive a minimum 90-day**
20 notification to any proposed implementation, cessation, or change in community water fluoridation
21 status.

22 **BOARD RECOMMENDATION: Received after the August 2025 Board of Trustees Meeting.**

Resolution No. 318S-2 Substitute

Report: N/A Date Submitted: 10/16/2025

Submitted By: Seventeenth Trustee District

Reference Committee: B (Dental Benefits, Practice, Science, Health and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time: _____ Amount On-going: _____

ADA Strategic Forecast Outcome: Public Profession: Drive evidence-based, ethical quality care.

1 **AMENDMENT OF RESOLUTION 318: AMENDMENT OF POLICY, OPERATIONAL POLICIES AND**
2 **RECOMMENDATIONS REGARDING COMMUNITY WATER FLUORIDATION**

3 The following resolution was submitted on Thursday, October 16, 2025, by Lianne Bell, leadership affairs
4 manager, Florida Dental Association on behalf of the Seventeenth Trustee District.

5 **Background:** Resolution 313 is a proposed rescission of the ADA Policy on Fluoridation of Water
6 Supplies as recommended by the Council on Advocacy for Access and Prevention (CAAP). The first
7 resolved clause of that policy is incorporated into this resolution.

8 The second resolved clause of the ADA Policy on Fluoridation of Water Supplies doesn't appear in any of
9 CAAP's other resolutions. We believe it is a necessary statement from the ADA that we continue to
10 support ongoing research into the effectiveness and safety of fluoridation. Without it, it could be construed
11 that the ADA no longer supports ongoing research into the effectiveness and safety of fluoridation, which
12 is not accurate.

13 **Resolution**

14 **318S-2. Resolved**, that the policy titled Operational Policies and Recommendations Regarding
15 Community Water Fluoridation (*Trans.*1997:673; 2015:273) be amended to read as follows
16 (additions are double underscored).

17 **Operational Policies and Recommendations Regarding Community Water Fluoridation**

18 **Resolved**, ~~that 1. The the~~ Association endorses community water fluoridation as a beneficial, safe,
19 socially equitable, and cost saving ~~safe, beneficial and cost effective and socially equitable public health~~
20 measure for preventing dental caries in children and adults, and be it further

21 **Resolved**, ~~that 2. The the~~ Association supports ongoing research on the effectiveness and safety
22 of community water fluoridation, supports the fluoridation of community water systems as
23 recommended by the 2015 U.S. Public Health Service Recommendation, the Centers for Disease
24 Control and Prevention, Healthy People 2030, and the 2022 World Health Organization global oral
25 health status report, and be it further

26 **Resolved**, ~~that 3. The the~~ Association urges encourages individual dentists and dental societies
27 to exercise collaborative leadership in all phases of activity ~~which that~~ lead to the initiation and
28 continuation of community water fluoridation, ~~including by~~ making scientific knowledge and
29 resources available to relevant communities of interest, the community and collaborating with
30 state and local agencies and be it further

1 **Resolved**, ~~that 4. The~~ the Association encourages governmental, philanthropic and other entities
2 to make funding available to communities seeking to initiate and/or maintain community water
3 fluoridation, and be it further

4 **Resolved**, ~~that 5. The~~ the Association supports the following actions to maintain the quality of the
5 nation's national community water fluoridation and its infrastructure:

- 6 • performance of periodic assessments of community water fluoridation infrastructure
7 needs by appropriate state agencies;
- 8 • allocation of needed resources to or by appropriate state agencies to upgrade and
9 maintain the fluoridation infrastructure; and
- 10 • observance of the standards established by the appropriate municipal authorities and
11 state agencies related to engineering and administrative recommendations for water
12 fluoridation, ~~in accordance with guidance issued by the Centers for Disease Control and~~
13 Prevention and be it further

14 **Resolved**, that the Association encourages for communities to receive a minimum 90-day
15 notification to any proposed implementation, cessation, or change in community water fluoridation
16 status.

17 **BOARD RECOMMENDATION: Received after the August 2025 Board of Trustees Meeting.**

Resolution No. 319 New

Report: N/A Date Submitted: August 2025

Submitted By: Council on Advocacy for Access and Prevention

Reference Committee: B (Dental Benefits, Practice, Science, Health and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time: _____ Amount On-going: _____

ADA Strategic Forecast Outcome: Public Profession: Increase and improve dental coverage and access.

1 **AMENDMENT OF POLICY, SCHOOL BASED ORAL HEALTH PROGRAMS**

2 **Background:** In accordance with Resolution 170H-2012 (*Trans.2012:370*), Regular Comprehensive
3 Policy Review, the Council on Advocacy on Access and Prevention (CAAP) reviewed the following
4 Association policies to determine their adequacy (or obsolescence) in modern times, and the merits of
5 any revisions

6 The Council examined the policy language and felt it required updated language. The Council
7 recommends that the following resolution be adopted.

8 **Resolution**

9 **319. Resolved**, that the policy titled School-Based Oral Health Programs (*Trans.2010:557*), be
10 amended to read as follows (additions underscored; deletions are ~~stricken~~).

11 **School-Based Oral Health Programs**

12 **Resolved**, that the American Dental Association recognizes that school-based oral health
13 programs can play an important role in preventing, identifying, managing and controlling ~~dental~~
14 ~~earies~~ diseases of the oral cavity in children and adolescents and can assist in the referral of
15 those patients to establish a dental home, if needed, and be it further

16 ~~**Resolved**, that the ADA create a page on its Web site dedicated to providing information on~~
17 ~~school-based oral health programs including links to external resources designed to assist~~
18 ~~professional providers, school boards and the public establish and maintain such programs in a~~
19 ~~safe and ethical manner, and be it further~~

20 ~~**Resolved**, that the ADA approach national school agencies, including but not limited to the~~
21 ~~National School Boards Association, to discuss possible collaborations to promote materials~~
22 ~~pertaining to~~ collaborates with key national organizations to promote and support school-based
23 oral health programs, and be it further

24 **Resolved**, that the ADA encourages state and local dental societies to promote and support
25 school based oral health programs

26 **BOARD RECOMMENDATION: Vote Yes.**

27 **BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)**

Resolution No. 320S-1 Substitute

Report: N/A Date Submitted: 10/13/2025

Submitted By: Sixteenth Trustee District

Reference Committee: B (Dental Benefits, Practice, Science, Health and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time: _____ Amount On-going: _____

ADA Strategic Forecast Outcome: Public Profession: Drive evidence-based, ethical quality care.

1 **AMENDMENT TO RESOLUTION 320: AMENDMENT TO THE OF POLICY, COMMUNITY BASED**
2 **TOPICAL FLUORIDE PROGRAMS**

3 The following resolution was submitted on Monday, October 13, 2025, by Phil Latham, executive director,
4 South Carolina Dental Association on behalf of the Sixteenth Trustee District.

5 **Background:** Although silver diamine fluoride (SDF) is included among fluoride products used in
6 dentistry, its primary purpose is to arrest existing decay rather than prevent it. SDF application requires a
7 clinical diagnosis of caries and a treatment plan that identifies SDF as the appropriate intervention. This
8 distinction highlights the critical role of the dentist in SDF use, which differs from most fluoride products
9 that are primarily preventive and can be applied without a diagnosis. Our wording emphasizes this
10 distinction to avoid categorizing SDF as purely preventive and ensures the dentist’s role remains central
11 when discussing its use within the broader spectrum of fluoride therapies.

12 **Resolution**

13 **320S-1. Resolved**, that the policy titled Community-Based Topical Fluoride Programs
14 (*Trans.2014:507*) be amended to read as follows (additions are double underscored).

15 **Community-Based Topical Fluoride Programs**

16 **Resolved**, the American Dental Association recognizes that community-based topical fluoride
17 programs, including fluoride varnish and silver diamine fluoride, are safe and efficacious in
18 reducing and managing dental caries as diagnosed by a licensed dentist, throughout the lifespan,
19 and be it further

20 **Resolved**, that advocacy efforts to add topical fluoride products as a dental benefit throughout
21 the lifespan by third-party payors be encouraged.

22 **BOARD RECOMMENDATION: Received after the August 2025 Board of Trustees meeting.**

Resolution No. 321 New

Report: N/A Date Submitted: August 2025

Submitted By: Council on Advocacy for Access and Prevention

Reference Committee: B (Dental Benefits, Practice, Science, Health and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time: _____ Amount On-going: _____

ADA Strategic Forecast Outcome: Public Profession: Drive evidence-based, ethical quality care.

1 **AMENDMENT OF POLICY, BOTTLED WATER, HOME WATER TREATMENT SYSTEMS AND**
2 **FLUORIDE EXPOSURE**

3 **Background:** In accordance with Resolution 170H-2012 (Trans.2012:370), Regular Comprehensive
4 Policy Review, the Council on Advocacy on Access and Prevention (CAAP) reviewed the following
5 Association policy to determine its adequacy (or obsolescence) in modern times, and the merits of any
6 revisions.

7 The Council identified a need to emphasize the varieties of packaged water along with filtration systems
8 used by consumers. After consulting the National Fluoridation Advisory Committee (NFAC), the Council
9 on Advocacy for Access and Prevention recommends that the following resolution be adopted.

10 **Resolution**

11 **321. Resolved**, that the policy titled Bottled Water, Home Water Treatment Systems and Fluoride
12 Exposure (*Trans.* 2002:390; 2013:342; 2021:327) be amended to read as follows (additions are
13 underscored; deletions are ~~stricken~~).

14 **Bottled Water, Home Water Treatment Systems and Fluoride Exposure**

15 **Resolved**, that in order to ensure optimal fluoride intake, the American Dental Association
16 supports actions by its members to educate their patients and communities regarding the safety
17 of tap water, level of fluoride in bottled water, including all commercially available packaged water
18 such as bottled, canned, or boxed, and the possible removal of fluoride by some home water
19 treatment systems such as reverse osmosis, and be it further

20 **Resolved**, that the American Dental Association ~~urges~~ encourages its members to inquire about
21 their patients' primary and secondary water sources and overall water consumption as part of the
22 health history, and be it further

23 **Resolved**, that the American Dental Association supports the labeling of ~~bottled packaged~~ water
24 with the fluoride concentration of the product ~~and company contact information including address,~~
25 ~~telephone number and website~~, and be it further

26 **Resolved**, that the American Dental Association ~~urges~~ encourages its members ~~and the public~~
27 ~~to refer to the International Bottled Water Association's "List of Brands Containing Fluoride,"~~ and
28 ~~be it further~~

29 **Resolved**, that the American Dental Association supports widespread education of the public on

1 the Centers for Disease Control and Prevention oral health website in order to better understand the
2 fluoride levels in their community. ~~the inclusion of information on the effect of various home water~~
3 ~~treatment system's on water fluoride levels.~~

4 **BOARD RECOMMENDATION: Vote Yes.**

5 **BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)**

- 1 3. Document and reference the guidelines of an appropriate dental or specialty
- 2 organization as the basis for their findings, including the definition of *Medical*
- 3 *Necessity* being used within the review.
- 4 4. Have a history of treating Medicaid recipients in the state in which the audited
- 5 dentist practices.
- 6 5. Have experience treating patients in a similar care delivery setting as the dentist
- 7 being audited, such as a hospital, surgery center or school-based setting,
- 8 especially if a significant portion of the audit targets such venues.

9 In addition, these entities shall be expected to conduct the review and audit in an efficient and
10 expeditious manner, including:

- 11 ~~1. Stating a reasonable period of time in which an audit can proceed before~~
- 12 ~~dismissal can be sought~~
- 13 ~~2. Defining the reasonable use of extrapolation in the initial audit request.~~

14 In its initial communication with the provider, the auditing entity should state the expected and
15 reasonable period of time in which the audit can be adequately performed. A dismissal of the
16 audit if it exceeds 180-days.

17 The ADA generally opposes extrapolation. Extrapolation is defined as the process of determining
18 an unknown value by projecting the results of a sample review to the broader universe from which
19 the same was drawn.

20 If audits utilize extrapolation, then (MCOs) or auditors should follow these guidelines for
21 extrapolation limits:

22 Extrapolation and statistical sampling are generally prohibited. In an overpayment audit, statistical
23 sampling or extrapolation may not be used for automated reviews and extrapolation cannot be
24 relied upon to determine or support the amount of an overpayment. An overpayment
25 determination must be based on evidence showing an overpayment for each individual claim.

26 **BOARD RECOMMENDATION: Vote Yes.**

27 **BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)**

1 workforce supported by a collaborative, well distributed, and appropriately skilled and scoped
2 team under the supervision of a licensed dentist is essential to fulfilling this commitment.
3 Having a sufficient number of students of various backgrounds interested in pursuing careers in
4 dentistry and a healthy number of graduates to provide care to all who require it depends upon a
5 number of critical factors, including sufficient government support of dental higher education,
6 overcoming current faculty shortages, providing affordable student loan programs, advanced
7 public health training and ensuring the financial viability of dental practices.

8 The American Dental Association supports the development of state legislation to resolve issues
9 related to access to dental care promulgated through increasing a healthy, skilled, well distributed
10 workforce consistent with the following principles.

11 A. Consistent Definitions

12 Terms referring to the dental access and members of the Allied Dental Team are defined
13 and utilized consistently.

14 B. Ongoing Curated Research

15 Data regarding the provision of dental care shall be updated, collected and reported,
16 including

- 17 • Forecasting of public demand for dental services;
- 18 • Research on Health Professional Shortage Areas (HPSAs); and
- 19 • Research to ensure that the supply of dental team personnel remains sufficient to
20 serve the population.

21 C. Healthy Workforce

22 • Dental societies are encouraged to engage with state regulatory agencies in their
23 mission to protect the public and provide support for dentists by eliminating barriers and
24 reducing stigma associated with seeking mental and behavioral health services, including
25 substance use disorders.

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

28 D. Financial Appropriations for Education Loans, Including Tax Relief

29 The ADA supports

- 30 • Decreasing financial barriers to pursue dental and allied dental team education;
- 31 • Mitigating financial barriers to practice in preferred choice of practice;
- 32 • Using federal and state funds to offset federal student loans in exchange for
33 public service, practicing in underserved areas, academic teaching and research
34 positions, and filling other gaps in areas of national need;
- 35 • Removing barriers that prohibit those with private graduate student loans from
36 taking advantage of state and federal student loan repayment programs;
- 37 • Tax deductibility of interest on health profession student loans; and
- 38 • Tax exemption for scholarship assistance and stipends awarded to health
39 professions students under federal programs.
- 40 • Both federal and state tax incentives should be available to improve distribution
41 of dentists in underserved areas regardless of practice type such as Federally Qualified
42 Health Centers, Community Health Centers or private practices.

43 E. Availability of Dentists and Allied Dental Team

- 1 • The dentist is the only health care provider who is able to diagnose and perform
2 surgical and irreversible procedures.
- 3 • The ADA supports care delivery models consistent with the requirement that
4 dentists are solely able to determine delegation within the dental team, within parameters
5 set by the state dental practice act.
- 6 • Dental hygiene licensure and practice must require graduation from a CODA-
7 accredited dental hygiene program, or successful completion of an equivalent program
8 that ensures clinical competency as approved by the state licensing board.
- 9 • The ADA supports the use of multiple entry pathways to the dental assisting
10 career and encourages advancement, education and job qualifications for dental
11 assistants through voluntary credentialing in duties permitted by the state dental practice
12 act. The ADA believes that licensure of dental assistants would create an unnecessary
13 barrier to entry to the profession.
- 14 • The ADA supports opportunities for military trained and federal service trained
15 allied dental team be incorporated into state level workforce at the level of their
16 competency.
- 17 • The ADA may support pilot programs that do not jeopardize the patient’s oral
18 health, as based on a valid assessment demonstrating that the program is necessary to
19 fulfill an unmet need and the program does not allow a nondentist to diagnose, treatment
20 plan or perform irreversible or surgical procedures.
- 21 • The ADA strongly urges that there should be a single state board of dentistry in
22 each state which serves as the sole licensing and regulatory authority for all dental
23 personnel.
- 24 • The ADA strongly urges state dental boards to require examination of candidates
25 for dental licensure separately from candidates for allied dental (non-dentist) licensure.
- 26 • The ADA supports licensure mobility pathways under which Allied Dental
27 Personnel licensed in good standing in one state may be licensed for practice in another
28 state without completing an additional clinical examination, provided such pathways
29 ensure that skill requirements remain in place for patient safety.
- 30 • Any proposed new member of the dental team shall be an individual supervised
31 by a dentist and be based upon a determination of need, sufficient education and
32 training, and a scope of practice that ensures the protection of the public’s oral health.

33 F. Scope of Dental Practice Laws Protected

- 34 • The primary purpose of dentists delegating functions to allied dental personnel is
35 to increase the capacity of the profession to provide patient care while retaining full
36 responsibility for diagnosis and the quality of care.
- 37 • The ADA supports the authority of each state government to adopt and enforce
38 laws and rules that regulate the practice of dentistry and enhance the oral health of the
39 public within its jurisdiction.
- 40 • In utilizing teledentistry, the extent of the supervision of allied dental personnel
41 should conform to the applicable dental practice act in the state, territory or jurisdiction of
42 the United States where the patient receives services and where the dentist is licensed.
- 43 • Preventive care services are an integral part of the comprehensive practice of
44 dentistry and should be rendered in accordance with the needs of the patient as
45 determined by a diagnosis and treatment plan developed and executed by the dentist.

1 • The scope of function and the level of supervision of the allied dental team
2 member should be determined by the state licensing boards with input from the American
3 Dental Association and the state dental societies.

4 • Supervision of allied dental team members may be personal, direct, or indirect,
5 according to the following definitions:

6 *Personal supervision.* A type of supervision in which the dentist is personally operating on a
7 patient and authorizes the dental allied personnel to aid treatment by concurrently performing a
8 supportive procedure.

9 *Direct supervision.* A type of supervision in which a dentist is in the dental office or treatment
10 facility, personally diagnoses and treatment plans the condition to be treated, personally
11 authorizes the procedures and remains in the dental office or treatment facility while the
12 procedures are being performed by the dental allied personnel, and evaluates their performance
13 before dismissal of the patient.

14 *Indirect supervision.* A type of supervision in which a dentist is in the dental office or treatment
15 facility, has personally diagnosed and treatment planned the condition to be treated, authorizes
16 the procedures and remains in the dental office or treatment facility while the procedures are
17 being performed by the allied dental personnel, and will evaluate the performance of the allied
18 dental personnel.

19 *General supervision.* A type of supervision in which a dentist is not required to be in the dental
20 office or treatment facility when procedures are provided but has personally diagnosed and
21 treatment planned the condition to be treated, has personally authorized the procedures, and will
22 evaluate the performance of the allied dental personnel. In order to assure the safety of the
23 patient, the following criteria must be followed whenever functions are performed under general
24 supervision.

25 1. Any patient to be treated by a dental hygienist must first become a patient of record of a
26 dentist or facility. A patient of record is defined as one who:

- 27 a. has been examined by the dentist;
28 b. has had a medical and dental history completed and evaluated by the dentist; and
29 c. has had his/her oral condition diagnosed and a treatment plan developed by the
30 dentist.

31 2. The dentist must provide to the dental hygienist prior written authorization to perform
32 clinical dental hygiene services for that patient of record. Such authorization should remain
33 in effect for a limited time period as specified by state law.

34 3. The dentist shall examine the patient following performance of clinical services by the
35 dental hygienist. Such examination shall be performed within a reasonable time as
36 determined by the nature of the services provided, the needs of the patient and the
37 professional judgment of the dentist.

38 *Public Health Supervision.* A type of supervision in which a licensed dental hygienist may provide
39 dental hygiene services, as specified by state law or regulations, when such services are
40 provided as part of an organized community program in various public health settings, as
41 designated by state law, and with general oversight of such programs by a licensed dentist
42 designated by the state.

1 G. Distribution of Dental Homes

- 2 • Dental care is essential to overall health and should be available to all
- 3 populations, regardless of their geographic location or demographics.

4 H. Non-Dental Providers or Non-dental Home Settings

5 No provision of this guidance shall be interpreted to expand the scope of dental practice to allow
6 untrained and/or unqualified personnel to perform any dental service.

- 7 • It is essential that non-dentists who provide preventive dental services utilize
- 8 care coordination to refer the patient to a dentist for a comprehensive examination and to
- 9 establish a dental home with a report of the services rendered given to the custodial
- 10 parent or legal guardian.

- 11 • Provision of preventive dental services by non-dental health care providers also
- 12 requires completion of an appropriate educational program that includes dental disease
- 13 risk assessment, dental caries and dental preventive techniques appropriate for the age
- 14 groups under their care.

- 15 • Non-dental health care professional training programs should include basic oral
- 16 health education in the curricula.

- 17 • When the employer of the dental hygienist is not a licensed dentist, the method
- 18 of compensation and other working conditions for the dental hygienist must not interfere
- 19 with the quality of dental care provided or the relationship between the responsible
- 20 supervising dentist and the dental hygienist.

21 and be it further

22 **Resolved**, that the following policies be rescinded.

- 23 • Statement Supporting the Dental Team Concept (*Trans.*2013:313)
- 24 • ADA’s Position on Dental Mid-Level Provider (*Trans.*2008:439)
- 25 • Maintenance of Multi-Pathway Options for Dental Assistants (*Trans.*1996:696)
- 26 • Statement on Credentialing Dental Assistants (*Trans.*1995:634)
- 27 • Federal Student Loan Forgiveness (*Trans.*2022:XXX)
- 28 • Federal Student Loan Programs (*Trans.*2019:297)
- 29 • Federal Student Loan Repayment Incentives (*Trans.*2019:297)
- 30 • Tax Treatment of Student Loan Interest, Scholarships and Stipends (*Trans.*2019:298)
- 31 • ADA’s Position on New Members of the Dental Team (*Trans.*2009:419)
- 32 • Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform
- 33 Irreversible Procedures (*Trans.*2010:521)
- 34 • Diagnosis or Performance of Irreversible Dental Procedures by Nondentists (*Trans.*2004:328;
- 35 2010:494)
- 36 • Measuring the Demand for Dental Services (*Trans.*1995:623)
- 37 • Support for Programs That Forecast Public Demand for Dental Services (*Trans.*1995:609)
- 38 • Dental Needs Survey (*Trans.*1985:588)
- 39 • Determining Health Professional Shortage Areas (*Trans.*1984:538; 1996:681; 2021:320;
- 40 2023:XXX)
- 41 • Comprehensive Policy Statement on Allied Dental Personnel (*Trans.*1996:699; 1997:691;
- 42 1998:713; 2001:467; 2002:400; 2006:307; 2010:505; 2021:330)
- 43 • Policy on Licensure of Dental Assistants (*Trans.*2000:474)

44 **BOARD RECOMMENDATION: Vote Yes.**

1 **BOARD VOTE: UNANIMOUS**

1 **WORKSHEET ADDENDUM**
2 **POLICIES TO BE RESCINDED**

3 **Statement Supporting the Dental Team Concept** (*Trans.2013:313*)

4 **Resolved**, that constituent dental societies, dental educators and dental examiners are encouraged to
5 work closely and cooperatively with the ADA to support the dental team concept to prevent fragmentation
6 of the dental team, and be it further

7 **Resolved**, that these parties are urged to support ADA policies on supervision of dental auxiliaries in all
8 settings including, but not limited to, educational institutions, skilled nursing facilities and public health
9 clinics.

10 **ADA's Position on Dental Mid-Level Provider** (*Trans.2008:439*)

11 **Resolved**, that the ADA's position on any proposed new member of the dental team shall be an individual
12 supervised by a dentist and be based upon a determination of need, sufficient education and training, and
13 a scope of practice that ensures the protection of the public's oral health.

14 **Maintenance of Multi-Pathway Options for Dental Assistants** (*Trans.1996:696*)

15 **Resolved**, that, similar to the multi-pathway mechanism used by the Dental Assisting National Board,
16 more than one pathway always be available for a candidate to become a dental assistant, including any
17 new category of dental assistant that may be created in the future.

18 **Statement on Credentialing Dental Assistants** (*Trans.1995:634*)

19 **Resolved**, that the American Dental Association recognizes and encourages the advancement of
20 education and job qualifications for dental assistants and thus believes that voluntary credentialing is
21 appropriate for dental assistants who perform duties as defined by the state dental practice acts.

22 **Policy on Licensure of Dental Assistants** (*Trans.2000:474*)

23 **Resolved**, that it is the policy of the American Dental Association that licensure of dental assistants is not
24 warranted.

25 **Federal Student Loan Forgiveness** (*Trans.2022:XXX*)

26 **Resolved**, that it is the position of the American Dental Association (ADA) that dentists should not be
27 excluded from government relief of public and commercial student loan debt without obligation or
28 condition, and be it further

29 **Resolved**, that the following principles guide the ADA efforts to shape specific student loan forgiveness
30 proposals:

- 31 1. Education debt associated with graduate and professional programs should be eligible.
32 2. Any means of testing should account for regional differences in cost of living and purchasing
33 power.
34 3. The consideration for eligibility and amount of forgiveness should account for the cost, length
35 and rigor of dental education programs.

36 **Federal Student Loan Programs** (*Trans.2019:297*)

37 **Resolved**, that the American Dental Association supports the federal graduate and professional degree

1 student loan programs authorized under the Higher Education Act of 1965, with an emphasis on:

- 2 1. Protecting access to federal Direct Unsubsidized Stafford Loans (Direct Loans) and Grad
- 3 PLUS loans for graduate and professional degree students.
- 4 2. Reinstating eligibility for graduate and professional degree students to take advantage of
- 5 federal Direct Subsidized Stafford Loans.
- 6 3. Removing annual and cumulative borrowing limits on federal student loans.
- 7 4. Lowering the interest rates and fees on federal student loans.
- 8 5. Capping total amount of interest that can accrue on federal student loans.
- 9 6. Halting the accrual of federal student loan interest while a dentist is completing a
- 10 medical/dental internship or residency.
- 11 7. Extending the period of federal student loan deferment until after a new dentist has
- 12 completed their medical/dental internship or residency.
- 13 8. Permitting federal graduate student loans to be refinanced more than once.
- 14 9. Simplifying and adding more transparency to the federal graduate student loan application
- 15 process.
- 16 10. Encouraging institutions of higher education and lenders to offer training to help students
- 17 make informed decisions about how to finance their graduate education.
- 18 11. Encouraging collaborative approaches to handling borrowers who fail (or are at risk of failing)
- 19 to fully repay their federal student loan(s) in the required time period, and be it further

20 **Resolved**, that the ADA's position on allowing private lenders to have a role in the federal student loan
21 program shall depend on whether the loan terms and conditions and borrower protections are guaranteed
22 to be as favorable or better than the existing system of federal student loans, and be it further

23 **Resolved**, that the ADA supports strengthening federal regulations for the protection of all student loan
24 borrowers.

25 **Federal Student Loan Repayment Incentives** (*Trans.2019:297*)

26 **Resolved**, that the American Dental Association supports using state and federal funds to provide
27 payments toward a dental professional's outstanding federal student loans in exchange for practicing in
28 underserved areas, entering and remaining in public service and academic teaching and research
29 positions, and filling other gaps in areas of national need, and be it further

30 **Resolved**, that the ADA supports removing barriers that prohibit those with private graduate student
31 loans from taking advantage of state and federal student loan repayment programs.

32 **Tax Treatment of Student Loan Interest, Scholarships and Stipends** (*Trans.2019:298*)

33 **Resolved**, that the American Dental Association supports the tax deductibility of interest on health
34 profession student loans, and be it further

35 **Resolved**, that the ADA supports a tax exemption for scholarship assistance and stipends awarded to
36 health professions students under federal programs.

37 **ADA's Position on New Members of the Dental Team** (*Trans.2009:419*)

38 **Resolved**, that the determination of workforce needs are under the jurisdiction of the state and are
39 determined at the state level, and any proposed new member of the dental team should be established at
40 the state level with the advice and counsel of the relevant ADA constituent dental society, and be it further

41 **Resolved**, that this does not include any ongoing pilot initiatives that the ADA presently is involved in,
42 and be it further

- 1 **Resolved**, that when state governments consider regulatory or legislative authorization of a new dental
2 team member, the ADA may assist and serve as a resource at the request of a constituent dental society
3 as they respond to workforce needs and advocate for the best workforce solution, and be it further
- 4 **Resolved**, that the ADA recommends that any new member of the dental team be supervised by a
5 dentist and be based upon a determination of need, sufficient education and training through a CODA
6 accredited program, and a scope of practice that ensures the protection of the public's oral health.
- 7 **Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform**
8 **Irreversible Procedures** (*Trans.2010:521*)
- 9 **Resolved**, that the ADA may support pilot programs that do not jeopardize the patient's oral health, as
10 based on a valid assessment demonstrating that the program is necessary to fulfill an unmet need and
11 the program does not allow a nondentist to diagnose, treatment plan or perform irreversible surgical
12 procedures, and be it further
- 13 **Resolved**, that the ADA critically review and seek opportunity for input into any pilot program or study
14 that has potential for significant impact on the dental profession, and be it further
- 15 **Resolved**, that the policy of the ADA shall be to actively participate in discussions/dialogue with
16 government, oral health care organizations or other agencies involved in dental workforce issues or oral
17 health care issues, and be it further
- 18 **Resolved**, that the policy of the ADA shall be to seek funding for Association studies on dental workforce
19 models or oral health care delivery issues or their evaluations, and be it further
- 20 **Resolved**, that if a pilot program involves a new member of the dental team, the new team member must
21 be supervised by a dentist, and be it further
- 22 **Resolved**, that the development of any new member of the dental team be based upon determination of
23 need, CODA-accredited dental school or advanced dental education program, and a scope of practice
24 that ensures the protection of the public's oral health.
- 25 **Diagnosis or Performance of Irreversible Dental Procedures by Nondentists** (*Trans.2004:328;*
26 *2010:494*)
- 27 **Resolved**, that the American Dental Association by all appropriate means strive to maintain the highest
28 quality of oral health care by maintaining that the dentist be the healthcare provider that performs
29 examinations/
30 evaluations, diagnoses, and treatment planning, and be it further
- 31 **Resolved**, that the dentist be the health care provider that performs surgical/irreversible procedures, and
32 be it further
- 33 **Resolved**, that surgical procedures be defined as the cutting or removal of hard or soft tissue.
- 34 **Measuring the Demand for Dental Services** (*Trans.1995:623*)
- 35 **Resolved**, that any measures of the capacity of the dental system to provide additional care take into
36 account the individual variations in practice styles, specialties, preferences, locations and patient demand
37 for dental services.

1 **Support for Programs That Forecast Public Demand for Dental Services** (*Trans.*1995:609)

2 **Resolved**, that the American Dental Association supports efforts to monitor, maintain and strengthen
3 programs that attempt to forecast public demand for dental services and which track trends in dental
4 services utilization, and be it further

5 **Resolved**, that this manpower information be forwarded to the appropriate Association agencies which
6 can assess its potential impact on any state or national legislative reform proposals.

7 **Dental Needs Survey** (*Trans.*1985:588)

8 **Resolved**, that the ADA Board of Trustees encourage and the ADA staff provide assistance to
9 constituent and dental societies who wish to conduct local or regional dental needs surveys, and be it
10 further

11 **Resolved**, that all costs for staff assistance not included in the Association budget be borne by the
12 constituent or component dental society conducting the study.

13 **Determining Health Professional Shortage Areas** (*Trans.*1984:538; 1996:681; 2021:320; 2023:XXX)

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

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

20 **Comprehensive Policy Statement on Allied Dental Personnel** (*Trans.*1996:699; 1997:691; 1998:713;
21 2001:467; 2002:400; 2006:307; 2010:505; 2021:330)

22 **General Principles**

23 Dentistry is committed to improving the health of the American public by providing the highest quality
24 comprehensive dental care, which includes the inseparable components of medical and dental history,
25 examination, diagnosis, treatment planning, treatment services and health maintenance. Preventive care
26 services are an integral part of the comprehensive practice of dentistry and should be rendered in
27 accordance with the needs of the patient as determined by a diagnosis and treatment plan developed and
28 executed by the dentist.

29 The dentist is ultimately responsible, ethically and legally, for patient care. In carrying out that
30 responsibility and to increase the capacity of the profession to provide patient care in the most cost-
31 effective manner, the dentist may delegate to allied dental personnel certain patient care functions for
32 which the allied dental personnel has been trained. In an ongoing effort to address the health care needs
33 of the American public, new members of the dental team may be developed. The scope of function and
34 level of supervision should be determined by the profession so as to ensure adequate patient care and
35 safety.

36 The recognized categories of allied dental personnel are dental hygienists, dental assistants, community
37 dental health coordinators and dental laboratory technicians. (See the glossary for definitions of each
38 category.) A dental laboratory technician who is employed in the dental office is considered to be allied
39 dental personnel. A dental technician who performs a supportive function in an environment outside the
40 dental office may be properly termed a supportive or allied member of the dental health team.

1 Delegation of Functions

2 The primary purpose of dentists delegating functions to allied dental personnel is to increase the capacity
3 of the profession to provide patient care while retaining full responsibility for the quality of care. This
4 responsibility includes identification of the need for specific types of allied dental personnel and
5 establishment of appropriate controls on the patient care services provided by allied dental personnel.

6 The American Dental Association has the responsibility to provide guidance to all agencies, organizations
7 and governmental bodies, such as state dental boards and legislatures, that have an interest in, or
8 responsibility and authority for, decisions on utilization, education, and supervision of allied dental
9 personnel. In this context, the primary responsibility is to assure that decisions on allied dental personnel
10 utilization will not adversely affect the health and well-being of the public or cause an increased risk to the
11 patient. In meeting these responsibilities, dentists must also identify those functions or procedures that
12 require the knowledge and skill of the dentist. Thus, the ADA must continue to promote that these
13 functions be performed by a licensed dentist in order to support the highest quality of oral health care by
14 maintaining that the dentist be the healthcare provider that performs examinations/evaluations;
15 diagnoses; treatment planning; and surgical/ irreversible procedures; prescribes work authorizations;
16 prescribes drugs and other medications; and administers enteral, parenteral or inhalational sedation, or
17 general anesthesia.

18 Nothing in this statement should be interpreted to limit a dentist from delegating to a properly trained
19 allied dental personnel responsibility for assisting the dentist in the performance of these functions under
20 the dentist's personal, direct or indirect supervision and in accordance with state law, if, in the dentist's
21 professional judgment, this is in the patient's best interest. The transfer of permissible functions from the
22 dentist to the allied dental personnel must not result in a reduced quality of patient care. In all cases, the
23 authority and responsibility of the dentist for the overall oral health of the patient must be maintained to
24 assure cost-effective delivery of services to the patient and avoid fragmentation of the dental team.

25 Utilization of allied dental personnel must be based on (1) the best interests of the patient; (2) the
26 education, training and credentialing of the allied dental personnel; (3) considerations of cost-
27 effectiveness and efficiency in delivery patterns; and (4) valid, independent research demonstrating the
28 feasibility and practicality of utilizing allied dental personnel in such roles in actual practice settings.

29 Delegation of Expanded Functions

30 Provision for the delegation of intraoral expanded functions to allied dental personnel which are included
31 in state dental practice acts and regulations should specify (1) education and training requirements by a
32 program accredited by the Commission on Dental Accreditation; (2) level of supervision by the dentist; (3)
33 assurance of quality; and (4) regulatory controls to assure protection of the public. Final decisions on
34 delegation of expanded functions should be made by the dentist, based on the best interests of the
35 patient and in compliance with legal requirements in the jurisdiction. Because of the complexity of the
36 procedures involved and the need to assure protection of the public, intraoral expanded functions as
37 defined in state dental practice acts and regulations shall be performed by allied dental personnel only
38 under the personal, direct or indirect supervision of the dentist and in accordance with state law.

39 Supervision of Allied Dental Personnel

40 In all instances, a dentist assumes responsibility for determining, on the basis of diagnosis, the specific
41 treatment patients will receive and which aspects of treatment may be delegated to qualified personnel.
42 As the dentist is best educated and trained to provide the care and has the responsibility for patient care,
43 supervision by the dentist is paramount in assuring the highest quality of care and the safety of the
44 patient. The degree of supervision required to assure that treatment is appropriate and does not
45 jeopardize the systemic or oral health of the patient varies with the nature of the procedure and the
46 medical and dental history of the patient, as determined with evaluation and examination by the dentist.

1 Supervision and coordination of treatment by a dentist are essential to comprehensive oral health care
2 and unsupervised practice by allied dental personnel has the potential to reduce the quality of oral health
3 care and could fail to protect the public. The unauthorized and improperly supervised delivery of care by
4 allied dental personnel is opposed by the American Dental Association. The types of supervision are
5 defined in the glossary of terminology at the end of this policy statement.

6 The ADA has always promoted policy that protects the health of the public. Personal, direct and indirect
7 supervision are the appropriate levels of supervision for the delegation of duties to allied dental
8 personnel. However in some states licensed dental hygienists are permitted to perform duties, except for
9 intraoral expanded functions, under general supervision or public health supervision, as delegated by the
10 supervising dentist. In order to assure the safety of the patient, the following criteria must be followed
11 whenever functions are performed under general supervision.

- 12 1. Any patient to be treated by a dental hygienist must first become a patient of record of a dentist. A
13 patient of record is defined as one who:
 - 14 a. has been examined by the dentist;
 - 15 b. has had a medical and dental history completed and evaluated by the dentist; and
 - 16 c. has had his/her oral condition diagnosed and a treatment plan developed by the dentist.
- 17 2. The dentist must provide to the dental hygienist prior written authorization to perform clinical dental
18 hygiene services for that patient of record. Such authorization should remain in effect for a limited
19 time period as specified by state law.
- 20 3. The dentist shall examine the patient following performance of clinical services by the dental
21 hygienist. Such examination shall be performed within a reasonable time as determined by the nature
22 of the services provided, the needs of the patient and the professional judgment of the dentist.

23 **Appropriate Settings for Dental Hygiene Services**

24 The settings in which a dental hygienist may perform legally delegated functions shall be limited to
25 treatment facilities under the jurisdiction and supervision of a dentist. When the employer of the dental
26 hygienist is not a licensed dentist, the method of compensation and other working conditions for the
27 dental hygienist must not interfere with the quality of dental care provided or the relationship between the
28 responsible supervising dentist and the dental hygienist.

29 The federal dental services are urged to assure that their utilization of allied dental personnel is in
30 compliance with policies of the American Dental Association.

31 Public oral health programs should utilize all appropriate dental team members in implementation of
32 programs which have been endorsed by constituent dental societies. The dental hygienist, in this setting,
33 may provide screening and preventive care services under an appropriate supervisory arrangement, as
34 specified in state practice acts and regulations, as well as oral health education programs for groups
35 within the community served.

36 **Allied Dental Personnel Education**

37 All personnel who participate in the provision of oral health care must have appropriate education and
38 training and meet any additional criteria needed to assure competence. The type and length of education
39 needed to prepare allied dental personnel to perform specific delegated patient care procedures should
40 be specified in state dental practice acts and regulations.

1 Licensed or legally permitted dentists must be involved in the clinical supervision of allied dental
2 personnel education programs, in accordance with state law. Programs should be administered or
3 directed by a dentist whenever possible.

4 Dental hygiene education programs are designed to prepare a dental hygienist to provide preventive
5 dental services under the direction and supervision of a dentist. Two academic years of study or its
6 equivalent in an education program accredited by the Commission on Dental Accreditation (CODA)
7 typically prepares the dental hygienist to perform clinical hygiene services. However, other programs,
8 CODA accredited or approved by the respective state's board of dental examiners, which utilize such
9 methods as institutionally-based didactic course work, in-office clinical training, or electronic distance
10 education can be an acceptable means to train dental hygienists. Boards of dentistry are urged to review
11 such innovative programs for acceptance.

12 Expanded functions education programs are designed to prepare dental auxiliaries to provide expanded
13 dental services under the direction and appropriate supervision of a dentist. Programs accredited by the
14 Commission on Dental Accreditation (CODA) typically prepare the expanded functions auxiliary to
15 perform legally permitted clinical services. However, other programs, CODA accredited or approved by
16 the respective state's board of dental examiners, which utilize such methods as institutionally-based
17 didactic course work, in-office clinical training, or electronic distance education can be an acceptable
18 means to train expanded functions auxiliaries. Boards of dentistry are urged to review such innovative
19 programs for acceptance.

20 Neither the dental hygiene education curriculum nor the expanded function education program provides
21 adequate preparation to enable graduates to provide comprehensive oral health care or to practice
22 without the supervision of a dentist.

23 Formal education and training are essential for preparing allied dental personnel to perform intraoral
24 expanded functions which are permitted by state law. Such expanded functions training should be
25 provided only in educational settings with the resources needed to provide appropriate preparation for
26 clinical practice under the supervision of a dentist.

27 **Licensure of Dental Hygienists**

28 There should be a single state board of dentistry in each state which serves as the sole licensing and
29 regulatory authority for all dental personnel. Graduation from a dental hygiene education program
30 accredited by the Commission on Dental Accreditation, or the successful completion by dental students of
31 an equivalent component of a predoctoral dental curriculum accredited by the Commission on Dental
32 Accreditation, is the essential educational eligibility requirement for dental hygiene licensure and practice.
33 The clinical portion of the dental hygiene licensure examination, during which patient care is provided,
34 must be conducted under the supervision of a licensed dentist.

35 **Constituent Legislative Activities**

36 Constituent dental societies should work with the state dental boards to assure that delegation of
37 functions, educational requirements, supervisory and setting provisions for allied dental personnel in state
38 dental practice acts and regulations are structured according to the basic principles contained in this
39 policy statement.

40 In order to maintain the highest standard of patient care, assure continuity of care and achieve cost-
41 effective delivery of services to the patient, constituent dental societies should seek to maintain, in statute
42 and regulation, the authority and responsibility of the dentist for the overall oral health of the patient.
43

1 **Glossary of Terminology Related to Allied Dental Personnel Utilization and Supervision**

2 This Glossary is designed to assist in developing a common language for discussion of allied dental
3 personnel issues by dental professionals and public policy makers. It should be noted that some of the
4 terms included do not lend themselves to rigid definition and can only be described as to use and
5 meaning. Also, certain terms are defined in dental practice acts and regulations, which vary from state to
6 state.

7 **Allied Dental Personnel:** Team members who assist the dentist in the provision of oral health care and
8 who are employed in dental offices or other patient care facilities.

9 **Authorization:** The act by a dentist of giving permission or approval to the allied dental personnel to
10 perform legally allowable functions, in accordance with the dentist's diagnosis and treatment plan.

11 **Community Dental Health:** (1) The overall oral health status of a geographically based population
12 group, (2) the branch of dentistry concerned with the distribution and causes of oral diseases in the
13 population and the management of resources for their prevention and treatment and (3) commonly used
14 to refer to programs which are designed to improve the oral health status of the population as a whole
15 and conducted under the direction of a dentist (such as access programs, education programs,
16 fluoridation and school-based mouthrinse programs).

17 **Community Dental Health Coordinator (CDHC):** An individual trained through the ADA licensed
18 curriculum as a dental trained professional with community health worker skills. Their aim is to improve
19 oral health education and to assist at-risk communities with disease prevention. Working under the
20 supervision of a dentist, a CDHC helps at-risk patients improve their preventive oral health through
21 education and awareness programs, navigate the health system and receive care from licensed dentists.
22 CDHCs also perform limited clinical duties only as allowed by their State Practice Acts until the patient
23 can receive comprehensive services from a dentist or dental hygienist. Upon graduation, they will work
24 primarily in public health and community settings like clinics, schools, faith based settings, senior citizen
25 centers, and Head Start programs in coordination with a variety of dental providers, including clinics,
26 community health centers, the Indian Health Service and private practice dental offices.

27 **Comprehensive Dental Care:** A coordinated approach, by a dentist, to the restoration or maintenance of
28 the oral health and function of the patient, utilizing the full range of clinically proven dental care
29 procedures, which includes examination and diagnostic, preventive and therapeutic services.

30 **Delegation:** The act by a dentist of directing allied dental personnel to perform specified legally allowable
31 functions.

32 **Dental Assistant:** An individual who may or may not have completed an accredited dental assisting
33 education program and who aids the dentist in providing patient care services and performs other
34 nonclinical duties in the dental office or other patient care facility. The scope of the patient care functions
35 that may be legally delegated to the dental assistant varies based on the needs of the dentist, the
36 educational preparation of the dental assistant and state dental practice acts and regulations. Patient care
37 services are provided under the supervision of a dentist. To avoid misleading the public, no occupational
38 title other than dental assistant should be used to describe this allied team member.

39 **Dental Hygienist:** An individual who has completed an accredited dental hygiene education program and
40 has been licensed by a state board of dental examiners to provide preventive care services under the
41 supervision of a dentist. Functions that may be legally delegated to the dental hygienist vary based on the
42 needs of the dentist, the educational preparation of the dental hygienist and state dental practice acts and
43 regulations, but always include, at a minimum, scaling and polishing the teeth. To avoid misleading the
44 public, no occupational title other than dental hygienist should be used to describe this allied team
45 member.

- 1 **Dental Laboratory Technician/Certified Dental Technician:** An individual who has the skill and
2 knowledge in the fabrication of dental appliances, prostheses and devices in accordance with a dentist's
3 laboratory work authorization. To avoid misleading the public, no occupational title other than dental
4 laboratory technician or certified dental technician (when appropriate) should be used to describe this
5 allied team member.
- 6 **Examination/Evaluation, Comprehensive:** A dentist performs an evaluation and recording of the
7 patient's dental and medical history and a general health assessment, and a thorough evaluation and
8 recording of the extraoral and intraoral conditions of the hard and soft tissues. This may require
9 interpretation of information acquired through additional diagnostic procedures. It includes an evaluation
10 for oral cancer where indicated, the evaluation and recording of dental caries, missing or unerupted teeth,
11 restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal
12 screening and/or charting), hard and soft tissue anomalies, etc.
- 13 **Examination/Evaluation, Limited:** A dentist performs an evaluation limited to a specific oral health
14 problem or complaint. This may require interpretation of information acquired through additional
15 diagnostic procedures. Typically, patients receiving this type of evaluation present with a specific problem
16 and/or dental emergencies, trauma, acute infections, etc.
- 17 **Expanded Functions:** Additional tasks, services or capacities, often including direct patient care
18 services, which may be legally delegated by a dentist to allied dental personnel. The scope of expanded
19 functions varies based on state dental practice acts and regulations but is generally limited to reversible
20 procedures which are performed under the personal, direct or indirect supervision of a dentist.
21 Authorization to perform expanded functions generally requires specific training in the function (also
22 expanded duties or extended functions).
- 23 **Functions:** An action or activity proper to an individual; a task, service or capacity which has been legally
24 delegated by a dentist to allied dental personnel (also duties or services).
- 25 **Oral Diagnosis:** The determination by a dentist of the oral health condition of an individual patient,
26 achieved through the evaluation of data gathered by means of history taking, direct examination, patient
27 conference, and such clinical aids and tests as may be necessary in the judgment of the dentist.
- 28 **Preventive Care Services:** The procedures used to prevent the initiation of oral diseases, which may
29 include screening, fluoride therapy, nutritional counseling, plaque control, and sealants.
- 30 **Screening:** Identifying the presence of gross lesions of the hard or soft tissues of the oral cavity.
- 31 **Supervision:** The authorization, direction, oversight and evaluation by a dentist of the activities
32 performed by allied dental personnel.
- 33 *Personal supervision.* A type of supervision in which the dentist is personally operating on a patient and
34 authorizes the allied dental personnel to aid treatment by concurrently performing a supportive procedure.
- 35 *Direct supervision.* A type of supervision in which a dentist is in the dental office or treatment facility,
36 personally diagnoses and treatment plans the condition to be treated, personally authorizes the
37 procedures and remains in the dental office or treatment facility while the procedures are being performed
38 by the allied dental personnel, and evaluates their performance before dismissal of the patient.
- 39 *Indirect supervision.* A type of supervision in which a dentist is in the dental office or treatment facility, has
40 personally diagnosed and treatment planned the condition to be treated, authorizes the procedures and
41 remains in the dental office or treatment facility while the procedures are being performed by the allied
42 dental personnel, and will evaluate the performance of the allied dental personnel.
- 43 *General supervision.* A type of supervision in which a dentist is not required to be in the dental office or
44 treatment facility when procedures are provided, but has personally diagnosed and treatment planned the

1 condition to be treated, has personally authorized the procedures, and will evaluate the performance of
2 the allied dental personnel.

3 *Public Health Supervision.* A type of supervision in which a licensed dental hygienist may provide dental
4 hygiene services, as specified by state law or regulations, when such services are provided as part of an
5 organized community program in various public health settings, as designated by state law, and with
6 general oversight of such programs by a licensed dentist designated by the state.

7 **Treatment Plan:** The sequential guide for the patient's care as determined by the dentist's diagnosis and
8 used by the dentist for the restoration to and/or maintenance of optimal oral health.

Resolution No. 324S-1 Substitute
Report: N/A Date Submitted: 10/16/2025
Submitted By: Fifth Trustee District

Reference Committee: B (Dental Benefits, Practice, Science, Health and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time: _____ Amount On-going: _____

ADA Strategic Forecast Outcome: Public Profession: Support a healthy, well-distributed, skilled and scoped workforce.

1 **AMENDMENT TO RESOLUTION 324: PROPOSED POLICY, STATEMENT ON WORKFORCE AND**
2 **ALLIED DENTAL TEAMS**

3 The following resolution was submitted on Thursday, October 16, 2025 by Jeannie Watson, senior
4 executive assistant, Georgia Dental Association on behalf of the Fifth Trustee District.

5 **Background:** In 2023, this House approved policy to ensure that dentists practicing in Health
6 Professional Shortage Areas are able to maintain the grants that support their ability to serve these
7 communities. If dentist-to-Population ratios are used as the sole metric, changes in the calculation could
8 jeopardize their qualification status. That would mean not only the loss of critical grants for these dentists
9 but also a reduction in access to care for the very patients who need it most. Please do not rescind this
10 portion of the existing policy on Health Professional Shortage Areas.

11 **Resolution**

12 **324S-1. Resolved**, that the following policy, Statement on Workforce and Allied Dental Teams, be
13 adopted as amended (additions underlined; deletions ~~stricken through~~):

14 **Statement on Workforce and Allied Dental Teams**

15 The American Dental Association has the responsibility to provide guidance to all agencies,
16 organizations and governmental bodies, such as state dental boards and legislatures, that have
17 an interest in, or responsibility and authority for, decisions on utilization, education, and
18 supervision of allied dental personnel. The ADA supports a diverse team of allied dental
19 personnel whose training and functions complement the dentist, prioritize patient access, and
20 provide quality care.

21 Dentistry is committed to improving the health of the American public by delivering the highest
22 quality comprehensive oral health care in a consistent, safe, and accessible manner. A healthy
23 workforce supported by a collaborative, well distributed, and appropriately skilled and scoped
24 team under the supervision of a licensed dentist is essential to fulfilling this commitment.
25 Having a sufficient number of students of various backgrounds interested in pursuing careers in
26 dentistry and a healthy number of graduates to provide care to all who require it depends upon a
27 number of critical factors, including sufficient government support of dental higher education,
28 overcoming current faculty shortages, providing affordable student loan programs, advanced
29 public health training and ensuring the financial viability of dental practices.

1 The American Dental Association supports the development of state legislation to resolve issues
 2 related to access to dental care promulgated through increasing a healthy, skilled, well distributed
 3 workforce consistent with the following principles.

4 A. Consistent Definitions

5 Terms referring to the dental access and members of the Allied Dental Team are defined
 6 and utilized consistently.

7 B. Ongoing Curated Research

8 Data regarding the provision of dental care shall be updated, collected and reported,
 9 including

- 10 • Forecasting of public demand for dental services;
- 11 • Research on Health Professional Shortage Areas (HPSAs); ~~and~~
- 12 • Understanding that the ADA opposes using dentist-to -population ratios as the
 13 exclusive measure for designating dental health professional shortage areas or for
 14 evaluating or recommending programs for dental education or dental care; and
- 15 • Research to ensure that the supply of dental team personnel remains sufficient to
 16 serve the population.

17 C. Healthy Workforce

- 18 • Dental societies are encouraged to engage with state regulatory agencies in their
 19 mission to protect the public and provide support for dentists by eliminating barriers and
 20 reducing stigma associated with seeking mental and behavioral health services, including
 21 substance use disorders.
- 22 • Dental societies should be advocates for dentists to have the same rights of
 23 privacy and confidentiality of personal medical information as other persons.

24 D. Financial Appropriations for Education Loans, Including Tax Relief

25 The ADA supports

- 26 • Decreasing financial barriers to pursue dental and allied dental team education;
- 27 • Mitigating financial barriers to practice in preferred choice of practice;
- 28 • Using federal and state funds to offset federal student loans in exchange for
 29 public service, practicing in underserved areas, academic teaching and research
 30 positions, and filling other gaps in areas of national need;
- 31 • Removing barriers that prohibit those with private graduate student loans from
 32 taking advantage of state and federal student loan repayment programs;
- 33 • Tax deductibility of interest on health profession student loans; and
- 34 • Tax exemption for scholarship assistance and stipends awarded to health
 35 professions students under federal programs.
- 36 • Both federal and state tax incentives should be available to improve distribution
 37 of dentists in underserved areas regardless of practice type such as Federally Qualified
 38 Health Centers, Community Health Centers or private practices.

39 E. Availability of Dentists and Allied Dental Team

- 40 • The dentist is the only health care provider who is able to diagnose and perform
 41 surgical and irreversible procedures.

- 1 • The ADA supports care delivery models consistent with the requirement that
2 dentists are solely able to determine delegation within the dental team, within parameters
3 set by the state dental practice act.
- 4 • Dental hygiene licensure and practice must require graduation from a CODA-
5 accredited dental hygiene program, or successful completion of an equivalent program
6 that ensures clinical competency as approved by the state licensing board.
- 7 • The ADA supports the use of multiple entry pathways to the dental assisting
8 career and encourages advancement, education and job qualifications for dental
9 assistants through voluntary credentialing in duties permitted by the state dental practice
10 act. The ADA believes that licensure of dental assistants would create an unnecessary
11 barrier to entry to the profession.
- 12 • The ADA supports opportunities for military trained and federal service trained
13 allied dental team be incorporated into state level workforce at the level of their
14 competency.
- 15 • The ADA may support pilot programs that do not jeopardize the patient’s oral
16 health, as based on a valid assessment demonstrating that the program is necessary to
17 fulfill an unmet need and the program does not allow a nondentist to diagnose, treatment
18 plan or perform irreversible or surgical procedures.
- 19 • The ADA strongly urges that there should be a single state board of dentistry in
20 each state which serves as the sole licensing and regulatory authority for all dental
21 personnel.
- 22 • The ADA strongly urges state dental boards to require examination of candidates
23 for dental licensure separately from candidates for allied dental (non-dentist) licensure.
- 24 • The ADA supports licensure mobility pathways under which Allied Dental
25 Personnel licensed in good standing in one state may be licensed for practice in another
26 state without completing an additional clinical examination, provided such pathways
27 ensure that skill requirements remain in place for patient safety.
- 28 • Any proposed new member of the dental team shall be an individual supervised
29 by a dentist and be based upon a determination of need, sufficient education and
30 training, and a scope of practice that ensures the protection of the public’s oral health.

31 F. Scope of Dental Practice Laws Protected

- 32 • The primary purpose of dentists delegating functions to allied dental personnel is
33 to increase the capacity of the profession to provide patient care while retaining full
34 responsibility for diagnosis and the quality of care.
- 35 • The ADA supports the authority of each state government to adopt and enforce
36 laws and rules that regulate the practice of dentistry and enhance the oral health of the
37 public within its jurisdiction.
- 38 • In utilizing teledentistry, the extent of the supervision of allied dental personnel
39 should conform to the applicable dental practice act in the state, territory or jurisdiction of
40 the United States where the patient receives services and where the dentist is licensed.
- 41 • Preventive care services are an integral part of the comprehensive practice of
42 dentistry and should be rendered in accordance with the needs of the patient as
43 determined by a diagnosis and treatment plan developed and executed by the dentist.
- 44 • The scope of function and the level of supervision of the allied dental team
45 member should be determined by the state licensing boards with input from the American
46 Dental Association and the state dental societies.

- 1 • Supervision of allied dental team members may be personal, direct, or indirect,
2 according to the following definitions:

3 *Personal supervision.* A type of supervision in which the dentist is personally operating on a
4 patient and authorizes the dental allied personnel to aid treatment by concurrently performing a
5 supportive procedure.

6 *Direct supervision.* A type of supervision in which a dentist is in the dental office or treatment
7 facility, personally diagnoses and treatment plans the condition to be treated, personally
8 authorizes the procedures and remains in the dental office or treatment facility while the
9 procedures are being performed by the dental allied personnel, and evaluates their performance
10 before dismissal of the patient.

11 *Indirect supervision.* A type of supervision in which a dentist is in the dental office or treatment
12 facility, has personally diagnosed and treatment planned the condition to be treated, authorizes
13 the procedures and remains in the dental office or treatment facility while the procedures are
14 being performed by the allied dental personnel, and will evaluate the performance of the allied
15 dental personnel.

16 *General supervision.* A type of supervision in which a dentist is not required to be in the dental
17 office or treatment facility when procedures are provided but has personally diagnosed and
18 treatment planned the condition to be treated, has personally authorized the procedures, and will
19 evaluate the performance of the allied dental personnel. In order to assure the safety of the
20 patient, the following criteria must be followed whenever functions are performed under general
21 supervision.

22 1. Any patient to be treated by a dental hygienist must first become a patient of record of a
23 dentist or facility. A patient of record is defined as one who:

- 24 a. has been examined by the dentist;
- 25 b. has had a medical and dental history completed and evaluated by the dentist; and
- 26 c. has had his/her oral condition diagnosed and a treatment plan developed by the
27 dentist.

28 2. The dentist must provide to the dental hygienist prior written authorization to perform
29 clinical dental hygiene services for that patient of record. Such authorization should remain
30 in effect for a limited time period as specified by state law.

31 3. The dentist shall examine the patient following performance of clinical services by the
32 dental hygienist. Such examination shall be performed within a reasonable time as
33 determined by the nature of the services provided, the needs of the patient and the
34 professional judgment of the dentist.

35 *Public Health Supervision.* A type of supervision in which a licensed dental hygienist may provide
36 dental hygiene services, as specified by state law or regulations, when such services are
37 provided as part of an organized community program in various public health settings, as
38 designated by state law, and with general oversight of such programs by a licensed dentist
39 designated by the state.

40 G. Distribution of Dental Homes

- 1 • Dental care is essential to overall health and should be available to all
- 2 populations, regardless of their geographic location or demographics.

3 H. Non-Dental Providers or Non-dental Home Settings

4 No provision of this guidance shall be interpreted to expand the scope of dental practice to allow
5 untrained and/or unqualified personnel to perform any dental service.

- 6 • It is essential that non-dentists who provide preventive dental services utilize
7 care coordination to refer the patient to a dentist for a comprehensive examination and to
- 8 • establish a dental home with a report of the services rendered given to the
9 custodial parent or legal guardian.

- 10 • Provision of preventive dental services by non-dental health care providers also
11 requires completion of an appropriate educational program that includes dental disease
12 risk assessment, dental caries and dental preventive techniques appropriate for the age
13 groups under their care.

- 14 • Non-dental health care professional training programs should include basic oral
15 health education in the curricula.

- 16 • When the employer of the dental hygienist is not a licensed dentist, the method
17 of compensation and other working conditions for the dental hygienist must not interfere
18 with the quality of dental care provided or the relationship between the responsible
19 supervising dentist and the dental hygienist.
- 20

21 and be it further

22 **Resolved**, that the following policies be rescinded.

- 23 • Statement Supporting the Dental Team Concept (*Trans.2013:313*)
- 24 • ADA's Position on Dental Mid-Level Provider (*Trans.2008:439*)
- 25 • Maintenance of Multi-Pathway Options for Dental Assistants (*Trans.1996:696*)
- 26 • Statement on Credentialing Dental Assistants (*Trans.1995:634*)
- 27 • Federal Student Loan Forgiveness (*Trans.2022:XXX*)
- 28 • Federal Student Loan Programs (*Trans.2019:297*)
- 29 • Federal Student Loan Repayment Incentives (*Trans.2019:297*)
- 30 • Tax Treatment of Student Loan Interest, Scholarships and Stipends (*Trans.2019:298*)
- 31 • ADA's Position on New Members of the Dental Team (*Trans.2009:419*)
- 32 • Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform
33 Irreversible Procedures (*Trans.2010:521*)
- 34 • Diagnosis or Performance of Irreversible Dental Procedures by Nondentists (*Trans.2004:328;*
35 *2010:494*)
- 36 • Measuring the Demand for Dental Services (*Trans.1995:623*)
- 37 • Support for Programs That Forecast Public Demand for Dental Services (*Trans.1995:609*)
- 38 • Dental Needs Survey (*Trans.1985:588*)
- 39 • Determining Health Professional Shortage Areas (*Trans.1984:538; 1996:681; 2021:320;*
40 *2023:XXX*)
- 41 • Comprehensive Policy Statement on Allied Dental Personnel (*Trans.1996:699; 1997:691;*
42 *1998:713; 2001:467; 2002:400; 2006:307; 2010:505; 2021:330*)
- 43 • Policy on Licensure of Dental Assistants (*Trans.2000:474*)

44 **BOARD RECOMMENDATION: Received after the August Board of Trustees Meeting.**

1 training and credentialing; (3) considerations-of-efficiency in delivery patterns; and (4) valid,
2 independent research demonstrating the feasibility and practicality of utilizing allied dental
3 personnel in such roles in actual practice settings. The allied dental team roles recognized by the
4 ADA are dental hygienists, dental assistants, community dental health coordinators, and dental
5 laboratory technicians.

6 **Assessment/Dental Assessment:** A limited clinical inspection that is performed to identify
7 possible signs of oral or systemic disease, malformation, or injury, and the potential need for
8 referral for diagnosis and treatment.

9 **Authorization:** The act by a dentist of giving permission or approval to the dental allied
10 personnel to perform legally allowable functions, in accordance with the dentist's diagnosis and
11 treatment plan.

12 **Community Dental Health:** (1) The overall oral health status of a geographically based
13 population group, (2) the branch of dentistry concerned with the distribution and causes of oral
14 diseases in the population and the management of resources for their prevention and treatment
15 and (3) commonly used to refer to programs which are designed to improve the oral health status
16 of the population as a whole and conducted under the direction of a dentist (such as access
17 programs, education programs, fluoridation and school-based mouthrinse programs).

18 **Community Dental Health Coordinator (CDHC):** An individual trained through the ADA
19 licensed curriculum to improve oral health education and to assist at-risk communities with
20 disease prevention, working under the supervision of a dentist.

21 **Comprehensive Dental Care:** A coordinated approach, by a dentist, to the restoration or
22 maintenance of the oral health and function of the patient, utilizing the full range of clinically
23 proven dental care procedures, which includes examination and diagnostic, preventive and
24 therapeutic services.

25 **Comprehensive Examination/Evaluation:** A dentist performs an evaluation and recording of the
26 patient's dental and medical history and a general health assessment, and a thorough evaluation
27 and recording of the extraoral and intraoral conditions of the hard and soft tissues. This may
28 require interpretation of information acquired through additional diagnostic procedures. It includes
29 an evaluation for oral cancer where indicated, the evaluation and recording of dental caries,
30 missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal
31 conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.

32 **Delegation:** The act by a dentist of directing allied dental personnel to perform specified legally
33 allowable functions.

34 **Dental Assistant:** An individual who aids the dentist in providing patient care services and
35 performs other nonclinical duties in the dental office or other patient care facility. The scope of the
36 patient care functions that may be legally delegated to the dental assistant varies based on the
37 needs of the dentist, the educational preparation of the dental assistant and state dental practice
38 acts and regulations. Patient care services are provided under the supervision of a dentist. To
39 avoid misleading the public, no occupational title other than dental assistant or certified dental
40 technician (when appropriate) should be used to describe this allied team member.

41 **Dental Hygienist:** An individual who has completed an accredited dental hygiene education
42 program or successful completion of an equivalent program that ensures clinical competency and
43 has been licensed by a state board of dental examiners to provide preventive and therapeutic
44 care services under the supervision of a dentist. Functions that may be legally delegated to the
45 dental hygienist vary based on the educational preparation of the dental hygienist and state
46 dental practice acts and regulations, but always include, at a minimum, scaling and polishing the

1 teeth. To avoid misleading the public, no occupational title other than dental hygienist should be
2 used to describe this allied team member.

3 **Dental Laboratory Technician/Certified Dental Technician:** An individual who has the skill and
4 knowledge in the fabrication of dental appliances, prostheses and devices in accordance with a
5 dentist's laboratory work authorization. To avoid misleading the public, no occupational title other
6 than dental laboratory technician or certified dental technician (when appropriate) should be used
7 to describe this allied team member.

8 **Dental Professional:** Any member of the dental team that communicates directly with the patient
9 about their dental needs. This person may be the dentist, hygienist, assistant, financial advisor,
10 office manager, or patient coordinator.

11 **Dental Therapist:** A dental therapist is an individual who has completed an accredited
12 educational program and has been licensed by a state board of dentistry to diagnose and provide
13 services as authorized by their state dental practice act. Functions that may be legally delegated
14 to the dental therapist vary based on the educational preparation of the dental therapist, state
15 dental practice acts and regulations, and the collaborative management agreement between the
16 therapist and their supervising dentist.

17 **Diagnosis:** The determination by a dentist of the oral health condition of an individual patient,
18 achieved through the evaluation of data gathered by means of history taking, direct examination,
19 patient conference, and interpretation of such clinical aids and tests as may be necessary in the
20 judgment of the dentist.

21 **Expanded Functions:** Additional tasks, services or capacities, often including direct patient care
22 services, which may be legally delegated by a dentist to allied dental personnel. The scope of
23 expanded functions varies based on state dental practice acts and regulations but is generally
24 limited to reversible procedures which are performed under the personal, direct or indirect
25 supervision of a dentist. Authorization to perform expanded functions generally requires specific
26 training in the function. Also referred to as expanded duties or extended functions.

27 **Expanded Function Dental Auxiliary/Assistant (EFDA):** An individual who has trained and
28 demonstrated proficiency in the expanded functions proscribed by their practice act. These
29 functions are outside of the scope of a licensed hygienist or a dental assistant, and require
30 additional training and certification prior to their performance in a dental office. An EFDA works
31 under the supervision of a dentist.

32 **Functions:** An action or activity proper to an individual; a task, service or capacity which has
33 been legally delegated by a dentist to allied dental personnel. Also referred to as duties or
34 services.

35 **Irreversible Procedure:** any procedure that alters the natural form and function of a patient's
36 maxillofacial region in a way that cannot be readily undone, including but not limited to the
37 removal of tooth structure.

38 **Limited Examination/Evaluation:** A dentist performs an evaluation limited to a specific oral
39 health problem or complaint. This may require interpretation of information acquired through
40 additional diagnostic procedures. Typically, patients receiving this type of evaluation present with
41 a specific problem and/or dental emergencies, trauma, acute infections, etc.

42 **Mid-Level provider:** Any individual with limited dental training who does not hold a DDS or DMD
43 degree and is not a recognized member of the allied dental team as defined in this glossary. They
44 may perform limited dental procedures as diagnosed by a dentist in accordance with state law

1 and as defined in state practice acts/regulation. Note this excludes Dental Hygienists and Dental
2 Therapists.

3 **Oral Preventive Assistant (OPA):** an expanded function dental assistant who has undergone
4 approved academic and clinical training and demonstrated proficiency in the functions prescribed
5 by their practice act. The OPA works under the direct supervision of a dentist, and provides
6 preventive care to healthy child and adult patients that have routine care or gingivitis. The scope
7 of an OPA is prescribed in state practice acts, but is generally limited to: measuring periodontal
8 pockets, removing supragingival calculus, application of fluoride and silver diamine fluoride, and
9 provision of oral hygiene instructions.

10 **Preventive Care Services:** The procedures used to prevent the initiation of oral diseases, which
11 may include screening, fluoride therapy, nutritional counseling, plaque control, and sealants.

12 **Screening:** Identifying the presence of gross lesions of the hard or soft tissues of the oral cavity.

13 **Structured Course in Radiography:** A planned sequence of instruction of specified content,
14 designed to meet stated educational objectives and to include evaluation of attainment of those
15 objectives.

16 **Supervising Dentist:** A dentist present on the premises of a care setting that is responsible for
17 authorizing, directing, overseeing, and evaluating all care provided by allied dental personnel.

18 **Supervision:** The authorization, direction, oversight and evaluation by a dentist of the activities
19 performed by dental allied personnel.

20 *Personal supervision.* A type of supervision in which the dentist is personally operating on a
21 patient and authorizes the dental allied personnel to aid treatment by concurrently performing a
22 supportive procedure.

23 *Direct supervision.* A type of supervision in which a dentist is in the dental office or treatment
24 facility, personally diagnoses and treatment plans the condition to be treated, personally
25 authorizes the procedures and remains in the dental office or treatment facility while the
26 procedures are being performed by the dental allied personnel, and evaluates their performance
27 before dismissal of the patient.

28 *Indirect supervision.* A type of supervision in which a dentist is in the dental office or treatment
29 facility, has personally diagnosed and treatment planned the condition to be treated, authorizes
30 the procedures and remains in the dental office or treatment facility while the procedures are
31 being performed by the allied dental personnel, and will evaluate the performance of the allied
32 dental personnel.

33 *General supervision.* A type of supervision in which a dentist is not required to be in the dental
34 office or treatment facility when procedures are provided but has personally diagnosed and
35 treatment planned the condition to be treated, has personally authorized the procedures, and will
36 evaluate the performance of the allied dental personnel. In order to assure the safety of the
37 patient, the following criteria must be followed whenever functions are performed under general
38 supervision.

39 1. Any patient to be treated by a dental hygienist must first become a patient of record of a
40 dentist or facility. A patient of record is defined as one who:

- 41 a. has been examined by the dentist;
42 b. has had a medical and dental history completed and evaluated by the dentist; and
43 c. has had his/her oral condition diagnosed and a treatment plan developed by the dentist.

- 1 2. The dentist must provide to the dental hygienist prior written authorization to perform
 2 clinical dental hygiene services for that patient of record. Such authorization should
 3 remain in effect for a limited time period as specified by state law.
 4 3. The dentist shall examine the patient following performance of clinical services by the
 5 dental hygienist. Such examination shall be performed within a reasonable time as determined
 6 by the nature of the services provided, the needs of the patient and the professional judgment
 7 of the dentist.

8 *Public Health Supervision.* A type of supervision in which a licensed dental hygienist may provide
 9 dental hygiene services, as specified by state law or regulations, when such services are
 10 provided as part of an organized community program in various public health settings, as
 11 designated by state law, and with general oversight of such programs by a licensed dentist
 12 designated by the state.

13 **Surgical Procedure:** The cutting or removal of hard or soft tissue.

14 **Treatment Plan:** The sequential guide for the patient's care as determined by the dentist's
 15 diagnosis and used by the dentist for the restoration to and/or maintenance of optimal oral
 16 health.

17 **BOARD RECOMMENDATION: Vote Yes.**

18 **Vote: Resolution 325**

BERG	Yes	DOWD	Abstain	KNAPP	Yes	STUEFEN	Yes
BOYLE	Yes	GRAHAM	Yes	MANN	Yes	TULAK-GORECKI	Yes
BROWN	Yes	HISEL	Yes	MARKARIAN	Yes	WANAMAKER	Yes
CAMMARATA	Yes	HOWARD	Yes	MERCER	Yes		
CHOPRA	Yes	IRANI	Yes	REAVIS	Yes		
DEL VALLE-SEPÚLVEDA	Yes	KAHL	Yes	ROSATO	Yes		

1 treatment procedures, and the establishment of a comprehensive treatment plan must be based
2 on the dentist's professional evaluation of the patient's individual needs, clinical findings, and the
3 best available scientific evidence, and be it further

4 **Resolved**, that the ADA emphasizes the critical importance of open, honest, and transparent
5 communication between the dentist and the patient throughout the diagnostic and treatment
6 planning process. Shared decision-making, based on a thorough discussion of treatment options,
7 potential risks and benefits, and consideration of the patient's preferences and values, is integral
8 to achieving informed consent and fostering a strong patient-dentist partnership, and be it further,

9 **Resolved**, that the American Dental Association opposes any external policies, financial
10 incentives, or administrative practices that incentivize, or mandate treatment decisions based on
11 cost containment or non-clinical factors, rather than on the dentist's professional judgment and
12 the patient's best interests, and be it further,

13 **Resolved**, that dentists must be free to recommend and provide necessary care without fear of
14 inappropriate denial or limitation of benefits based on arbitrary or non-validated criteria, and be it
15 further

16 **Resolved**, that the American Dental Association supports the dentist's role in utilizing appropriate
17 and evolving diagnostic technologies and in applying the principles of evidence-based dentistry to
18 inform their clinical decision-making, and be it further

19 **Resolved**, that the dentist's professional judgment is informed by their education, training, clinical
20 experience, and understanding of current scientific literature, and be it further,

21 **Resolved**, that the American Dental Association urges constituent and component dental
22 societies to actively support and advocate for the principles of dentist's professional judgment and
23 treatment planning within their respective jurisdictions. This includes resisting policies or
24 regulations that infringe upon the dentist's ability to provide patient-centered care and promoting
25 an environment where dentists can freely exercise their professional expertise in the best interest
26 of their patients.

27 and be it further

28 **Resolved**, that the policies entitled "Infringement on Dentists Judgement" (*Trans.*1991:634;
29 2016:61), and "Dentist's Freedom to Exercise Individual Clinical Judgement" (*Trans.*1997:705) be
30 rescinded.

31 **BOARD RECOMMENDATION: Vote Yes.**

32 **BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)**

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**WORKSHEET ADDENDUM
POLICIES TO BE RESCINDED**

3 **Infringement on Dentists' Judgment** (*Trans.*1991:634; 2016:61)

4 **Resolved**, that the American Dental Association encourage constituent and component dental societies
5 to actively support Association policy which identifies the treatment plan for a patient as the exclusive
6 prerogative of the attending dentist as agreed to by the informed patient, and be it further

7 **Resolved**, that the appropriate agencies of the Association support and assist dental societies in
8 resisting, by whatever lawful means possible, infringement upon dentists' ability to freely exercise their
9 professional judgment.

10 **Dentist's Freedom to Exercise Individual Clinical Judgment** (*Trans.*1997:705)

11 **Resolved**, that the American Dental Association advocate legislation or regulation at the federal level to
12 ensure that dentists are free to exercise individual clinical judgment and render appropriate treatment to
13 their patients without undue influence by any third-party business entity, and be it further

14 **Resolved**, that the constituent societies be urged to advocate similar legislation or regulation at the state
15 level.

Resolution No. 327 New

Report: N/A Date Submitted: August 2025

Submitted By: Council on Dental Practice

Reference Committee: B (Dental Benefits, Practice, Science, Health and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time: _____ Amount On-going: _____

ADA Strategic Forecast Outcome: Public Profession: Drive evidence-based, ethical quality care.

1 **RECISSION OF POLICY, SUMMARY OF RECOMMENDATIONS, REPORT 5 OF THE BOARD OF**
2 **TRUSTEES TO THE HOUSE OF DELEGATES, ON PREVENTION AND CONTROL OF DENTAL**
3 **DISEASE THROUGH IMPROVED ACCESS TO COMPREHENSIVE CARE**

4 **Background:** In accordance with Resolution 170H-2012 (*Trans.2012:370*) Regular Comprehensive
5 Policy Review, the Council on Dental Practice reviewed the policy titled: Summary of Recommendations,
6 Report 5 of the Board of Trustees to the House of Delegates, on Prevention and Control of Dental
7 Disease Through Improved Access to Comprehensive Care (*Trans.1979:357, 596; 2020:287*).

8 The Council upon review of Report 5 felt that the recommendations requested specific actions that were
9 fulfilled as reported to the 1980 House of Delegates and again to the 2021 HOD. CDP felt that the
10 statement is a collection of directives rather than a policy statement.

11 Further, the specific actions enumerated were already completed or undertaken and were being
12 addressed by the appropriate ADA agencies.

13 **Resolution**

14 **327. Resolved,** that the following policy entitled Summary of Recommendations, Report 5 of the
15 Board of Trustees to the House of Delegates, on Prevention and Control of Dental Disease Through
16 Improved Access to Comprehensive Care (*Trans.1979:357, 596; 2020:287*) be rescinded.

17 **BOARD RECOMMENDATION: Vote Yes.**

18 **BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)**

**WORKSHEET ADDENDUM
POLICY TO BE RESCINDED**

**Summary of Recommendations, Report 5 of the Board of Trustees to the House of Delegates, on
Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care
(Trans.1979:357, 596; 2020:287)**

Resolved, that the House of Delegates approves the scope and direction of Report 5 on the
Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care and
requests implementation of its recommendations through coordinated Association activity.

1. Increase Association efforts to promote the concepts of prevention within the profession and the public sector, including government.
2. Draw freely on the special professional abilities of dentists who are experts in practice, in public health, in research and in education.
3. Actively seek allies throughout society on specific activities that will help improve access to care for all.
4. Maintain and coordinate council and other Association activities involved in this program.
5. Maintain quality dental care in all aspects of the delivery system.
6. Seek new ways for the Association to assist state and local dental health units to strengthen themselves.
7. Speak clearly to the public and to government about their respective responsibilities with respect to dental health.
8. Recognition that the traditional form of private practice will remain the major source of dental care coupled with an understanding that other sources of care exist and should receive objective attention.
9. Press for more efficient administration of and more equitable reimbursement under Medicaid and similar programs.
10. Intensify efforts at the federal level to mandate basic dental benefits for all Medicaid recipients.
11. Explore the funding of a pilot program to obtain broader Medicaid dental care benefits at the state level.
12. Explore the use of elementary and secondary schools in providing patient education, referral and oral prophylaxis dental services to children.
13. Emphasize comprehensive dental services in addressing the need of the elderly.
14. Advocate for an adequately funded and efficiently administered dental benefit plan supporting the oral health of the elderly.
15. Seek ways to extend private group dental prepayment benefits to the elderly.
16. Develop minimal criteria that state dental societies must take to be eligible for Association assistance to provide access programs for denture care.
17. Investigate ways to improve increased opportunities for dental care for the elderly through greater availability and effective utilization of dentists and dental auxiliaries.
18. Establish a national organization concerned with the dental health of the elderly.
19. Develop a program to provide assistance and information to state and local societies to assist dentists in caring for handicapped and disabled patients.
20. Maintain support of the Dental Lifeline Network
21. Identify and publicize other sources of care for the handicapped, institutionalized and homebound.
22. Develop a better information base on the dental health needs of the long-term homebound.

- 1 23. Help establish appropriate continuing education for practitioners and cooperate
- 2 with dental educators regarding any necessary additions to the undergraduate and
- 3 postgraduate dental school curricula.
- 4 24. Implement appropriate methods of providing more accessible dental care to
- 5 nursing home residents.
- 6 25. Explore the potential for resolving problems of limited health manpower and
- 7 capital resources in nursing homes.
- 8 26. Reexamine existing Association policy respecting the National Health Service
- 9 Corps and program activity.
- 10 27. Continued support of the Health Professions Placement Network.
- 11 28. Continued support of the Dental Planning Information System to enhance its
- 12 ability to provide information on care delivery in remote areas.
- 13 29. Cooperate more closely with dental health departments in states with a high
- 14 number of remote area residents, including possible funding of demonstration
- 15 projects.
- 16 30. Expansion of the Association's present role in stimulating the growth of dental
- 17 prepayment.
- 18 31. Broaden sources of prepayment coverage beyond the workplace.
- 19 32. Support extension of group dental prepayment benefits to federal employees and
- 20 military dependents.
- 21 33. Work with private and governmental groups in developing a more detailed base
- 22 of information on dental prepayment.

1 **BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)**

1
2

**WORKSHEET ADDENDUM
POLICY TO BE RESCINDED**

3 **Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care**
4 **(*Trans.*1979:357, 596)**

5 **Resolved**, that the House of Delegates approves the scope and direction of Report 5 on the Prevention
6 and Control of Dental Disease Through Improved Access to Comprehensive Care and requests
7 implementation of its recommendations through coordinated Association activity.

1 Consistent with the discussion in the Report of the Strategic Forecasting Committee, bolded text on
2 numerated items in 320H-2024, Appendix 2, indicates the SFC's priorities for the coming year.

3 The SFC, following input from applicable council leadership, the Public Profession Subcommittee, and
4 members of the Public Profession Action Groups, has identified proposed revisions to the Resolution
5 320H-2024 Public Profession five-year goals, as well as to 320H-2024, Appendix 2. These proposed
6 amendments as shown in the below resolution, include:

- 7 • Reformatting of the goals that fall under the Promote Healthy Behaviors high-level outcome.
- 8 • The adjustment of the five-year goal concerning dental care use. This adjustment reflects a
9 reduction in desired outcome from 50% utilization to 47% utilization. Given the changes proposed
10 to Medicaid and the impact of recent regulatory decisions impacting the Medicare Advantage
11 market, achieving the target of 50% that was modeled prior to the 2024 national elections is
12 difficult.
- 13 • The adjustment of the five-year goal concerning sugar intake. This adjustment reflects a change
14 to the metric to rely on data outside of those collected and reported by the Centers for Disease
15 Control and Prevention (CDC). In light of recent changes at the CDC, it is unclear if data will
16 continue to be collected to report on the Healthy People 2030 goals, which, if absent, would make
17 it impossible to track.
- 18 • The adjustment of the five-year goal concerning community water fluoridation. This adjustment
19 reflects current legislative and regulatory challenges to water fluoridation.
- 20 • The addition of Goal 1e, concerning HPV vaccines, to Public Profession Table 1 in Appendix 2,
21 following the House's adoption of this goal in October 2024.
- 22 • The addition of Objective 1e, accompanying Goal 1e.
- 23 • The removal of "Key Results" from all Public Profession Tables in Appendix 2. As councils have
24 reviewed the Strategic Forecast adopted in 2024, and in light of the Quarterly Business Review
25 (QBR)'s production, the key results are appearing in the QBR now and moving forward. They are
26 tracked and updated regularly within the QBR as input is received.

27

Resolution

28 **329. Resolved**, that the five-year goals within the Public Profession Component of the Strategic
29 Forecast, as adopted in Resolution 320H-2024, be amended as shown below (additions
30 underscored; deletions ~~stricken through~~):

- 31 • By 2030, at least ~~47~~50% of the U.S. population should utilize oral health care. (Supporting an
32 increase in and improvement of dental coverage and access, while also highlighting the need
33 for a healthy, well-distributed, skilled, and scoped workforce.)
- 34 • By 2030, the majority of clinicians are aware of new guidelines within 18 months of
35 publication, and ADA and the ADA Forsyth Institute remain the leaders on research,
36 guidelines, and standards for dentistry and oral health. (Supporting driving evidence-based
37 ethical quality care.)
- 38 • By 2030, improve public behavior such that:
 - 39 ○ ~~Mean added sugar intake (g/day) is reduced by 5%. By 2030, only 11.5% of daily~~
40 ~~calories are from added sugars consumed by people aged 2 years and over.~~
41 (Supporting promotion of healthy behaviors.)
 - 42 ○ ~~By 2030, only~~ No more than 11.3% of children grades 6-12 report using any product
43 containing nicotine in the past 30 days. (Supporting promotion of healthy behaviors).
 - 44 ○ At least 70% of people in communities where naturally occurring fluoride is not high
45 are served by community water systems with optimally fluoridated water. ~~By 2030,~~
46 ~~77.1% of people served by community water systems will have optimally fluoridated~~
47 ~~water.~~ (Supporting promotion of healthy behaviors.)
 - 48 ○ ~~By 2030, a~~ At least 80% of adolescents aged 13 through 15 years received

1 recommended doses of the HPV vaccine. (Supporting promotion of healthy
2 behaviors.)

3 and be it further

4 **Resolved**, that Resolution 320H-2024, Appendix 2, be amended as shown below (additions
5 underscored; deletions ~~stricken through~~):

6 **BOARD COMMENT:** The ADA Board of Trustees has reviewed the Strategic Forecasting Committee
7 (SFC) resolution and expresses its appreciation for the Committee's ongoing work. The Board transmits
8 the resolution for consideration by the House of Delegates.

9 **BOARD RECOMMENDATION: Vote Yes to Transmit.**

10 **BOARD VOTE: UNANIMOUS**

**Public Profession
 Appendix 2**

The tables below outline the work product of all levels of the SFC with regard to Public Profession discussions. The Outcomes category notes the highest level, overarching target of the Strategic Forecast. The tables also contain input from Councils and Committees, in addition to that of the Action Groups, especially in the areas of Objectives.

- Purpose: Indicate the reason this outcome is sought.
- Five-Year Goals: Indicates the current five-year highest priority targets.
- Outcomes: Represent the highest-level desired state for the ADA to reach.
- Objectives & Key Results: Represent sSupporting goals and tactical initiatives that may assist in might support reaching the desired outcomes, subject to evaluation and potential implementation by the ADA entities charged with the area of responsibility under which they fall AND availability of funds.
- ~~In certain instances, within the key results, “x” means the baseline has yet to be determined and the measure will be inserted once that baseline work is completed.~~
- Bolded text on numerated items indicates elements identified as high-priority.

Public Profession Table 1

Purpose	5-Year Goals	Outcomes	Objectives	Key Results
<p>1. Improve oral health.</p> <p>Ensure dentistry thrives in tomorrow’s healthcare environment.</p>	<p>1a. <u>By 2030, improve public behavior such that mean added sugar intake (g/day) is reduced by 5%.</u></p> <p>By 2030, only 11.5% of daily calories are from added sugars consumed by people aged 2 years and over.</p> <p>Baseline / Source: 13.5% of daily calories are from added sugars consumed by people aged 2+ years [Healthy People 2020: 2017–2020].</p>	<p>1. Promote healthy behaviors.</p>	<p>1a. <u>Children and parents / guardians will reduce consumption of foods and beverages high in added sugars / ultra-processed foods.</u></p>	<p>1a. By 2030, x% of children and parents / guardians report reduction in consumption of foods and beverages high in added sugars.</p> <p>Baseline / Source: Not available/ New Data Collection Needed by HPI</p>
	<p>1b. <u>By 2030, improve public behavior such that no more than only 11.3% of children grades 6-12 report using any product containing nicotine in the past 30 days.</u></p> <p>Baseline: 18.3% for children grades 6 - 12 report using any tobacco product in the past 30 days [Healthy People 2030].</p>		<p>1b. Children will reduce use of any product containing nicotine (cigarettes & vaping).</p>	<p>1b. By 2030, x% of children refrain from using nicotine containing products.</p> <p>Baseline / Source: Not available/ New Data Collection Needed by HPI</p>

	<p>1c. Brushing behavior change goal for 2030 still to be defined. Baseline data needs to be established.</p>		<p>1c. People will brush 2x per day with fluoride toothpaste.</p>	<p>1c. By 2030, x% of parents of vulnerable at-risk children report improvement in brushing behavior. Baseline / Source: Not available/ New Data Collection Needed by HPI.</p>
	<p>1d. <u>By 2030, improve public behavior such that at least 70% of people in communities where naturally occurring fluoride is not high are served by community water systems with optimally fluoridated water.</u> By 2030, 77.1% of people served by community water systems will have optimally fluoridated water. Baseline: 72.8% of community water systems are fluoridated [Healthy People 2030, OH-11]</p>		<p>1d. Children, adults, people with physical and/or mental disabilities, and the elderly population will benefit from systemic and topical fluoride modes of action delivered by water fluoridation.</p>	<p>1d. By 2030, 77.1% of people served by community water systems will have optimally fluoridated water as recommended by the U.S. Department of Health and Human Services.</p>
	<p>1e. By 2030, improve public behavior such that at least 80% of adolescents aged 13 through 15 years received recommended doses of the HPV vaccine.</p>		<p>1e. Adolescents aged 13-15 will receive recommended doses of the HPV vaccine.</p>	

Public Profession Table 2				
Purpose	5-Year Goals	Outcomes	Objectives	Key Results
<p>2. Improve oral health. Ensure dentistry thrives in tomorrow's healthcare environment.</p>	<p>2. By 2030, at least 4750% of the U.S. population should utilize care. Baseline/Source: 43.3% for U.S. population overall and 24.9% for low-income adults [MEPS/ HPI Analysis]</p>	<p>2. Increase and improve dental coverage & access.</p>	<p>2a. Employer-sponsored dental plans will be comprehensive, efficiently administered, meet standards with minimum cost-sharing and will have adequate reimbursement rates to support a sufficient provider network.</p>	<p>2a. By 2025, establish criteria to define "comprehensive" benefits. -By 2030, the majority of covered individuals in the employer-sponsored large group markets are in plans that appropriately address annual maximums and co-insurance with coverage, plan policies and use of premium dollars are transparently reported to participants and providers.</p>

			<p>-By 2030, ensure that self-funded plans are subject to state laws (e.g., non-covered services, assignment of benefits etc.) and payers cannot claim ERISA pre-emption.</p> <p>-By 2025, ADA and state dental associations will have an aligned commercial insurance reform agenda across the Tripartite and by 2026, any state public affairs funding allocated for the commercial market will be directed to move this agenda forward.</p> <p>Baseline / Source: Industry Data Reports</p>	
			<p>2b. State Medicaid programs will provide comprehensive dental benefits to adults, will be efficiently administered, and will have adequate reimbursement rates to support a sufficient provider network to increase access for children and adults.</p>	<p>2b. By 2025, ADA and state dental associations have an aligned Medicaid reform agenda across the Tripartite and by 2026, any state public affairs funding allocated for the Medicaid market is directed to move this agenda forward.</p> <p>-By 2030, all state Medicaid programs include an appropriately defined comprehensive adult dental benefits.</p> <p>-By 2030, fewer low-income adults report cost barriers to dental care.</p> <p>-By 2030, all state Medicaid programs will have sufficient provider networks.</p> <p>Baseline / Source: TMSIS, MEPS Data available</p>
			<p>2c. Dental insurance plans offered on ACA marketplaces will meet standards including comprehensive benefit, and minimum cost-sharing requirements (like separate dental deductibles), will be efficiently administered, and will have adequate reimbursement rates to support a sufficient provider network.</p>	<p>2c. By 2030, all states establish oral health for adults as a required EHB in ACA health insurance marketplaces and adult oral health benefits with separate dental deductibles are required to be purchased.</p> <p>Baseline / Source: Staff assessment</p>

			<p>2d. If Medicare includes dental benefits, then the program should be sufficiently funded and efficiently administered, and the benefit should meet standards including range of services necessary to achieve and maintain oral health and minimum cost-sharing requirements in line with ADA policy.</p>	<p>2d. By 2030, CMS adopts a payment system for dental services recommended by the ADA for those dental services intrinsically related to medical procedures covered by Medicare. If CMS further expands payment for dental services under Medicare, then ADA will work to assure that an appropriately defined range of services necessary to achieve and maintain oral health is included to assure necessary services can be accessed by beneficiaries. Baseline / Source: Staff Assessment</p>
			<p>2e. Vulnerable patients will be able to navigate care to establish a dental home.</p>	<p>2e. By 2030, 30% of low-income adult Medicaid beneficiaries visit the dentist. By 2030, at least 3 state Medicaid programs have a tool to help beneficiaries find open appointment times with participating dental providers. Baseline / Source: TMSIS, MEPS Data available</p>
		<p>3. Support a diverse, healthy, well-distributed, skilled and scoped workforce.</p>	<p>3a. Dentists and team members will be comfortable seeking mental health care and fewer will report burnout and levels of distress.</p>	<p>3a. By 2030, based on the Well-Being Index (WBI) risk assessment data of most recent reassessments, decrease the number of participants distressed and struggling by 12%, therefore decreasing the risk of suicide. Baseline / Source: 2023 ADA sponsored Mayo WBI Index</p>
			<p>3b. Dentists will practice to the level of their competency, utilizing technology to support their practice. There will be a sufficient pipeline of allied team members such as hygienists, assistants and EFDA as needed within each state to optimize access to</p>	<p>3b. By 2025, conduct necessary studies to establish policy along with a futuristic model dental practice act for what the dental team of the future looks like, including for public health/safety net workforce agreed upon by key stakeholders. By 2025, ADA and state dental associations will have an aligned workforce legislative agenda across the Tripartite and by 2026, any state public affairs</p>

			<p>care under the supervision of the dentist in line with ADA policy.</p>	<p>funding allocated for workforce issues will be directed to move this agenda forward. By 2030, the pipeline of allied team members should be such that dental offices report that they are able to fill positions within x months. Baseline / Source: HPI Survey</p>
			<p>3c. Dental workforce will thrive as new practice models emerge including models within integrated healthcare systems in alignment with current ADA policy.</p>	<p>3c. By 2025, initiate the process of identification of what the practice model of the future looks like including dentistry as part of primary care, agreed upon by identified key stakeholders and in alignment with ADA policy. By 2030, deliver clinical support tools to enhance dentists' clinical care and solutions to manage administrative functions for the office to increase practice efficiency for all practice models. Baseline / Source: Staff Assessment.</p>
			<p>3d. Dental workforce will be sufficient and appropriately distributed geographically, and education costs will not limit dentists from serving in underserved areas.</p>	<p>3d. By 2030, a higher share of the U.S. population will have adequate geographic access to dentists, particularly populations in rural areas, and Medicaid populations. Baseline / Source: HPI Data Available</p>
			<p>3e. An adequate number of dental residency programs will exist to accommodate graduating dental students and such programs are sufficiently funded using federal / state dollars.</p>	<p>3e. By 2030, there is sufficient and stable funding through HHS like the GME funding streams, for all primary care (GPR, AEGD) and dental specialty residency programs. Baseline / Source: Staff Assessment</p>

Public Profession Table 3

Purpose	5-Year Goals	Outcomes	Objectives	Key Results
<p>4. Improve oral health.</p> <p>Ensure dentistry thrives in tomorrow's healthcare environment.</p>	<p>4. By 2030, the majority of clinicians are aware of new guidelines within 18 months of publication, and ADA and the ADA Forsyth Institute remain the leaders on research, guidelines, and standards for dentistry and oral health.</p> <p>Baseline/ Source: 42.1% adherence to guidelines [Unpublished calculated from 2023 Registry Sample].</p>	<p>4. Drive evidence-based, ethical quality care.</p>	<p>4a. ADA will publish evidence-based clinical practice guidelines and dental teams will continuously learn from care experience and research including their own performance to provide high-quality care.</p>	<p>4a. By 2025, publish at least 1 evidence-based guideline every 18 months with at least x% of all practicing dentists aware of new guidelines within the next 6 months.</p> <p>-By 2029, at least top 5 practice management systems will provide clinical decision support tools and performance dashboards based on ADA guidelines at the point of care.</p> <p>Baseline / Source: Staff Assessment & Industry Survey</p>
			<p>4b. Medical colleagues will learn that oral health is a modifiable risk factor for overall health and EHR/EDR systems will allow multidisciplinary teams to coordinate care in support of whole person health.</p>	<p>4b. By 2026, all key medical societies accept oral health as a modifiable risk factor for overall health.</p> <p>-By 2027, the Office of the National Coordinator for Health IT adopts a robust roadmap for clinical and administrative data exchange in dentistry including strategies to incentivize adoption of EHR's, safe and responsible incorporation of AI in clinical care and secure exchange of patient information.</p> <p>-By 2030, at least 50% of the dental EDR market is able to exchange data seamlessly between dental-dental and dental-medical systems to coordinate care.</p> <p>Baseline / Source: Staff Assessment & Industry Survey</p>
			<p>4c. The United States government and manufacturers will rely on ADA for standards and ethical guidance on technology including Artificial / Augmented Intelligence.</p>	<p>4c. By 2030, the (1) Food and Drug Administration (FDA) recognizes at least 60% of applicable ADA and ADA-informed ISO standards to establish safety and efficacy of dental products, (2) ONC recognizes ADA interoperability standards for clinical and</p>

				<p>administrative data exchange, (3) CMS only uses Dental Quality Alliance measures for dental programs, and (4) Any federal agency and all national organizations developing standards that may impact practice of dentistry and patient safety rely on ADA for dental expertise.</p> <p>-By 2030, establish mechanisms to ensure that the use of AI-driven technologies in dentistry are ethically sound and meaningfully contribute to improvements in patient care and oral health.</p> <p>Baseline / Source: Staff Assessment and FDA Reports</p>
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1 **Vote: Resolution 331**

BERG	Yes	DOWD	Yes	KNAPP	Yes	STUEFEN	Yes
BOYLE	Yes	GRAHAM	Yes	MANN	Yes	TULAK-GORECKI	Yes
BROWN	Yes	HISEL	Yes	MARKARIAN	Yes	WANAMAKER	Yes
CAMMARATA	Yes	HOWARD	Yes	MERCER	Absent		
CHOPRA	Yes	IRANI	Yes	REAVIS	Yes		
DEL VALLE-SEPÚLVEDA	Yes	KAHL	Yes	ROSATO	Yes		

1 and use of certified products by ADA members is optional. This framework aligns with common
2 certification practices across healthcare and information technology and respects all applicable antitrust
3 and trade regulations.

4 This certification model is inspired by successful federal efforts such as the [ONC Health IT Certification](#)
5 [Program](#), where vendors voluntarily undergo technical review against transparent standards and fund
6 their own certification. Similarly, the ADA certification would be dentist-facing, not vendor-facing, and
7 would deliver exclusive resources to member dentists while allowing vendors to publicly market their
8 certified status. This ensures alignment with ADA's membership value goals without requiring dues
9 funding.

10 **Resolution**

11 **301. Resolved**, that the appropriate ADA agency convene a task force, including representatives
12 from relevant ADA councils and independent experts in software engineering, data security, dental
13 informatics, and regulatory compliance, to establish a voluntary ADA Certification Program, and be
14 further

15 **Resolved**, that the ADA Certification Program identify dental software platforms and imaging
16 systems that meet defined criteria for security, interoperability, regulatory compliance, and data
17 ownership, and be it further

18 **Resolved**, that certification under the ADA Certification Program shall require:

- 19 1. documented use of modern encryption standards and multi-factor authentication for all user
20 accounts;
- 21 2. the ability to export all practice and patient data in clearly labeled, structured, and non-
22 proprietary formats—such as CSV, JSON, XML, JPEG, PNG, STL, MP4, or other common
23 formats—with full access to the database schema or dictionary. This export functionality must
24 be directly accessible to authorized users within the software itself and must not require
25 vendor intervention, support tickets, or additional fees;
- 26 3. for any modules used in diagnosis, treatment planning, or image processing, current FDA
27 Class II clearance under *CFR Title 21, §892.2050* is required. This includes, but is not limited
28 to, capturing images, controlling intraoral sensors, and performing advanced functions such
29 as segmentation, 3D visualization, or diagnostic measurements; and
- 30 4. vendors must affirm in writing that all patient health information and practice data constitute
31 the records of the licensed dental practice, consistent with applicable federal and state law.
32 Vendors shall ensure that such information remains fully accessible to the practice for
33 treatment, payment, and health care operations, and shall not restrict the practice's ability to
34 access, transfer, or use these records. In addition, vendors must support patients' rights
35 under federal and state law to obtain copies of their health information in a timely manner and
36 in the format requested, including electronic formats where available.

37 and be it further

38 **Resolved**, that after the appropriate ADA agency has finalized the program design, the agency shall
39 collaborate with the Board of Trustees to implement the program. The certification shall be made
40 available as a dentist-facing, member-exclusive resource to assist in software evaluation and serve
41 as a valuable ADA membership benefit, and be it further

42 **Resolved**, that the appropriate ADA agency shall develop and publish a standard export schema or
43 schema guideline to accompany certification requirements, which vendors may either adopt directly

1 or provide a usable mapping (crosswalk) to. This schema shall allow dentists to interpret, migrate,
 2 and retain access to their data using clearly defined, structured documentation. The task force shall
 3 allow all certification criteria are transparent, objective, and non-exclusionary in order to maintain
 4 compliance with applicable trade and antitrust laws. The certification shall remain voluntary and shall
 5 not restrict members from using non-certified platforms, and be it further

6 **Resolved**, that the ADA Certification Program shall be vendor-funded and shall not rely on member
 7 dues. The task force shall propose a fee structure to support the program's sustainability, modeled
 8 after industry-standard health IT certification programs, and be it further

9 **Resolved**, that while ADA-certified status may be publicly visible, access to the program's evaluation
 10 materials, schema documentation, and implementation tools shall be restricted to ADA members as
 11 a benefit of membership.

12 **BOARD COMMENT:** The Board recognizes the important sentiment expressed within this resolution.
 13 Data exchange and interoperability between systems and the ability for dentists and offices to import and
 14 export data between practice management systems is a very important issue as record keeping becomes
 15 more electronic.

16 However, the Board questions the feasibility of the proposed resolution as written. The Meaningful Use
 17 program provided significant monetary incentives for software vendors to participate in that certification
 18 program as recently experienced with vendors in the ADA Forsyth certification program. There is no
 19 guarantee that dental software vendors are willing to voluntarily participate in a certification program.
 20 Further, the financial implication of \$400,000 noted on the resolution is a conservative estimate and
 21 includes many assumptions. The Board anticipates that actual expenses would potentially be much
 22 higher. Given current financial constraints the Board recommends not pursuing the program described.

23 **BOARD RECOMMENDATION: Vote No.**

24 **Vote: Resolution 301**

BERG	No	DOWD	No	KNAPP	No	STUEFEN	No
BOYLE	No	GRAHAM	No	MANN	No	TULAK-GORECKI	No
BROWN	No	HISEL	No	MARKARIAN	No	WANAMAKER	No
CAMMARATA	No	HOWARD	No	MERCER	Absent		
CHOPRA	No	IRANI	No	REAVIS	No		
DEL VALLE-SEPÚLVEDA	No	KAHL	No	ROSATO	No		

Resolution No. 303 New

Report: N/A Date Submitted: June 18, 2025

Submitted By: Dr. Spencer Bloom, Delegate, Illinois

Reference Committee: B (Dental Benefits, Practice, Science, Health and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time: _____ Amount On-going: _____

ADA Strategic Forecast Outcome: Public Profession: Increase and improve dental coverage and access.

1 **SUPPORTING TRIBAL SELF-DETERMINATION IN ORAL HEALTH WORKFORCE DECISIONS**

2 The following resolution was submitted on Wednesday, June 18, 2025, by Dr. Spencer Bloom, delegate,
3 Illinois.

4 **Background:** American Indian and Alaska Native (AI/AN) communities continue to experience the
5 highest levels of oral health disparities in the United States. Nearly 80% of AI/AN children and more than
6 60% of adults are affected by untreated dental disease, the highest rates of any group in the country
7 ([CareQuest Institute for Oral Health, American Indian and Alaska Native Communities: Overcoming](#)
8 [Barriers to Oral Health Equity, May 15, 2023, page 5](#)).

9 The Alaska Native Tribal Health Consortium has demonstrated that community-based providers such as
10 Dental Health Aide Therapists (DHATs), working within the federally authorized Community Health Aide
11 Program, can safely and effectively expand access to dental care in remote areas. This model has proven
12 to be culturally appropriate, cost-effective, and self-sustaining, serving more than 40,000 Alaska Natives
13 ([CareQuest Institute for Oral Health, 2023, pp. 19-21](#)).

14 Congress reauthorized the Indian Health Care Improvement Act in 2010 but added a statutory barrier that
15 blocks other tribes from using this model. The statute, [25 U.S.C. § 1616\(d\)\(2\)](#), prohibits DHATs outside of
16 Alaska unless the state expressly authorizes it. This federal requirement undermines tribal self-
17 determination by forcing sovereign tribal nations to seek state permission before implementing a health
18 workforce model for their own people. The Swinomish Indian Tribal Community in Washington has
19 already challenged this by independently licensing DHATs to meet dire local needs (see American
20 Journal of Public Health, *Indian Country Leads National Movement to Knock Down Barriers to Oral*
21 *Health*, 2017;107(S1):S81–S84. DOI: 10.2105/AJPH.2017.303663. Available at:
22 <https://pubmed.ncbi.nlm.nih.gov/28661807> and <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5497874>).

23 The ADA's current policies oppose nondentists performing irreversible procedures, but applying these
24 rules to sovereign tribal nations is an overreach (*Diagnosis or Performance of Irreversible Dental*
25 *Procedures by Nondentists*, Trans.2004:328; 2010:494; and *Comprehensive Policy Statement on Allied*
26 *Dental Personnel*, Trans.1996:699; 2021:330). We would never presume to dictate to Mexico, Canada, or
27 any other sovereign nation how to structure their health care systems. Yet by opposing tribal authority to
28 choose their own dental workforce models, that is effectively what the ADA is doing to sovereign nations
29 within the United States.

30 Respecting tribal sovereignty is not about endorsing nondentist surgery across the country. It is about
31 recognizing that tribal nations have the right to govern their own health systems, a right that predates the
32 United States. To deny them that right is inconsistent with the ADA's own Principles of Ethics, especially
33 Patient Autonomy and Justice.

1 **Resolution**

2 **303. Resolved**, that the ADA policy titled “Diagnosis or Performance of Irreversible Dental
3 Procedures by Nondentists” (*Trans.* 2004:328; 2010:494), be amended as follows (additions are
4 underscored and deletions in ~~strikethrough~~):

5 **Resolved**, that the American Dental Association by all appropriate means strive to maintain the
6 highest quality of oral health care by maintaining that the dentist be the healthcare provider that
7 performs examinations/evaluations, diagnoses, and treatment planning, and be it further

8 **Resolved**, that the dentist be the health care provider that performs surgical/irreversible
9 procedures, except when such procedures are authorized and regulated within the sovereign
10 health system of a federally recognized tribal nation for the care of its own members, and be it
11 further

12 **Resolved**, that surgical procedures be defined as the cutting or removal of hard or soft tissue.

13 and be it further

14 **Resolved**, that the ADA policy titled “Comprehensive Policy Statement on Allied Dental Personnel”
15 (*Trans.* 1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307; 2010:505; 2021:330), section
16 titled Delegation of Functions be amended as follows (additions are underlined and deletions in
17 ~~strikethrough~~):

18 **Delegation of Functions**

19 The primary purpose of dentists delegating functions to allied dental personnel is to increase the
20 capacity of the profession to provide patient care while retaining full responsibility for the quality of
21 care. This responsibility includes identification of the need for specific types of allied dental
22 personnel and establishment of appropriate controls on the patient care services provided by
23 allied dental personnel.

24 The American Dental Association has the responsibility to provide guidance to all agencies,
25 organizations and governmental bodies, such as state dental boards and legislatures, that have
26 an interest in, or responsibility and authority for, decisions on utilization, education, and
27 supervision of allied dental personnel. In this context, the primary responsibility is to assure that
28 decisions on allied dental personnel utilization will not adversely affect the health and well-being
29 of the public or cause an increased risk to the patient. In meeting these responsibilities, dentists
30 must also identify those functions or procedures that require the knowledge and skill of the
31 dentist. Thus, the ADA must continue to promote that these functions be performed by a licensed
32 dentist in order to support the highest quality of oral heal care by maintaining that the dentist be
33 the healthcare provider that performs examinations/evaluations; diagnoses; treatment planning;
34 and surgical/irreversible procedures; prescribes work authorizations; prescribes drugs and other
35 medications; and administers enteral, parenteral or inhalational sedation, or general anesthesia,
36 provided, however, that this limitation shall not apply to dental workforce models governed by
37 federally recognized tribal nations under their sovereign authority for the delivery of care to their
38 members within tribal health systems.

39 Nothing in this statement should be interpreted to limit a dentist from delegating to a properly
40 trained allied dental personnel responsibility for assisting the dentist in the performance of these
41 functions under the dentist’s personal, direct or indirect supervision and in accordance with state
42 law, if, in the dentist’s professional judgment, this is in the patient’s best interest. The transfer of
43 permissible functions from the dentist to the allied dental personnel must not result in a reduced

1 quality of patient care. In all cases, the authority and responsibility of the dentist for the overall
 2 oral health of the patient must be maintained to assure cost-effective delivery of services to the
 3 patient and avoid fragmentation of the dental team.

4 Utilization of allied dental personnel must be based on (1) the best interests of the patient; (2) the
 5 education, training and credentialing of the allied dental personnel; (3) considerations of cost-
 6 effectiveness and efficiency in delivery patterns; and (4) valid, independent research
 7 demonstrating the feasibility and practicality of utilizing allied dental personnel in such roles in
 8 actual practice settings.

9 and be it further

10 **Resolved**, that the policy “Tribal Self-Determination in Oral Health Workforce Decisions” be adopted
 11 as follows:

12 **Resolved**, that the American Dental Association shall not oppose the efforts of federally
 13 recognized tribal nations to change federal statutes restricting their authority to determine their
 14 own oral health workforce models, and be it further

15 **Resolved**, that if requested by a federally recognized tribal nation, the ADA shall provide written
 16 acknowledgement of support for that tribe’s right to self-determination in oral health workforce
 17 decisions.

18 **BOARD COMMENT:** The Board recognizes the right of tribal nations to determine pathways to support
 19 access to care for their populations. The Board respectfully notes that ADA policies do not serve as
 20 mandates. Tribal nations, states, federal legislators and regulators have always had the freedom to
 21 establish policies as desired with ADA positions serving as guidelines. The Board strongly believes that
 22 pathways to assure access to care should be uniformly upheld. Policies with regards to the oral health
 23 workforce and ADA’s beliefs on scope of practice are clearly expressed in various other existing oral
 24 health workforce policies with amendments to some of these policies submitted to this House for
 25 consideration. The Board urges the House to consider the needs of the tribal nations as part of the
 26 deliberations on amendments to other submitted workforce policies.

27 **BOARD RECOMMENDATION: Vote No.**

28 **Vote: Resolution 303**

BERG	No	DOWD	No	KNAPP	No	STUEFEN	No
BOYLE	No	GRAHAM	No	MANN	No	TULAK-GORECKI	No
BROWN	No	HISEL	Absent	MARKARIAN	No	WANAMAKER	No
CAMMARATA	No	HOWARD	No	MERCER	No		
CHOPRA	No	IRANI	No	REAVIS	Absent		
DEL VALLE-SEPÚLVEDA	No	KAHL	No	ROSATO	No		

1 ~~**Resolved**, that the ADA supports federal advocacy efforts to increase funding for women’s oral~~
 2 ~~health research, ensure that women are adequately represented as research subjects in dental~~
 3 ~~clinical trials, and help disseminate research information on women’s oral health issues as~~
 4 ~~needed and appropriate.~~

5 **BOARD COMMENT:** Recognizing that the ADA does not have a policy defining gender identity, the
 6 Board recommends this important policy remain focused on need for oral healthcare during pregnancy
 7 rather than specifying the population or individuals who should seek care.

8 **330B. Resolved**, that the policy on Comprehensive Statement on Oral Health Services During
 9 Pregnancy (*Trans.2024:XXX*) be amended as follows (additions underlined, deletions ~~stricken~~
 10 ~~through~~):

11 ~~**Resolved**, that the ADA encourage all pregnant persons and person of child-bearing age to have~~
 12 ~~a regular dental examinations and dental treatment as needed throughout all~~
 13 ~~stages of pregnancy, and be it further~~

14 **Resolved**, that the ADA acknowledges that preventive, diagnostic, restorative and surgical dental
 15 treatment rendered to promote health and eliminate disease is safe throughout pregnancy, is
 16 supported by the American College of Obstetrics and Gynecology, and is effective at maintaining
 17 ~~the oral and overall health during pregnancy of the pregnant person, and be it further~~

18 ~~**Resolved**, that dental coverage of pregnant persons be extended for one-year post-~~
 19 ~~partum to be included in all dental benefit programs to improve the dental health of the pregnant~~
 20 ~~person during pregnancy as well as to promote Age One dental visits for very young children, and~~
 21 ~~be it further~~

22 ~~**Resolved**, that the ADA supports federal advocacy efforts to increase funding for women’s oral~~
 23 ~~health research, ensure that women are adequately represented as research subjects in dental~~
 24 ~~clinical trials, and help disseminate research information on women’s oral health issues as~~
 25 ~~needed and appropriate.~~

26 **BOARD RECOMMENDATION: Vote Yes on the Substitute.**

27 **Vote: Resolution 330B**

BERG	Yes	DOWD	Yes	KNAPP	Yes	STUEFEN	Yes
BOYLE	Yes	GRAHAM	Yes	MANN	Yes	TULAK-GORECKI	Yes
BROWN	Yes	HISEL	Yes	MARKARIAN	Yes	WANAMAKER	Yes
CAMMARATA	Yes	HOWARD	Yes	MERCER	Absent		
CHOPRA	Yes	IRANI	Yes	REAVIS	Yes		
DEL VALLE-SEPÚLVEDA	Yes	KAHL	Yes	ROSATO	Yes		

Resolution No. 332 New

Report: N/A Date Submitted: September 3, 2025

Submitted By: Seventeenth Trustee District

Reference Committee: B (Dental Benefits, Practice, Science, Health and Related Matters)

Total Net Financial Implication: \$250,000 Net Dues Impact: \$3

Amount One-time: _____ Amount On-going: \$250,000

ADA Strategic Forecast Outcome: Public Profession: Drive evidence-based, ethical quality care.

1 **STRATEGY TO PROTECT COMMUNITY WATER FLUORIDATION THROUGH RAPID RESPONSE,**
2 **EXPERT ENGAGEMENT, AND PUBLIC EDUCATION**

3 The following resolution was submitted on Wednesday, September 3, 2025, by Lianne Bell, leadership
4 affairs manager, Florida Dental Association on behalf of the Seventeenth Trustee District.

5 **Background:** Fluoride’s impact on overall health: Dental decay is the most common chronic disease
6 worldwide, affecting both adults and children. It is more common than obesity, diabetes, and asthma. Left
7 untreated, decay can progress to abscesses, which may spread infection to the brain, lungs, and heart,
8 also potentially causing life-threatening illness or even death. Importantly, dental decay is almost entirely
9 preventable.

10 Evidence shows that community water fluoridation, combined with fluoridated toothpaste and dental
11 sealants, is among the most effective strategies to reduce decay. While healthy dietary choices, good oral
12 hygiene, regular dental visits, and professionally applied topical fluorides all play important roles, only
13 water fluoridation consistently reaches every member of a community. By delivering fluoride passively,
14 without requiring any changes to daily routines, optimally fluoridated water reduces dental decay by at
15 least 25%. It is also the most cost-effective preventive measure compared with other modalities.

16 Fluoridation benefits everyone, regardless of age, socioeconomic status, race, ethnicity, education, or
17 access to care. Those least likely to visit a dentist, such as individuals with disabilities, residents of long-
18 term care facilities, the elderly, and low-income families, gain the most from this intervention. For many,
19 especially those living in poverty who experience twice the rate of decay, water fluoridation may be the
20 only preventive dental care they ever receive. It helps level the playing field between the “haves” and
21 “have-nots.”

22 The controversy around fluoridation: Naturally fluoridated water, at optimal or higher levels, already
23 serves nearly 12 million U.S. residents, according to 2022 CDC data. Overall, more than 209 million
24 people served by community water systems currently receive fluoridated water.

25 The ADA has long supported community water fluoridation as an effective, safe and equitable public
26 health measure. However, recent developments highlight growing challenges. In the past year, two states
27 enacted bans on water fluoridation, driven largely by misinformation, disinformation, and public skepticism
28 that run counter to decades of scientific consensus. These policy reversals jeopardize the oral health of
29 millions, especially vulnerable populations, and underscore the urgent need for dentistry to take a
30 proactive, organized role in addressing emerging threats.

31 A coordinated response: The proposed resolution strengthens existing ADA policy by:

- 32
- Establishing a framework to counter misinformation and disinformation

- 1 • Supporting consistent messaging at the local, state, and national levels
- 2 • Reinforcing the critical role of fluoridation in protecting community health

3 The ADA Fluoride Ambassador Program, launched in early 2025, brings together dentists, hygienists,
4 dental assistants, medical providers, and community leaders to combat misinformation, disinformation
5 and flawed research fueling opposition to fluoridation. While this program is promising, it will take two to
6 three years to become fully effective.

7 In the meantime, communities face threats that can arise with little warning, sometimes within hours or
8 days. This resolution calls for the creation of a rapid-response “mobile strike force,” available 24/7, to
9 support local and state advocates. By coordinating with both public and private partners, this team would
10 help communities defend fluoridation and ensure positive outcomes for oral health nationwide.

11 **Resolution**

12 **332. Resolved**, the American Dental Association prioritize efforts to counter misleading claims
13 regarding the safety and efficacy of community water fluoridation, fluoride supplementation, and
14 fluoride varnish, and be it further

15 **Resolved**, that the ADA maintain a bank of Subject Matter Experts (SME), both existing and newly
16 trained, and develop these SME in partnership with similarly interested professional organizations, to
17 provide testimony, technical assistance, expert opinions, recorded presentations, literature and other
18 resources to assist state and local communities and healthcare professionals when needed in efforts
19 to support the use of fluoride as a means to improve oral health, and be it further

20 **Resolved**, that the American Dental Association provide ongoing education to all interested dentists,
21 through recorded presentations and literature on current and pressing fluoridation topics, and be it
22 further

23 **Resolved**, that the appropriate ADA agencies develop a strategy to communicate our message to
24 patients, members of our community, leadership, dental and medical professionals, and water plant
25 personnel.

26 **Board Recommendation: Received after the August 2025 Board of Trustees Meeting.**

1 False and misleading determinations can adversely impact access to needed care, health outcomes, and
2 the trust between a patient and provider.

3 LLMs risk exposure of protected and confidential information, necessitating assurance that users have
4 taken sufficient steps to mitigate that risk.

5 Therefore, in support of the ADA *Principles of Ethics and Code of Professional Conduct* that include
6 truthfulness and veracity to provide transparency, justice and fairness to ensure outputs reflect impartial,
7 just, and equitable standards, autonomy to provide informed decision making that is accurate, transparent
8 and understandable for patients and providers and beneficence to guard against hallucinations that may
9 harm patient safety, the framers of this resolution believe the establishment of ADA policy stipulating
10 disclosure to benefit plan members, patients and submitting providers, of generative AI use by third party
11 payers in the claims review and adjudication process.

12 References

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20 Jan 2023; updated April 2, 2024.
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24 reality: AI-written research papers and the ethics of the large language models in scholarly
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26 Resolution

27 **335. Resolved**, that third-party payers disclose to benefit plan members, patients, and submitting
28 providers the use of generative artificial intelligence (GenAI) tools in claims review and adjudication,
29 and be it further

30 **Resolved**, that such disclosure include the reasons why the claim was selected for review and
31 GenAI use was necessary, and be it further

32 **Resolved**, that for transparency of the risk exposure and level of bias a claim may experience from
33 the application of GenAI in the adjudication process, disclosure should include the name and model
34 of the AI tool used, how it was trained for this task, the prompts or inputs applied to adjudicate the
35 claim, and whether the use was internal by a human, automated, or a contracted human reviewer,
36 and be it further

37 **Resolved**, that disclosure affirm the application of such tools in the adjudication process was subject
38 to human oversight, how confidential information was protected, and the steps taken to mitigate
39 biased, false, or misleading determinations.

40 **Board Recommendation: Received after the August 2025 Board of Trustees Meeting.**

1 should be provided in a timely way to facilitate patients receiving needed care without undue
2 delay.

3 and be it further

4 **Resolved**, that the updated standards be communicated to organizations that represent dental
5 benefit plan providers.

6 **Board Recommendation: Received after the August 2025 Board of Trustees Meeting.**

WORKSHEET ADDENDUM**Standards for Dental Benefit Plans (Trans.1988:478; 1989:547; 1993:696; 2000:458; 2001:428; 2008:453; 2010:546)**

1. Organized dentistry at all levels should be regularly consulted by third-party payers with respect to the development of dental benefit plans that best serve the interests of covered patients.
2. Joint efforts should be made by organized dentistry and third-party payers to promote oral health with emphasis on preventive treatment.
3. Plan purchasers should be informed that oral conditions change over time and, therefore, "maximum lifetime benefit" reimbursement restrictions should not be included in dental plans. Dental plans should be designed to meet the oral health needs of patients.
4. Patients should have freedom of choice of dentist and all legally qualified dentists should be eligible to render care for which benefits are provided.
5. Plans that restrict patients' choice of dentists should not be the only plans offered to subscribers. In all instances where this type of plan is offered, patients should have the annual option to choose a plan that affords unrestricted choice of dentist, with comparable benefits and equal premium dollars.
6. The provisions and promotion of the program should be in accordance with the *Principles of Ethics* of the American Dental Association and the codes of ethics of the constituent and component societies involved.
7. The design of dental benefits plans differs from that of medical plans:
 - Dental disease does not heal without therapeutic intervention, so early treatment is the most efficient and least costly.
 - The need for dental care is universal and ongoing, rather than episodic.
 - The need for dental care is highly predictable and does not have the characteristics of an insurable risk.
 - The dental needs of individuals in an insured group vary considerably.
 - Patient cooperation and post-treatment maintenance is critical to the success of dental treatment and the prevention of subsequent disease.

Therefore, the American Dental Association recommends that for preventive, diagnostic and emergency services, dental benefit plans should not contain deductibles or patient copayments, because they discourage patients from entering the system. Patient participation in the cost of complex care should be sufficient to motivate patients to adequately maintain their oral health.

Rather than excluding categories of services, the Association believes that cost containment is best achieved by varying the patient participation in the costs of treatment and imposing annual limitations on benefits.

8. In order that the patient and dentist may be aware of the benefits provided by a dental benefit plan, the extent of any benefits available under the plan should be clearly defined, limitations or exclusions described, and the application of deductibles, copayments and coinsurance factors explained to the patients by the third-party payers and employers. This should be communicated in advance of treatment.

Patients should also be reminded that they are fundamentally responsible to the dentist for the total payment of services received. In those instances where the plan makes partial payment directly to the dentist, the remaining portion for which the patient is responsible should be prominently noted in the Explanation of Benefits Statement (EOB) provided to the patient.
9. Each dentist should have the right to determine whether to accept payment directly from a third-party payer.
10. Third-party payers should make use of dental society peer review mechanisms as the preferred method for the resolution of differences regarding the provision of professional services. Effective

- 1 peer review of fee disputes, quality, and appropriateness of treatment should be made available
2 by the dental profession.
- 3 11. Procedures for claims processing should be efficient and reimbursement should be prompt. The
4 third-party payer should use or accept the American Dental Association's "ADA Dental Claim
5 Form" and the *Code on Dental Procedures and Nomenclature* that the Council on Dental Benefit
6 Programs has approved after appropriate consultation with representatives of nationally
7 recognized dental benefit organizations and the ADA-recognized dental specialty organizations.
- 8 12. Dentists should comply with reasonable requests from third-party payers for information regarding
9 services provided to patients covered under a plan.
- 10 13. Third-party payers' administrative procedures should be designed to enhance the dentist-patient
11 relationship and avoid any interference with it.
- 12 14. When patient eligibility is certified through the predetermination process, the third-party payer
13 shall be committed to reimburse on the basis of that initial certification within the provisions of that
14 plan, unless and until written notification is provided in a timely manner to the dentist and the
15 patient by the payer that change in eligibility status has occurred.
- 16 15. When such a change in eligibility occurs, a period of not less than 30 days should be allowed for
17 continuation and, when possible, completion of treatment.
- 18 16. The treatment plan of the attending dentist, as agreed upon by the patient, shall remain the
19 exclusive prerogative of the dentist and should not be unilaterally interfered with by third-party
20 administrators or payers, or their consultants.
- 21 17. The American Dental Association opposes any abuse of the "Least Expensive, Professionally
22 Acceptable Treatment" concept and will inform the public of the barrier such abuse represents to
23 the attainment of quality dental care. When an insoluble dispute occurs between an attending
24 dentist and third party regarding a treatment plan, peer review should be accepted by all parties
25 involved as the mechanism for solution. Peer review should be entered into prior to the third-party
26 payer's determination of reimbursable benefits in such cases.
- 27 18. A dental benefit plan should include the following procedures:
- 28 A. *Diagnostic*. Provides the necessary procedures to assist the dentist in evaluating the conditions
29 existing and the dental care required.
- 30 B. *Preventive*. Provides the necessary procedures or techniques to assist in the prevention of
31 dental abnormalities or disease.
- 32 C. *Emergency Care*. Provides the necessary procedures for treatment of pain and/or injury. It
33 should also cover the necessary emergency procedures for treatment to the teeth and
34 supporting structures.
- 35 D. *Restorative*. Provides the necessary procedures to restore the teeth.
- 36 E. *Oral and Maxillofacial Surgery*. Provides the necessary procedures for extractions and other
37 oral surgery including preoperative and postoperative care.
- 38 F. *Endodontics*. Provides the necessary procedures for pulpal and root canal therapy.
- 39 G. *Periodontics*. Provides the necessary procedures for treatment of the tissue supporting the
40 teeth.
- 41 H. *Prosthodontics*. Provides the necessary procedures associated with the construction,
42 replacement, or repair of fixed prostheses, removable partial dentures, complete dentures and
43 maxillofacial prostheses.
- 44 I. *Orthodontics*. Provides the necessary treatment for the supervision, guidance and correction of
45 developing and mature dentofacial structures.
- 46 19. The financial reserves of the plan should be adequate to assure continuity of the program.
- 47 20. Reimbursement schedules and claim documentation requirements should be based on
48 procedures performed by the dentist and not on the specialty status of the dentist performing
49 them.
- 50 21. The methodology used by plan administrators to set reimbursement schedules should rely on
51 current, geographic and other relevant data and be readily available to patients, plan purchasers
52 and dentists.

- 1 22. Profiling to establish a different rate of reimbursement for the provider should not be used as a
- 2 means of cost control by the plan administrators.
- 3 23. The data, calculations and methodology used for practice profiling of individual dentists should be
- 4 made available to those dentists upon request.
- 5 24. Information on the possibility of post-payment utilization review, and any consequences of same,
- 6 must be provided to both participating and non-participating dentists.

NEW BUSINESS—MAJORITY VOTE RECEIVED FOR CONSIDERATION

Resolution No. 336 New

Report: N/A Date Submitted: October 25, 2025

Submitted By: Thirteenth Trustee District

Reference Committee: B (Dental Benefits, Practice, Science, Health and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time: _____ Amount On-going: _____

ADA Strategic Forecast Outcome: Public Profession: Promote healthy behaviors.

1 **RECOGNITION OF TYPE 1 DIABETES AS A DISTINCT ORAL HEALTH HIGH AT-RISK**
2 **CATEGEGORY**

3 **Background:** Currently ADA policies and educational materials refer to “diabetes” as a general risk factor
4 for oral disease, without distinguishing between Type 1 and Type 2 Diabetes. This conflation overlooks
5 the unique pathophysiology, autoimmune nature, and oral health risks associated with Type 1 Diabetes
6 (T1D), particularly in children and adolescents.

7 Individuals with Type 1 Diabetes face elevated risk for dental caries, enamel decalcification, eating
8 disorders, periodontal disease, xerostomia, and delayed healing—differently than Type 2 Diabetics and
9 compounded due to disease management challenges such as nighttime carbohydrate dosing and
10 immune dysregulation.

11 While Type 2 Diabetes is often associated with lifestyle-related metabolic conditions, Type 1 Diabetes is a
12 lifelong autoimmune disease with distinct clinical implications. Explicit recognition of Type 1 Diabetes as a
13 separate at-risk population will guide more accurate education, research, and care strategies for our
14 member dentists and all dental professionals.

15 **Resolution**

16 **336. Resolved,** that the American Dental Association (ADA) recognize individuals with Type 1
17 Diabetes (T1D) as a distinct oral health at-risk population, separate from those with Type 2 Diabetes,
18 and be it further

19 **Resolved,** that the appropriate ADA agencies review and propose updates to relevant policies,
20 educational materials, and advocacy efforts to reflect the unique oral health risks and management
21 needs of individuals with T1D, particularly children and adolescents, and be it further

22 **Resolved,** that ADA explore opportunities to support interdisciplinary collaboration and oral health
23 preventive strategies—such as the development of oral health guidance at the time of T1D
24 diagnosis—to improve long-term outcomes and reduce oral health disparities in this.

25 **Board Recommendation: Received after the August 2025 Board of Trustees Meeting.**