Minutes of the 162nd Annual Session of the American Dental Association House of Delegates

October 13-16, 2021
Las Vegas, Nevada

Wednesday, October 13, 2021

First Meeting of the House of Delegates

Call to Order: The First Meeting of the 162nd Annual Session of the American Dental Association House of Delegates was called to order by the Speaker of the House of Delegates, Dr. W. Mark Donald, Mississippi, at 12:30 p.m., Wednesday, October 13, 2021, in the Mandalay Bay North Convention Center.

Special Presentation: Dr. Manuel A. Cordero, General Director and Chief Executive Officer of the Hispanic Dental Association, presented Dr. Kathleen T. O'Loughlin, ADA Executive Director, with a Certificate of Honorary Membership in the Hispanic Dental Association.

Moment of Reflection: The House observed a moment of silence for attendees to reflect in a manner of each individual's choosing.

Pledge of Allegiance: Dr. Christopher R. Jordan, delegate, U.S. Air Force, led the members of the House in reciting the Pledge of Allegiance.

Announcements: For the benefit of the delegates and alternate delegates, the Speaker reviewed announcements regarding delegate and alternate delegate seating in the House of Delegates, live stream broadcasting of the meetings of the House, technology support, microphones, availability of district representatives, and a planned update from the general counsel at the conclusion of the first meeting of the House.

Introductions: The Speaker introduced the officers of the Association who were seated on the dais, and the former ADA presidents who were seated in the House.

Ethics Statement: The Speaker called attention to the Ethics Statement which appears in the *Manual of the House of Delegates and Supplemental Information* and asked that members read the Statement prior to the start of deliberations of the House of Delegates.

Report of the Standing Committee on Credentials, Rules and Order: Dr. David L. Fried, Connecticut, Committee chair, presented the Committee's report. The other members of the Committee were: Dr. Shafa Amirsoltani, Illinois; Dr. Natalie Carr-Bustillo, Florida; Dr. Ann E. Christopher, Maryland; Dr. Matthew S. Kolkman, Indiana; Dr. Robert A. Neal, Texas; Dr. Susan M. Orwick-Barnes, Tennessee; Dr. Werner W. Schneider, Arkansas; and Dr. Debra S. West, Nebraska.

Approval of Certified Delegates. Dr. Fried reported that a list of certified delegates and alternate delegates as of October 6, 2021, was posted on ADA Connect. Subsequent to the October 6 posting, the following requests relating to the credentialing of a new delegate and new alternate delegate were presented:

Delegates
Dr. Kelly A. Roth, Ohio
Dr. Jessica A. Meeske, Nebraska
Dr. Gigi E. Meinecke, Maryland

Alternate Delegates
Dr. Mary T. Wallace, Alabama
Dr. Seth A. Walbridge, Pennsylvania

Dr. Fried reported that the Committee considered the requests to be the result of extenuating circumstances and recommended that the individuals be credentialed. On behalf of the Committee, Dr. Fried moved Resolution 98 (*Supplement:*1030) as amended. Hearing no objection, the Speaker declared Resolution 98, as amended, adopted.

98H-2021. Resolved, that the list of certified delegates and alternate delegates posted in the HOD Supplemental Information library on the House of Delegates community of ADA Connect be approved as the official roster of voting delegates and alternate delegates that constitute the 2021 House of Delegates of the American Dental Association.

Dr. Fried reported the presence of a quorum.

Dr. Fried reminded everyone of the provisions of the ADA Disclosure Policy in effect during the meetings of the House and during the reference committee hearings. The Speaker asked that such disclosures be made prior to speaking to any resolution where such relationship would be applicable.

Minutes of the 2020 Session of the House of Delegates. On behalf of the Committee, Dr. Fried moved Resolution 99 (*Supplement:*1031). The Speaker asked if there were any corrections to the minutes; hearing none, the Speaker declared the minutes adopted.

99H-2021. Resolved, that the minutes of the 2020 session of the House of Delegates be approved.

Adoption of Agenda and Order of Agenda Items. On behalf of the Committee, Dr. Fried moved Resolution 100 (*Supplement:*1032).

Hearing no objection, Resolution 100 was adopted.

100H-2021. Resolved, that the agenda as presented in the *2021 Manual of the House of Delegates and Supplemental Information* be adopted as the official order of business for this session, and be it further
Resolved, the Speaker is authorized to alter the order of the agenda as deemed necessary in order to expedite the business of the House.

Referrals of Reports and Resolutions. On behalf of the Committee, Dr. Fried moved Resolution 101 (*Supplement:*1033).

Hearing no objection, Resolution 101 was adopted.

101H-2021. Resolved, that the list of referrals recommended by the Speaker of the House of Delegates be approved.

The Speaker announced that Resolution 7S-1 was revised; editorial changes were made to Resolution 40 and Resolution 67; and the financial implication was corrected for Resolution 85S-1 and Resolution 104.

The Speaker announced the following withdrawn resolutions.

Resolution 72—Generating More Inclusive Feedback on Matters Before the House of Delegates—withdrawn by the Eleventh Trustee District

Resolution 77—Proposed Amendment to the Comprehensive ADA Policy Statement on Teledentistry—withdrawn by the Eighth Trustee District

Resolution 87—Increasing Transparency into the Revenue and Expenses of Campaigns for Office with Elections Held During the House of Delegates—withdrawn by the Eleventh Trustee District

Consideration of New Business. The Speaker announced that three items of New Business were submitted:

Fourth Trustee District Resolution 106—Fair Delegate Allocation for Federal Dental Services (*Supplement*:5229)

Sixteenth Trustee District Resolution 107—Standard Form for Consolidating Dental Implant and Implant Restoration Data (*Supplement*:3025)

Fifth and Sixteenth Trustee Districts Resolution 108—National Commission on Recognition of Dental Specialties and Certifying Boards Requirements for Recognition Review (*Supplement:*4111)

Items of New Business submitted less than 15 days prior to the opening of the annual session require a majority vote of the delegates present and voting in order to be considered.

Hearing no objection, the Speaker declared that Resolution 106, Resolution 107 and Resolution 108 would be considered as new business. The Speaker announced that Resolution 106 would be referred to Reference Committee D, Resolution107 would be referred to Reference Committee B and Resolution 108 would be referred to Reference Committee C.

Dr. Fried noted that the balance of the Committee's report was informational, but highlighted information regarding the process of substituting delegates and alternates during meetings of the House; the schedule of reference committee hearings and the posting and paper distribution of reference committee reports; the prohibition against proxy voting in the House of Delegates; and the time for voting for elective offices on the House floor.

Prior to the Report of the President, Dr. Chad P. Gehani, immediate past president, at the invitation of the Speaker, addressed the House of Delegates.

Report of the President: Dr. Daniel J. Klemmedson addressed the House of Delegates. He commented on the new areas of focus that came about since he was elected president-elect, most notably COVID-19, ADA's involvement in the political process, health equity, and increased potential for a dental benefit in Medicare. He stated, "If we apply the same sharp focus, clear intention and group action that propelled us through COVID-19, then, yes, we can solve many more of our most pressing problems. Every step forward contributes to our progress." He also commented on the importance of the House passing a resolution on the culture of safety in dentistry and a resolution proclaiming that dentistry is essential health care; saying, "We proclaimed it. Now we must own it. … Our place in health care is solidified. We have an obligation to address the health care needs of all patients, those who have, and those who have not. … Ultimately, as essential health care professionals, dentists must assume and honor this real and implicit social contract to care for the oral health care needs of all people." Dr. Klemmedson closed by expressing his gratitude for those who showed him the value of organized dentistry. He thanked his district and the House of Delegates, and his wife for her encouragement. The Report of the President (*Supplement*:2124) was referred to Reference Committee A (Budget, Business, Membership and Administrative Matters) and was posted on ADA Connect.

Report of the Treasurer: Dr. Ted Sherwin presented to the House of Delegates his report on the status of the Association's finances.

Report of the Executive Director: Dr. Kathleen T. O'Loughlin presented her annual report to the House of Delegates.

Presentation of Reports of the Board of Trustees: On behalf of the Board of Trustees, Dr. Linda K. Himmelberger, Third District Trustee, presented the reports of the Board of Trustees to the House of Delegates.

Nominations to Councils. Dr. Himmelberger moved Resolution 56 (*Supplement:*1020) on behalf of the Board of Trustees.

Hearing no objection, Resolution 56 was adopted by general consent.

56H-2021. Resolved, that the nominees put forward for membership on ADA councils be elected.

The Speaker noted that it is the custom that the newly elected members of councils assume office after the close of the last meeting of the House of Delegates.

Dr. Himmelberger reported that the names of members retiring from ADA councils and commissions are identified in Board Report 1 and thanked these members of behalf of the Board of Trustees.

Dr. Himmelberger noted that Reports 1 through 10 of the Board of Trustees to the House of Delegates were referred to the appropriate reference committees.

Dr. Himmelberger asked the House to observe a moment of silence in memory of the former leaders who passed away since the last session of the House of Delegates.

Nominations of Officers

President-elect: The Speaker called for nominations for the office of president-elect. Dr. Paula S. Crum, Wisconsin, nominated Dr. Julio H. Rodriguez, Wisconsin, for the office of president-elect; and Dr. Christopher G. Liang, Maryland, nominated Dr. George R. Shepley, Maryland, for the office of president-elect. The Speaker asked if there were any additional nominations; there were none. Acceptance speeches were given by each president-elect candidate. The Speaker announced that the names of the candidates would be placed on the ballot for election on Saturday, October 16.

Second Vice President: The Speaker called for nominations for the office of second vice president. Dr. Tamara S. Berg, Oklahoma, nominated Dr. Douglas Auld, Oklahoma, for the office of second vice president; Dr. Najia Usman, Ohio, nominated Dr. Mark E. Bronson, Ohio, for the office of second vice-president; Dr. Darlene A. Oleski, Pennsylvania, nominated Dr. I. Jay Freedman, Pennsylvania, for the office of second vice president; and Dr. Jeena E. Devasia, Virginia, nominated Dr. Elizabeth C. Reynolds, Virginia, for the office of second vice president. The Speaker asked if there were any additional nominations; there were none. Acceptance speeches were given by the second vice president candidates. The Speaker announced that the names of the candidates would be placed on the ballot for election on Saturday, October 16.

Treasurer: The Speaker called for nominations for the office of treasurer. Dr. Cynthia Southern, Virginia, nominated Dr. Ted Sherwin, Virginia, for the office of treasurer. The Speaker noted that the ADA *Governance Manual* requires candidates for Treasurer to submit a standardized *curriculum vitae* to the Executive Director at least 120 days prior to the convening of the House of Delegates in order to be nominated. No additional *curriculum vitae* were submitted. Therefore, in accordance with the ADA *Governance Manual*, the Speaker declared Dr. Ted Sherwin duly elected. Dr. Sherwin briefly addressed the House.

Presentation of Incoming Trustees: The Speaker presented the following incoming trustees, elected by their respective Trustee Districts:

Dr. James M. Boyle, III, Pennsylvania, Third District Trustee
Dr. Frank J. Graham, New Jersey, Fourth District Trustee
Dr. Marshall H. Mann, Georgia, Fifth District Trustee
Dr. Michele M. Tulak-Gorecki, Michigan, Ninth District Trustee

Remarks by the Chair of the American Dental Political Action Committee (ADPAC): Dr. L. Stephen Ortego, ADPAC chair, addressed the House of Delegates thanking members for their continued support of ADPAC.

Report of the General Counsel: Mr. Scott W. Fowkes, general counsel, addressed the House of Delegates providing an overview of legal issues relating to the dental profession.

Adjournment

A motion was made to adjourn the First Meeting of the ADA House of Delegates by Mr. Marco A. Gargano, American Student Dental Association. Hearing no objection, the Speaker declared the First Meeting of the ADA House of Delegates adjourned at 3:41 p.m., Wednesday, October 13, 2021.

Saturday, October 16, 2021

Second Meeting of the ADA House of Delegates

Call to Order: The Second Meeting of the 162nd Annual Session of the ADA House of Delegates was called to order at 7:30 a.m., Saturday, October 16, 2021, by the Speaker of the House of Delegates, Dr. W. Mark Donald.

Recognition of New Delegates and Alternate Delegates: The Speaker asked first time delegates and alternates to stand and be recognized.

Report of the Standing Committee on Credentials, Rules and Order: Dr. David L. Fried, Committee chair, announced that the Committee had received requests relating to the credentialing of a new alternate delegate and acting secretaries. The Committee considered these requests to be the result of extenuating circumstances and recommended that the following individuals be credentialed:

Alternate Delegate
Dr. Steven G. Feldman, Maryland

Secretaries
Ms. Michelle M. Nichols-Cruz, Michigan
Ms. Jeannie Watson, Georgia

Hearing no objection, the Speaker announced that the credentials were granted.

Dr. Fried announced the presence of a quorum and read the ADA Disclosure Policy.

Voting for Elective Officers: Voting for officer elections took place in the House of Delegates through electronic voting on the House floor.

The Speaker opened the vote for the office of president-elect. The candidates on the ballot, listed in alphabetical order, were as follows: Dr. Julio H. Rodriguez, Wisconsin; and Dr. George R. Shepley, Maryland. Hearing no objection, the Speaker closed the vote. The Speaker called for the House to stand at ease while the voting results were tallied.

The Speaker announced that Dr. George R. Shepley, Maryland, had been elected to the office of president-elect.

The Speaker opened the vote for the office of second vice president. The candidates on the ballot, listed in alphabetical order, were as follows: Dr. Douglas Auld, Oklahoma; Dr. Mark E. Bronson, Ohio; Dr. I. Jay Freedman, Pennsylvania; and Dr. Elizabeth Reynolds, Virginia. Hearing no objection, the Speaker closed the vote. The Speaker called for the House to stand at ease while the voting results were tallied.

The Speaker announced that there would be a run-off election for the office of second vice president between Dr. Mark E. Bronson, Dr. I. Jay Freedman and Dr. Elizabeth Reynolds. The Speaker opened the vote for the run-off election for second vice president. Hearing no objection, the Speaker closed the vote and the House stood at ease while voting results were tallied.

The Speaker announced that there would be a run-off election for the office of second vice president between Dr. Mark E. Bronson and Dr. I. Jay Freedman. The Speaker opened the vote for the run-off election for second vice president. Hearing no objection, the Speaker closed the vote and the House stood at ease while voting results were tallied.

The Speaker announced that Dr. Mark E. Bronson, Ohio, had been elected to the office of second vice president. Dr. Julio H. Rodriguez, Dr. George R. Shepley, Dr. Douglas Auld, Dr. Elizabeth Reynolds, Dr. I. Jay Freedman and Dr. Mark E. Bronson briefly addressed the House.

Announcements: The Speaker announced that no additional New Business resolutions had been submitted.

Dr. Eva F. Ackley, Florida, requested that Resolution 31—Amendment of Chapter IX, Section A of the Governance and Organizational Manual of the American Dental Association be withdrawn.

On vote, Resolution 31 was withdrawn.

As a point of information, Dr. Alan L. Felsenfeld asked whether Dr. Ackley had requested that Resolution 31 be withdrawn, or removed from the consent calendar.

Dr. Ackley clarified that her intent was to remove Resolution 31 from the Reference Committee C Consent Calendar.

Dr. Daniel J. Gesek, Florida, moved to reconsider the motion to withdraw Resolution 31.

On vote, the motion to reconsider the motion to withdraw Resolution 31 was adopted.

The Speaker announced that Resolution 31 would be placed back on the Reference Committee C Consent Calendar.

Priority Agenda Items: Two priority agenda items were identified by the Reference Committees; the resolutions were considered in the following order:

- Proposed Amendments to the Comprehensive ADA Policy Statement on Teledentistry—Council on Ethics, Bylaws and Judicial Affairs Resolution 86, Board of Trustees Substitute Resolution 86BS-1, Thirteenth Trustee District Resolution 86BS-2 and Reference Committee D Substitute Resolution 86RC (Reference Committee D)
- Approval of 2022 Budget—Board of Trustee Resolution 75 (Reference Committee A)

The first priority agenda item was presented by Dr. Frank P. Iuorno, Jr., Virginia, chair, Reference Committee D.

Proposed Amendments to the Comprehensive ADA Policy Statement on Teledentistry (Council on Ethics, Bylaws and Judicial Affairs Resolution 86, Board of Trustees Substitute Resolution 86BS-1, Thirteenth Trustee District Resolution 86BS-2 and Reference Committee D Substitute Resolution 86RC)**:** The Reference Committee reported as follows:

> With respect to Resolutions 86, 86BS-1 and 86BS-2, the Reference Committee received testimony voicing concern that the proposed policy equates treatment performed via teledentistry techniques with treatment provided during in-person or face-to-face encounters. Specifically, there was testimony that lines 13-15 of Worksheet Page 5191 and language beginning at the end of line 42 of Page 5192 through line 2 of Worksheet Page 5193 should be deleted because it indicates that care provided through teledentistry and in-person care are equivalent.
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> The Reference Committee spent substantial time reviewing and discussing the passages that were requested to be deleted. Ultimately, the Committee believed that the deletion of the first portion of line 13 on Worksheet Page 5191 removed the question of equivalency of care from the paragraph in lines 13-15 of Page 5191. As amended by 86BS-1, the Committee believes that passage only specifies that insurer reimbursement for services provided by teledentistry and in-person care be made at the same rate. Similarly, after review and discussion of the Reimbursement section of the policy (page 5192, line 40 through page 5193, line 2) the Committee felt that the section focuses on the issue of reimbursement,

and not on the issue of whether the care provided by teledentistry techniques and in-person or face-to-face care is equivalent.

The Reference Committee also received testimony on and thoroughly reviewed and discussed the amendments proposed by Resolution 86BS-2. All of the testimony received concerning the proposed narrowing of the information to be provided to teledentistry patients recited in Paragraph 3 of the Patients' Rights section of the policy (5193a (3 of 4), lines 3-9) of Resolution 86BS-2 was positive, and the Committee found itself in agreement with those revisions. Very limited testimony was received concerning the proposed revision to Paragraph 4 of the Patients' Rights section of the policy (5193a (3 of 4) lines 10-12). Following the Committee's review and discussion, the Committee was in agreement that a further amendment to Paragraph 4 is in order, and therefore proposes the following resolution, Resolution 86RC in lieu of Resolution 86, Resolution 86BS-1 and Resolution 86BS-2:

86RC. Resolved, that the Comprehensive ADA Policy Statement on Teledentistry (*Trans.*2015:244; 2020:107) be amended as follows (additions underscored; deletions ~~stricken~~):

Comprehensive ADA Policy Statement on Teledentistry

Teledentistry refers to the use of telehealth systems and methodologies in dentistry. Telehealth refers to a broad variety of technologies and tactics to deliver virtual medical, health, and education services. Telehealth is not a specific service, but a collection of means to enhance care and education delivery.

Teledentistry can include patient care and education delivery using, but not limited to, the following modalities:

Synchronous (live video): Live, two-way interaction between a person (patient, caregiver, or provider) and an ~~provider~~ oral health care practitioner using audiovisual telecommunications technology.

Asynchronous (store and forward): Transmission of recorded health information (for example, radiographs, photographs, video, digital impressions and photomicrographs of patients) through a secure electronic communications system to a practitioner, who uses the information to evaluate a patient's condition or render a service outside of a real-time or live interaction.

Remote patient monitoring (RPM): Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider (sometimes via a data processing service) in a different location for use in care and related support of care.

Mobile health (mHealth): Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and personal digital assistants (PDA).

General Considerations: While in-person (face to face) ~~direct~~ examination has been historically the most direct way to provide care, advances in technology have expanded the options for dentists to communicate with patients and with remotely located licensed dental team members. The ADA believes that examinations performed using teledentistry can be an effective way to extend the reach of dental professionals, increasing access to care by reducing the effect of distance barriers to care.

Teledentistry has the capability to expand the reach of a dental home to provide needed dental care to a population within reasonable geographic distances and varied locations where the services are rendered.

In order to achieve this goal, services delivered via teledentistry must be consistent with how they would be delivered in person. Examinations and subsequent interventions performed using teledentistry must be based on the same level of information that would be available in an in person (face to face) environment, and it is the legal responsibility of the dentist to ensure that all records collected are sufficient for the dentist to make a diagnosis and treatment plan. The treatment of patients who receive services via teledentistry must be properly documented and should include providing the patient with a summary of

services. A dentist who uses teledentistry shall have adequate knowledge of the nature and availability of local dental resources to provide appropriate follow-up care to a patient following a teledentistry encounter. A dentist shall refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in case of emergency.

~~As the care provided is equivalent to in person care, i~~ Insurer reimbursement of services provided must be made at the same rate that it would be made for the services when provided in-person, including reimbursement for the teledentistry codes as appropriate.

Patients' Rights: Dental patients whose care is rendered or coordinated using teledentistry modalities have the right to expect:

1. That any dentist delivering, directing or supervising services to a patient of record using teledentistry technologies will be licensed in ~~the~~ a state or other territory or jurisdiction of the United States~~, where the patient receives services,~~ or be providing these services as otherwise authorized by the ~~that state's~~ dental board of that state, territory or jurisdiction.

2. That any dentist delivering, directing or supervising services to a new patient using teledentistry technologies will be licensed in the state or other territory or jurisdiction of the United States where the patient receives the services.

~~2~~3. Access to the name, practice address, telephone number, emergency contact information, and email address of the virtual practice. Access to the names, licensure information, and board certification qualifications of ~~the~~ all oral health care practitioners who ~~is providing the~~ provide care via teledentistry in the practice. Prior to the virtual visit, the patient should be informed of the name, licensure information, and qualification of the oral healthcare practitioners conducting the visit and virtual care.

~~3~~4. That the delivery of services through teledentistry technologies will follow evidence-based practice guidelines, to the degree they are available, consistent with accepted standards of care as a means of ensuring patient safety, quality of care and positive health outcomes.

~~4~~5. That patients will be informed about the identity of the providers collecting or evaluating their information or providing treatment, and of any costs they will be responsible for in advance of the delivery of services.

~~5~~6. That relevant patient information will be collected prior to performing services using teledentistry technologies and methods including medical, dental, and social history, and other relevant demographic and personal information.

~~6~~7. That the provision of services using teledentistry technologies will be properly documented, that ~~and~~ the records and documentation collected will be provided to the patient upon request and that the limitations (if any) of teledentistry encounters should be disclosed to a patient prior to the initiation of any teledentistry encounter.

8. That any patient has the right to discuss their treatment with any third party. A patient should not be required to agree to any provision that restricts the patient's freedom to bring any concerns about their dental treatment to the attention of an entity of the patient's choosing.

~~7~~9. That services provided using teledentistry technologies and methods include care coordination as a part of a dental home and that the patient's records be made available to any entity that is serving as the patient's dental home.

~~8~~10. That the patient will be actively involved in treatment decisions, will be able to choose how they receive a covered service, including considerations for urgency, convenience and satisfaction and without such penalties as higher deductibles, co-payments or coinsurance relative to that of in-person (face to face) services.

~~9~~11. That the dentist shall determine the delivery of services using teledentistry technologies and all services are performed in accordance with applicable laws and regulations addressing the privacy and security of patients' private health information.

Quality of Care: The dentist is responsible for, and retains the authority for ensuring, the safety and quality of services provided to patients using teledentistry technologies and methods. Services delivered via teledentistry should be consistent with in-person (face to face) services, and the delivery of services utilizing these modalities must abide by laws addressing privacy and security of a patient's dental/medical information.

Supervision of Allied Dental Personnel: The extent of the supervision of allied dental personnel should conform to the applicable dental practice act in the state, territory or jurisdiction of the United States where the patient receives services and where the dentist is licensed. The dentist should be knowledgeable regarding the competence and qualifications of the allied personnel utilized, and should have the capability of immediately contacting both the allied dental personnel providing service and the patient receiving services. All services delivered by allied dental personnel should be consistent with the ADA Comprehensive Statement on Allied Dental Personnel.

Licensure: Dentists ~~and allied dental personnel~~ who deliver services through teledentistry modalities must be licensed or credentialed in accordance with the laws of the state, territory or jurisdiction in which the dentist practices. Allied dental personnel who deliver services through teledentistry modalities must be licensed or credentialed in accordance with the laws of the state, territory or other jurisdiction in which the patient receives service. The delivery of services via teledentistry must comply with the ~~state's~~ scope of practice laws, regulations or rules applicable to the encounter. Teledentistry cannot be used to expand the scope of practice or change permissible duties of ~~dental auxiliaries~~ allied dental personnel. The American Dental Association opposes a single national federalized system of dental licensure for the purposes of teledentistry.

Reimbursement: Dental benefit plans and all other third-party payers, in both public (e.g. Medicaid) and private programs, shall provide coverage for services using teledentistry technologies and methods (synchronous or asynchronous) delivered to a covered person to the same extent that the services would be covered if they were provided through in-person (face to face) encounters. Coverage for services delivered via teledentistry modalities will be at the same levels as those provided for services provided through in-person (face to face) encounters and not be limited or restricted based on the technology used or the location of either the patient or the provider as long as the health care provider is licensed ~~in the state where the patient receives service~~ as indicated above.

Technical Considerations: Dentists are encouraged to consider conformance with applicable data exchange standards to facilitate delivery of services via teledentistry modalities. These include, but are not limited to, Digital Imaging and Communications in Medicine (DICOM) standards when selecting and using imaging systems, X12/HL7 for the exchange of information and ICD-9/10-CM/SNOMED/SNODENT for documentation consistency.

Dr. Iuorno moved Resolution 86RC in lieu of Resolution 86 (*Supplement:*5187), Resolution 86BS-1 (*Supplement:*5190) and Resolution 86BS-2 (*Supplement:*5193a) with the Committee Recommendation to Vote Yes.

Dr. Robert J. Wilson, Jr., Maryland, chair of the Council on Ethics, Bylaws and Judicial Affairs spoke in support of Resolution 86RC, stating, "On behalf of the entire Council, I wish to thank the Reference Committee for their thoughtful work on this resolution, and I wish the House to know that the entire Council supports [Resolution] 86RC and the recommendations to adopt in lieu of."

Dr. Julius N. Manz, New Mexico, moved to amend Resolution 86RC in the first sentence of the policy statement by adding the words "when a patient is at an originating site and the dentist is located at a distant site" after the word "dentistry" so that the first paragraph of the policy statement would read as follows:

Teledentistry refers to the use of telehealth systems and methodologies in dentistry when a patient is at an originating site and the dentist is located at a distant site. Telehealth refers to a broad variety of technologies and tactics to deliver virtual medical, health, and education services. Telehealth is not a specific service, but a collection of means to enhance care and education delivery.

and item 2. under the “Patients’ Rights” section of the policy statement, by adding the words “of the originating site” after the words “United States,” so that item 2. would read as follows:

2. That any dentist delivering, directing or supervising services to a new patient using teledentistry technologies will be licensed in the state or other territory or jurisdiction of the United States of the originating site where the patient receives the services.

In speaking to the amendment, Dr. Manz stated, “The terms we use to describe diagnosis and treatment at a distant site are critical for defining the use or the abuse of teledentistry. Two terms that are common to telehealth are ‘originating site,’ which is the location of the patient, and the ‘distant site,’ which is the location of the practitioner providing the care. Cynical attempts to change the meanings of these terms confuse the jurisdictional boundaries and nullify patient safeguards. This amendment would clarify the use of these terms in ADA’s teledentistry policy and standardize their use in discussions about regulation, liability and patient’s rights.”

Dr. Gary S. Davis, Pennsylvania, spoke against the proposed amendment stating, “I believe it’s best for the ADA policy to be written broadly enough to be applied to all states and territories. I just looked at the New Mexico Telehealth Act…and I do see the definition for ‘originating site’ as a place where a patient may receive health care and they list 14 sites. But I do not see ‘distant site.’ I see ‘health care providers.’ And CMS defines ‘originating site’ as the location where Medicare patients get physician or provider medical service, but instead of distant site, it lists distant site providers. In [Pennsylvania], our Department of Health uses CMS guidance, but uses both the terms ‘distant site provider’ and ‘distant site.’ So what’s my point? ADA policy should be broad, and individual states can apply their own nuances. I’m just concerned language in the [amendment] may not align with all other states. …”

As a point of information, Dr. Davis asked whether “distant site” and “originating site” apply to all states or does it align with all the states’ telehealth acts.

The Speaker responded, “…The response is, with 50 states, at this point in time we cannot answer that question. That would take some time to do some research.”

Dr. Jill M. Burns, Indiana, and member of the Council on Ethics, Bylaws and Judicial Affairs, spoke against the proposed amendment. She said, “… we wrote this language to cover all 50 states. I don’t think we need the specific language included for one specific situation. I believe that any state can use this policy in their legal search for teledentistry, and I don’t believe that we need this amendment.”

Dr. Steven A. Saxe, Nevada, spoke in support of the proposed amendment. He said, “I speak in favor of this amendment to the resolution, as all 50 states currently do not possess teledentistry statue and regulations. And many states look to the American Dental Association for guidance of this particular verbiage.”

Dr. Robert J. Wilson, Jr., Maryland, spoke against the amendment, stating, “It is critical to this resolution that the items 1. and 2. under ‘Patients’ Rights’ are clear and concise. Although I’m sympathetic to the issues New Mexico is having in their state legislature, [these] amendments are not well thought out and they’re not well researched. We don’t have adequate background. We should not be making a decision like this on the fly in this House of Delegates. It may have merit, but it needs further study. Perhaps next year.”

Dr. Matthew J. Messina, Ohio, spoke against the amendment, stating, “…The policy statement really is best said if it’s broad and doesn’t attempt to chase individual state legislation. One of the things we do learn with this is that, yes, the legislation in teledentistry across the states is varied and states are adding things. The ADA, through state government affairs, supports states that are looking to pass legislation, and our policy is guidance, and we learn things. But the other part about it is, as we know, legislation on a state-by-state

basis is constantly changing. Even if something has been passed, we end up kind of coming back playing legislative whack-a-mole sometimes trying to keep things under control. The ADA policy is best if it's simple, clear and stable."

A motion was made to vote immediately on the proposed amendment. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, the proposed amendment was not adopted.

On vote, Resolution 86RC was adopted in lieu of Resolution 86, Resolution 86BS-1 and Resolution 86BS-2.

86H-2021. Resolved, that the Comprehensive ADA Policy Statement on Teledentistry (*Trans.*2015:244; 2020:107) be amended as follows (additions underscored; deletions ~~stricken~~):

Comprehensive ADA Policy Statement on Teledentistry

Teledentistry refers to the use of telehealth systems and methodologies in dentistry. Telehealth refers to a broad variety of technologies and tactics to deliver virtual medical, health, and education services. Telehealth is not a specific service, but a collection of means to enhance care and education delivery.

Teledentistry can include patient care and education delivery using, but not limited to, the following modalities:

Synchronous (live video): Live, two-way interaction between a person (patient, caregiver, or provider) and an ~~provider~~ oral health care practitioner using audiovisual telecommunications technology.

Asynchronous (store and forward): Transmission of recorded health information (for example, radiographs, photographs, video, digital impressions and photomicrographs of patients) through a secure electronic communications system to a practitioner, who uses the information to evaluate a patient's condition or render a service outside of a real-time or live interaction.

Remote patient monitoring (RPM): Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider (sometimes via a data processing service) in a different location for use in care and related support of care.

Mobile health (mHealth): Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and personal digital assistants (PDA).

General Considerations: While in-person (face to face) ~~direct~~ examination has been historically the most direct way to provide care, advances in technology have expanded the options for dentists to communicate with patients and with remotely located licensed dental team members. The ADA believes that examinations performed using teledentistry can be an effective way to extend the reach of dental professionals, increasing access to care by reducing the effect of distance barriers to care.

Teledentistry has the capability to expand the reach of a dental home to provide needed dental care to a population within reasonable geographic distances and varied locations where the services are rendered.

In order to achieve this goal, services delivered via teledentistry must be consistent with how they would be delivered in person. Examinations and subsequent interventions performed using teledentistry must be based on the same level of information that would be available in an in person (face to face) environment, and it is the legal responsibility of the dentist to ensure that all records collected are sufficient for the dentist to make a diagnosis and treatment plan. The treatment of patients who receive services via teledentistry must be properly documented and should include providing the patient with a summary of services. A dentist who uses teledentistry shall have adequate knowledge of the nature and availability of local dental resources to provide appropriate follow-up care to a patient following a teledentistry

encounter. A dentist shall refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in case of emergency.

~~As the care provided is equivalent to in person care, i~~ Insurer reimbursement of services provided must be made at the same rate that it would be made for the services when provided in-person, including reimbursement for the teledentistry codes as appropriate.

Patients' Rights: Dental patients whose care is rendered or coordinated using teledentistry modalities have the right to expect:

1. That any dentist delivering, directing or supervising services to a patient of record using teledentistry technologies will be licensed in ~~the~~ a state or other territory or jurisdiction of the United States~~, where the patient receives services,~~ or be providing these services as otherwise authorized by the ~~that state's~~ dental board of that state, territory or jurisdiction.

2. That any dentist delivering, directing or supervising services to a new patient using teledentistry technologies will be licensed in the state or other territory or jurisdiction of the United States where the patient receives the services.

~~2~~3. Access to the name, practice address, telephone number, emergency contact information, and email address of the virtual practice. Access to the names, licensure information, and board certification qualifications of ~~the~~ all oral health care practitioners who ~~is providing the~~ provide care via teledentistry in the practice. Prior to the virtual visit, the patient should be informed of the name, licensure information, and qualification of the oral healthcare practitioners conducting the visit and virtual care.

~~3~~4. That the delivery of services through teledentistry technologies will follow evidence-based practice guidelines, to the degree they are available, consistent with accepted standards of care as a means of ensuring patient safety, quality of care and positive health outcomes.

~~4~~5. That patients will be informed about the identity of the providers collecting or evaluating their information or providing treatment, and of any costs they will be responsible for in advance of the delivery of services.

~~5~~6. That relevant patient information will be collected prior to performing services using teledentistry technologies and methods including medical, dental, and social history, and other relevant demographic and personal information.

~~6~~7. That the provision of services using teledentistry technologies will be properly documented, that ~~and~~ the records and documentation collected will be provided to the patient upon request and that the limitations (if any) of teledentistry encounters should be disclosed to a patient prior to the initiation of any teledentistry encounter.

8. That any patient has the right to discuss their treatment with any third party. A patient should not be required to agree to any provision that restricts the patient's freedom to bring any concerns about their dental treatment to the attention of an entity of the patient's choosing.

~~7~~9. That services provided using teledentistry technologies and methods include care coordination as a part of a dental home and that the patient's records be made available to any entity that is serving as the patient's dental home.

~~8~~10. That the patient will be actively involved in treatment decisions, will be able to choose how they receive a covered service, including considerations for urgency, convenience and satisfaction and without such penalties as higher deductibles, co-payments or coinsurance relative to that of in-person (face to face) services.

~~9~~11. That the dentist shall determine the delivery of services using teledentistry technologies and all services are performed in accordance with applicable laws and regulations addressing the privacy and security of patients' private health information.

Quality of Care: The dentist is responsible for, and retains the authority for ensuring, the safety and quality of services provided to patients using teledentistry technologies and methods. Services delivered via teledentistry should be consistent with in-person (face to face) services, and the delivery of services utilizing these modalities must abide by laws addressing privacy and security of a patient's dental/medical information.

Supervision of Allied Dental Personnel: The extent of the supervision of allied dental personnel should conform to the applicable dental practice act in the state, territory or jurisdiction of the United States where the patient receives services and where the dentist is licensed. The dentist should be knowledgeable regarding the competence and qualifications of the allied personnel utilized, and should have the capability of immediately contacting both the allied dental personnel providing service and the patient receiving services. All services delivered by allied dental personnel should be consistent with the ADA Comprehensive Statement on Allied Dental Personnel.

Licensure: Dentists ~~and allied dental personnel~~ who deliver services through teledentistry modalities must be licensed or credentialed in accordance with the laws of the state, territory or jurisdiction in which the dentist practices. Allied dental personnel who deliver services through teledentistry modalities must be licensed or credentialed in accordance with the laws of the state, territory or other jurisdiction in which the patient receives service. The delivery of services via teledentistry must comply with the ~~state's~~ scope of practice laws, regulations or rules applicable to the encounter. Teledentistry cannot be used to expand the scope of practice or change permissible duties of ~~dental auxiliaries~~ allied dental personnel. The American Dental Association opposes a single national federalized system of dental licensure for the purposes of teledentistry.

Reimbursement: Dental benefit plans and all other third-party payers, in both public (e.g. Medicaid) and private programs, shall provide coverage for services using teledentistry technologies and methods (synchronous or asynchronous) delivered to a covered person to the same extent that the services would be covered if they were provided through in-person (face to face) encounters. Coverage for services delivered via teledentistry modalities will be at the same levels as those provided for services provided through in-person (face to face) encounters and not be limited or restricted based on the technology used or the location of either the patient or the provider as long as the health care provider is licensed ~~in the state where the patient receives service~~ as indicated above.

Technical Considerations: Dentists are encouraged to consider conformance with applicable data exchange standards to facilitate delivery of services via teledentistry modalities. These include, but are not limited to, Digital Imaging and Communications in Medicine (DICOM) standards when selecting and using imaging systems, X12/HL7 for the exchange of information and ICD-9/10-CM/SNOMED/SNODENT for documentation consistency.

The second priority agenda item was presented by Dr. Mary Krempasky Smith, Washington, chair, Reference Committee A.

Approval of 2022 Budget (Board of Trustees Resolution 75): The Reference Committee reported as follows:

The Reference Committee concurs with the Board of Trustees and supports adoption of Resolution 75.

75. Resolved, that the 2022 Annual Budget of revenues and expenses, including net capital requirements, be approved.

Dr. Krempasky Smith moved Resolution 75 (*Supplement:*2084) with the Committee recommendation to Vote Yes.

Dr. Marshall H. Mann, Georgia, stated, “First of all, I’d like to commend the Board of Trustees on presenting a balanced budget to the House of Delegates. I do however want to remind the House that there are many, many resolutions that have financial implications, and I hope that the House will be considering those recommendations very carefully.”

The Speaker informed the House that it will be approving the preliminary budget at this time.

On vote, the preliminary budget was adopted. See page XXX for the adoption of the final budget (Resolution 75).

Report of Reference Committee A (Budget, Business, Membership and Administrative Matters)

The Report of Reference Committee A was presented by Dr. Mary Krempasky Smith, Washington, chair. The other members of the Committee were: Dr. Frank C. Barnashuk, New York; Dr. Mark S. Chaney, Louisiana; Dr. Michael J. Frankman, South Dakota; Dr. William L. Ingram, V, Alabama; Dr. Eric W. Knudsen, Michigan; Dr. James Mancini, Pennsylvania; Dr. Jonathan W. Rich, Kentucky; and Dr. Katie E. Stuchlik, Texas.

Consent Calendar (Reference Committee A Resolution 109): The Reference Committee reported as follows:

The appended Resolution 109 lists resolutions referred and considered by this Reference Committee that received no or limited testimony, all positive testimony, all negative testimony, or the Reference Committee feels these resolutions were fully debated, with all issues considered. The Reference Committee’s recommended action (adopt, adopt in lieu of, not adopt or refer) is identified on each resolution presented on the consent calendar. By adopting Resolution 109, the recommendations of the Reference Committee on the consent calendar resolutions will become the actions of the House of Delegates. It should be noted that if a resolution on the consent calendar is to “adopt in lieu of” with a Committee Recommendation to Vote No **and** the resolution remains on the approved consent calendar, the resolution is defeated and the underlying resolutions are automatically moot.

As customary, before voting on the consent calendar, any delegate wishing to discuss an item on the consent calendar has the right to request that resolution be extracted and considered separately.

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

Resolution 44—(Adopt)—Sustaining the Pipeline of Volunteer Leadership (*Supplement*:2002) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

Resolution 69—(Adopt)—Proposed Policy on ADA Diversity and Inclusion (*Supplement*:2008) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

Resolution 78—(Adopt)—Amendment of the Policy, Four-Year Recent Graduate Reduced Dues Program (*Supplement*:2114) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

Resolution 84—(Adopt)—Rescission of the Policy, Qualifications for Membership (*Supplement*:2115) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

Resolution 90RC—(Adopt Resolution 90RC in lieu of Resolutions 90 and 90S-1)—Eliminating Barriers for Underrepresented Minorities into the Dental Profession (*Supplement*:2118) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

Resolution 102RC—(Adopt Resolution 102RC in lieu of Resolution 102)—Strategy for Engaging Dental Residents (*Supplement:*2119) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

Resolution 103—(Not Adopt)—Resources for ADA Dentist Members Transitioning into Retirement (*Supplement*:2120) $: None
COMMITTEE RECOMMENDATION: Vote No.

Resolution 105—(Not Adopt)—Increasing Transparency and Improving Member Engagement Through Virtual Testimony at the House of Delegates Reference Committees (*Supplement*:2123) $: None
COMMITTEE RECOMMENDATION: Vote No.

Dr. Krempasky Smith moved Resolution 109 with the Committee Recommendation to Vote Yes.

A request was made to remove the following resolution from the Consent Calendar:

Resolution 103 removed by Dr. Cary J. Limberakis, Pennsylvania

Hearing no objection, the amended Resolution 109 was adopted by general consent.

109H-2021. Resolved, that the recommendations of Reference Committee A on the following resolutions be accepted by the House of Delegates.

Resolution 44—(Adopt)—Sustaining the Pipeline of Volunteer Leadership (*Supplement*:2002) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

Resolution 69—(Adopt)—Proposed Policy on ADA Diversity and Inclusion (*Supplement*:2008) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

Resolution 78—(Adopt)—Amendment of the Policy, Four-Year Recent Graduate Reduced Dues Program (*Supplement*:2114) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

Resolution 84—(Adopt)—Rescission of the Policy, Qualifications for Membership (*Supplement*:2115) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

Resolution 90RC—(Adopt Resolution 90RC in lieu of Resolutions 90 and 90S-1)—Eliminating Barriers for Underrepresented Minorities into the Dental Profession (*Supplement*:2118) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

Resolution 102RC—(Adopt Resolution 102RC in lieu of Resolution 102)—Strategy for Engaging Dental Residents (*Supplement:*2119) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

~~**Resolution 103**—(Not Adopt)—Resources for ADA Dentist Members Transitioning into Retirement (*Supplement*:2120) $: None~~
~~**COMMITTEE RECOMMENDATION: Vote No.**~~

Resolution 105—(Not Adopt)—Increasing Transparency and Improving Member Engagement Through Virtual Testimony at the House of Delegates Reference Committees (*Supplement*:2123) $: None
COMMITTEE RECOMMENDATION: Vote No.

Note: For the purpose of a fully documented record, the text of the resolutions presented in Resolution 109H follows.

Consent Calendar Resolutions—Adopted/Adopted in Lieu of

Sustaining the Pipeline of Volunteer Leadership

44H-2021. Resolved, that the following policy titled "Sustaining the Pipeline of Volunteer Leadership" be adopted:

Sustaining the Pipeline of Volunteer Leadership

Resolved, that new dentists be considered as essential leaders in the tripartite, and be it further
Resolved, that constituent dental societies be urged to develop and implement strategies to grow and maintain new dentist participation in leadership, which may include:

- Leadership development
- Dedicated leadership positions for new dentists
- Programs that support the pathway to leadership for new graduates
- Other opportunities to foster leadership growth,

and be it further
Resolved, that the policy titled "New Dentist Involvement in Volunteer Leadership" (*Trans.*2009:487) be rescinded.

Proposed Policy on ADA Diversity

69H-2021. Resolved, that the following Policy on Diversity and Inclusion be adopted:

The ADA is committed to a culture of diversity and inclusion to foster a safe and equitable environment for its membership. In this environment, representation matters and every member is provided intentional opportunities to make meaningful contributions. Diverse viewpoints and needs are heard, valued and respected.

The ADA embraces diversity and inclusion to drive innovation and growth, ensure a relevant and sustainable organization and deliver purposeful value to members, prospective members, and stakeholders. The ADA's commitment to diversity and inclusion will further advance the dental profession, improve the oral health of the public, and achieve optimal health for all.

Amendment of the Policy, Four-Year Recent Graduate Reduced Dues Program

78H-2021. Resolved, that the ADA policy, Four-Year Recent Graduate Reduced Dues Program (*Trans.*2008:482), be amended as follows (additions underscored; deletions ~~stricken~~):

Two ~~Four~~-Year Recent Graduate Reduced Dues Program

Resolved, that the ADA urges constituent and component societies to adopt the ADA two ~~four-~~ year reduced dues structure for recent dental school graduates.

Rescission of the Policy, Qualifications for Membership

84H-2021. Resolved, that the ADA policy, Qualifications for Membership (*Trans.*1959:219; 1996:672; 2013:365), be rescinded.

Eliminating Barriers for Underrepresented Minorities into the Dental Profession

90H-2021. Resolved, that an ADA Task Force be convened by the ADA President ~~that will~~ to explore the current barriers for entry into the dental profession by underrepresented ~~minorities~~ populations, and be it

further
Resolved, that invitations be extended to at least, but not limited to, the American Dental Education Association, American Student Dental Association, National Dental Association, Hispanic Dental Association and Society of American Indian Dentists to nominate members of their respective organizations to participate in the Task Force, and be it further
Resolved, the ~~ADA~~ Task Force will develop ~~policies and a~~ broad-reaching ~~strategy~~ strategies and action plans that will strengthen and support a workforce that is more representative of the population, and be it further
Resolved, that the Task Force shall report its findings and recommendations to the 2022 ADA House of Delegates.

Strategy for Engaging Dental Residents

102H-2021. Resolved, that starting with the 2022 House of Delegates, the appropriate ADA agencies provide regular status reports on the efforts to engage, connect, recruit and develop long-term relationships with dentists in post-graduate programs.

Consent Calendar Resolution—Not Adopted

Increasing Transparency and Improving Member Engagement Through Virtual Testimony at the House of Delegates Reference Committees

105. Resolved, that the House of Delegates form an ADA task force to present a two-year pilot proposal to the 2022 House of Delegates for expanding reference committee testimony to members in a virtual format and making House of Delegates resolutions, reports, and other, non-privileged information accessible to all members virtually.

Non-Consent Resolution

Resources for ADA Dentist Members Transitioning Into Retirement (Third Trustee District Resolution 103): The Reference Committee reported as follows:

The Reference Committee heard considerable testimony on Resolution 103. Testimony in favor of Resolution 103 included recommendations that the resources need to focus on more than financial topics and be directed to all members, not just for those with immediate plans to retire. Con testimony referenced many resources that already exist, including those provided by the Council on Members Insurance and Retirement Programs, and ADABIG's support for members transitioning out of practice. The Reference Committee also noted that ADABEI and the Council on Dental Practice provide resources to support various aspects of transition.

The consensus of the Reference Committee was that the ADA is already addressing the proposed resolution, and that it would be difficult to formulate an action plan given the comprehensive nature of the resources requested.

103. Resolved, that the appropriate agencies evaluate and develop a program that could possibly include a full-time counselor/advisor, and continuing education, both live face-to-face and virtual, to guide its members who are or will be transitioning into retirement, with resources to include, but not be limited to:

- basics of retirement living
- mental and emotional needs
- social needs
- current health needs
- long-term healthcare needs
- retirement budget
- personal or spiritual growth, and of course

- fun

and be it further
Resolved, that the appropriate agencies report back to the 2022 House of Delegates regarding said program and the financial implication of implementing it.

Dr. Krempasky Smith moved Resolution 103 (*Supplement:*2120) with the Committee recommendation to Vote No.

Dr. Cary J. Limberakis, Pennsylvania, moved to amend Resolution 103 in each of the resolving clauses and adding a third resolve clause so that Resolution 103 would read as follows:

Resolved, that the appropriate agencies inventory all ADA course and program offerings related to ADA dentist members transitioning into retirement ~~evaluate and develop a program that could possibly include a full-time counselor/advisor, and continuing education, both live face-to-face and virtual, to guide its members who are or will be transitioning into retirement, with resources~~ to include, but not necessarily be limited to:

- ~~basics of retirement living~~
- wellness (e.g. mental and emotional needs,
- ~~social needs~~
- current health needs,
- long-term healthcare needs).
- work-life balance (e.g. social needs, ~~retirement budget~~
- personal or spiritual growth)., ~~and of course~~
- ~~fun~~

and be it further
Resolved, that a determination be made as to whether there are any unmet needs in the current offerings, along with estimated costs to meet those needs,
~~that the appropriate agencies report back to the 2022 House of Delegates regarding said program and the financial implication of implementing it.~~ and be it further,
Resolved, that a determination be made on the feasibility and costs of developing an easily accessible electronic catalog, with a report on the findings to the 2022 House of Delegates.

In speaking to the proposed amendment, Dr. Limberakis stated, "In the discussions initiated by Resolution 103, we've heard about the resources ADA already makes available to members to assist with retirement planning. Those existing resources do constitute a nice member benefit. That said, the discussions over the past few days leave the impression that even fairly well informed members know little about how to access specific components of these resources and that their exists at least a possibility those resources aren't as comprehensive as perhaps they should be. This is a critical issue that will affect the well-being of all our members eventually, not just those currently transitioning into retirement. So we feel it is important to be sure we're fully addressing all the critical retirement-related needs of our members. The amended resolution will help to do that by focusing attention specifically on issues like wellness and work-life balance that, though vital, are too often neglected; assessing current retirement-related programs to determine conclusively if there are significant unmet needs in this area; determining how best to facilitate that easy button."

Dr. I. Jay Freedman, Pennsylvania, spoke in support of the proposed amendment. He said, "… this is a member benefit that, while it may not be in the headlights of our youngest cohort, they will be there eventually, and if we have the ability to evaluate what we currently have, we can fill the gaps so that we have a comprehensive program moving forward."

Dr. D. Douglas Cassat, California, spoke against the proposed amendment, stating, "These services are available. You know, all you got to do is subscribe to the AARP magazine, and you're getting this every single week, almost. … we spend 40 years in practice preparing for retirement, and I don't believe that it's the ADA's responsibility to offer these services to our members."

Dr. Geralyn M. Menold, California, spoke in support of the proposed amendment, stating, "… having retired a year ago, and I know that it was a pandemic and circumstances were different, but I think until a dentist retires they don't realize the emotional and social changes that they go though. And, you know, you just feel like you've lost your whole worth in the community, and you have to find other resources. So I think an audit of what is available would be in order."

Dr. Steven A. Saxe, Nevada, spoke in support of the proposed amendment, stating, "We're the American Dental Association, and over the years we've spent resources on these topics. Considering our current website and the lack of easy navigation of it, I think it's important that we do adopt this, because of the resources already expended by this group. We should not rely on AARP for anything that we've already spent our money on. And I appreciate the maker's concern on this, because when you go to our website, it is literally impossible to find all this material compiled"

A motion was made to vote immediately on the proposed amendment. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, the proposed amendment was not adopted.

On vote, Resolution 103 was not adopted.

Report of Reference Committee B (Dental Benefits, Practice and Related Matters)

The Report of Reference Committee B was presented by Dr. Shakalpi R. Pendurkar, California, chair. The other members of the Committee were: Dr. Ravichandra Juluri, Illinois; Dr. Rebekah N. Lucier-Pryles, Vermont; Dr. Margaret Madonian, New York; Dr. Angela P. Noguera, District of Columbia; Dr. Timothy W. Penberthy, Idaho; Dr. Sara E. Stuefen, Iowa; Dr. Rodney J. Thornell, Utah; and Dr. David L. Vorherr, Ohio.

Consent Calendar (Reference Committee B Resolution 110) The Reference Committee reported as follows:

The appended Resolution 110 lists resolutions referred and considered by this Reference Committee that received no or limited testimony, all positive testimony, all negative testimony, or the Reference Committee feels these resolutions were fully debated, with all issues considered. The Reference Committee's recommended action (adopt, adopt in lieu of, not adopt or refer) is identified on each resolution presented on the consent calendar. By adopting Resolution 110, the recommendations of the Reference Committee on the consent calendar resolutions will become the action of the House of Delegates. It should be noted that if a resolution on the consent calendar is to "adopt in lieu of" with a Committee Recommendation to Vote No **and** the resolution remains on the approved consent calendar, the resolution is defeated and the underlying resolutions are automatically moot.

As customary, before voting on the consent calendar, any delegate wishing to discuss an item on the consent calendar has the right to request that resolution be extracted and considered separately.

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

Resolution 42RC—(Adopt Resolution 42RC in lieu of Resolution 42)—Amendment to the Policy Statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders (*Supplement*:3000) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 43—(Adopt)—Proposed ADA Policy Statement on the Use of Augmented Intelligence in Dentistry (*Supplement*:3003) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 54—(Adopt)—Rescission of Policy, Individual Practice Association (*Supplement*:3006) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 55—(Adopt)—Rescission of Policy, Support for Individual Practice Associations (*Supplement*:3008) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 63—(Adopt)—Proposed Policy for the Elimination of Wait Periods for Children in Dental Benefit Plans (*Supplement*:3010) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 71—(Adopt)—Amendment of the Policy, Third-Party Payers Overpayment Recovery Practices (*Supplement*:3012) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 74—(Adopt)—Proposed Policy, Dental Benefits Within Affordable Care Act Marketplace and a Public Option (*Supplement*:3017) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 79—(Not Adopt)—National Dental Endosseous Implant Registry (*Supplement*:3018) $: 40,000
COMMITTEE RECOMMENDATION: Vote No

Resolution 85RC—(Adopt Resolution 85RC in lieu of Resolutions 85, 85S-1 and 85S-2)—Addressing the Dental Team Workforce Shortage (*Supplement*:3021) $: 125,000
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 88RC—(Adopt Resolution 88RC in lieu of Resolution 88)—Reinstatement of ADA Third Party Payer Concierge Service (*Supplement*:3022) $: 200,000 per year for five years
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 89—(Not Adopt)—Addressing Third Party Dental Reimbursement Rates (*Supplement*:3023) $: None
COMMITTEE RECOMMENDATION: Vote No

Resolution 93RC—(Adopt Resolution 93RC in lieu of Resolution 93)—Developing Safeguards to Protect Employee Dentists (*Supplement*:3024) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 107—(Adopt)—Standard Form for Consolidating Dental Implant and Implant Restoration Data (*Supplement*:3025) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Dr. Pendurkar moved Resolution 110 with the Committee Recommendation to Vote Yes.

Requests were made to remove the following resolutions from the Consent Calendar:

Resolution 42RC was removed by Dr. John C. Comisi, South Carolina
Resolution 85RC was removed by Dr. Michael T. Flynn, Minnesota
Resolution 88RC was removed by Dr. D. Douglas Cassat, California

On vote, the amended Resolution 110 was adopted.

110H-2021. Resolved, that the recommendations of Reference Committee B on the following resolutions be accepted by the House of Delegates.

~~**Resolution 42RC**—(Adopt Resolution 42RC in lieu of Resolution 42)—Amendment to the Policy Statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders (*Supplement*:3000) $: None~~
~~**COMMITTEE RECOMMENDATION: Vote**~~

Resolution 43—(Adopt)—Proposed ADA Policy Statement on the Use of Augmented Intelligence in Dentistry (*Supplement*:3003) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 54—(Adopt)—Rescission of Policy, Individual Practice Association (*Supplement*:3006) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 55—(Adopt)—Rescission of Policy, Support for Individual Practice Associations (*Supplement*:3008) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 63—(Adopt)—Proposed Policy for the Elimination of Wait Periods for Children in Dental Benefit Plans (*Supplement*:3010) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 71—(Adopt)—Amendment of the Policy, Third-Party Payers Overpayment Recovery Practices (*Supplement*:3012) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 74—(Adopt)—Proposed Policy, Dental Benefits Within Affordable Care Act Marketplace and a Public Option (*Supplement*:3017) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 79—(Not Adopt)—National Dental Endosseous Implant Registry (*Supplement*:3018) $: 40,000
COMMITTEE RECOMMENDATION: Vote No

~~**Resolution 85RC**—(Adopt Resolution 85RC in lieu of Resolutions 85, 85S-1 and 85S-2)—Addressing the Dental Team Workforce Shortage (*Supplement*:3021) $: 125,000~~
~~**COMMITTEE RECOMMENDATION: Vote Yes**~~

~~**Resolution 88RC**—(Adopt Resolution 88RC in lieu of Resolution 88)—Reinstatement of ADA Third Party Payer Concierge Service (*Supplement*:3022) $: 200,000 per year for five years~~
~~**COMMITTEE RECOMMENDATION: Vote Yes**~~

Resolution 89—(Not Adopt)—Addressing Third Party Dental Reimbursement Rates (*Supplement*:3023) $: None
COMMITTEE RECOMMENDATION: Vote No

Resolution 93RC—(Adopt Resolution 93RC in lieu of Resolution 93)—Developing Safeguards to Protect Employee Dentists (*Supplement*:3024) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 107—(Adopt)—Standard Form for Consolidating Dental Implant and Implant Restoration Data (*Supplement*:3025) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Note: For the purpose of a fully documented record, the text of the resolutions presented in Resolution 110H follows.

Consent Calendar Resolutions—Adopted/Adopted in Lieu of

Proposed ADA Policy Statement on the Use of Augmented Intelligence in Dentistry

43H-2021. Resolved, that the ADA Policy Statement on the Use of Augmented Intelligence in Dentistry be adopted.

ADA Policy Statement on the Use of Augmented Intelligence in Dentistry

Augmented intelligence (AI) is the theory and development of computer systems that can perform tasks that would otherwise require human intelligence, such as visual perception, speech recognition, decision-making and translation between languages. The term may also be applied to any software that performs intelligent behavior and acts intelligently.

The ADA supports using AI as a tool to supplement the dentist's clinical judgment rather than a technology to replace or override it, while taking into account a patient's clinical presentation, including history, examination, and relevant tests.

- The ADA encourages the development of thoughtfully designed, high-quality, clinically validated dental AI.
- The ADA urges dental professionals to become fully informed about AI technology and how it might support the delivery of patient care.
- The ADA encourages training and education for dental students to ensure that all clinicians in the United States can incorporate AI into clinical practice.

Dental AI Developers: The ADA urges entities to incorporate the following principles when developing AI systems for dental care applications:

- Integrate, when possible, the perspective of practicing dentists in the development, design, validation, and implementation of dental care AI;
- Design and evaluate AI systems following the best practices in dentistry;
- Ensure that the development process of such systems is transparent and conforms to leading standards for reproducibility;
- Address bias and avoid introducing or exacerbating health care disparities when testing on vulnerable populations or deploying new AI tools;
- Demonstrate the efficacy and accuracy of AI systems with reliable data obtained from the relevant clinical domains;
- Safeguard the privacy of patients and other individuals and securing their personal and medical information.

Clinical Practitioners: The ADA supports the following principles for the introduction of AI systems into clinical dental practice:

- Produce outcomes that match or exceed the currently accepted standard of care;
- Prioritize patient safety when using an AI system;
- Encourage dental educators to introduce clinical AI systems in practice and to foster digital literacy in the current and future dental workforce;
- An AI system in clinical dental practice should be supervised by a dentist;
- Identify and acknowledge the limitations of an AI system in clinical decision-making, and continue to collaborate or consult with clinical colleagues as appropriate;
- Demonstrate the efficacy of AI systems with reliable data obtained from the relevant clinical domains;
- Interpret data from dental AI to allow for clinical observation and judgment input from dentists, with an ongoing emphasis on risk management, accountability, and bias;
- Obtain the appropriate informed consent, permission, privacy controls, checks for accuracy and relevance of any patient data used in original development or ongoing refinement of AI algorithms;

- Use patient data only for the stated purpose and storing such data securely.

Third-Party Payers: The ADA supports the following principles for the introduction of AI systems into the claims adjudication processes by third-party payers:

- All decisions on treatment are appropriately the result of a joint discussion between the patient and the dentist;
- If AI is used by dental benefit plans as a tool to assist with claims processing or adjudication, that tool should not be used to diagnose or dictate a treatment plan that interferes with the doctor-patient decision process or deny any benefits that the patient is entitled to under their plan;
- Any AI tool used by third party payers should not be used to direct patients to specified preferred providers;
- AI systems should not allow for denial of claims without consultant review.

Rescission of Policy, Individual Practice Association

54H-2021. Resolved, that the ADA policy Individual Practice Association (*Trans.*1990:540) be rescinded.

Rescission of Policy, Support for Individual Practice Associations

55H-2021. Resolved, that the policy titled Support for Individual Practice Associations (IPAs) (*Trans.*1988:475; 1994:655; 2000:458; 2013:305) be rescinded.

Proposed Policy for the Elimination of Wait Periods for Children in Dental Benefit Plans

63H-2021. Resolved, that the American Dental Association supports the elimination of wait periods for treatment, including orthodontic treatment, for children from dental benefit plans.

Amendment of Policy, Third-Party Payers Overpayment Recovery Practices

71H-2021. Resolved, that the policy titled Third-Party Payers Overpayment Recovery Practices (*Trans.*1999:930; 2013:312) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the American Dental Association shall and its constituent societies are urged to seek or support legislation to prevent third-party payers from withholding assigned benefits or recouping payment when a payment made in error has been made on behalf of a different patient covered by the same third-party payer or because of an alleged overpayment to a different dentist, and be it further

Resolved, that dental plans should not retroactively deny, adjust, or seek recoupment or refund of a paid claim for dental care expenses submitted by a provider for any reason, other than fraud or for duplicate payments on claims received from the same plan for the same service from a provider, after the expiration of six months from the date that the initial claim was paid. The plan must provide information about why a refund is due, including the name of the patient, date of service and service provided along with the reason for the overpayment and allow the provider six months before the refund must be paid. The provider should be allowed 30 days to contest the refund request, and be it further

Resolved, that dental plans, representing self-funded and fully-insured plans, be urged to adopt these guidelines as an industry-wide standard for alleged overpayment of benefits to dentists.

Proposed Policy, Dental Benefits within Affordable Care Act Marketplace and a Public Option

74H-2021. Resolved, that within the Marketplaces established by the Affordable Care Act:

- Dental coverage should be available to consumers through Stand Alone Dental Plans.
- Diagnostic and preventive dental services embedded within Qualified Health Plans should be covered without any additional co-payment, co-insurance or deductibles.

- Dental care is essential across the individual's life span. Individuals seeking to purchase benefits in the Marketplaces must be able to purchase dental benefits without having to first purchase a medical plan.
- Plan designs should remain flexible and offer consumers adequate choices balancing cost and benefit value.
- Dental Plans offered in the Marketplaces must be required to transparently report Dental Loss Ratios (DLR).
- Cost sharing assistance or premium tax credits should be available to consumers purchasing dental plans.

and be it further
Resolved, that if a public option plan that includes pediatric or adult dental benefit plans were introduced within the Marketplaces established by the Affordable Care Act, then such plans should:

- Allow freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit.
- Not force any providers, including those already participating in existing public programs, to join a Marketplace plan network and instead should support fair market competition, including meaningful negotiation of contracts and annual adjustment of fee schedules.
- Only include minimal and reasonable administrative requirements to promote participation and provide meaningful access.

Developing Safeguards to Protect Employee Dentists

93H-2021. Resolved, that the appropriate ADA agency assess the feasibility of creating guidelines, best practices or educate members on mechanisms to assure accuracy of claims submitted by the office or a third party on behalf of the treating dentist, and be it further
Resolved, that a report be submitted to the 2022 House of Delegates.

Standard Form for Consolidating Dental Implant and Implant Restoration Data

107H-2021. Resolved, that the appropriate ADA agency create a form for patients and dental records that consolidates the data on placed implants and implant restorations to include the date of placement, implant manufacturer, type, size and intraoral location as well as abutment manufacturer, type, size and dental laboratory, and be it further
Resolved, that the ADA urge dentists to use the form for patient records and provide a copy to the patient.

Consent Calendar Resolutions—Not Adopted

National Dental Endosseous Implant Registry

79. Resolved, that the American Dental Association investigate the establishment of a dental endosseous implant registry, and be it further
Resolved, that the registry maintain data on placed implants by patient, date of placement, implant manufacturer, type, size and intraoral location, and be it further
Resolved, that the database be accessible by dentists only and for the express purpose of providing information that can be of assistance in improving patient care, and be it further
Resolved, that a report with any recommendations be presented to the 2022 American Dental Association House of Delegates meeting.

Addressing Third Party Dental Reimbursement Rates

89. Resolved, that the ADA communicate to dental insurance industry leaders that COVID-related increases in dental staffing costs and enhanced infection control expenses have increased the cost of dental care and third party payer reimbursement rates should be adjusted accordingly.

Non-Consent Resolutions

Amendment to the Policy Statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders (Council on Dental Practice Resolution 42 and Reference Committee B Resolution 42RC): The Reference Committee reported as follows:

The Reference Committee received testimony in support of Resolution 42. Several commenters requested specific amendments to the policy proposed by the Council on Dental Practice (CDP). One commenter requested removal of the word “surgical” to include other available modalities of sleep apnea care. The Reference Committee agreed with this comment.

A second commenter requested removal of “home” in the context of tests that may be ordered or administered by dentists. The Reference Committee acknowledged that the ability to order or administer tests is subject to applicable laws and currently varies by jurisdiction. However, the Committee was in favor of a broader ADA policy that would remain appropriate as scope of practice issues evolve.

Therefore, the Reference Committee recommends adoption of the following resolution (additions are double underscored, deletions are ~~double stricken~~ to reflect additional changes from the Reference Committee to the policy proposal submitted by the Council on Dental Practice).

42RC. Resolved, that the Statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders (*Trans.*2017:269; 2019:270) be amended as follows (further additions are double underscored, and deletions are ~~double stricken~~.)

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

Sleep related breathing disorders (SRBD) are disorders characterized by disruptions in normal breathing patterns. SRBD are potentially serious medical conditions caused by anatomical airway collapse and altered respiratory control mechanisms. Common SRBD include snoring, upper airway resistance syndrome (UARS) and obstructive sleep apnea (OSA). OSA has been associated with metabolic, cardiovascular, respiratory, dental and other diseases. In children, undiagnosed and/or untreated OSA can be associated with cardiovascular problems, impaired growth as well as learning and behavioral problems.

Dentists can and do play an essential role in the multidisciplinary care of patients with certain sleep related breathing disorders and are well positioned to identify patients at greater risk of SRBD. SRBD can be caused by a number of multifactorial medical issues and are therefore best treated through a collaborative model. Working in conjunction with our colleagues in medicine, dentists have various methods of mitigating these disorders. In children, the dentist’s recognition of suboptimal early craniofacial growth and development or other risk factors may lead to medical referral or orthodontic/orthopedic intervention to treat and/or prevent SRBD. Various ~~surgical~~ modalities exist to treat SRBD. Oral appliances, specifically custom-made, titratable devices can improve SRBD in adult patients. ~~compared to no therapy or placebo devices~~. Oral appliance therapy (OAT) can improve or effectively treat OSA in adult patients, especially those who are intolerant of continuous positive airway pressure (CPAP). Dentists are the only health care provider with the knowledge and expertise to provide OAT.

The dentist’s role in the treatment of SRBD includes the following:

- Dentists are encouraged to screen patients for SRBD as part of a comprehensive medical and dental history to recognize symptoms such as daytime sleepiness, choking, snoring or witnessed apneas and an evaluation for risk factors such as obesity, retrognathia, or

hypertension. If patients are at risk and appropriate candidates for ~~home~~ sleep apnea tests (~~H~~SAT) the dentist may order or administer the appropriate ~~H~~SAT ~~directly~~ in accordance with applicable laws. If risk for SRBD is determined, ~~these~~ patients and pertinent patient information and ~~H~~SAT data should be referred, ~~as needed,~~ to the appropriate physicians for ~~proper~~ diagnosis.

- In children, screening through history and clinical examination may identify signs and symptoms of deficient growth and development, or other risk factors that may lead to airway issues. If risk for SRBD is determined, intervention through medical/dental referral or evidenced based treatment may be appropriate to help treat the SRBD and/or develop an optimal physiologic airway and breathing pattern.
- Oral appliance therapy is an appropriate treatment for mild and moderate obstructive sleep apnea, and for severe obstructive sleep apnea when a CPAP cannot or will not be ~~is not~~ tolerated by the patient.
- When a physician diagnoses obstructive sleep apnea in a patient and the treatment with oral appliance therapy is recommended through written or electronic referral, a dentist should evaluate the patient for the appropriateness of fabricating a suitable oral appliance. If deemed appropriate, a dentist should fabricate an oral appliance, monitor its effectiveness and titrate the appliance as necessary.
- Dentists should obtain appropriate patient consent for treatment that reviews the proposed treatment plan, all available options and any potential side effects of using OAT and expected appliance longevity.
- Dentists treating SRBD with OAT should be capable of recognizing and managing the potential side effects through treatment or proper referral.
- Dentists who provide OAT to patients should monitor and adjust the Oral Appliance (OA) for treatment efficacy as needed, or at least annually. As titration of OAs has been shown to affect the final treatment outcome and overall OA success, ~~the use of unattended cardiorespiratory (Type 3) or (Type 4) portable monitors~~ home sleep apnea tests (HSAT) may be used by the dentist to help define the optimal target position of the mandible. A dentist trained in the use of ~~these portable monitoring devices~~ HSAT'S may assess the objective interim results for the purposes of OA titration.
- Surgical procedures may be considered as a secondary treatment for OSA when CPAP or OAT is inadequate or not tolerated. In selected cases, such as patients with concomitant dentofacial deformities, surgical intervention may be considered as a primary treatment.
- Dentists treating SRBD should continually update their knowledge and training of dental sleep medicine with related continuing education.
- Dentists should maintain regular communications with the patient's referring physician and other healthcare providers ~~to~~ regarding the patient's treatment progress and any recommended follow-up treatment.
- Follow-up sleep testing ~~by a physician~~ should be conducted so the physician ~~to~~ is able to evaluate the improvement or confirm treatment efficacy for the OSA, especially if the patient develops recurring OSA relevant symptoms or comorbidities.

Dr. Pendurkar moved Resolution 42RC in lieu of Resolution 42 (*Supplement*:3000) with the Committee Recommendation to Vote Yes.

Dr. John C. Comisi, South Carolina, moved to substitute Resolution 42S-1 for Resolution 42RC.

42S-1. Resolved, that the Statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders (*Trans.*2017:269; 2019:270) be amended as follows (additions are double underscored, and deletions are ~~double stricken~~.)

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

Sleep related breathing disorders (SRBD) are disorders characterized by disruptions in normal breathing patterns. SRBD are potentially serious medical conditions caused by anatomical airway collapse and altered respiratory control mechanisms. Common SRBD include snoring, upper airway resistance syndrome (UARS) and obstructive sleep apnea (OSA). OSA has been associated with metabolic, cardiovascular, respiratory, dental and other diseases. In children, undiagnosed and/or untreated OSA can be associated with cardiovascular problems, impaired growth as well as learning and behavioral problems.

Dentists can and do play an essential role in the multidisciplinary care of patients with certain sleep related breathing disorders and are well positioned to identify patients at greater risk of SRBD. SRBD can be caused by a number of multifactorial medical issues and are therefore best treated through a collaborative model. Working in conjunction with our colleagues in medicine, dentists have various methods of mitigating these disorders. In children, the dentist's recognition of suboptimal early craniofacial growth and development or other risk factors may lead to medical referral or orthodontic/orthopedic intervention to treat and/or prevent SRBD. Various ~~surgical~~ modalities exist to treat SRBD. Oral appliances, specifically custom-made, titratable devices can improve SRBD in adult patients. ~~compared to no therapy or placebo devices~~. Oral appliance therapy (OAT) can improve or effectively treat OSA in adult patients, especially those who are intolerant of continuous positive airway pressure (CPAP). Dentists are the only health care provider with the knowledge and expertise to provide OAT.

The dentist's role in the treatment of SRBD includes the following:

- Dentists are encouraged to screen patients for SRBD as part of a comprehensive medical and dental history to recognize symptoms such as daytime sleepiness, choking, snoring or witnessed apneas and an evaluation for risk factors such as obesity, retrognathia, or hypertension. If patients are at risk and appropriate candidates for home sleep apnea tests (HSAT) the dentist may order or administer the HSAT directly. If risk for SRBD is determined, ~~these~~ patients and pertinent patient information and HSAT data should be referred, ~~as needed,~~ to the appropriate sleep physicians for ~~proper~~ diagnosis.
- In children, screening through history and clinical examination may identify signs and symptoms of deficient growth and development, or other risk factors that may lead to airway issues. If risk for SRBD is determined, intervention through medical/dental referral or evidenced based treatment may be appropriate to help treat the SRBD and/or develop an optimal physiologic airway and breathing pattern.
- Oral appliance therapy is an appropriate treatment for mild and moderate obstructive sleep apnea, and for severe obstructive sleep apnea when a CPAP cannot or will not be ~~is not~~ tolerated by the patient.
- When a sleep physician diagnoses obstructive sleep apnea in a patient and the treatment with oral appliance therapy is recommended through written or electronic referral, a dentist should evaluate the patient for the appropriateness of fabricating a suitable oral appliance. If deemed appropriate, a dentist should fabricate an oral appliance, monitor its effectiveness and titrate the appliance as necessary.
- Dentists should obtain appropriate patient consent for treatment that reviews the proposed treatment plan, all available options and any potential side effects of using OAT and expected appliance longevity.
- Dentists treating SRBD with OAT should be capable of recognizing and managing the potential side effects through treatment or proper referral.
- Dentists who provide OAT to patients should monitor and adjust the Oral Appliance (OA) for treatment efficacy as needed, or at least annually. As titration of OAs has been shown to affect the final treatment outcome and overall OA success, ~~the use~~ of ~~unattended~~

~~cardiorespiratory (Type 3) or (Type 4) portable monitors~~ (HSAT) may be used by the dentist to help define the optimal target position of the mandible. A dentist trained in the use of ~~these portable monitoring devices~~ HSAT'S may assess the objective interim results for the purposes of OA titration.

- Surgical procedures may be considered as a secondary treatment for OSA when CPAP or OAT is inadequate or not tolerated. In selected cases, such as patients with concomitant dentofacial deformities, surgical intervention may be considered as a primary treatment.
- Dentists treating SRBD should continually update their knowledge and training of dental sleep medicine with related continuing education.
- Dentists should maintain regular communications with the patient's referring physician and other healthcare providers to the patient's treatment progress and any recommended follow-up treatment.
- Follow-up sleep testing ~~by a physician~~ should be conducted so a sleep ~~the~~ physician ~~to~~ is able to evaluate the improvement or confirm treatment efficacy for the OSA, especially if the patient develops recurring OSA relevant symptoms or comorbidities.

In speaking to the substitute, Dr. Comisi stated, "Upon review of 42RC, it was determined that there was a need to enable a more broadly applicable policy that can be effectively used by state societies to help influence and effect change in dental practice acts, as we have accomplished in South Carolina. We urge the House to support the substitute, which will provide a clearer pathway from medicine and our state boards to recognize the importance of dentistry in therapeutic care of our mutual patients."

Dr. Mahfouz M. Gereis, California, spoke against the substitute resolution, stating, "… the resolution as written is very restrictive, and, in reality, in my opinion, it's a step backwards. First of all, it limits the dentist's ability in two areas very clearly. Number one, it limits the ability of the dentist to only be able to…prescribe a home study;…it talks about the oral appliance specifically custom made. Titratable devices can improve sleep breathing disorders. So it talks about being able to titrate these appliances. … it talks about the dental appliance can improve or effectively treat obstructive sleep apnea in adult patients, especially those who are intolerable of a CPAP machine. To be able to titrate a dental appliance with a CPAP machine to reduce pressure cannot be achieved by a home study. It has to be done in a laboratory setting where the patient sleeps fitted with the appliance and the CPAP machine and a technician during the sleep period would adjust the pressure to come up with the ultimate pressure. This is very restrictive to us. The other area where I felt that it is not appropriate,…it talks about the data should be referred to appropriate sleep physician for diagnosis. Now, sleep physicians is a specialty that's not having a lot of members. In the area where I practice, and I have been practicing treating sleep patients for over 20 years, I have four sleep laboratories in this area. Three of them are run by psychiatrists and "palmorists" and they are not sleep specialists. Again, we should be able to refer this to the appropriate physicians that treats those patients, not restrict us to try to find a sleep specialist that might not be available in the area. … [The substitute resolution] would make us look, in the eyes of our patients and colleagues, as technicians that fabricate appliances… We are physicians, not technicians."

Dr. Prabu Raman, Missouri, spoke against the substitute resolution, stating, "… I object to this, including the word 'sleep.' I know it is probably well intentioned. It limits the physicians who could diagnose and verify treatment efficacy only to sleep physicians. … Limiting physicians who can diagnose and verify treatment efficacy to only sleep physicians would severely impact access to care for many of my patients, especially those rural Americans. Additionally, I do not think it is the role of the ADA to determine the qualification of a physician to be able to diagnose or verify treatment efficacy. Clearly, any physician can do anything that their practice act allows. Respectfully, I think that as a physician, that should be left to our medical colleagues at the AMA and the state medical boards."

Dr. Thomas S. Kelly, Ohio, spoke against the substitute resolution, stating, "Speaking against the resolution specifically related to the word 'sleep physician.' American Academy of Dental Sleep Medicine does not designate the specific sleep physician. It just says that we should refer to a physician and then allow the physician to decide…if they're qualified or where the patient should be going."

Dr. Comisi stated, "… there seems to be some consternation regarding the phraseology 'sleep physician' and if it's appropriate, I would remove the word 'sleep physician' in those areas where they are if that would help to make this resolution more acceptable to the House. … Just to edit, editorially remove the terminology 'sleep physician' and leave it as 'physician.'"

The Speaker responded, "It put me a little behind on that one, because we've already debated the 'sleep.' So I am going to not allow that. And we'll just continue to debate this resolution and vote it up or down. It's only two items in that area, and the 'surgical' is already removed. That's really the crux of your motion, if I understand it."

A motion was made to vote immediately on substituting Resolution 42S-1 for Resolution 42RC. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, the motion to substitute Resolution 42S-1 for Resolution 42RC was not adopted.

The Speaker stated that Resolution 42RC was now before the House.

Dr. Dipika T. Shah, New Jersey, moved to amend Resolution 42RC in the second paragraph of the proposed Policy Statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders by replacing the words "continuous positive airway pressure (CPAP)" with the words "positive airway pressure therapy (PAP therapy)" so that the second paragraph would read as follows:

> Dentists can and do play an essential role in the multidisciplinary care of patients with certain sleep related breathing disorders and are well positioned to identify patients at greater risk of SRBD. SRBD can be caused by a number of multifactorial medical issues and are therefore best treated through a collaborative model. Working in conjunction with our colleagues in medicine, dentists have various methods of mitigating these disorders. In children, the dentist's recognition of suboptimal early craniofacial growth and development or other risk factors may lead to medical referral or orthodontic/orthopedic intervention to treat and/or prevent SRBD. Various ~~surgical~~ modalities exist to treat SRBD. Oral appliances, specifically custom-made, titratable devices can improve SRBD in adult patients. ~~compared to no therapy or placebo devices~~. Oral appliance therapy (OAT) can improve <u>or effectively treat</u> OSA in adult patients, especially those who are intolerant of ~~continuous positive airway pressure (CPAP)~~ <u>positive airway pressure therapy (PAP therapy)</u>. Dentists are the only health care provider with the knowledge and expertise to provide OAT.

and amend the final paragraph by deleting the words "especially if the patient develops recurring OSA relevant symptoms or comorbidities," so that the last paragraph would read as follows:

> Follow-up sleep testing ~~by a physician~~ should be conducted <u>so the physician</u> ~~to~~ <u>is able to</u> evaluate the improvement or confirm treatment efficacy for the OSA~~, especially if the patient develops recurring OSA relevant symptoms or comorbidities~~.

In speaking to the proposed amendment, Dr. Shah stated, "The word "CPAP" should be changed to "PAP" as the "PAP" is the more generic term inconclusive of many kinds of PAPS; ;examples, CPAP, APAP, BiPAP, et cetera."

On vote, the proposed amendment was adopted.

On vote, Resolution 42RC, as amended, was adopted in lieu of Resolution 42.

42H-2021. Resolved, that the Statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders (*Trans.*2017:269; 2019:270) be amended as follows (further additions are <u>double underscored</u>, and deletions are ~~double stricken~~.)

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

Sleep related breathing disorders (SRBD) are disorders characterized by disruptions in normal breathing patterns. SRBD are potentially serious medical conditions caused by anatomical airway collapse and altered respiratory control mechanisms. Common SRBD include snoring, upper airway resistance syndrome (UARS) and obstructive sleep apnea (OSA). OSA has been associated with metabolic, cardiovascular, respiratory, dental and other diseases. In children, undiagnosed and/or untreated OSA can be associated with cardiovascular problems, impaired growth as well as learning and behavioral problems.

Dentists can and do play an essential role in the multidisciplinary care of patients with certain sleep related breathing disorders and are well positioned to identify patients at greater risk of SRBD. SRBD can be caused by a number of multifactorial medical issues and are therefore best treated through a collaborative model. Working in conjunction with our colleagues in medicine, dentists have various methods of mitigating these disorders. In children, the dentist's recognition of suboptimal early craniofacial growth and development or other risk factors may lead to medical referral or orthodontic/orthopedic intervention to treat and/or prevent SRBD. Various ~~surgical~~ modalities exist to treat SRBD. Oral appliances, specifically custom-made, titratable devices can improve SRBD in adult patients. ~~compared to no therapy or placebo devices~~. Oral appliance therapy (OAT) can improve or effectively treat OSA in adult patients, especially those who are intolerant of ~~continuous positive airway pressure (CPAP)~~ positive airway pressure therapy (PAP therapy). Dentists are the only health care provider with the knowledge and expertise to provide OAT.

The dentist's role in the treatment of SRBD includes the following:

- Dentists are encouraged to screen patients for SRBD as part of a comprehensive medical and dental history to recognize symptoms such as daytime sleepiness, choking, snoring or witnessed apneas and an evaluation for risk factors such as obesity, retrognathia, or hypertension. If patients are at risk and appropriate candidates for ~~home~~ sleep apnea tests (~~H~~SAT) the dentist may order or administer the appropriate ~~H~~SAT ~~directly~~ in accordance with applicable laws. If risk for SRBD is determined, ~~these~~ patients and pertinent patient information and ~~H~~SAT data should be referred, ~~as needed,~~ to the appropriate physicians for ~~proper~~ diagnosis.
- In children, screening through history and clinical examination may identify signs and symptoms of deficient growth and development, or other risk factors that may lead to airway issues. If risk for SRBD is determined, intervention through medical/dental referral or evidenced based treatment may be appropriate to help treat the SRBD and/or develop an optimal physiologic airway and breathing pattern.
- Oral appliance therapy is an appropriate treatment for mild and moderate obstructive sleep apnea, and for severe obstructive sleep apnea when a CPAP cannot or will not be ~~is not~~ tolerated by the patient.
- When a physician diagnoses obstructive sleep apnea in a patient and the treatment with oral appliance therapy is recommended through written or electronic referral, a dentist should evaluate the patient for the appropriateness of fabricating a suitable oral appliance. If deemed appropriate, a dentist should fabricate an oral appliance, monitor its effectiveness and titrate the appliance as necessary.
- Dentists should obtain appropriate patient consent for treatment that reviews the proposed treatment plan, all available options and any potential side effects of using OAT and expected appliance longevity.
- Dentists treating SRBD with OAT should be capable of recognizing and managing the potential side effects through treatment or proper referral.
- Dentists who provide OAT to patients should monitor and adjust the Oral Appliance (OA) for treatment efficacy as needed, or at least annually. As titration of OAs has been shown to affect the final treatment outcome and overall OA success, ~~the use of unattended cardiorespiratory (Type 3) or (Type 4) portable monitors~~ home sleep apnea tests (HSAT) may

be used by the dentist to help define the optimal target position of the mandible. A dentist trained in the use of ~~these portable monitoring devices~~ HSAT'S may assess the objective interim results for the purposes of OA titration.

- Surgical procedures may be considered as a secondary treatment for OSA when CPAP or OAT is inadequate or not tolerated. In selected cases, such as patients with concomitant dentofacial deformities, surgical intervention may be considered as a primary treatment.
- Dentists treating SRBD should continually update their knowledge and training of dental sleep medicine with related continuing education.
- Dentists should maintain regular communications with the patient's referring physician and other healthcare providers ~~to~~ regarding the patient's treatment progress and any recommended follow-up treatment.
- Follow-up sleep testing ~~by a physician~~ should be conducted so the physician ~~to~~ is able to evaluate the improvement or confirm treatment efficacy for the OSA~~, especially if the patient develops recurring OSA relevant symptoms or comorbidities~~.

Addressing the Dental Team Workforce Shortage (Indiana Dental Association Resolution 85, Third Trustee District Resolution 85S-1, Indiana Dental Association Resolution 85S-2 and Reference Committee B Resolution 85RC): The Reference Committee reported as follows:

The Reference Committee received testimony in support of and against Resolutions 85, 85S-1 and 85S-2. Specifically, the majority of commenters supported combining the intent expressed in Resolutions 85S-1 and 85S-2 by using 85S-2 as the basis and including the fourth resolving clause from 85S-1. Therefore, the Reference Committee recommends adoption of the following Resolution.

85RC. Resolved, that the appropriate ADA agency distribute existing print and social media communications materials to state and local dental societies to use to promote and encourage middle and high school students to consider careers in dentistry, dental hygiene and dental assisting, and be it further
Resolved, that the appropriate ADA agency study the issue of dental hygienist and dental assistant employment tenure to determine variables that lead to attrition and high employee turnover, as well as variables that encourage long term employees. The research will be used to develop a toolkit that dentists can use to help increase the tenure of dental team members, and be it further
Resolved, that the appropriate ADA agency request ADEA to collaborate in conducting a study of accredited dental hygiene and assisting programs and formulate ideal enrollment recommendations by state and or region and make this information available to state and local dental societies, as well as dentistry, hygiene and assisting education administrators, and be it further
Resolved, that the appropriate ADA agency investigate financial incentives, such as possible tax abatements and grants, to motivate educational institutions to create, or expand existing, dental hygiene and dental assisting programs in order to expedite the resolution of the workforce issue.

Dr. Pendurkar moved Resolution 85RC in lieu of Resolution 85 (*Supplement:*3021), Resolution 85S-1 (*Supplement*:3020a) and Resolution 85S-2 (*Supplement*:3021b) with the Committee Recommendation to Vote Yes.

Dr. Michael T. Flynn, Minnesota, spoke against Resolution 85RC. He said, "I know workforce shortages are dire, and we're all familiar with that, and we're frustrated. I think Resolution 85RC is a frustration resolution. The resolves involved with it are going to be hard to get in a timely fashion, and I think getting expected results to move the needle will not happen. I think the ADA has resources to help the workforce shortages and will help the states, because I believe the states are very individually involved in this."

Dr. Duc M. Ho, Texas, chair of the Council on Dental Practice, spoke in support of Resolution 85RC, stating, "On behalf of the Council on Dental Practice, I'd like to speak in favor of Resolution 85RC. Although our Council genuinely understands and appreciates the concern of the Tenth District. We share, along with many other members of this very Association, as well as our own executive director, that genuine unease of a scarce and depleted workforce. Some may argue that the ADA does a lot of this already, or that this is a

waste of money. Some would say we hear you, this will be our top priority and this is a communication issue. Perhaps. However, as a Council who has primary oversight of workforce issues, we would contend this resolution, which addresses the real issues of workforce for the average, every day, dues paying, practicing member, is an opportunity to demonstrate that the first priority are not words but a call to action, an opportunity to further direct our Council, our Association to do more and do better through distribution, education and advocacy. Yes, this costs money. $1.25 in your dues, to be specific. But this is also an important issue for our members. This resolution is our opportunity to not only say but to show our members and non-members, we hear you, and we will act as instructed."

Dr. Kevin W. Dens, Minnesota, spoke against Resolution 85RC, stating, "There's no doubt that there's overwhelming support for this. The problem in the Tenth District sees that the amount of money spent, this should already be being done in the Council on Dental Practice. ADA News…came out with two new flyers in response to this. They are available. Much of the work should be done. Is it necessary to give them an extra $125,000 to do the work that they're already doing and they should be doing? …

Dr. Samuel E. Selcher, Pennsylvania spoke in support of Resolution 85RC. He said, "…Back in the '80s, we had a similar problem. I was involved with our local area. We set up a hygiene school. We have been turning out 24 hygienists coming into the program every year. I started advertising for a hygienist last December, either part-time or full time. Have had no response. This is a problem that's been a long time in the making, exacerbated by COVID. We need to do everything we can, and it is going to be a process to get programs started, to get more auxiliary personnel. This will affect literally the production of dentistry through the whole United States as our offices decrease our productivity. If we do anything here, it is to help our members to be able to make a living and to serve the population we serve."

Further pro and con discussion ensued. Individuals speaking in support of Resolution 85RC commented that the dental team workforce shortage is a crisis and one of the most important issues for the ADA to address, and that the financial implication of the Resolution is worth the cost. Individuals speaking against Resolution 85RC commented that the workforce shortage would be best handled at the state level and in local communities and that work to address the shortage is already being done by the ADA and the Council on Dental Practice.

A motion was made to vote immediately on Resolution 85RC. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, Resolution 85RC was adopted in lieu of Resolution 85, Resolution 85S-1 and Resolution 85S-2.

> **85H-2021. Resolved**, that the appropriate ADA agency distribute existing print and social media communications materials to state and local dental societies to use to promote and encourage middle and high school students to consider careers in dentistry, dental hygiene and dental assisting, and be it further
> **Resolved**, that the appropriate ADA agency study the issue of dental hygienist and dental assistant employment tenure to determine variables that lead to attrition and high employee turnover, as well as variables that encourage long term employees. The research will be used to develop a toolkit that dentists can use to help increase the tenure of dental team members, and be it further
> **Resolved**, that the appropriate ADA agency request ADEA to collaborate in conducting a study of accredited dental hygiene and assisting programs and formulate ideal enrollment recommendations by state and or region and make this information available to state and local dental societies, as well as dentistry, hygiene and assisting education administrators, and be it further
> **Resolved**, that the appropriate ADA agency investigate financial incentives, such as possible tax abatements and grants, to motivate educational institutions to create, or expand existing, dental hygiene and dental assisting programs in order to expedite the resolution of the workforce issue.

Reinstatement of ADA Third-Party Payer Concierge Service (Fourteenth Trustee District Resolution 88 and Reference Committee B Resolution 88RC): The Reference Committee reported as follows:

> The Reference Committee received testimony only in support of Resolution 88. The Council on Dental Benefit Programs (CDBP) supported the intent of Resolution 88 but noted that the purpose of the Concierge Service, if re-instated, should be to provide value to the state dental associations. Testimony

noted that several state associations have insufficient staff to be able to support members with dental benefit issues. The Reference Committee agreed with the testimony and supports adoption of the following Resolution (additions are <u>underscored;</u> deletions are ~~stricken~~).

88RC. Resolved, that the ADA restart and significantly promote its third-party dental insurance concierge service for a five-year period, at which time this service can be re-evaluated as ~~an ADA member~~ <u>a state dental association</u> benefit.

Dr. Pendurkar moved Resolution 88RC in lieu of Resolution 88 (*Supplement:*3022) with the Committee Recommendation to Vote Yes.

As a point of information, Dr. William A. Simon, Illinois, asked what the numbers were in 2019 for the distribution of calls to the concierge service as they related to coding issues versus third-party payer issues.

At the request of the Speaker, Dr. Dave Preble, senior vice president, Practice Institute, responded that 8,500 calls came in on the issue of CDT and third-party payer concierge. Of the 8,500 calls, 6,000 were CDT calls and 2,500 were third-party concierge.

Dr. D. Douglas Cassat, California, spoke against Resolution 88RC stating, “In the background material, and obviously just with the discussion that was presented, this is a service that does not have very much utilization. We’re asking here to spend a million dollars, $200,000 a year for five years and for the approximate cost of $2 per member per year. I’m very sensitive to the Finance and Budget Committee in their challenge to control expenses for the American Dental Association, and as such, we always need to be diligent at looking at programs that are not utilized and are not effective for our membership.”

Dr. Randall C. Markarian, Illinois, chair of the Council on Dental Benefit Programs, stated, “Initially we were not in total favor of the original resolution, which is why we suggested an amendment during the reference committee. The third-party concierge has never been as an effective member benefit, and that is why it was discontinued. While we have continued to answer calls related to the CDT, the calls about payer-related issues were referred to the states. Some states do not have the resources to handle these calls, and that is why we consider this resolution as it stands as a state benefit. The ADA handles the centralized calls so the states don’t have to devote resources that they don’t have towards it.”

Further discussion in support of Resolution 88RC ensued. Individuals speaking in support of the Resolution commented that the concierge service was especially important for smaller states that don’t have the staff to answer the volume of calls generated on CDT and third-party payers and that the service is a critical member and state association benefit. Individuals also commented that promoting the concierge service will help make more members aware that the service is available so that it will be utilized more.

Dr. Spencer R. Bloom, Illinois, asked for clarification on the reason for the $200,000 financial implication for Resolution 88RC.

Dr. Preble responded that the $200,000 assumes $160,000 per year would be for compensation for staff who would be needed to answer CDT and third-party payer questions. The other $40,000 is for promotion of the concierge service since many members aren’t aware of the service.

Dr. Bloom responded, “…I understand that the coding calls will still be received. The staff for that exists and you’re suggesting that there’s an additional 160,000; that I question.

Dr. Preble responded stating, “Yes. The coding calls are still being answered and the staff that do that are fully occupied with that. When the concierge service was discontinued, we let staff go. We would have to rehire that staff in order to do this.”

As a point of information, Dr. Jonathan B. Knapp, Connecticut, asked “The way this program has historically been set up, since we’re promoting this as a state benefit, have there been requirements for reporting back to the states in terms of what the ADA is seeing from each state?”

The Speaker responded, “It is tracked, but we don’t have that information with us, but it is tracked so that the states can get the information that they need.”

A motion was made to vote immediately on Resolution 88RC. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, Resolution 88RC was adopted in lieu of Resolution 88.

88H-2021. Resolved, that the ADA restart and significantly promote its third-party dental insurance concierge service for a five-year period, at which time this service can be re-evaluated as ~~an ADA member~~ a state dental association benefit.

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

The Report of Reference Committee C was presented by Dr. Christopher J. Smiley, Michigan, chair. The other members of the Committee were: Dr. Theodore M. Baer, Washington; Dr. Jeff O. Capes, Georgia; Dr. Anthony C. Caputo, Arizona; Dr. Martin G. Dominger, New York; Dr. Rebecca S. King, North Carolina; Dr. Sarah Percy Tovar, Texas; Dr. Kristi M. Soileau, Louisiana; and Dr. James A.H. Tauberg, Pennsylvania.

Consent Calendar (Reference Committee C Resolution 111) The Reference Committee reported as follows:

The appended Resolution 111 lists resolutions referred and considered by this Reference Committee that received no or limited testimony, all positive testimony, all negative testimony, or the Reference Committee feels these resolutions were fully debated, with all issues considered. The Reference Committee’s recommended action (adopt, adopt in lieu of, not adopt or refer) is identified on each resolution presented on the consent calendar. By adopting Resolution 111, the recommendations of the Reference Committee on the consent calendar resolutions will become the actions of the House of Delegates. It should be noted that if a resolution on the consent calendar is to “adopt in lieu of” with a Committee Recommendation to Vote No and the resolution remains on the approved consent calendar, the resolution is extracted and the underlying resolutions are automatically moot.

As customary, before voting on the consent calendar, any delegate wishing to discuss an item on the consent calendar has the right to request that resolution be removed and considered separately.

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

Resolution 31—(Adopt)—Amendment of Chapter IX, Section A of the Governance and Organizational Manual of the American Dental Association (*Supplement*:4001) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 32RC—(Adopt Resolution 32RC in lieu of Resolutions 32)—Amendment of the Policy: Review of ADA Definition: Continuing Competency (*Supplement*:4005) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 46—(Adopt)—Special Care Dentistry Association (*Supplement*:4057)
$: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 47—(Adopt)—Continuing Education Market Research (*Supplement*:4058)
$: 35,000
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 48—(Adopt)—Developing Continuing Education Activities (*Supplement*:4059)
$: 7,500
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 49—(Adopt)—Proposed Policy: Patients With Special Needs (*Supplement*:4060) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 64—(Adopt)—Amendment of the Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting (*Supplement*:4065) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 65RC—(Adopt Resolution 65RC in lieu of Resolution 65)—Amendment of the Policy, Research Funds (*Supplement*:4066) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 66—(Adopt)—Rescission of the Policy, Comparative Effectiveness Research and Patient-Centered Outcomes Research (*Supplement*:4069) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 80—(Adopt)—Electronic Archiving of State and Component Dental Publications (*Supplement*:4099) $: 5,000
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 81RC—(Adopt Resolution 81RC in lieu of Resolution 81 and Resolution 81S-1)—Response to Resolution 74-2020—Elder Care Work Group—Elder Care Strategies for Continuing Education (*Supplement*:4101) $: 10,000
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 96RC—(Adopt Resolution 96RC in lieu of Resolution 96 and Resolution 96S-1)—The Practice of Dentistry and Cannabis (*Supplement*:4108) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 97—(Not Adopt)—Development of Best Practices for the Inclusion of Research with Negative Findings and Failed Replications Studies (*Supplement*:4107) $: None
COMMITTEE RECOMMENDATION: Vote No

Resolution 104RC—(Adopt Resolution 104RC in lieu of Resolution 104)—Financial Literacy Among New Dentists and Dental Students (*Supplement*:4110) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 108—(Adopt)—National Commission on Recognition of Dental Specialties and Certifying Boards Requirements for Recognition Review (*Supplement*:4111) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 113RC—(Adopt)—Report 1 of the Council on Scientific Affairs Report 1 to the House of Delegates: Response to Resolution 21H-2020—Feasibility of Assessing the Role of Dental Health in the Management of Diseases and Medical Conditions $: None
COMMITTEE RECOMMENDATION: Vote Yes

Dr. Smiley moved Resolution 111 with the Committee Recommendation to Vote Yes.

At the request of the Speaker, Dr. Marcelo Araujo, chief science officer, provided information related to Resolution 113RC: Report 1 of the Council on Scientific Affairs to the House of Delegates: Response to Resolution 21H-2020—Feasibility of Assessing the Role of Dental Health in the Management of Diseases and Medical Conditions. Dr. Araujo stated, “The intent of 113RC is to allow us to advocate for funding. When the original resolution came to CSA, we found that there’s not enough research in this area for us to compile enough data to create a guideline of systematic review. By advocating for funding, we allow Science and Governmental Affairs to go through the appropriation methods of Congress and ask for funding on this specific area.” Dr. Araujo further clarified that there is no financial implication for Resolution 113RC.

Requests were made to remove the following resolutions from the Consent Calendar:

Resolution 65RC removed by Dr. Prabu Raman, Missouri
Resolution 31 removed by Dr. Eva F. Ackley, Florida

Hearing no objection, the amended Resolution 111 was adopted by general consent.

111H-2021. Resolved, that the recommendations of Reference Committee C on the following resolutions be accepted by the House of Delegates.

~~**Resolution 31**—(Adopt)—Amendment of Chapter IX, Section A of the Governance and Organizational Manual of the American Dental Association (*Supplement*:4001) $: None~~
~~**COMMITTEE RECOMMENDATION: Vote Yes**~~

Resolution 32RC—(Adopt Resolution 32RC in lieu of Resolutions 32)—Amendment of the Policy: Review of ADA Definition: Continuing Competency (*Supplement*:4005) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 46—(Adopt)—Special Care Dentistry Association (*Supplement*:4057)
$: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 47—(Adopt)—Continuing Education Market Research (*Supplement*:4058)
$: 35,000
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 48—(Adopt)—Developing Continuing Education Activities (*Supplement*:4059)
$: 7,500
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 49—(Adopt)—Proposed Policy: Patients With Special Needs (*Supplement*:4060)
$: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 64—(Adopt)—Amendment of the Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting (*Supplement*:4065) $: None
COMMITTEE RECOMMENDATION: Vote Yes

~~**Resolution 65RC**—(Adopt Resolution 65RC in lieu of Resolution 65)—Amendment of the Policy, Research Funds (*Supplement*:4066) $: None~~
~~**COMMITTEE RECOMMENDATION: Vote Yes**~~

Resolution 66—(Adopt)—Rescission of the Policy, Comparative Effectiveness Research and Patient-Centered Outcomes Research (*Supplement*:4069) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 80—(Adopt)—Electronic Archiving of State and Component Dental Publications (*Supplement*:4099) $: 5,000
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 81RC—(Adopt Resolution 81RC in lieu of Resolution 81 and Resolution 81S-1)—Response to Resolution 74-2020 - Elder Care Work Group—Elder Care Strategies for Continuing Education (*Supplement*:4101) $: 10,000
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 96RC—(Adopt Resolution 96RC in lieu of Resolution 96 and Resolution 96S-1)—The Practice of Dentistry and Cannabis (*Supplement*:4108) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 97—(Not Adopt)—Development of Best Practices for the Inclusion of Research with Negative Findings and Failed Replications Studies (*Supplement*:4107) $: None
COMMITTEE RECOMMENDATION: Vote No

Resolution 104RC—(Adopt Resolution 104RC in lieu of Resolution 104)—Financial Literacy Among New Dentists and Dental Students (*Supplement*:4110) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 108—(Adopt)—National Commission on Recognition of Dental Specialties and Certifying Boards Requirements for Recognition Review (*Supplement*:4111) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 113RC—(Adopt)—Report 1 of the Council on Scientific Affairs Report 1 to the House of Delegates: Response to Resolution 21H-2020—Feasibility of Assessing the Role of Dental Health in the Management of Diseases and Medical Conditions $: None
COMMITTEE RECOMMENDATION: Vote Yes

Note: For the purpose of a fully documented record, the text of the resolutions presented in Resolution 111H follows.

Consent Calendar Resolutions—Adopted/Adopted in Lieu of

Amendment of the Policy: Review of ADA Definition: Continuing Competency

32H-2021. Resolved, that the ADA definition of Continuing Competency (*Trans.*1999:939) be amended as follows (additions underscored; deletions ~~stricken~~):

Continuing Competency: The continuance of the ~~appropriate knowledge and skills~~ appropriateness, necessity and quality of the care provided by ~~the~~ dentists in order to maintain and improve the dental, oral, and craniofacial health ~~care~~ of ~~his or her~~ their patients in accordance with the ethical principles of dentistry.

Special Care Dentistry Association

46H-2021. Resolved, that the findings of the feasibility study conducted by the Council on Dental Education and Licensure be provided to the Special Care Dentistry Association for its consideration in pursuing an accreditation process and accreditation standards for advanced education programs in special needs dentistry by the Commission on Dental Accreditation, and be if further
Resolved, that the Special Care Dentistry Association be urged to collaborate with advanced dental education programs and their sponsoring institutions to enhance the current scope and depth of instruction related to special needs dentistry and to encourage the establishment of more training programs in special needs dentistry.

Continuing Education Market Research

47H-2021. Resolved, that market research be conducted to learn more about the continuing education interests of practicing dentists related to managing and treating patients with special needs, i.e., people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly.

Developing Continuing Education Activities

48H-2021. Resolved that a variety of continuing education activities related to special needs dentistry be developed by the appropriate ADA agency.

Proposed Policy: Patients with Special Needs

49H-2021. Resolved, that the following policy be adopted:

Patients with Special Needs

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

Amendment of the Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting

64H-2021. Resolved, that the Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting (*Trans.*1998:743; 2000:481; 2004:309; 2012:469; 2016:300) be amended as follows (additions underscored; deletions ~~stricken~~):

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

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

Rescission of the Policy, Comparative Effectiveness Research and Patient-Centered Outcomes Research

66H-2021. Resolved, that the policy titled Comparative Effectiveness Research and Patient-Centered Outcomes Research (*Trans.*2011:457; 2016:302) be rescinded.

Electronic Archiving of State and Component Dental Publications

80H-2021. Resolved, that the appropriate ADA agencies explore creating or facilitating a searchable digital archive for tripartite publications and report back to the 2022 House of Delegates.

Response to Resolution 74-2020—Elder Care Work Group—Elder Care Strategies for Continuing Education

81H-2021. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder care strategies on both the oral-systemic connection and the dental management of the medically complex older adult as priority projects, and be it further

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

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

on the need for a more active collaboration and consultation between dental and medical providers when managing medically complex older adults.

3. the development of continuing education~~al curricula~~ for the delivery of preventive and quality of life dental care for institutional, long-term care and home-bound individuals to allow for greater access in their respective environments.

The Practice of Dentistry and Cannabis

96H-2021. Resolved, that the ADA encourage the development of best practices for the management of patients and their caregivers, dentists, and dental team members who are under the influence of cannabis.

Financial Literacy Among New Dentists and Dental Students

104H-2021. Resolved, that the appropriate ADA agencies inventory all ADA course and program offerings related to debt management, practice management, financial advisor services, and financial literacy for new dentists and students and be it further,
Resolved, that a determination be made as to whether there are any gaps in the current offerings, along with estimated costs to close those gaps and be it further,
Resolved, that a determination be made on the feasibility and costs of developing an easily accessible electronic catalog, with a report on the findings to the 2022 House of Delegates.

National Commission on Recognition of Dental Specialties and Certifying Boards Requirements for Recognition Review

108H-2021. Resolved, that the Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists, currently used by the National Commission on Recognition of Dental Specialties and Certifying Boards, be reviewed by the ADA Council on Dental Education and Licensure in 2022, rather than 2023, and be it further
Resolved, that CDEL report its findings and any proposed revisions to the Requirements for Recognition to the National Commission and to the 2022 ADA House of Delegates.

Report 1 of the Council on Scientific Affairs Report 1 to the House of Delegates: Response to Resolution 21H-2020—Feasibility of Assessing the Role of Dental Health in the Management of Diseases and Medical Conditions

113H-2021. Resolved, that the ADA advocate for external funding of research for the identification and treatment of pre-existing or underlying oral health conditions that may impact post-medical/surgical outcomes, particularly for patients who are at greater risk of adverse medical outcomes.

Consent Calendar Resolution—Not Adopted

Development of Best Practices for the Inclusion of Research with Negative Findings and Failed Replications Studies

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

Non-Consent Resolutions

Amendment of Chapter IX, Section A of the Governance and Organizational Manual of the American Dental Association (Commission for Continuing Education Provider Recognition Resolution 31): The Reference Committee reported as follows:

The Reference Committee heard limited testimony related to Resolution 31. The majority testified in support of the resolution noting that appointment of a member of the American Association of Dental Boards (AADB), which recently launched a new program for accrediting continuing dental education activities, i.e., the Accrediting Continuing Education (ACE), to the Commission for Continuing Education Provider Recognition (CCEPR) creates a potential conflict of interest as the ACE program is a competing business interest. The testimony supported the intended amendment of CCEPR's *Rules* and *Policies and Procedures* to ensure representation of the regulatory community by appointing a member of a state dental board or jurisdictional dental agency. Supporting testimony also noted that the Academy of General Dentistry which sponsors a national program recognizing continuing dental education, i.e., AGD Pace, does not appoint a representative to the Commission. The Committee agrees with the Board of Trustees and the Council on Dental Education and Licensure and recommends adoption of Resolution 31.

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

Commission for Continuing Education Provider Recognition. The number of and the method of selection of members of the Commission for Continuing Education Provider Recognition shall be governed by the Rules of the Commission for Continuing Education Provider Recognition, except that ~~six~~ five (~~6~~5) members shall be selected as follows:

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

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

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

Dr. Smiley moved Resolution 31 (*Supplement:*4001) with the Committee Recommendation to Vote Yes.

Dr. Eva F. Ackley, Florida, moved to amend Resolution 31 by adding item c., which reads as follows:

c. One (1) member who is an active member of the American Association of Dental Boards and also, if eligible, an active, life or retired member of this Association shall be selected by the Commission, and who is not directly involved with ACE.

In speaking to the proposed amendment, Dr. Ackley stated, "As is stated in the background of this resolution, to help ensure that the Commission continues to receive input from individuals with insight and experience in the regulatory community, the Commission shall appoint a member who is a member of a state board or a dental jurisdiction. Now, that board member could be practicing in a state and be on a board and not know any information of any other state in the country, whereas a member of the American Association of Dental Boards is a current or past board member who takes the time, the interest to share information with other state board members. Do you want insight from one state or all states? When I inquired, it's okay for an AADB member to apply for this position as long as the Commission is the entity that choses that person. Are we an inclusive organization or are we trying to go it alone? Is there a reason to include an active member of the American Dental Education Association and exclude an active member of AADB? Are we choosing who we are going to collaborate with and who we aren't? Communication between all dental organizations will make us a strong profession. Let's not start to alienate certain groups from our discussions. Let's be smart. Let's be inclusive."

At the request of the Speaker, Dr. Kathleen O'Loughlin, executive director, provided information regarding Resolution 31, stating, "Regarding the conflict of interest issue, governing bodies have within their governance rights the right to determine what is a conflict of interest in terms of their mission, their goals, their purpose. The Commission [has had] this discussion and [put] in writing their resolution and their wish. [They] determined that membership in AADB, regardless of whether you're an officer or just a member, would be such a conflict of interest given their launching a competing product into the marketplace. So they were within their governing rights to make this determination. We can give you a legal opinion. Mr. Fowkes would be happy to weigh in here, but I think that is something the House should consider is the governing body itself makes the determination of what conflict of interest can be tolerated and at what level that conflict rises to an irreconcilable conflict. And the Commission, itself, already discussed that and made that determination."

Discussion in opposition to the proposed amendment ensued. Individuals speaking against the proposed amendment commented that the amendment changes the purpose of Resolution 31, which is to eliminate the conflict of interest that arose from the launch of the new AADB Accrediting Continuing Education (ACE) program.

As a point of information, Dr. Daniel J. Gesek, Jr., Florida, asked, "Could we get an opinion on the difference of who is certifying exactly what? So what does CCERP certify versus what does this ACE program certify and compare them, please?"

At the request of the Speaker, Dr. Anthony J. Ziebert, senior vice president, Education and Profession Affairs, respond to Dr. Gesek's question stating, "They are both certifying CE providers, recognizing CE providers."

On vote, the proposed amendment was not adopted.

On vote, Resolution 31 was adopted.

31H-2021. Resolved, that Chapter IX. Section A.3 of the *Governance and Organizational Manual of the American Dental Association* be amended as shown below (additions underscored; deletions ~~stricken~~):

Commission for Continuing Education Provider Recognition. The number of and the method of selection of members of the Commission for Continuing Education Provider Recognition shall be governed by the Rules of the Commission for Continuing Education Provider Recognition, except that ~~six~~ five (~~6~~5) members shall be selected as follows:

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

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

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

Amendment of the Policy, Research Funds (Council on Scientific Affairs Resolution 65 and Reference Committee C Resolution 65RC): The Reference Committee reported as follows:

The Reference Committee heard only positive testimony on Resolution 65. One speaker asked that the phrase research funding be changed to "training grants." However, the Reference Committee felt this term was more restrictive and believes the proposed amendment best captures the intent of the resolution.

The Reference Committee agrees with CSA Resolution 65, that the current Policy on Research Funds be amended to focus more directly on research funding advocacy. This includes the second resolving clause, which was added to reflect the need for—and importance of—ADA advocacy to support the diversification of the research workforce in the oral health sciences. The Reference Committee appreciates the importance of the ADA's and CSA's long term relationships with oral health research organizations. Recent HOD and profession-wide interest in the treatment of diverse populations, including eldercare, special needs dentistry, and the oral-systemic connection suggest an urgent need for sustained, robust funding support from appropriate external agencies and organizations in oral health research across a patient's lifespan.

The revised policy reflects the role of funding, as well as the experiences and perspectives of those being funded. The Reference Committee believes that the proposed revisions to this policy statement are timely, appropriate, and present a clear public stance for the ADA on diversity and equity in the research landscape and workforce (additions double underscored; deletions double ~~stricken~~).

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

Policy Statement on Research ~~Funds~~Fundings Advocacy

Resolved, that the ADA ~~urges appropriate external agencies and organizations to provide~~ advocate for sustained, robust funding ~~for~~ in basic, translational, ~~and~~ clinical, dental, oral and craniofacial health research for the improvement of health outcomes in diverse populations across their lifespan ~~advances the scientific basis of dentistry and the oral and craniofacial health sciences~~, and be it further

Resolved, that the ADA advocate for external funding to enhance gender, racial and ethnic diversity and equity across the research workforce in the oral and craniofacial health sciences.

Dr. Smiley moved Resolution 65RC in lieu of Resolution 65 (*Supplement:*4066) with the Committee Recommendation to Vote Yes.

Dr. Prabu Raman, Missouri, moved to divide the question to vote separately on the first resolving clause of Resolution 65RC and the second resolving clause of Resolution 65RC, and requested that all votes regarding Resolution 65RC be done via the voting machines.

In speaking to the proposed motion, Dr. Raman stated, "A foundational principle of democracy is secret ballots. I want to be certain that no delegate feels pressure to do it one way or the other in the matter. If it's the will of the House to support both resolves, then so be it. I speak in support of the first resolve and oppose the second resolve."

To clarify the intention of the proposed motion, the Speaker stated, "Your request has been to divide the question and vote on the first resolved clause first and the second resolved clause next. I granted that request. The second request is for this to be placed on the machine. I also grant that request." The Speaker asked if any delegate wished to appeal his decision; the decision of the Chair was not appealed.

The Speaker announced that the first resolving clause would be numbered Resolution 65RCa and the second resolving clause would be numbered Resolution 65RCb.

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

Policy Statement on Research ~~Funds~~Fundings Advocacy

Resolved, that the ADA ~~urges appropriate external agencies and organizations to provide~~ advocate for sustained, robust funding ~~for~~ in basic, translational, ~~and~~ clinical, dental, oral and craniofacial health research for the improvement of health outcomes in diverse populations across their lifespan

~~advances the scientific basis of dentistry and the oral and craniofacial health sciences, and be it further~~

Dr. Raman spoke in support of Resolution 65RCa. He said, “I enthusiastically support diversity and inclusion. … I support that as ADA policy for leadership positions in the Association. I celebrated when Dr. Gehani was elected as president-elect and Dr. Sabates was elected as president-elect and then Dr. Cohlmia is selected to be the new executive director. In my own personal life, my wife is from Korea. We have three wonderful daughters. My first son-in-law was born in Iran. Second son-in-law’s parents came from Punjabi, from India. And my third daughter is engaged to marry a Caucasian with Louisiana roots. All we care was they are good men and good husbands to our daughters.”

On Vote, Resolution 65RCa was adopted in lieu of Resolution 65.

65aH-2021. Resolved, that the ADA Policy Statement on Research Funds (*Trans.*1984:519; 1999:974; 2016:302) be amended as follows (additions underscored; deletions ~~stricken~~):

Policy Statement on Research ~~Funds~~Funding~~s~~ Advocacy

> **Resolved**, that the ADA ~~urges appropriate external agencies and organizations to provide~~ advocate for sustained, robust funding ~~for~~ in basic, translational, ~~and~~ clinical, dental, oral and craniofacial health research for the improvement of health outcomes in diverse populations across their lifespan ~~advances the scientific basis of dentistry and the oral and craniofacial health sciences, and be it further~~

The Speaker announced that Resolution 65RCb would be discussed next.

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

Policy Statement on Research ~~Funds~~Funding~~s~~ Advocacy

> **Resolved**, that the ADA advocate for sustained, robust funding in basic, translational, clinical, dental, oral and craniofacial health research for the improvement of health outcomes in diverse populations across their lifespan.
> **Resolved,** that the ADA advocate for external funding to enhance gender, racial and ethnic diversity and equity across the research workforce in the oral and craniofacial health sciences.

Dr. Praba Raman, Missouri, spoke against Resolution 65RCb, stating, “...The second resolve requires the ADA to advocate for such funding to enhance gender, racial and ethnic diversity and equity across the research workforce. When it comes to scientists engaged in basic, translational, clinical, dental, oral and craniofacial health research, what is really important? The health outcomes in diverse populations, right? The first resolve already addresses that. Do we not fund the best scientists, the best researchers to be doing this work? Don’t we want those researchers that are selected to know that they were picked because they are the best at their work, not because of their melanin content? To paraphrase Dr. Martin Luther King, the scientists and researchers that are funded to be judged by content of their minds and their scientific work rather than the color of their skin. So the second resolved should not become ADA policy to advocate for scientist researchers to be fit based on external, immutable characteristics they did not choose.”

Dr. Jessica A. Meeske, Nebraska, chair of the Council on Advocacy for Access and Prevention, spoke in support of Resolution 65RCb, stating, “It is in line with what the CAAP is proposing in terms of oral health equity and is also in line with what we have been spending much of our time talking about with enhancing diversity and inclusion. I would also like to remind the House, it does not say in this resolving clause that we’re giving any priority to a person of diverse background. It says that we are advocating only for external funding.”

Dr. Ana K. Bedran-Russo, chair of the Council on Scientific Affairs, spoke in support on Resolution 65RCb. She said, “…I’m a member of the AADR and I’m an NIH fund researcher for the past 17 years. I also

serve as a standing member of numerous NIH study sections that review scientific merit of grant applications. … Diversity is a core value of the ADA. ADA and CSA have long-term relationships with oral health research organizations. Funding for research of and training of the workforce remains inequitable. A significant portion of federal funding continues to be awarded to white male researchers over the age of 55, even though this sector is no longer the majority of full-time dental researchers in academia. The resolution also aligns with the NIH and NIDCR efforts to create opportunities for researchers of diverse background. The united initiative from NIH aims to identify and address the structural races within the NIH supported programs and the greater scientific community. The policy will reflect the role of both the level and nature of funding, as well as the experiences and perspectives of those being funded. The Council believes that the proposed revisions to this policy statement are timely, appropriate and presents a clear public position to the ADA diversity and equity in the research landscape and workforce. And, finally, as stated by Dr. Meeske, the resolution is aligned with the health equity resolution, Resolution 55, approved by this House."

Dr. Stephen W. Robertson, Kentucky, spoke against Resolution 65RCb, stating, "We had an intense discussion about this in our district meeting, and there were several things and actually…the biggest debate was how do you even interpret the second resolve clause? And the fact that we couldn't come to an agreed resolution in our room made us a little leery of this becoming printed ADA policy. Another thing about that is that we already have a policy that we promote and seek out diversity, so this is sort of a redundant statement. And we're stepping a little out of our lane here adding this resolve clause, because this is not about diversity within the ADA. This is about us reaching out and telling people outside of the ADA how they need to do their business. And the word 'advocate' was something we talked about a lot, because that means that you're actively going to go out and do this. Who from the ADA are we actively going to send out to advocate for this and outside research organizations? So there were a lot of things with this resolve clause that we had issues with, and we really felt all this is covered already in ADA policy, and that this did not support the first resolve clause, so we asked to split and defeat this."

Dr. Steven G. Feldman, Maryland, spoke against Resolution 65RCb, stating, "I'm a member of the New Dentist Committee, but I speak as an individual. Reading this section of the resolution, it seems like it can be interpreted in many different ways. But the pro testimony that we've heard kind of makes it clear exactly what it's getting at. I want to categorically state that treating anyone differently based on the color of their skin is the definition of racism. This is wrong, and I oppose it."

Dr. Lawrence A. White, Illinois, commented on Resolution 65RCb, stating, "…I think that this resolution is well intentioned, but it's incredibly vague, and I think that it should be pulled or tabled. I would hate to see this body vote against the spirit of what we're trying to do. And I should say not me personally. I was not a part of this resolution. But I think it's certainly the policy of the ADA to be very—to encourage diversity and inclusion, and I think this is an awkward stumble in that effort. I would hope that this could be resolved at a future House, but I don't think that this is the best effort, the best presentation of this—of the thinking behind this policy."

Dr. Fredrick P. Babinowich, New Jersey, spoke against Resolution 65RCb, stating, "In reading this, I have one problem, and that's the word 'equity.' I think many in this room are confusing 'equity' with 'equality.' I would, therefore, like the word 'equity' to be stricken and instead 'more equality,' because that, I think, is what we're trying to say here. 'Equity' is a term which has now become very popular, but it does not relate to this resolution. …

Dr. Robert J. Wilson, Jr., Maryland, chair of the Council on Ethics, Bylaws and Judicial Affairs, moved to refer Resolution 65RCb to the appropriate agency for further consideration and report back to the 2022 House of Delegates.

Dr. Robert M. Peskin, New York, moved to suspend the Rules of the House of Delegates to allow for Resolution 65RCb to be tabled.

The Speaker announced that the motion to suspend the Rules requires a two-thirds affirmative vote and takes precedence over the motion to refer Resolution 65RCb. The Speaker clarified that if the House adopted the motion to suspend the Rules, a motion could then be made to table Resolution 65RCb. In response to a

question, the Speaker clarified that if a motion to table Resolution 65RCb were adopted, the Resolution would be removed entirely from consideration.

On Vote, the motion to suspend the Rules of the House of Delegates to allow for Resolution 65RCb to be tabled was not adopted.

A motion was made to vote immediately on the motion to refer; on vote, the motion to vote immediately was adopted by a two-thirds affirmative vote. On vote, the motion to refer Resolution 65RCb to the appropriate agency for further consideration and report back to the 2022 House of Delegates was adopted.

Study Dental School Demographics: All Dental Schools Are Not Created Equal (Fourteenth Trustee District Resolution 92): The Reference Committee reported as follows:

The Reference Committee heard considerable testimony on this resolution. Some believed that the Association has a responsibility to assist pre-dental students making an informed decision concerning their future dental education along with an understanding of the return on the investment of a dental education over their lifetime. However, the Reference Committee also heard that robust career guidance and financial and debt planning tools are available both on the ADA and ADEA websites. HPI publishes annually the Survey of Dental Education Series, reporting on general program information, tuition, admissions, attrition, student and graduate data, curriculum, and financial management of all accredited dental schools in the U.S., and posts dental statistics briefs.

Others testified in opposition, noting the ADA has spent more than $750,000 and a dozen resolutions addressing the topic, calling for actions, including the formation of several Task Forces which have resulted in new programs and ongoing initiatives such as: student loan consolidation at a lower interest rate via Laurel Road; successful advocacy efforts to reduce interest rates for federal student loans; continued efforts in advocating for federal and state student loan forgiveness programs; increased monitoring of student debt matters by HPI; adoption of strengthened CODA accreditation standards related to not only student loan financing of dental education, but also related to personal finances, career information and guidance as to practice, post-graduate and research opportunities.

The Reference Committee learned that there is potential conflict of interest associated with developing quality metrics/standards that may be in conflict with the accreditation standards and decisions promulgated by the Commission on Dental Accreditation, the United States Department of Education (USDE) recognized and profession-wide accepted authority on the quality of dental education programs.

After careful consideration, the Reference Committee does not support Resolution 92. Any ranking has the potential to disenfranchise students who choose to attend a school that may be ranked lower than another. This presents a long-term reputational risk to the Association, as well as its current and future members.

For these reasons, the Reference Committee opposes adoption of Resolution 92.

92. Resolved, the ADA form a task force that establishes metrics to compare the dental school educational experience and financial implications across CODA accredited dental schools to assist prospective dental students in making choices to include but not limited to the following:

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

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

Dr. Smiley moved Resolution 92 (*Supplement:*4105) with the Committee Recommendation to Vote No.

Dr. Bryan T. Marshall, Colorado, move to refer Resolution 92 to the appropriate agency

In speaking to the motion to refer, Dr. Marshall stated, “I think everyone knows here that there’s been several new dental schools that have come up around the country, and it really is important for our future colleagues to have some objective information on those schools, because it’s a big financial impact for them. In order to do that, we need to carefully structure the information to give to them. We also need to have accurate information on how much this is going to cost to do. And I think that in order to do this, one of the ADA agencies has to do it. And within a year, that should be good enough to give us the information so we can make a good decision. These are our future colleagues. It’s important that they know what they’re getting into.”

Pro and con discussion on the motion to refer ensued. Individuals speaking against the motion to refer commented that they did not support Resolution 92, or that they did support Resolution 92 and preferred that it be voted on by this House. Individuals speaking in support of the motion to refer commented that Resolution 92 could provide an important member benefit and the Resolution could be improved upon if referred to the appropriate agency.

A motion was made to vote immediately on the motion to refer. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, the motion to refer was not adopted.

Dr. Paul S. Albicocco, New York, spoke against Resolution 92, stating, “This has been debated in reference committee and on the House floor today with many concerning the idea of comparison, which is actually a ranking. Ranking of dental schools, as indicated in the background statement alone, optics involving ranking is a major concern due to dental schools process of CODA credentials already established and not being clear on the metrics of the process used in the ranking process. I am concerned also about the $190,000 impact and potential future costs and how they came to that amount. The monies would go towards task force and consultants, but the question that I have is how much goes to each. And it’s not clearly defined. We also feel that more information is needed to have discussion with regards to the ADA comparison of dental schools. … Rankings of dental schools similar to other professional schools was, I believe, the basis of this resolution’s origin, however, the feeling is that this resolution divides ADA accredited schools and puts our profession in poor light. The support of the background statement alone is enough towards failure of this resolution where it state, the hiring of graduates is based on the level of competency. Wow. When graduating and applying for position into the private dental practice, I thought we were graduating competent dentists into our community. … Measuring the top student at a school that is ranked number one at the bottom of their class versus a student attending a school ranked number 50 at the top of their class cannot be compared equally. Let’s face it. My patients never ask me what dental school I went to nor the rankings. All they care about is that I show compassion.”

Dr. Steven A. Saxe, Nevada, spoke in support of Resolution 92. He said, “Let’s talk about ranking. Right now currently a dental student cannot be ranked fairly. Currently the entire National Dental Board exam scores, part one and part two are pass/fail. There is no way to rank the quality of performance in specific areas of dentistry. And, secondly, of those dental students, they also can’t be ranked on their academic achievements at their particular schools because most of the dental schools have gone to pass/fail. So we can’t be ranked if we wish to go to postdoctoral education. So all those dental students need to go outside the system. They need to learn how to be a second year medical student, for example, to obtain consideration for oral and maxillofacial surgery programs, and several of the other postdoctoral educational models also require them to go outside the system, study outside of their curriculum that’s CODA approved in order to be ranked. So let’s talk ranking. We’ve dropped the ball on ranking. …all we have been talking about is the fact that we have to have a fifth year in our curriculums and potentially students who graduate as a doctor in some states now have to have an extra year of GPR just to apply for licensure because there might be some

problem. What's the motivation behind dental schools opening in every community? The fact that we have a population that needs to be addressed and serviced, such as the economically underserved or the geographically restricted, that's a good reason for us to have dental schools, and that's a great reason for us to have dentists in those particular areas. It's not for for-profit dental schools to be opening in our backyard turning out dentists in three years where we question whether or not, as this body, whether or not three years is even enough to be a qualified doctor. … So there's a lot of question here about the quality of education. There's a lot of question about the motivation of the educational system now being put before us… Where are we going with our education? What does it mean to be a doctor anymore? I stand in support of this resolution, because there's a lot of unanswered questions. And CDEL…may not want to see this, but they need to respond. It is our—why do we have CDEL? What is the point? How do we communicate with CODA? Is it just off…limits to us? Please think about this closely. This is the future of our profession."

Mr. Scott Fowkes, general counsel, stated, "I would just like to advise the participants in this debate to keep the discussion general, not with respect to particular schools or particular types of schools, because that borders on competition issues and antitrust concerns."

Mr. Colton Cannon, president, American Student Dental Association, spoke against Resolution 92, stating, "The American Student Dental Association concurs with the Reference Committee that this resolution and any resultant ranking system may potentially disenfranchise students and damage the reputation of the ADA and ASDA. We stand in opposition to this resolution"

A motion was made to vote immediately on Resolution 92. On vote, the motion to vote immediately was adopted by a two-thirds affirmative vote.

As a point of inquiry, Dr. Stephen W. Robertson, Kentucky, asked, "Our general counsel just came and told us to watch the discussion because of competition issues with the FTC. If we can't talk about it in the room, how can we do this? Can I have a clarification on that?"

The Speaker responded stating, "Our legal counsel advised if you want to have discussions on it, it could go into closed session, so somebody would have to make a motion to go in closed session. We would have to clear the House floor of only voting delegates at that time. But you voted to vote immediately. So, we're voting immediately on Resolution 92."

On vote, Resolution 92 was not adopted.

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

The Report of Reference Committee D was presented by Dr. Frank P. Iuorno, Jr., Virginia, chair. The other members of the Committee were: Dr. Robert J. Hanlon, Jr., California; Dr. Cyrus B. Javadi, Oregon; Dr. Michael W. Johnson, Public Health Service; Dr. Zacharias J. Kalarickal, Florida; Dr. Amber P. Lawson, Georgia; Dr. Sharon J. Perlman, Illinois; Dr. Michael C. Smuin, Utah; and Dr. Douglas A. Wyckoff, Missouri.

Consent Calendar (Reference Committee D Resolution 112) The Reference Committee reported as follows:

> The appended Resolution 112 lists resolutions referred and considered by this Reference Committee that received no or limited testimony, all positive testimony, all negative testimony, or the Reference Committee feels these resolutions were fully debated, with all issues considered. The Reference Committee's recommended action (adopt, adopt in lieu of, not adopt or refer) is identified on each resolution presented on the consent calendar. By adopting Resolution 112, the recommendations of the Reference Committee on the consent calendar resolutions will become the actions of the House of Delegates. It should be noted that if a resolution on the consent calendar is to "adopt in lieu of" with a Committee Recommendation to Vote No and the resolution remains on the approved consent calendar, the resolution is defeated and the underlying resolutions are automatically moot.
>
> As customary, before voting on the consent calendar, any delegate wishing to discuss an item on the consent calendar has the right to request that resolution be extracted and considered separately.

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

Resolution 1—(Adopt)—Proposed Policy, Rank and Status of Dentists in the Uniformed Services (*Supplement*:5000) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 2—(Adopt)—Amendment of the Policy, Dental Research by Military Departments (*Supplement*:5004) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 3—(Adopt)—Proposed Policy, Anesthesia Coverage Under Health Plans (*Supplement*:5007) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 4—(Adopt)—Proposed Policy, Provisions for ERISA Plans (*Supplement*:5011) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 5—(Adopt)—Rescission of the Policy, Advocating for ERISA Reform (*Supplement*:5015) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 6—(Adopt)—Amendment of the Policy, Use of Expert Witnesses in Liability Cases (*Supplement*:5018) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 7S-1—(Adopt Resolution 7S-1 in lieu of Resolution 7)—Amendment to the Policy, Professional Liability Insurance Legislation (*Supplement*:5024a) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 8—(Adopt)—Rescission of the Policy, Costs for the Submission of Electronic Dental Claims (*Supplement*:5025) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 9—(Adopt)—Amendment of the Policy, Fee-For-Service Medicaid Programs (*Supplement*:5029) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 10—(Adopt)—Amendment of the Policy, Medicaid and Indigent Care Funding (*Supplement*:5032) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 11—(Adopt)—Amendment of the Policy, Use of Dentist-To-Population Ratios (*Supplement*:5035) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 12—(Adopt)—Rescission of the Policy, Maldistribution of the Dental Workforce (*Supplement*:5039) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 13—(Refer)—Rescission of the Policy, Availability of Dentists for Underserved Populations (*Supplement*:5042) $: None
COMMITTEE RECOMMENDATION: Vote Yes on Referral

Resolution 14S-1—(Adopt Resolution 14S-1 in lieu of Resolution 14)—Amendment to Resolution 14: Proposed Policy, Guaranteeing Patient's Freedom of Choice of Dentist (*Supplement*:5049a) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 15—(Adopt)—Proposed Policy, Discrimination of Benefit Payment Based on Professional Degree of Provider (*Supplement*:5051) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 16—(Adopt)—Amendment of the Policy, Freedom of Choice in Publicly Funded Aid Programs (*Supplement*:5054) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 17—(Adopt)—Amendment of the Policy, Limited English Proficiency (*Supplement*:5056) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 18—(Adopt)—Amendment of the Policy, Protection of Retirement Assets (*Supplement*:5059) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 19—(Adopt)—Amendment of the Policy, Suggested Dental Practice Acts (*Supplement*:5062) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 20—(Adopt)—Rescission of the Policy, State Regulation of Advertising (*Supplement*:5065) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 21—(Adopt)—Rescission of the Policy, ADA Assistance in Legislative Initiatives (*Supplement*:5070) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 22—(Adopt)—Rescission of the Policy, Dental Focus in Federal Health Agencies (*Supplement*:5073) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 23—(Adopt)—Amendment of the Policy, Confidentiality and Privacy Regarding Health Information (*Supplement*:5078) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 24—(Adopt)—Amendment of the Policy, Need for HIPAA Standards Reform (*Supplement*:5081) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 25—(Adopt)—Rescission of the Policy, Legislation Prohibiting Waiver of Patient Copayment/OverBilling (*Supplement*:5083) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 26—(Adopt)—Rescission of the Policy, Legislation Reflecting ADA Policy on Primary Dental Health Care Provider (*Supplement*:5085) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 27—(Adopt)—Amendment to the Policy, Support for Adult Medicaid Dental Services (*Supplement*:5087) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 28—(Adopt)—Rescission of the Policy, Legislative Separation of Medicine and Dentistry (*Supplement*:5090) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 29—(Adopt)—Rescission of the Policy, Adding the ADA Definition of Dentistry to Existing Dental Regulatory Provisions (*Supplement*:5170) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 30RC—(Adopt Resolution 30RC in lieu of Resolution 30)—Amendment of the Policy, Antitrust Reform (*Supplement*:5094) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 33—(Adopt)—Amendment of the Policy, Legislative Delegations (*Supplement*:5099) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 34—(Adopt)—Amendment and Simplification of *Bylaws* Chapter I., Section 20.B. (*Supplement*:5102) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 35—(Adopt)—Response to Referred Resolution 64-2020, Amendment of Chapter III., Section 120. of the ADA *Bylaws* (*Supplement*:5106) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 36—(Adopt)—Proposed Policy, Support for the American Academy of Pediatric Dentistry Policy on Early Childhood Caries (*Supplement*:5108) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 37—(Adopt)—Rescission of the Policy, Preventive Dental Procedures (*Supplement*:5113) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 38—(Adopt)—Amendment of the Policy, Health Planning Guidelines (*Supplement*:5116) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 39—(Adopt)—Rescission of the Policy, High Blood Pressure Programs (*Supplement*:5119) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 40S-1—(Adopt Resolution 40S-1 in lieu of Resolution 40)—Amendment of the Policy, Communication and Dental Practice (*Supplement*:5123a) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 41—(Adopt)—Amendment of the Policy, Encouraging the Development of Oral Health Literacy Continuing Education Programs (*Supplement*:5124) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 45—(Adopt)—Amendment to Section 3.A. of the ADA *Principles of Ethics and Code of Professional Conduct* (*Supplement*:5127) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 50—(Adopt)—Amendment of the Policy, Use of Health Literacy Principles for All Patients (*Supplement*:5130) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 52—(Adopt)—Amendment of the Policy, Bottled Water, Home Water Treatment Systems and Fluoride Exposure (*Supplement*:5131) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 53—(Adopt)—The New Dentist Committee Chair Serving on the Board of Trustees (*Supplement*:5134) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 57—(Adopt)—Proposed Policy, American Academy of Pediatric Dentistry Statement on Perinatal and Infant Oral Health Care (2021) (*Supplement*:5136) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 58—(Adopt)—Proposed Policy, Oral Health Equity (*Supplement*:5145)
$: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 59—(Adopt)—Amendment of the Policy, Women's Oral Health: Patient Education (*Supplement*:5146) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 60S-1—(Adopt Resolution 60S-1 in lieu of Resolution 60)—Amendment of the Policy, Non-Dental Providers Completing Educational Program on Oral Health (*Supplement*:5150a) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 61S-1—(Adopt Resolution 61S-1 in lieu of Resolution 61)—Amendment of the Policy, Non Dental Providers Notification of Preventive Dental Treatment (*Supplement*:5153a) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 62RC—(Adopt Resolution 62RC in lieu of Resolution 62)—Amendment of the Policy, Limited Oral Health Literacy Skills and Understanding in Adults (*Supplement*:5154) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 67S-1—(Adopt Resolution 67S-1 in lieu of Resolution 67)—Amendment of the Policy, Comprehensive Statement on Allied Dental Personnel (*Supplement*:5158a) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 68—(Adopt)—Amendment to the Policy, Oral Health Education in Schools (*Supplement*:5159) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 73—(Adopt)—Clarifying Amendments to the *Manual of the House of Delegates* Relating to Delegate Allocation (*Supplement*:5165) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 82—(Adopt)—Proposed Policy: A Culture of Safety in Dentistry – Voluntary Reporting (*Supplement*:5178) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 83RC—(Adopt Resolution 83RC in lieu of Resolution 83)—Establishment of a Medicaid Task Force (*Supplement*:5183) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 91—(Not Adopt)—Mid-Level Provider Impact Study (*Supplement*:5195)
$: None
COMMITTEE RECOMMENDATION: Vote No

Resolution 94—(Adopt)—State Representation and Alternate Delegates (*Supplement*:5197)
$23,000; Amount On-going; Net Dues Impact: $0.23
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 95RC—(Adopt Resolution 95RC in lieu of Resolution 95)—Prioritizing the Mental Health of Dentists (*Supplement*:5198) $50,000; Net Dues Impact: $0.50
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 106RC—(Adopt Resolution 106RC in lieu of Resolution 106)—Fair Delegate Allocation for Federal Dental Services (*Supplement*:5229) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Dr. Iuorno moved Resolution 112 with the Committee Recommendation to Vote Yes.

At the request of the Speaker, Dr. Kathleen O'Loughlin, executive director, provided clarification on Resolution 53 stating, "…What is being asked of the House is essentially to vote to approve that person's right to vote on the Board of Trustees. Currently, the Chair of the New Dentist Committee has been participating fully in all of the Board meetings this year, and there has been no financial implication or impact. That is why there is no financial impact listed in the resolution material. The reason why it could have a potential future impact is that it would be up to the ADA Board of Trustees to assign this assessment of this position to the Compensation Committee, which has the responsibility of taking a look at stipends, remunerations and, you know, any kind of expense protocols afforded to the Board of Trustees. But because this is a position that was not historically funded, despite the fact that he was fully participating, it was not included in the resolution. … But that is not to say in the future the Board of Trustees, within their rights, and within a charter of the Compensation Committee could consider some type of remuneration depending on the desires of the New Dentist Committee and the full Board of Trustees."

Requests were made to remove the following resolutions from the Consent Calendar:

Resolution 94 removed by Dr. Lauryne M. Vanderhoof, Michigan
Resolution 14S-1 removed by Dr. Neil C. Nunokawa, Hawaii
Resolution 4 removed by Dr. David J. Hildebrandt, Louisiana
Resolution 3 removed by Dr. Zachary A. Kouri, Iowa
Resolution 28 removed by Dr. Amber P. Lawson, Georgia

Dr. Daniel J. Gesek, Jr., Florida, moved to withdraw Resolution 13: Rescission of the Policy, Availability of Dentists for Underserved Populations.

On vote, the motion to withdraw Resolution 13 was adopted

As a point of order, Dr. Monica M. Hebl, Wisconsin, stated that she was at the microphone to speak against withdrawing Resolution 13 prior to the vote on withdrawal. Hearing no objection, the Speaker allowed the motion to withdraw Resolution 13 to be debated followed by a re-vote on the motion to withdraw Resolution 13.

Dr. Hebl spoke against the motion to withdraw Resolution 13, stating, "Again, I realize that vote was very lopsided, so I'm fighting an uphill battle, but I think that working on the supply side so that we can solve access to care issues is really important. It might not go back to CGA, but it could go to a different, appropriate council, and I think that should not be withdrawn, because it's such an important thing, and it was not part of the…oral health equity resolution. And there is nowhere in the policy manuals that we are working on the supply side to make sure that our underserved patients are taken care of."

On vote, the motion to withdraw Resolution 13 was adopted.

Hearing no objection, the amended Resolution 112 was adopted by general consent.

112H-2021. Resolved, that the recommendations of Reference Committee D on the following resolutions be accepted by the House of Delegates.

Resolution 1—(Adopt)—Proposed Policy, Rank and Status of Dentists in the Uniformed Services (*Supplement*:5000) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 2—(Adopt)—Amendment of the Policy, Dental Research by Military Departments (*Supplement*:5004) $: None
COMMITTEE RECOMMENDATION: Vote Yes

~~**Resolution 3**—(Adopt)—Proposed Policy, Anesthesia Coverage Under Health Plans (*Supplement*:5007) $: None~~
~~**COMMITTEE RECOMMENDATION: Vote Yes**~~

~~**Resolution 4**—(Adopt)—Proposed Policy, Provisions for ERISA Plans (*Supplement*:5011) $: None~~
~~**COMMITTEE RECOMMENDATION: Vote Yes**~~

Resolution 5—(Adopt)—Rescission of the Policy, Advocating for ERISA Reform (*Supplement*:5015) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 6—(Adopt)—Amendment of the Policy, Use of Expert Witnesses in Liability Cases (*Supplement*:5018) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 7S-1—(Adopt Resolution 7S-1 in lieu of Resolution 7)—Amendment to the Policy, Professional Liability Insurance Legislation (*Supplement*:5024a) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 8—(Adopt)—Rescission of the Policy, Costs for the Submission of Electronic Dental Claims (*Supplement*:5025) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 9—(Adopt)—Amendment of the Policy, Fee-For-Service Medicaid Programs (*Supplement*:5029) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 10—(Adopt)—Amendment of the Policy, Medicaid and Indigent Care Funding (*Supplement*:5032) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 11—(Adopt)—Amendment of the Policy, Use of Dentist-To-Population Ratios (*Supplement*:5035) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 12—(Adopt)—Rescission of the Policy, Maldistribution of the Dental Workforce (*Supplement*:5039) $: None
COMMITTEE RECOMMENDATION: Vote Yes

~~**Resolution 13**—(Refer)—Rescission of the Policy, Availability of Dentists for Underserved Populations (*Supplement*:5042) $: None~~
~~**COMMITTEE RECOMMENDATION: Vote Yes on Referral**~~

~~**Resolution 14S-1**—(Adopt Resolution 14S-1 in lieu of Resolution 14)—Amendment to Resolution 14: Proposed Policy, Guaranteeing Patient's Freedom of Choice of Dentist (*Supplement*:5049a) $: None~~
~~**COMMITTEE RECOMMENDATION: Vote Yes**~~

Resolution 15—(Adopt)—Proposed Policy, Discrimination of Benefit Payment Based on Professional Degree of Provider (*Supplement*:5051) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 16—(Adopt)—Amendment of the Policy, Freedom of Choice in Publicly Funded Aid Programs (*Supplement*:5054) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 17—(Adopt)—Amendment of the Policy, Limited English Proficiency (*Supplement*:5056) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 18—(Adopt)—Amendment of the Policy, Protection of Retirement Assets (*Supplement*:5059) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 19—(Adopt)—Amendment of the Policy, Suggested Dental Practice Acts (*Supplement*:5062) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 20—(Adopt)—Rescission of the Policy, State Regulation of Advertising (*Supplement*:5065) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 21—(Adopt)—Rescission of the Policy, ADA Assistance in Legislative Initiatives (*Supplement*:5070) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 22—(Adopt)—Rescission of the Policy, Dental Focus in Federal Health Agencies (*Supplement*:5073) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 23—(Adopt)—Amendment of the Policy, Confidentiality and Privacy Regarding Health Information (*Supplement*:5078) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 24—(Adopt)—Amendment of the Policy, Need for HIPAA Standards Reform (*Supplement*:5081) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 25—(Adopt)—Rescission of the Policy, Legislation Prohibiting Waiver of Patient Copayment/OverBilling (*Supplement*:5083) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 26—(Adopt)—Rescission of the Policy, Legislation Reflecting ADA Policy on Primary Dental Health Care Provider (*Supplement*:5085) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 27—(Adopt)—Amendment to the Policy, Support for Adult Medicaid Dental Services (*Supplement*:5087) $: None
COMMITTEE RECOMMENDATION: Vote Yes

~~**Resolution 28**—(Adopt)—Rescission of the Policy, Legislative Separation of Medicine and Dentistry (*Supplement*:5090) $: None~~
~~**COMMITTEE RECOMMENDATION: Vote Yes**~~

Resolution 29—(Adopt)—Rescission of the Policy, Adding the ADA Definition of Dentistry to Existing Dental Regulatory Provisions (*Supplement*:5170) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 30RC—(Adopt Resolution 30RC in lieu of Resolution 30)—Amendment of the Policy, Antitrust Reform (*Supplement*:5094) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 33—(Adopt)—Amendment of the Policy, Legislative Delegations (*Supplement*:5099) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 34—(Adopt)—Amendment and Simplification of *Bylaws* Chapter I., Section 20.B. (*Supplement*:5102) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 35—(Adopt)—Response to Referred Resolution 64-2020, Amendment of Chapter III., Section 120. of the ADA *Bylaws* (*Supplement*:5106) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 36—(Adopt)—Proposed Policy, Support for the American Academy of Pediatric Dentistry Policy on Early Childhood Caries (*Supplement*:5108) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 37—(Adopt)—Rescission of the Policy, Preventive Dental Procedures (*Supplement*:5113) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 38—(Adopt)—Amendment of the Policy, Health Planning Guidelines (*Supplement*:5116) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 39—(Adopt)—Rescission of the Policy, High Blood Pressure Programs (*Supplement*:5119) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 40S-1—(Adopt Resolution 40S-1 in lieu of Resolution 40)—Amendment of the Policy, Communication and Dental Practice (*Supplement*:5123a) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 41—(Adopt)—Amendment of the Policy, Encouraging the Development of Oral Health Literacy Continuing Education Programs (*Supplement*:5124) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 45—(Adopt)—Amendment to Section 3.A. of the ADA *Principles of Ethics and Code of Professional Conduct* (*Supplement*:5127) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 50—(Adopt)—Amendment of the Policy, Use of Health Literacy Principles for All Patients (*Supplement*:5130) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 52—(Adopt)—Amendment of the Policy, Bottled Water, Home Water Treatment Systems and Fluoride Exposure (*Supplement*:5131) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 53—(Adopt)—The New Dentist Committee Chair Serving on the Board of Trustees (*Supplement*:5134) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 57—(Adopt)—Proposed Policy, American Academy of Pediatric Dentistry Statement on Perinatal and Infant Oral Health Care (2021) (*Supplement*:5136) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 58—(Adopt)—Proposed Policy, Oral Health Equity (*Supplement*:5145)
$: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 59—(Adopt)—Amendment of the Policy, Women's Oral Health: Patient Education (*Supplement*:5146) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 60S-1—(Adopt Resolution 60S-1 in lieu of Resolution 60)—Amendment of the Policy, Non-Dental Providers Completing Educational Program on Oral Health (*Supplement*:5150a) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 61S-1—(Adopt Resolution 61S-1 in lieu of Resolution 61)—Amendment of the Policy, Non Dental Providers Notification of Preventive Dental Treatment (*Supplement*:5153a) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 62RC—(Adopt Resolution 62RC in lieu of Resolution 62)—Amendment of the Policy, Limited Oral Health Literacy Skills and Understanding in Adults (*Supplement*:5154) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 67S-1—(Adopt Resolution 67S-1 in lieu of Resolution 67)—Amendment of the Policy, Comprehensive Statement on Allied Dental Personnel (*Supplement*:5158a) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 68—(Adopt)—Amendment to the Policy, Oral Health Education in Schools (*Supplement*:5159) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 73—(Adopt)—Clarifying Amendments to the *Manual of the House of Delegates* Relating to Delegate Allocation (*Supplement*:5165) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 82—(Adopt)—Proposed Policy: A Culture of Safety in Dentistry – Voluntary Reporting (*Supplement*:5178) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 83RC—(Adopt Resolution 83RC in lieu of Resolution 83)—Establishment of a Medicaid Task Force (*Supplement*:5183) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 91—(Not Adopt)—Mid-Level Provider Impact Study (*Supplement*:5195)
$: None
COMMITTEE RECOMMENDATION: Vote No

~~**Resolution 94**—(Adopt)—State Representation and Alternate Delegates (*Supplement*:5197)~~
~~$23,000; Amount On-going; Net Dues Impact: $0.23~~
~~**COMMITTEE RECOMMENDATION: Vote Yes**~~

Resolution 95RC—(Adopt Resolution 95RC in lieu of Resolution 95)—Prioritizing the Mental Health of Dentists (*Supplement*:5198) $50,000; Net Dues Impact: $0.50
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 106RC—(Adopt Resolution 106RC in lieu of Resolution 106)—Fair Delegate Allocation for Federal Dental Services (*Supplement*:5229) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Note: For the purpose of a fully documented record, the text of the resolutions presented in Resolution 112H follows.

Consent Calendar Resolutions—Adopted/Adopted in Lieu of

Proposed Policy, Rank and Status of Dentists in the Uniformed Services

1H-2021. Resolved, that the following policy titled Rank and Status of Dentists in the Uniformed Services be adopted:

Rank and Status of Dentists in the Uniformed Services

Resolved, that flag rank(s) of dental officers should be protected and enhanced in all branches of the uniformed services, and their offices should have the appropriate status and funding to carry out their missions effectively, and be it further
Resolved, that the American Dental Association supports a 2-star equivalent rank or higher for the chief dental officers for the uniformed services and the Veterans Administration, and be it further
Resolved, that graduates of a two year comprehensive dental residency or a dental specialty residency recognized by the National Commission on Recognition of Dental Specialties should be awarded special pay while serving in the federal dental services, and be it further
Resolved, that the following policies be rescinded:

- Compensation of Dental Specialists in the Federal Dental Services (*Trans.*1990:557; 2012:496)
- Restoration of the Rank of Brigadier General to the Army Reserve Position of Deputy Assistant Surgeon General for Dental Services (*Trans.*1992:622)
- Dentistry in the Armed Forces (*Trans.*1972:718; 2012:496)
- Rank Equivalency for Chief Dental Officers of the Federal Dental Services (*Trans.*2012:496)

Amendment of the Policy, Dental Research by Military Departments

2H-2021. Resolved, that policy titled Dental Research by Military Departments (*Trans.*1970:451; 2016:316) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the ADA considers oral and craniofacial research to be an integral component of the military dental corps' mission and believes that each military branch should continue to support such research at the basic and applied science levels.~~ military dental research is unique in that it focuses on the oral and craniofacial needs of active duty military personnel, such as:

- Improving dental readiness.
- Minimizing in-theater dental emergencies.
- Treating and ameliorating combat-related disfigurement and loss of facial function.

and be it further
Resolved, that each military branch should continue to support such research.

Rescission of the Policy, Advocating for ERISA Reform

5H-2021. Resolved, that the policy titled Advocating for ERISA Reform (*Trans.*2009:474; 2014:500) be rescinded.

Amendment of the Policy, Use of Expert Witnesses in Liability Cases

6H-2021. Resolved, that the policy titled Use of Expert Witnesses in Liability Cases (*Trans.*1986:531) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

> **Resolved,** that ~~the American Dental Association urge constituent dental societies to actively support legislation and changes in court rules that would require~~ plaintiffs and their attorneys in professional liability actions should be required to include with each complaint the affidavit of a health care professional~~,~~ who practices in the same field or specialty as the defendant and who has reviewed the patient record and related materials, stating that there is reasonable and meritorious cause for filing the action, and be it further
>
> **Resolved,** that ~~constituent dental societies be urged to actively support legislation and changes in court rules that would require~~ expert witnesses in court proceedings should be required to possess the clinical knowledge and skill to qualify them on the subject of their testimony and familiarity with the practices and customs of practitioners in good standing in the locality where the defendant practiced when the incident occurred, and be it further
>
> **Resolved,** that ~~constituent dental societies also be urged to actively support legislation and changes in~~ court rules ~~requiring courts in appropriate cases to instruct~~ should require that juries be instructed on the availability of alternative treatments and the role of patients in their own care, as appropriate.

Amendment to the Policy, Professional Liability Insurance Legislation

7H-2021. Resolved, that the policy titled Professional Liability Insurance Legislation (*Trans.*1984:548) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

> **Resolved,** that the American Dental Association monitor and constituent dental societies ~~support~~ be urged to monitor federal and state legislation for challenges to tort reform that would result in liability insurance premiums ~~skyrocketing~~ rising and leading to increased health care costs for patients~~., as appropriate, to deal fairly and equitably with the problems of rapidly increasing professional liability insurance costs which contribute significantly to higher costs of health care services for patients~~, and be it further
>
> **Resolved,** that the ADA should stand ready to aid and assist constituent dental societies experiencing a crisis of rising malpractice insurance premiums due to tort reform challenges. ~~legislative or other approaches to the professional liability problem be studied and developed in cooperation with other health organizations and interested parties~~.

Rescission of the Policy, Costs for the Submission of Electronic Dental Claims

8H-2021. Resolved, that the policy titled Costs for the Submission of Electronic Dental Claims (*Trans.*1995:623) be rescinded.

Amendment of the Policy, Fee-For-Service Medicaid Programs

9H-2021. Resolved, that the policy titled Fee-For-Service Medicaid Programs (*Trans.*1999:957) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

> **Resolved,** that ~~the ADA support and encourage states to~~ states should adopt adequately funded fee-for-service models for Medicaid programs to increase dentist participation and increase access to care for Medicaid participants.

Amendment of the Policy, Medicaid and Indigent Care Funding

10H-2021. Resolved, that the policy titled Medicaid and Indigent Care Funding (*Trans.*2006:338; 2014:499) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

> **Resolved,** that the ~~ADA make lobbying for adequate funds~~ American Dental Association supports adequate funding to provide oral health care to Medicaid and other indigent care populations ~~a high priority and that the constituent and component societies be urged to do the same, and be it further~~.

~~**Resolved,** that the ADA and its constituent and component societies carry out an intensive educational program, subject to current budgetary limits, to enlighten the public and government agencies of the value of oral health care and the consequences of untreated oral health disease to the overall health of our citizens and to health care payment systems, and be it further~~
~~**Resolved,** that the appropriate ADA agency study how to improve health outcomes through greater accountability and responsibility of dental patients to the care, educational and preventive opportunities provided to them~~.

Amendment of the Policy, Use of Dentist-To-Population Ratios

11H-2021. Resolved, that the policy titled Use of Dentist-to-Population Ratios (*Trans.*1984:538; 1996:681) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the American Dental Association urges all governmental, professional and public agencies, and schools of dentistry to refrain from using~~ dentist-to-population ratios ~~exclusively in~~ should not be used as the exclusive measure for designating dental health professional shortage areas or for evaluating or recommending programs for dental education or dental care.

Rescission of the Policy, Maldistribution of the Dental Workforce

12H-2021. Resolved, that the policy titled Maldistribution of the Dental Workforce (*Trans.*2001:442; 2014:500) be rescinded.

Proposed Policy, Discrimination of Benefit Payment Based on Professional Degree of Provider

15H-2021. Resolved, that the following policy titled Discrimination of Benefit Payment Based on Professional Degree of Provider be adopted:

Discrimination of Benefit Payment Based on Professional Degree of Provider

Resolved, that that the American Dental Association opposes discrimination of benefit payment based on the type of license and/or professional degree of the dentist and/or physician, and be it further
Resolved, that the policy titled Legislation Prohibiting Discrimination of Benefit Payment Based on Professional Degree of Provider (*Trans.*1989:562) be rescinded.

Amendment of the Policy, Freedom of Choice in Publicly Funded Aid Programs

16H-2021. Resolved, that the policy titled Freedom of Choice in Publicly Funded Aid Programs (*Trans.*2006:344) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the ADA pursue regulatory or legislative action to mandate that~~ any licensed dentist ~~may~~ should be able to participate in a publicly funded program without joining a third-party network that requires them to also see privately funded commercial patients under a managed care contract.

Amendment of the Policy, Limited English Proficiency

17H-2021. Resolved, that the policy titled Limited English Proficiency (*Trans.*2005:338) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the American Dental Association ~~work with the appropriate federal agencies, advocacy groups, trade associations, and other stakeholders to ensure that~~ considers accommodating the language needs of English-limited patients ~~is recognized as~~ to be a shared responsibility, which cannot be fairly visited upon any one segment of a community, and be it further
~~**Resolved,** that the Association support appropriate legislation and initiatives that would enhance the ability of individuals of limited English proficiency to effectively communicate in English with their dentist and the dental office staff, and be it further~~

> **Resolved,** that the ~~Association oppose federal legislative and regulatory~~ ADA opposes efforts that would unreasonably add to the administrative, financial, or legal liability of providing dental services to limited English proficient patients, such as being required to provide interpreters on demand as a condition of treating patients receiving state and/or federal benefits~~, and be it further~~
> ~~**Resolved,** that constituent and component dental societies be encouraged to support state, local, and private sector efforts to address the language needs of English-limited patients, and be it further~~
> ~~**Resolved,** that dental and allied dental programs be encouraged to educate students about the challenges associated with treating patients of limited English proficiency~~.

Amendment of the Policy, Protection of Retirement Assets

18H-2021. Resolved, that the policy titled Protection of Retirement Assets (*Trans.*1987:521) be amended as follows (additions are underscored; deletions are ~~stricken~~):

> **Resolved,** that ~~the ADA strongly support efforts by the constituent society at the state legislature level to enact laws which exempt IRS qualified Keogh, Corporate Pension or Profit Sharing Plans, and Individual Retirement Accounts from attachment to satisfy any nondomestic judgment~~ retirement savings accounts should be exempt from nondomestic judgments.

Amendment of the Policy, Suggested Dental Practice Acts

19H-2021. Resolved, that the policy titled Suggested Dental Practice Acts (*Trans.*1978:529) be amended as follows (additions are underscored; deletions are ~~stricken~~):

> **Resolved,** that ~~the ADA supports only those suggested dental practice acts that are consistent with Association policies, and be it further~~
> ~~**Resolved,** that the appropriate agency of the Association provide a timely, ongoing analysis to constituent societies of any suggested state dental laws that are developed by any agency outside the Association, with particular references as to how such proposed dental practice acts may be in conflict with Association policies~~ state dental practice acts should be consistent with American Dental Association policies, as appropriate and feasible.

Rescission of the Policy, State Regulation of Advertising

20H-2021. Resolved, that the policy titled State Regulation of Advertising (*Trans.*1984:549) be rescinded.

Rescission of the Policy, ADA Assistance in Legislative Initiatives

21H-2021. Resolved, that the policy titled ADA Assistance in Legislative Initiatives (*Trans.*1982:513) be rescinded.

Rescission of the Policy, Dental Focus in Federal Health Agencies

22H-2021. Resolved, that the policy titled Dental Focus in Federal Health Agencies (*Trans.*2012:497) be rescinded.

Amendment of the Policy, Confidentiality and Privacy Regarding Health Information

23H-2021. Resolved, that the policy titled Confidentiality and Privacy Regarding Health Information (*Trans.*1999:951; 2000:507) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

> **Resolved,** that the following be adopted as the American Dental Association's policy on health information confidentiality and privacy.
>
> **Legislation**
>
> - The Association supports legislative and regulatory actions that protect the confidentiality and privacy of patient health information.

- In particular, the Association believes minimum safeguards are needed to protect patients against wrongful disclosure and/or use of patient identifiable information, and to protect their providers as a result of wrongful disclosure or use by third parties who are properly given access to that information.

Limits on disclosure and use of patient-identifiable information
- Generally, the disclosure and/or use of patient-identifiable information by health care providers should be limited to that which is necessary for the proper care of the patient, or authorized by the patient and/or other applicable law.
- Use of patient-identifiable health information by an entity that receives that information from a patient's health care provider should be limited to that necessary for the proper care of the patient, except for research purposes as identified herein.
- Subsequent holders of patient information should be prohibited from changing health information or conclusions submitted by the patient's health care provider.

Patients' rights
- Patients should have the right to know who has access to their personally identifiable health information and how that information has been used.
- A patient's general consent to the release of confidential health information to a third party, such as a health plan, should not be legally sufficient to permit subsequent release by that third party of the information.
- With appropriate limitations designed to protect the integrity of the attending doctor's records and to ensure against unauthorized disclosure or unduly burdensome requests, patients should be afforded the opportunity to see their treatment records and obtain copies.

Unauthorized disclosure of patient-identifiable health information
- Patients should have a fair opportunity to seek legal redress if their personally identifiable health information has been willfully and wrongly released.
- No liability should arise against a provider who, in good faith and for the purpose of providing appropriate health care, unintentionally releases confidential health information in a manner not permitted by law.
- A health care provider who has properly disclosed patient-identifiable health information to a third party should be immune from liability for subsequent disclosure or misuse of that information by that third party.

Use of health information for research
- Generally, all identifying information should be removed when health records are used for research purposes. Identifiable data should be released only after approval of an Institutional Review Board, pursuant to applicable review procedures and protocols.
- Legislative exemptions to patient consent requirements for research purposes should be narrowly drawn.

Use of health information by law enforcement
- Except as otherwise provided by applicable laws, law enforcement officials should be required to obtain a binding court order, warrant or subpoena before having access to patient records.

Practice considerations
- Dentists should know their ethical and legal obligations regarding patient confidentiality and privacy.
- Dentists should engage in sound risk management techniques to ensure compliance, including office protocols, record maintenance and training to protect such information.

~~and be it further~~
~~**Resolved,** that the Association track and advocate privacy laws governing the Internet in their applicability to the privacy of patient records, and be it further~~

~~**Resolved,** that the Association advocate in its legislative and regulatory efforts that all points of potential interception, sale or unauthorized electronic transmission from doctor to third party be included in consideration of electronic privacy laws.~~

Amendment of the Policy, Need for HIPAA Standards Reform

24H-2021. Resolved, that the policy titled *Need for HIPAA Standards Reform (Trans.2003:384; 2016:317)* be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the appropriate agencies of the American Dental Association work with the dental specialty organizations and other health care associations to continue to make every effort to limit the adverse effects of the HIPAA regulations for dentists and their patients, and be it further
Resolved, that the appropriate Association agency seek the establishment of reasonable transition periods between proposed new versions of the electronic dental claim standard so as to reduce the substantial financial burden placed on small providers, such as dentists, to implement new electronic claims standards~~, and be it further~~
~~**Resolved,** that the appropriate Association agency encourage educational efforts by HHS to clarify the HIPAA regulations and counter the misrepresentations and misunderstandings that interfere with the doctor-patient relationship and are impeding the effective delivery of quality health care~~.

Rescission of the Policy, Legislation Prohibiting Waiver of Patient Copayment/OverBilling

25H-2021. Resolved, that the policy titled Legislation Prohibiting Waiver of Patient Copayment/Overbilling (*Trans.*1990:534) be rescinded.

Rescission of the Policy, Legislation Reflecting ADA Policy on Primary Dental Health Care Provider

26H-2021. Resolved, that the policy titled Legislation Reflecting ADA Policy on Primary Dental Health Care Provider *(Trans.*1981:564; 1990:559*)* be rescinded.

Amendment to the Policy, Support for Adult Medicaid Dental Services

27H-2021. Resolved, that the policy titled Support for Adult Medicaid Dental Services (*Trans.*2004:327) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the ADA adopt policy supporting the inclusion of~~ comprehensive adult dental services should be included in the federal Medicaid program as an integral part of overall health, and be it further
~~**Resolved,** that the ADA take every opportunity to educate policy makers that, consistent with ADA's position on health system reform (*Trans.*1993:664; *Trans.*1994:656) oral health is an integral part of overall health, and be it further~~
Resolved, that adult coverage under Medicaid should not be left to the discretion of individual states but rather, should be provided consistent with all other basic health care services.

Rescission of the Policy, Adding the ADA Definition of Dentistry to Existing Dental Regulatory Provisions

29H-2021. Resolved, that the policy titled Adding the ADA Definition of Dentistry to Existing Dental Regulatory Provisions (*Trans.*2001:440) be rescinded.

Amendment of the Policy, Antitrust Reform

30H-2021. Resolved, that the policy titled Antitrust Reform (*Trans.*2016:314) be amended as follows (additions are underscored; deletions are ~~stricken~~):

~~**Resolved,** that the ADA strongly supports eliminating the current insurance industry exemption from anti-trust laws including support for legislation to clarify, Amend or, if necessary, repeal the McCarran-Ferguson Act's antitrust immunity for the business of health insurance, and be it further~~

Resolved, that the ~~ADA~~American Dental Association strongly opposes any legislation that would extend an antitrust exemption to the insurance industry for information gathering endeavors such as collecting and distributing information on cost and utilization of health care services, and be it further
Resolved, that the ADA supports changes in federal antitrust laws that will enable dentists to practice effectively within the health care system, and be it further
Resolved, that the ADA supports legislative and regulatory activities to change the antitrust safe harbor guideline for dental networks based on percentage of provider participation in favor of a guideline relying on a health plan's market share, and be it further
Resolved, that the ADA work closely with constituent and component societies to provide them the most current and comprehensive antitrust information and guidance available, on an as-needed basis, and be it further
Resolved, that the ADA utilize appropriate resources to work with other provider groups to amend antitrust laws to allow dentists and other providers to negotiate collectively with health care purchasers, and be it further
Resolved, that the ADA support effective regulation of insurance companies including**:** the establishment of requirements for disclosure to dentists prior to signing network participation contracts**;** and current and complete information relating to the establishment of payment reimbursement rates and claims experience~~.~~, and be it further
Resolved, that the ADA supports changes in antitrust laws that would make professional societies and their members ~~should be~~ exempt from antitrust scrutiny for the narrow area of collective bargaining, so that dental societies can collectively negotiate on behalf of members.

and be it further
Resolved, that the policies titled Legislative Support to Allow Collective Bargaining by Professional Societies (*Trans.*2001:440; 2015:271) and Financial, Political and Administrative Consequences of Collective Bargaining Legislation (*Trans.*2000:506) be rescinded**.**

Amendment of the Policy, Legislative Delegations

33H-2021. Resolved, that the policy titled Legislative Delegations *(Trans.*1982:550; 1995:648) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the ~~Association continue to encourage individual ADA members to join the ADA Grassroots Program, and be it further~~
~~**Resolved,** that ADA members representing constituent and component societies who travel to Washington, D.C. be encouraged to visit with their senators and representatives to discuss legislative issues of importance to the profession and to coordinate this activity with the ADA Washington Office~~ American Dental Association encourages members to join and actively participate in the American Dental Political Action Committee's Grassroots Program.

Amendment and Simplification of Bylaws Chapter I., Section 20.B.

34H-2021. Resolved, that Chapter **I**, Section B. of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

B. LIFE MEMBER. Any person holding a D.D.S., D.M.D. or equivalent degree shall be eligible to be a life member of this Association if he or she meets the following qualifications:

a. Association Membership. The member has been:

1. ~~Has been an~~ An active and/or retired member in good standing of this Association for at least thirty (30) consecutive years or a total of at least forty (40) non-consecutive years; or

2. ~~Was a~~ A member of the National Dental Association for twenty-five (25) years and has been an active and/or retired member in good standing of this Association for at least ten (10) years;

b. Reached the age of at least sixty-five (65) during the previous calendar year; and

c. Maintains membership in good standing in a constituent and component, if such exists, and in this Association.

~~d. A member may also qualify for life member status by having been a member of the National Dental Association for twenty-five (25) years and subsequently holding membership in this Association for at least ten (10) years and having reached the age of at least sixty-five (65) during the previous calendar year.~~

Response to Referred Resolution 64-2020, Amendment of Chapter III., Section 120. of the ADA Bylaws

35H-2021. Resolved, that Chapter III., Section 120. of the ADA *Bylaws* be amended as shown below (additions underscored, deletions ~~stricken through~~):

Section 120. METHOD OF ELECTION: Elective officers and members of councils and committees shall be elected by ballot, except that when there is only one candidate, such candidate may be declared elected by the Speaker of the House of Delegates. The Secretary shall provide facilities for voting.

1. When one is to be elected, and more than one has been nominated, the majority of the ballots cast shall elect. In the event no candidate receives a majority on the first ballot, the candidate with the fewest votes shall be removed from the ballot and the remaining candidates shall be balloted upon again. This process shall be repeated until one (1) candidate receives a majority of the votes cast.

2. When more than one is to be elected, and the nominees exceed the number to be elected, ~~the votes cast shall be non-cumulative, and~~ the following applies:

   a. Each voting member may vote for a number of nominees not to exceed the number to be elected; and

   b. For any single nominee, only one vote may be cast by each voting member;

   c. The candidates receiving the greatest number of votes shall be elected.

Proposed Policy, Support for the American Academy of Pediatric Dentistry Policy on Early Childhood Caries

36H-2021. Resolved, that the following policy titled Support for the American Academy of Pediatric Dentistry Policy on Early Childhood Caries be adopted:

Support for the American Academy of Pediatric Dentistry Policy on Early Childhood Caries

Resolved, that the American Dental Association supports the Policy Statement of the American Academy of Pediatric Dentistry (AAPD) on Early Childhood Caries (2021):

> The AAPD recognizes the unique and often virulent nature of ECC. Non-dental healthcare providers who identify ECC in a child should refer the patient to a dentist for treatment and establishment of a dental home (AAPD Dental home) immediate intervention is indicated, and non-surgical interventions should be implemented when possible to postpone or reduce the need for surgical treatment approaches. Because children who experience ECC are at greater risk for subsequent caries development, preventive measures (e.g., dietary counseling, reinforcement of toothbrushing with fluoridated toothpaste), more frequent professional visits with applications of topical fluoride, and restorative care are necessary.

Rescission of the Policy, Preventive Dental Procedures

37H-2021. Resolved, that the policy titled Preventive Dental Procedures (*Trans.*1967:325; 2013:342) be rescinded.

Amendment of the Policy, Health Planning Guidelines

38H-2021. Resolved, that the policy titled Health Planning Guidelines (*Trans.*1983:545; 2014:503) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the following health planning objectives be adopted:

1. The Association supports a voluntary system of cooperative health planning at the state and local level.
2. Health planning should be directed at locally determined efforts to improve access to health care and avoid duplication of effort to maximize limited resources.
3. Dentists should have equal input along with other health care providers.
4. Public and private sector financing for health planning should have adequate appropriations designated to accomplish the state objectives.
5. The Association supports collaboration with state and local oral health coalitions to complete the objectives of effective health planning in areas of common ground between the organizations.

Rescission of the Policy, High Blood Pressure Programs

39H-2021. Resolved, that the policy titled High Blood Pressure Programs *(Trans.1974:643; 2013:343)* be rescinded.

Amendment of the Policy, Communication and Dental Practice

40H-2021. Resolved, that the policy titled Communication and Dental Practice (*Trans.*2008:454; 2013:342) be amended to read as follows (additions are double underscored; deletions are double ~~stricken~~):

Resolved, that the ADA affirms that ~~culturally competent, plain language, accurate~~ clear, accurate and effective communication is an essential skill for patient-centered dental practice, and be it further

Resolved, that this communication be delivered in a culturally competent manner.

Amendment of the Policy, Encouraging the Development of Oral Health Literacy Continuing Education Programs

41H-2021. Resolved, that the policy titled Encouraging the Development of Oral Health Literacy Continuing Education Programs (*Trans.*2006:316) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the Council on Dental Education and Licensure and other appropriate ADA agencies encourage the development of undergraduate, graduate and continuing education programs to train dentists and allied dental team members to effectively communicate in a culturally-competent, plain language, accurate manner with all patients. ~~with limited literacy skills.~~

Amendment to Section 3.A. of the ADA Principles of Ethics and Code of Professional Conduct

45H-2021. Resolved, that Section 3.A. of the ADA *Principles of Ethics & Code of Professional Conduct* be amended by deletion as follows (deletion ~~stricken through~~):

3.A. COMMUNITY SERVICE.

Since dentists have an obligation to use their skills, knowledge and experience for the improvement of the ~~dental~~ health of the public and are encouraged to be leaders in their community, dentists in such service shall conduct themselves in such a manner as to maintain or elevate the esteem of the profession.

Amendment of the Policy, Use of Health Literacy Principles for All Patients

50H-2021. Resolved, that the policy titled Use of Health Literacy Principles for All Patients (*Trans.*2016:322) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the ADA supports the continuing education of oral health professionals regarding the use of health literacy principles and plain language for all patients and providers to make it easier for them to navigate, understand and use appropriate information and services to help patients be stewards of their oral health.

Amendment of the Policy, Bottled Water, Home Water Treatment Systems and Fluoride Exposure

52H-2021. Resolved, that policy titled Bottled Water, Home Water Treatment Systems and Fluoride Exposure (*Trans.*2002:390; 2013:342) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that in order to ensure optimal fluoride intake, the American Dental Association supports actions by its members to educate their patients and communities regarding the level of fluoride in bottled water and the possible removal of fluoride by some home water treatment systems, and be it further
Resolved, that the American Dental Association urges its members to inquire about their patients' primary and secondary water source as part of the health history and be it further
Resolved, that the American Dental Association supports the labeling of bottled water with the fluoride concentration of the product and company contact information including address, ~~and~~ telephone and website, and be it further
Resolved, that the American Dental Association urges its members and the public to refer to the International Bottled Water Association's "List of Brands Containing Fluoride", and be it further
Resolved, that the American Dental Association supports the inclusion of information on the effect of various home water treatment system's ~~effect~~ on water fluoride levels ~~with each home water treatment system~~.

The New Dentist Committee Chair Serving on the Board of Trustees

53H-2021. Resolved, that Chapter V. BOARD OF TRUSTEES, Section 10. COMPOSITION and Section 40 INSTALLATION of the Bylaws be amended as follows (additions are underscored, deletions are ~~stricken~~):

Section 10. COMPOSITION: The Board of Trustees shall consist of one (1) trustee from each trustee district. Such trustees, the President-elect, and the two Vice-Presidents and the chair of the New Dentist Committee shall constitute the voting members of the Board of Trustees. The President, the Treasurer and the Executive Director of the Association, except as otherwise provided in the Bylaws, shall be non-voting members of the Board of Trustees.

* * *

Section 40. INSTALLATION: The installation of trustee nominees and the New Dentist Committee chair shall be as provided in the Governance Manual.

and be it further
Resolved, that Chapter V., Section B. Nomination, Declaration of Election and Installation Procedure of the *Governance and Organizational Manual of the American Dental Association* be amended as follows (additions are underscored, deletions are ~~stricken~~).

B. Nomination, Declaration of Election and Installation Procedure. The name of each nominee for the office of trustee brought forward by the nominee's trustee district shall be read to the House of Delegates by the Speaker of the House of Delegates. Because there is only a single nominee provided by each trustee district, following the reading of names, the Speaker of the House of Delegates shall declare the nominees elected. The newly elected trustees and the New Dentist Committee chair shall be installed by the President or the President's designee.

Proposed Policy, American Academy of Pediatric Dentistry Statement on Perinatal and Infant Oral Health Care (2021

57H-2021. Resolved, that the following policy titled Support for the American Academy of Pediatric Dentistry Guideline on Perinatal and Infant Oral Health Care be adopted:

Support for the American Academy of Pediatric Dentistry Guideline on Perinatal and Infant Oral Health Care

Resolved, that the American Dental Association supports the American Academy of Pediatric Dentistry Anticipatory Guideline on Perinatal and Infant Oral Health Care (2021):

Anticipatory guidance in the perinatal and infant period includes assessment of any growth and development issues that the parents should be aware of or need referral to the child's medical provider. AAPD BP Periodicity Schedule Assessment of caries risk that should be considered in counselling the parents regarding the child's fluoride exposure, including consumption optimally fluoridated water, appropriate frequency and quantity of brushing with fluoridated toothpaste, and need for professional topical fluoride applications. (AAPD BP Fluoride) Anticipatory guidance during this infant period also entails oral hygiene instruction, dietary counselling regarding sugar consumption, frequency of periodic oral examinations (AAPD Periodicity Schedule), and information regarding non-nutritive habits that if prolonged may result in flaring of the maxillary incisor teeth, open bite, and a posterior cross bite. (Dogramaci and Rossi-Fedele, 2016). Counselling regarding safety and prevention of orofacial trauma would include discussions of play objects, pacifiers, car seats, electrical cords, and injuries due to falls when learning to walk.

Recommendations

1. Advise expecting and new parents regarding the importance of their own oral health and the possible transmission of cariogenic bacteria from parent/primary caregiver to the infant.

2. Encourage establishment of a dental home that includes medical history, dental examination, risk assessment, and anticipatory guidance for infants by 12 months of age.

3. Provide caries preventive information regarding: high frequency sugar consumption; brushing twice-daily with optimal amount fluoridated toothpaste; safety and efficacy of optimally-fluoridated community water; and for children at risk for dental caries, fluoride varnish and dietary fluoride supplements (if not consuming optimally-fluoridated water).

4. Assess caries risk to facilitate the appropriate preventive strategies as the primary dentition begins to erupt.

5. Provide information to parents regarding common oral conditions in newborns and infants, non-nutritive oral habits (e.g., digit sucking, use of a pacifier), teething (including use of analgesics and avoidance of topical anesthetics), growth and development, and orofacial trauma (including play objects, pacifiers, car seats, electric cords, and falls when learning to walk).

6. When ankyloglossia results in functional limitations or causes symptom, the need to surgical intervention should be assessed on an individual basis.

7. When a patient presents with a prematurely erupted primary tooth (i.e., natal or neonatal tooth), decisions regarding intervention should be individualized, based on the interference with feeding, the risk of detachment and aspiration, and any medical or contributing considerations.

Proposed Policy, Oral Health Equity

58H-2021. Resolved, that the American Dental Association (ADA) defines oral health equity as optimal oral health for all people. The ADA is committed to promoting equity in oral health care by continuing research and data collection, advocating to positively impact the social determinants of oral health, reinforcing the integral role of oral health in overall health, supporting cultural competency and diversity in dental treatment, disease prevention education, and supporting efforts to improve equitable access to oral health care.

Amendment of the Policy, Women's Oral Health: Patient Education

59H-2021. Resolved, that the policy titled Women's Oral Health: Patient Education (*Trans.*2001:428; 2014:504), be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

~~Women's~~ Parent and Caregiver Oral Health: Patient Education

Resolved, that the ADA work with federal and state agencies, constituent and component societies and other appropriate organizations to incorporate oral health education information into health care educational outreach efforts directed at ~~mothers~~ parents, caregivers and their children, and be it further

Resolved, that the ADA work with the ~~obstetric~~ prenatal and perinatal professional community to ensure that ~~pregnant mothers~~ expectant parents and caregivers are provided relevant oral health care information during the perinatal period.

Amendment of the Policy, Non-Dental Providers Completing Educational Program on Oral Health

60H-2021. Resolved, that the policy titled Non-Dental Providers Completing Educational Program on Oral Health (*Trans.*2004:301; 2014:505) to be amended as follows (additions are double underscored; deletions are double ~~stricken~~):

Resolved, that only dentists, physicians and their properly supervised and trained designees, be allowed to provide preventive dental services to patients of all ages ~~to infants and young children~~, and be it further

Resolved, that anyone that provides preventive dental services ~~to infants and young children~~ should have completed an appropriate educational program on oral health, ~~common oral pathology,~~ dental disease risk assessment, dental caries and dental preventive techniques appropriate for the age groups under their care ~~this age group~~, and be it further

Resolved, that the ADA ~~urge~~ encourage constituent societies to support this policy.

Amendment of the Policy, Non Dental Providers Notification of Preventive Dental Treatment

61H-2021. Resolved, that the policy titled Non Dental Providers Notification of Preventive Dental Treatment (*Trans.*2004:303; 2014:505) be amended to read as follows (additions are double underscored):

Resolved, that prior to any preventive dental treatment, a dental disease risk assessment should be performed by a dentist or appropriately trained dental or medical provider, and be it further

Resolved, that risk assessments, screenings or oral evaluations of patients by non-dentists are not to be considered comprehensive dental exams, and be it further

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

Amendment of the Policy, Limited Oral Health Literacy Skills and Understanding in Adults

62H-2021. Resolved, that the policy titled Limited Oral Health Literacy Skills and Understanding in Adults (*Trans.*2006:317; 2013:342) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

> **Resolved,** that ADA recognizes a lack of health literacy as a significant ~~that limited oral health literacy is a potential~~ barrier to effective prevention, diagnosis and treatment of oral disease, and be it further
> **Resolved,** that dental offices encourage staff training in the principles of health literacy to improve patient health outcomes.

Amendment of the Policy, Comprehensive Statement on Allied Dental Personnel

67H-2021. Resolved, that the definitions of the term “Community Dental Health Coordinator” in the policy titled Comprehensive Policy Statement on Allied Dental Personnel (*Trans.*1996:699; 1998:713; 2001:467; 2002:400; 2006:307; 2010:505) be amended as follows (further additions are double underscored and deletions are double ~~stricken~~):

> **Community Dental Health Coordinator (CDHC):** An individual trained ~~in an ADA pilot program as a community health worker with dental skills~~ through the ADA licensed curriculum as a dental trained professional with community health worker skills. Their aim is to improve oral health education and to assist at-risk communities with disease prevention. Working under the supervision of a dentist, a CDHC helps at-risk patients improve their preventive oral health through education and awareness programs, navigate the health system and receive care from ~~a dentist in an appropriate clinic~~ licensed dentists.
>
> ~~CDHCs also perform limited clinical duties, such as screenings, fluoride treatments, placement of sealants and temporary restorations and simple teeth cleanings.~~ CDHCs also perform limited clinical duties only as allowed by their State Practice Acts ~~such as screenings, fluoride treatments, and sealant placement~~ until the patient can receive comprehensive services from a dentist or dental hygienist. Upon graduation, they will work primarily in public health and community settings like clinics, schools, ~~churches,~~ faith based settings, senior citizen centers, and Head Start programs in coordination with a variety of dental providers, including clinics, community health centers, the Indian Health Service and private practice ~~dentists~~ dental offices.

Amendment to the Policy, Oral Health Education in Schools

68H-2021. Resolved, that policy titled Oral Health Education in Schools *(Trans.2014:506; 2016:319)* be amended as follows (additions are underscored; deletions are ~~stricken~~):

> **Resolved,** that the Council on ~~Access, Prevention and Interprofessional Relations~~ Advocacy for Access and Prevention work with the appropriate ADA agencies and national education organizations to increase the number of school districts requiring oral health education for K-12 students based on the ~~2012~~ 2016 School Health Policies and Practices Study (SHPPS) data, and be it further
> **Resolved,** that, where applicable, the ADA supports the inclusion of the current National Health Education Standards in the accreditation requirements for all public, ~~and~~ private and charter elementary and secondary schools.

Clarifying Amendments to the Manual of the House of Delegates Relating to Delegate Allocation

73H-2021. Resolved, that the *Manual of the House of Delegates,* Representation of Constituents and Periodic Reapportionment of Delegates and Alternate Delegates, Section A., be amended as follows (additions underscored, deletions ~~stricken through~~):

> **Section A. Goal of Delegate Apportionment**
>
> The allocation of the remaining delegates over the minimum number of delegates allocated to each constituent and the District of Columbia Dental Society shall be made pursuant to the delegate

allocation methodology set forth in this section of the *Manual of the House of Delegates*. The goals of the delegate apportionment scheme adopted by the ADA is to (i) achieve as close to proportional representation of active, life and retired members of ~~the Association~~ constituents and federal dental services as possible while providing for the minimum representational requirements set forth in the *Governance and Organizational Manual of the American Dental Association* (*Governance Manual*); (ii) providing for representation of the American Student Dental Association; and (iii) maintaining the size of the House of Delegates as close to 473 delegates as possible while meeting the other goals recited in this herein.

and be it further
Resolved, that the *Manual of the House of Delegates*, Representation of Constituents and Periodic Reapportionment of Delegates and Alternate Delegates, Subsection B.3., be amended as follows (additions underscored, deletions ~~stricken through~~):

Subsection B.3. Determination of the True Proportional Delegate Counts for each Constituent and each Federal Dental Service
Divide each constituent's and each federal dental service's total membership by the ~~total membership of the Association~~ total constituent and federal dental service membership of the Association. Multiply the resulting percentage of membership for each constituent and federal dental service by the target number of delegates set forth in section B.1. of this methodology less the number of delegates allocated to the American Student Dental Association in section B.2. of this allocation methodology. The resulting true proportional delegate numbers will be used later in the delegate allocation methodology.

and be it further
Resolved, that the *Manual of the House of Delegates,* Representation of Constituents and Periodic Reapportionment of Delegates and Alternate Delegates, Subsection B.5., be amended as follows (additions underscored, deletions ~~stricken through~~):

Subsection B.5. Calculation of Non-Minimum Membership Total
Subtract the total membership numbers of each constituent and federal dental service identified as being excluded from the remaining steps of the delegate allocation methodology from the ~~total membership of the Association~~ total constituent and federal dental service membership of the Association. The resulting non-minimum membership total will be used in the remaining delegate allocation methodology steps.

Proposed Policy: A Culture of Safety in Dentistry—Voluntary Reporting

82H-2021. Resolved, that the American Dental Association acknowledges the value of self-reporting dental patient safety issues to a certified Patient Safety Organization that complies with the Patient Safety Rule of the Department of Health and Human Services, as critical to our professional responsibility for education and self-regulation, and be it further
Resolved, the American Dental Association encourages the voluntary reporting of near misses and adverse incidents to the Dental Patient Safety Foundation in an anonymous and non-discoverable manner, and be it further
Resolved, that the American Dental Association utilizes submitted reports to develop and report on improved safety measures for the profession of dentistry.

Establishment of a Medicaid Task Force

83H-2021. Resolved, that a Task Force meet virtually and develop a cohesive and broad-reaching strategy for federal and state Medicaid and Children's Health Insurance Program advocacy to reduce administrative burdens and create sustainable reimbursement for participating dentists. Issues addressed should include, but not be limited to:

- Credentialing
- Funding and reasonable reimbursement

- Benefit design and administration
- Appropriate auditing practices
- Coordination when multiple state program administrators exist
- Managed care design and implementation
- Requirements for stakeholder involvement
- Best practices and model programs to use as benefit and policy benchmarks

and be it further,
Resolved, that the Task Force be comprised of ~~equal~~ representation from the Board of Trustees, Council on Dental Benefit Programs, Council on Government Affairs, Council on Advocacy for Access and Prevention, at-large Delegates or Alternate Delegates of the 2021 House of Delegates, with Medicaid provider experience when possible, and state dental association staff with public program advocacy experience, with such representatives and the task force chair appointed by the ADA President, and be it further
Resolved, the advocacy strategy should include policy actions that the ADA and state advocates can pursue at the federal and state level, including adequate ADA public affairs support to ensure successful outcomes, and be it further
Resolved, that the Task Force shall report its recommendations to the 2022 ADA House of Delegates.

Prioritizing the Mental Health of Dentists

95H-2021. Resolved, that the appropriate agency of the ADA ~~analyze~~, in conjunction with mental health consultants, analyze the availability of resources to support the mental health of dentists, and collect information regarding existing health and wellness programs from across the tripartite and other professional organizations including, but not limited to the American Medical Association, the American Student Dental Association, and the New Dentist Committee. ~~to include the collection of information from national, state and local entities about:~~

- ~~activities available to support mental health~~
- ~~efficacy of current activities~~
- ~~prevailing mental health issues in their area~~

and be further
Resolved, that the ADA then use the collected information to ~~partner with mental health experts to~~:

- Explore partnering with third-party mental health providers for our membership;
- Analyze the existing well-being conference for potential enhancement;
- Create a toolkit to help prevent dentist suicide, including a guide for responding to a suicide or unexpected death; and recommendations for practice coverage for short-term and long-term absences due to mental illness and permanent absence due to suicide or unexpected death;
- And identify best practices, then consider the creation of an effective mental health and wellness campaign for our members

- ~~create an effective mental health wellness campaign for our members~~
- ~~explore the possibility of partnering with a third-party therapy provider to provide access to mental health care for our membership~~
- ~~analyze the existing well-being conference and consider how it could be expanded~~
- ~~create a toolkit to assist members with regard to practice coverage for short-term, long-term and permanent absences~~
- ~~study what other health-related professional organizations are doing for mental health including ASDA and NDC~~
- ~~create guidance around the ethics of reporting mental health crisis and suicide~~

and be it further

Resolved, that ADA explore safeguarding dentists from punitive action by state dental boards as well as third party credentialing; with regard to mental health issues and report back to the 2022 House of Delegates with an actionable plan.
~~**Resolved,** that the ADA partner with mental health experts to create a legislative strategy regarding safeguarding dentists from punitive action from state boards as well as third party credentialing; with regard to mental health issues and report back to the 2022 House of Delegates with an actionable plan.~~

Fair Delegate Allocation for Federal Dental Services

106H-2021. Resolved, that the appropriate agency propose revisions to ~~revise~~ the delegate allocation methodology found in the *Manual of the House of Delegates* so that a minimum of two delegates is allocated to each of the Federal Dental Services, and be it further
Resolved, that a report on the requested revisions be provided to the 2022 House of Delegates.

Consent Calendar Resolutions—Not Adopted

Mid-Level Provider Impact Study

91. Resolved, that the ADA collect data on mid-level providers to evaluate the impact on access to care.

This would include but not be limited to:

- the number in each state
- practice settings
- populations served
- individual state mandates

and be it further
Resolved, that a report be made to the 2022 ADA House of Delegates.

Non-Consent Resolutions

Proposed Policy, Anesthesia Coverage Under Health Plans (Council on Government Affairs Resolution 3): The Reference Committee reported as follows:

The Reference Committee concurs with the Board of Trustees and supports adoption of the following resolution.

3. Resolved, that the following policy titled Anesthesia Coverage Under Health Plans be adopted:

Anesthesia Coverage Under Health Plans

Resolved, the ADA supports the position that all health plans, including those governed by the Employee Retirement Income Security Act, should be required to cover general anesthesia and/or hospital or outpatient surgical facility charges incurred by covered persons who receive dental treatment under anesthesia, due to a documented physical, mental or medical reason as determined by the treating dentist(s) and/or physician, and be it further
Resolved, that the policy titled ERISA Reform (*Trans.*1998:738) be rescinded.

Dr. Iuorno moved Resolution 3 (*Supplement:*5007) with the Committee recommendation to Vote Yes.

Dr. Zachary A. Kouri, Iowa, moved to amend Resolution 3 in the first resolving clause by adding the words “complexity, behavioral,” after the word “documented” so that the first resolving clause would read as follows:

Resolved, the ADA supports the position that all health plans, including those governed by the Employee Retirement Income Security Act, should be required to cover general anesthesia and/or hospital or

outpatient surgical facility charges incurred by covered persons who receive dental treatment under anesthesia, due to a documented complexity, behavioral, physical, mental or medical reason as determined by the treating dentist(s) and/or physician, and be it further

In speaking to the amendment, Dr. Kouri stated, “Since January in Iowa there has been…an MCO that has been denying coverage for pediatric dental patients going to the OR. And the reason is because none of these kids have any physical, mental or medical reason to be taken to the OR. There are other reasons, however, that they need to be taken to the OR, is because they are two-and-a-half-year-old and their mouths are full of disease. So as we were speaking with the Tenth District, we were thinking about adding age to that. But that’s not exactly accurate either. You can have some young patients that are able to tolerate more treatment as other young patients, and some older patients that can’t tolerate treatment at all on the spectrum of pediatric dentistry. So the real issue comes with complexity or behavioral. We feel adding those two words will again make this Resolution 3 be even more powerful.”

On vote, the proposed amendment was adopted.

On vote, Resolution 3, as amended, was adopted.

3H-2021. Resolved, that the following policy titled Anesthesia Coverage Under Health Plans be adopted:

Anesthesia Coverage Under Health Plans

Resolved, the ADA supports the position that all health plans, including those governed by the Employee Retirement Income Security Act, should be required to cover general anesthesia and/or hospital or outpatient surgical facility charges incurred by covered persons who receive dental treatment under anesthesia, due to a documented complexity, behavioral, physical, mental or medical reason as determined by the treating dentist(s) and/or physician, and be it further
Resolved, that the policy titled ERISA Reform (*Trans.*1998:738) be rescinded.

Adjournment

Dr. Mai Ly Duong, Arizona, moved to adjourn the Second Meeting of the House of Delegates. Without objection, the Speaker declared the Second Meeting of the ADA House of Delegates adjourned at 11:57 a.m., Saturday, October 16, 2021.

Saturday, October 16, 2021

Third Meeting of the ADA House of Delegates

Call to Order: The Third Meeting of the 162nd Annual Session of the ADA House of Delegates was called to order at 1:07 p.m., Saturday, October 16, 2022, by the Speaker of the House of Delegates, Dr. W. Mark Donald.

Special Order of Business—Installation Ceremony

Prior to the installation ceremony, the Speaker recognized the following retiring ADA officers and trustees and thanked them for their service and dedication.

Dr. Daniel J. Klemmedson, president
Dr. Vincent U. Rapini, first vice president
Dr. Linda K. Himmelberger, trustee, Third District
Dr. Jay F. Harrington, Jr., trustee, Fifth District
Dr. Julio H. Rodriguez, trustee, Ninth District

The Speaker also introduced the continuing members of the Board of Trustees and thanked them for their service on behalf of the profession.

Dr. Richard J. Rosato, trustee, First District
Dr. Paul R. Leary, trustee, Second District
Dr. Michael D. Medovic, trustee, Sixth District
Dr. Chad R. Leighty, trustee, Seventh District
Dr. Susan Becker Doroshow, trustee, Eighth District
Dr. Scott L. Morrison, trustee, Tenth District
Dr. Linda J. Edgar, trustee, Eleventh District
Dr. Terry Fiddler, trustee, Twelfth District
Dr. James D. Stephens, trustee, Thirteenth District
Dr. Brett Kessler, trustee, Fourteenth District
Dr. Craig S. Armstrong, trustee, Fifteenth District
Dr. Gary D. Oyster, trustee, Sixteenth District
Dr. Rudolph T. Liddell, trustee, Seventeenth District
Dr. Maria C. Maranga, first vice president
Dr. Ted Sherwin, treasurer
Dr. Kathleen T. O'Loughlin, executive director

The Speaker recognized Dr. Klemmedson for the purpose of installing the new officers and trustees. Prior to installing these individuals, Dr. Klemmedson recognized the Speaker for his service.

The following new officers and trustees were introduced:

Dr. James M. Boyle, III, trustee, Third District
Dr. Frank J. Graham, trustee, Fourth District
Dr. Marshall H. Mann, trustee, Fifth District
Dr. Michele M. Tulak-Gorecki, trustee, Ninth District (not in attendance)
Dr. Mark E. Bronson, second vice president

Installation of Officers and Trustees. Dr. Klemmedson installed Dr. Cesar R. Sabates, Florida, as ADA President; Dr. George R. Shepley, as ADA President-elect; Dr. Mark E. Bronson, Ohio, as second vice president; Dr. Ted Sherwin, as treasurer; and the new trustees. Dr. Klemmedson extended congratulations to the new officers and trustees.

Additionally, Dr. Klemmedson asked the members of the House of Delegates, and they collectively agreed, to pledge their support by accepting assignments when called upon, by bringing forward the opinions and concerns of the members in their districts and by engaging in open and honest debate on issues.

Presentation to Dr. Klemmedson: Dr. Sabates, as the newly installed ADA President, presented Dr. Klemmedson with the insigne of past president and a certificate of appreciation recognizing his dedication to the Association and the dental profession.

Presentation of Dr. Cesar Sabates: Dr. Sabates addressed the members of the House of Delegates. He thanked his family, both “by relation and by profession”, including his wife, Lydia, his children and grandson, his parents, brother and sisters. He thanked members and friends from his local and state associations and leaders of the ADA: Drs. Daniel Klemmedson and Chad Gehani; retiring executive director, Dr. Kathleen O’Loughlin and incoming executive director, Dr. Raymond Cohlmia; those in the U.S. armed services; delegates and ADA’s professional team. He said, “I thank you for sharing your gifts with the ADA, for going the extra mile and for demonstrating the power of working together. I will need you so much more than ever in the year to come.” He also commented on the time that had passed since ADA leaders had gathered in person and said, “We are here to shape the direction of our profession and our association, and although each of us has our own unique journey, I believe that we are brought together in a divine purpose to restore within our patients the fundamental dignity of health and well-being. … When our patients are able to live without pain, when they can smile with confidence, that’s more than just a day’s work. It’s an improvement of a fellow human being’s quality of life, and that’s the true impact of a dentist.”

Dr. Sabates commented on the generosity of dentists who volunteer to provide free care to those in need. He also commented on ADA’s important focus on oral health equity and role in mental health for dentists. Dr. Sabates concluded by speaking to the challenges of the COVID-19 pandemic stating, “Life is precious. Our work is important. Despite the difficulties, we have seen what we are made of. We are mighty. We are kind. We are resilient.”

The installation ceremony concluded following Dr. Sabates’ remarks.

Address of the Incoming Executive Director: Dr. Raymond A. Cohlmia, incoming executive director, addressed the House of Delegates and highlighted his goals for advancing the ADA.

Remarks of the Chair of the American Dental Political Action Committee (ADPAC): Dr. L. Stephen Ortego expressed appreciation to members of the House of Delegates for their generous donations as well as the many others who donated to ADPAC during the annual meeting.

Report of the Standing Committee on Credentials, Rules and Order: Dr. David L. Fried, Committee chair, announced that the Committee had received a request relating to the credentialing of a new alternate delegate. The Committee considered this request to be the result of extenuating circumstances and recommended that the following individual be credentialed:

Alternate Delegate
Dr. Jennifer L. Thompson, New Mexico

Hearing no objection, the Speaker declared the credentials granted.

Dr. Fried announced the presence of a quorum and read the ADA Disclosure Policy.

Unfinished Business

Report of Reference Committee D (Continued)

Dr. Frank P. Iuorno, Jr., chair, Reference Committee D, returned to the podium to present the Reference Committee’s remaining items of business.

Proposed Policy, Provisions for ERISA Plans (Council on Government Affairs Resolution 4): The Reference Committee reported as follows:

The Reference Committee concurs with the Board of Trustees and supports adoption of the following resolution.

4. Resolved, that the following policy titled Provisions for ERISA Plans be adopted:

Provisions for ERISA Plans

Resolved, that the American Dental Association supports the following provisions for ERISA plans:

1. Beneficiaries of employee health benefit plans should have the right to receive health care from the providers of their choice
2. Employee health benefit plans should be prohibited from discriminating against legally qualified health care providers and to assure the solvency of such plans
3. Plan subscribers in Employee Retirement Income Security Act-regulated dental benefit programs should have the same protections that are commonly enjoyed by subscribers of state-regulated programs
4. Self-insured payers and/or utilization review organizations should be held liable for any negligent utilization review decision that overturns the health care provider’s clinical decision
5. Patients who suffer as the result of negligent utilization review decisions should be entitled to meaningful remedies and fair compensation
6. Patients who are denied benefits should have the right to an appropriate appeal mechanism under self-funded group health plans

and be it further
Resolved, that the policies titled Support Legislation Amending the Employee Retirement Income Security Act (*Trans.*1982:550; 1989:561), Employee Retirement Income Security Act (ERISA) Enforcement Activities (*Trans.*1992:622), Amendment of Employee Retirement Income Security Act (*Trans.*1994:644), and Amendments to ERISA to Achieve Greater Protections for Patients and Providers (*Trans.*1995:649) be rescinded.

Dr. Iuorno moved Resolution 4 (*Supplement:*5011) with the with the Committee Recommendation to Vote Yes.

Dr. David J. Hildebrandt, Louisiana, moved to amend Resolution 4 in item 3. of the first resolving clause by adding the words “including the elimination of missing tooth clauses after one year of premium payments and the prohibition of down coding of fixed prosthesis to removable prosthesis” after the words “state-regulated programs” so that item 3. would read as follows:

3. Plan subscribers in Employee Retirement Income Security Act-regulated dental benefit programs should have the same protections that are commonly enjoyed by subscribers of state-regulated programs <u>including the elimination of missing tooth clauses after one year of premium payments and the prohibition of down coding of fixed prosthesis to removable prosthesis</u>

In speaking to the proposed amendment, Dr. Hildebrandt stated, “So our state has been very effective in creating legislation to protect our patients’ rights. Unfortunately, those legislations do not apply to ERISA insurance companies. Two of our big wins in Louisiana were to have the elimination of missing tooth clauses on all insurance premiums after a patient has paid one year of premiums. We’ve had many patients who paid premiums for many, many years, and the insurance company would never pay to replace a missing tooth. So that was one of our big wins. Another one is downcoding of ‘fixed prosthesis’ to ‘removable.’ Again, we feel that insurance companies have misrepresented their plans by offering to pay for fixed prostheses, but when

the patient goes to use their benefits, they downcode it to removable, so they're essentially not paying for the benefit that the patient thinks that they are getting. So these are two biggies that we think would be important for our legislatures at the federal level to start working on ERISA plans to include some of these patient benefits, and that's why we'd like to make this amendment."

On vote, the proposed amendment was adopted.

On vote, Resolution 4, as amended, was adopted.

4H-2021. Resolved, that the following policy titled Provisions for ERISA Plans be adopted:

Provisions for ERISA Plans

Resolved, that the American Dental Association supports the following provisions for ERISA plans:

1. Beneficiaries of employee health benefit plans should have the right to receive health care from the providers of their choice

2. Employee health benefit plans should be prohibited from discriminating against legally qualified health care providers and to assure the solvency of such plans

3. Plan subscribers in Employee Retirement Income Security Act-regulated dental benefit programs should have the same protections that are commonly enjoyed by subscribers of state-regulated programs including the elimination of missing tooth clauses after one year of premium payments and the prohibition of down coding of fixed prosthesis to removable prosthesis

4. Self-insured payers and/or utilization review organizations should be held liable for any negligent utilization review decision that overturns the health care provider's clinical decision

5. Patients who suffer as the result of negligent utilization review decisions should be entitled to meaningful remedies and fair compensation

6. Patients who are denied benefits should have the right to an appropriate appeal mechanism under self-funded group health plans

and be it further
Resolved, that the policies titled Support Legislation Amending the Employee Retirement Income Security Act (*Trans.*1982:550; 1989:561), Employee Retirement Income Security Act (ERISA) Enforcement Activities (*Trans.*1992:622), Amendment of Employee Retirement Income Security Act (*Trans.*1994:644), and Amendments to ERISA to Achieve Greater Protections for Patients and Providers (*Trans.*1995:649) be rescinded.

Proposed Policy, Guaranteeing Patient's Freedom of Choice of Dentist (Council on Government Affairs Resolution 14 and Third Trustee District Resolution 14S-1): The Reference Committee reported as follows:

The Reference Committee concurs with the Third Trustee District and supports adoption of Resolution 14S-1 in lieu of Resolution 14 with the Committee Recommendation to Vote Yes on Resolution 14S-1.

14S-1. Resolved, that the following policy titled Guaranteeing Patient's Freedom of Choice of Dentist be adopted:

Guaranteeing Patient's Freedom of Choice of Dentist

Resolved, that the patient's right to choose any licensed dentist ~~to deliver his or her oral health care without any type of coercion~~ must be preserved, and be it further
Resolved, that the American Dental Association opposes any arrangement that eliminates, interferes with, or otherwise limits the patient's freedom of choice, and be it further

> **Resolved,** that the policy titled Legislation to Guarantee Patient's Freedom of Choice of Dentist (*Trans.*1995:631) be rescinded.

Dr. Iuorno moved Resolution 14S-1 (*Supplement:*5049a) in lieu of Resolution 14 (*Supplement:*5046) with the Committee Recommendation to Vote Yes.

Dr. Michael R. Varley, Colorado, moved to amend Resolution 14S-1 by adding a new resolving clause between the second and last resolving clause. The new resolving clause would read as follows:

> **Resolved,** that any plan with an arrangement that eliminates, interferes with, or otherwise limits the patient's freedom of choice, should include notice to prospective plan purchasers and recipients that it may be necessary to change dentists to utilize coverage.

In speaking to the amendment, Dr. Varley stated, "I'm concerned certainly about patients who sign up for medical plans and find out that they have been placed on closed panel dental plans without their knowledge. So I added a little bit of teeth to this resolution by adding the above…"

Dr. Theodore J. Rockwell, Pennsylvania, spoke in support of the proposed amendment, stating, "Just wanted to say that the Third District supports this friendly amendment."

On vote, the proposed amendment was adopted.

A delegate from the floor spoke in support of Resolution 14S-1, as amended, stating, "Member of the Council on Governmental Affairs. On behalf of the Council, we support this amended Resolution 14S-1."

On vote, Resolution 14S-1, as amended, was adopted.

14H-2021. Resolved, that the following policy titled Guaranteeing Patient's Freedom of Choice of Dentist be adopted:

Guaranteeing Patient's Freedom of Choice of Dentist

> **Resolved,** that the patient's right to choose any licensed dentist ~~to deliver his or her oral health care without any type of coercion~~ must be preserved, and be it further
> **Resolved,** that the American Dental Association opposes any arrangement that eliminates, interferes with, or otherwise limits the patient's freedom of choice, and be it further
> **Resolved,** that any plan with an arrangement that eliminates, interferes with, or otherwise limits the patient's freedom of choice, should include notice to prospective plan purchasers and recipients that it may be necessary to change dentists to utilize coverage.
> **Resolved,** that the policy titled Legislation to Guarantee Patient's Freedom of Choice of Dentist (*Trans.*1995:631) be rescinded.

Rescission of the Policy, Legislative Separation of Medicine and Dentistry (Council on Government Affairs Resolution 28): The Reference Committee reported as follows:

The Reference Committee concurs with the Council on Government Affairs and the Board of Trustees and supports adoption of the resolution to rescind this policy.

28. Resolved, that the policy titled Legislative Separation of Medicine and Dentistry (*Trans.*1996:715) be rescinded.

Dr. Iuorno moved Resolution 28 (*Supplement:*5090) with the Committee Recommendation to Vote Yes.

Dr. Amber P. Lawson, Georgia, spoke against Resolution 28, stating, "The overall concept of a medical-dental integration is beneficial and something we should strive to integrate into our dental practices so that we can better serve our patients, because oral health is a distinct part of overall health. However, our profession should be concerned with the potential unintended consequences of this legislatively, especially considering how certain dental stakeholders appear to be aligning themselves in the Medicare conversation. My concern

is that we could be unintentionally reducing the role and importance of general dentists when it comes to providing preventative and restorative care for children in underserved populations. For these reasons I'm against rescinding our current policy on the legislation separation of medicine and dentistry."

Dr. Mark A. Vitale, New Jersey and vice chair of the Council on Government Affairs commented on Resolution 28, stating, "[The Council on Government Affairs] CGA would like to support the Fifth District's desire to maintain this original policy on legislative separation of medicine and dentistry, and we look forward to discussing with them and revisiting the policy later."

On vote, Resolution 28 was not adopted.

State Representation and Alternate Delegates (Fourteenth Trustee District Resolution 94): The Reference Committee reported as follows:

> The Reference Committee concurs with the Fourteenth Trustee District and supports the adoption of Resolution 94.
>
> The Standing Committee on Constitution and Bylaws approves the wording of Resolution 94 as submitted.
>
> **94. Resolved,** that the Chapter III., Section 10.B. of the ADA *Bylaws* be amended as follows (additions underscored; deletions ~~stricken~~ through):
>
>> B. ALTERNATE DELEGATES. Each constituent and each federal dental service may select from among its active, life and retired members up to ~~the same number of~~ two alternate delegates for each ~~as~~ delegate~~s~~. The American Student Dental Association may select from among its active members up to the same number of alternate delegates as delegates.

Dr. Iuorno moved Resolution 94 (*Supplement*:5197) with the Committee Recommendation to Vote Yes.

Dr. Julius N. Manz, New Mexico, spoke in support of Resolution 94, stating, "I think this resolution is really about diversity, specifically about diversity of thought and expertise. Small states don't have the same opportunity as large states do to bring sufficient numbers of individuals to represent a significant amount of diversity and thought to their caucus and the House of Delegates. To be clear, Resolution 94 does not require anybody to utilize the alternate delegate. It simply allows that opportunity. States would most likely and logically utilize this alternate delegate if it was in their advantage to do so. Large states would probably not then necessarily bring alternate delegates, and it is unlikely that this would make a significant amount of increase in the numbers that would come to the House or to the caucuses. …"

As a point of information, Dr. Todd R. Christy, Michigan, asked, "… is it true that the financial implications for Resolution 94 only included the funding for the beverages in the back of the House, and are there any other costs that should be considered as well?"

At the request of the Speaker, Dr. Elizabeth Shapiro, chief of governance and strategy management, stated that the added cost depends on the number of additional alternates that states would bring to the House if Resolution 94 were adopted. Expenses would depend on the type of additional space utilized whether that be two ballrooms, one large ballroom, or exhibit hall space. She noted that costs for a second ballroom at the current meeting site of Las Vegas is estimated at $58,000. A single room would require venues in larger cities, which are often more expensive. Holding the meeting using exhibit space would require additional costs such as $60,000 for carpeting to absorb sound and there would likely be additional IT costs. Other costs that would be increased include printing one-third more reference committee reports (approximately $10,000); and purchasing and maintaining extra tables with electrical outlets, which would be a one-time cost of approximately $200,000 followed by the ongoing cost of replacing damaged tables each year. Dr. Shapiro also noted that constituents would have added costs to fund the travel for more alternate delegates and that caucus meeting room sizes would need to increase, which could reduce the number of venues that could accommodate the size of the House. She also noted that it's difficult to tell how many

additional alternates would attend the House since the number of states that would actually double their alternates is unknown.

Dr. Lauryne M. Vanderhoof, Michigan, spoke against Resolution 94, stating, “My concerns for this was the finance and the logistics, which we just heard all about from having our questions answered, so just to reiterate, you know, it’s going to be more than the $23,000 price implication that’s listed, and from a logistics standpoint, finding venues that are big enough that can accommodate our size, the ADA won’t know how many delegates we’re bringing, but they need to prepare for the full amount if we do increase the House by a third of the size. So, I’m not denying the concerns of this resolution. I think they’re valid, but if we expand the House potentially by a third of the size just for leadership development and to increase diversity in our voice, I don’t think this is the way to do it because of the financial and logistic complications.”

Dr. Jamie D. Goad, New Mexico, spoke in support of Resolution 94, stating, “It would allow smaller delegations the option, and only the option to have a variety of opinions and ideas from rural areas, young dentists, specialists, and it would also aid in leadership development.”

Dr. David Casteel, Wisconsin, spoke against Resolution 94. He said, “…For a size comparison, the U.S. House of Representatives has 435 voting members and six non-voting members representing 333 million U.S. citizens. The ADA House of Delegates in contrast in strikingly larger, at 483 delegates, and currently up to an equal amount of alternates representing 162,000 members. For simplicity, we already involve over double the U.S. House of Representatives in our processes representing far less than one one-thousandth of the population. I’m concerned by continued dilution, business will be more difficult to conduct, initiating a town hall rather than formal bodies for governance. As a new dentist, I firmly believe that leadership development is imperative to long-term success of our organization and our profession. Districts or states are already allowed to send as many people as they would like. They are also already able to participate in a majority of the events of the House of Delegates. The only difference is they won’t receive a formal title.”

Dr. David M. White, Nevada, chair of the Council on Government Affairs, spoke in support of Resolution 94, stating, “Currently, I am one of the youngest chairs to ever be on CGA. And coming from a state that’s very small, and we are standing to lose a current delegate with the reshuffling, this is going to be crippling for us. And we are facing two issues, a diversity issue and also a leadership development issue. And so for us this could provide the opportunity to do this. I know that…the big issues right now is cost, unknown costs. And so I would make a recommendation, I guess that we can make a friendly motion, but my intent is to put a cap on this. … But even just two alternates per state could make a significant difference in knowing the cost but also opening it up to all the different diverse modalities of practice, potential ethics or even new dentists as an opportunity to leadership development and also bring greater exposure to the process.”

Dr. James I. Lopez, Georgia, spoke against Resolution 94, stating, “… it is unnecessary and it would cost the association money. Only the designated delegate or the alternate who has rotated with the delegate can be on the floor of the House. We also fear some unintended consequences. Potentially, this could lead to delegates wanting to have two alternates for each delegate, because in our caucuses, all alternates have input and a vote on such things as district policies and for the ADA Trustee. The intended purpose of an alternate delegate is to replace a delegate if the delegate needs to leave the floor. States should be encouraged to bring members as guests to their caucuses for input as needed.”

As a point of information, Dr. Karen D. Foster, Colorado, asked, “We heard testimony that delegations can bring as many guests as they want, and I’m not disputing that. However, only credentialed delegates and alternate delegates have access to ADA Connect; is that not true, in order to get the resolutions?

In response, the Speaker stated, “… any member can get the resolutions, reports and non-privileged information. It’s on ADA.org…”

Dr. Robert M. Peskin, New York, moved to refer Resolution 94 to the appropriate agency for further study and report back to the 2022 House of Delegates. In speaking to the motion to refer, Dr. Peskin stated, “We’ve heard already this afternoon there’s a lot of variables that maybe didn’t meet the eye when we first read this resolution. It’s not that I’m opposed to the overall concept of it, but I just don’t think we know enough and including the timeframe in which something like this can be implemented.”

Discussion in support of the motion to refer ensued. Individuals speaking in support of the motion to refer commented that more information on how Resolution 94 could be implemented was needed and that an increase in alternate delegates should be limited to constituents that are currently allotted a small number of alternate delegates.

A motion was made to vote immediately on the motion to refer. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, the motion to refer Resolution 94 for further study and report back to the 2022 House of Delegates was adopted.

Report of Reference Committee A (Continued)

Dr. Mary Krempasky Smith, chair, Reference Committee A, returned to the podium to present the Reference Committee's remaining items of business.

Approval of 2022 Budget (Board of Trustees Resolution 75)

The Treasurer, Dr. Ted Sherwin, reported updated budget projections. With the financial implications of the House adopted resolutions, the 2022 budget results in a deficit of $386,000, which could be covered by an additional dues increase of $4 dollars above the proposed $9 dollar dues increase.

As a point of information, Dr. Mark J. Weinberger, New York, asked if the $386,000 deficit could be brought down to $0 dollars with more efficiencies. In response, Dr. Sherwin said, "Yes, we can manage a 0.3 percent budget deficit."

Dr. Gary K. Dubin, Connecticut, asked if the $386,000 deficit could be covered by reserves. In response, Dr. Sherwin said, "... this amount is small enough in the size of the budget if the House chooses to go on and run this small deficit budget, we can manage this. Will we have a deficit at the end of the year? Too many things will happen this year that we can't even predict so I can't tell you 'yes' or 'no."

Dr. David J. Dear, Missouri, asked, "… if we could make up this deficit easily, why don't we do that anyway?" Dr. Sherwin responded, "So I didn't say easily. I said manage. The House can make it up with a $4 dollar increase and then we go in with a zero or strictly balanced budget. So I'm just saying we can manage it. There's a difference."

A motion was made to vote immediately on Resolution 75. On vote, the motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, Resolution 75 was adopted.

75H-2021. Resolved, that the 2022 Annual Budget of revenues and expenses, including net capital requirements, be approved.

Establishment of Dues Effective January 1, 2022 (Board of Trustees Resolution 76): The Reference Committee reported as follows:

The Reference Committee heard very limited testimony regarding Resolution 76.

The Reference Committee agrees with the Board of Trustees and supports adoption of Resolution 76.

76. Resolved, that the dues of ADA active members shall be $582.00, effective January 1, 2022.

Dr. Krempasky Smith moved Resolution 76 (*Supplement:*2085) with the Committee Recommendation to Vote Yes.

Resolution 76 required a sixty percent affirmative vote.

Dr. Bruce D. Grbach, Ohio, moved to amend Resolution 76 by changing the proposed dues from $582 to $586

In speaking to the amendment, Dr. Grbach stated, “I would like to amend this to increase to $586 so that we have a balanced budget.”

Dr. Gary K. Dubin, Connecticut, spoke against the proposed amendment, stating, “Again, with my earlier comments about keeping in mind what the Treasurer intended to do in his original budget, it was to make up some of these things with surplus and maybe take less money from the insurance royalties and place that extra money into the dues and keep it at $9 to sell to our members that this is just an inflationary increase.”

Dr. Grbach stated, “My point would be, why not start the year even instead of a deficit.”

Dr. Nancy K. Treiber, Connecticut, spoke against the proposed amendment, stating, “I think the $9 dollar dues increase is adequate and it’s something that people can accept. I think if we do need the money over the course of the year, then we should take it from reserves. It’s not a large amount of money that we’re talking about.”

Dr. Edmund C. March, Illinois, spoke in support of the proposed amendment. He said, “I think that as a House of Delegates, if we’re going to add costs to the budget, that we should also have the responsibility and the courage to, when it comes to the dues increase, to put our money where it’s easy to spend money if we’re not the ones that have to say you need to increase the dues.”

On vote, the proposed amendment was not adopted.

Dr. Kerri T. Simpson, West Virginia, spoke against Resolution 76, stating, “I obviously am on an uphill battle here, because I’m pretty sure I’m the only one who may be opposing this, but to be a hundred percent honest, when I went into my district…I actually was all for this. Luckily, this is why we have what we do in the House of Delegates and have our caucus. Spoke with a lot of people and they actually changed my mind. I understand the $9 dollars doesn’t seem like a lot. Just don’t go to Starbucks one day or don’t buy the $20 bottle of water in your room here. But I do have to say, we who are in here at the House of Delegates, we one hundred percent understand why we need to do this. We also are the ones to 110 percent get the value of our ADA membership. My concern is that we come out of this, to those who just came out of one of the largest…pandemic yet, and they see that, oh, House of Delegates just raised another $9 dollars on us. And, again, $9 dollars doesn’t seem like a lot, but to those who maybe aren’t understanding the whole value yet or they’re struggling to still make payments on certain things, I just worry that this is going to come across as we don’t have consideration for them.”

As a point of information, Dr. Steven J. Kend, California, asked, “Question for the Treasurer. Could he tell us what the deficit would be if we do not have the $9 dollar increase in dues?”

In response, Dr. Sherwin said, “So the deficit is for $1.286 million. So what does that mean? It means that we start the year behind. It means that all year we’re trying to figure out how we’re going to handle that. We don’t really want to spend more out of reserves for ongoing expenses. That’s not what reserves are for. Plus our reserves, as those of you who were in the summit know, we’re putting those to use already. So they—they’re already being put to use every year. The quasi endowment is bringing us 40 dues dollars to help us keep the dues down. And then we’re spending out of reserves to meet—to pay for those big opportunities that we aren’t increasing dues higher. Those of you who have been around the House for a while, remember back in the early 2000s, we had a very, very large dues abatement special assessment, and then in the 2010 or ’12 area, we had a large IT special assessment. What we’re trying to do now is keep dues to just inflation. Why? Because what we see is, we affect membership more when we have large dues increases. Small dues increases, like what we have today very seldom affect our—the number of members. So, if we were to skip this year, run this deficit, then next year we’re probably going to have to have a much larger dues increase to make up the deficit or we are going to have to cut much needed programs to members and states. So they’re the ones who are going to feel the loss. So this is why the Board decided on the numbers that it wanted to, because the studies that we see are that we will least affect membership by small, regular inflationary dues increases.”

As a point of information, Dr. Robert S. Roda, Arizona, asked, "… do we have any information historically on how many member we lose when we raise dues a dollar or two dollars? …"

At the request of the Speaker, Dr. Kathleen O'Loughlin, executive director, responded, stating, "…Retention rate is between 93 and 94 percent very consistently. And in the past when dues have been increased, we have seen a little short-term attrition and then it comes right back to normal. A little short-term attrition, but then the numbers recover."

Dr. Olin A. Elliott, II, Kentucky, spoke against Resolution 76, stating, "I would like to…point out a few things that I think the House needs to be aware of or you probably already know. Yeah, we're talking about that we passed the incremental dues policy that we would try to follow the CPI. We also have a policy in place that says that we'd like to have our reserves at 50 percent. We worked hard to establish that policy for our reserves. Presently, if my numbers are correct, our reserves right now stand at 108 percent. That's quite a bit above what we established as what we want to maintain our reserves at. I think the key here is what we talked about with perception. Our members have just gone through one of the most difficult years of their entire careers. And $9 dollars, although it's not a lot, can be perceived as that we're poking them again. Now, I also understand and feel like most of you that we have done a lot as our Association to help them through this, and as we've looked at some of the moneys that have been generated for them. But I still think it's a matter of perception. I don't think this is the time for us to do a dues increase with us having our reserves at over 58 percent above what we established that we want to maintain in that. I would ask you not to pass this dues increase and let's take this money out of our well-endowed reserves."

Dr. Jeffrey A. Kahl, Colorado, chair of the Council on Membership, spoke in support of Resolution 76, stating, "As the Treasurer so eloquently pointed out, I want to remind you guys, that there was a lot of debate and a lot of thought that went into dues streamlining…particularly the CPI, you know, cost of an inflation increase. We're going to have years like this where we're running a deficit, but if the Council on Membership and the organization continue to do its job to grow membership, our membership revenue will get to the point someday where we may have a surplus. The idea is that we're not having this conversation every year, though. You know, I encourage you guys to let that mechanism work the way it's supposed to work, and you know, trust the organization and your Treasurer to balance things accordingly. So I would support the budget, which is what we're really talking about right now. We already debated the dues. Support the budget."

A motion was made to vote immediately. On vote, the motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, Resolution 76 was adopted.

76H-2021. Resolved, that the dues of ADA active members shall be $582.00, effective January 1, 2022.

Concluding Remarks of the Speaker: The Speaker made the following statement:

> The actions of this House of Delegates are no longer the opinions, wishes or suggestions or recommendations of any individual, committee or officer but are now the actions of the entire House of Delegates. And as this House of Delegates is authorized under the Association's *Bylaws* to act for the entire association, they are the actions of the entire Association. It is now incumbent upon every member of this Association to accept the actions of this House of Delegates as the actions of the American Dental Association.

Recognition of Retiring Delegates and Alternate Delegates: The Speaker requested that all retiring delegates and alternate delegates stand; the House applauded the individuals in recognition of their service.

Point of Personal Privilege

Dr. Cesar R. Sabates, incoming president, stated, "I would like to express my gratitude and this House's gratitude for your service as Speaker of the House. So please accept our applause and gratitude for all you have done for us. Thank you."

Adjournment

Dr. Amro Elkhatieb, California, moved to adjourn the 162nd Annual Session of the ADA House of Delegates. Without objection, the Speaker declared the 162nd Annual Session of the ADA House of Delegates adjourned *sine die* at 3:39 p.m., on Saturday, October 16, 2021.