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++See Highlighted Correction, Page 3020a
±**New Business—Majority Vote Received for Consideration (Posted October 7)
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**Newly Received (Received and Processed September 24; Posted September 30)  
***Newly Received (Received and Processed September 22 – 28; Posted October 5)  
++See Highlighted Correction, Page 3020a  
±**New Business–Majority Vote Received for Consideration (Posted October 7)
AMENDMENT TO THE POLICY STATEMENT ON THE ROLE OF DENTISTRY IN THE TREATMENT OF SLEEP RELATED BREATHING DISORDERS

Background: The American Academy of Dental Sleep Medicine (AADSM) issued a position statement in 2020 on the Scope of Practice for Dentists Ordering or Administering Home Sleep Apnea Tests. The position statement advocates that a dentist “with appropriate training and education should not be prohibited from ordering or administering a home sleep apnea test (HSAT). HSAT results should be interpreted by a licensed physician for diagnosis and verification of treatment efficacy.” Dr. Chad Gehani, then-ADA president, forwarded the position statement to the Council on Dental Practice (CDP/the Council) for its consideration.

The Council proposed an amendment to the American Dental Association’s (ADA) current statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders to be more descriptive regarding dentists ordering or administering home sleep apnea tests. The amended policy statement will align with AADSM’s position and be relevant to the current situation with appropriate language and terminology.

Resolution

42. 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 underscored, deletions are 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 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 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 HSATS 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 the physician is able to evaluate the improvement or confirm treatment efficacy for the OSA, especially if the patient develops recurring OSA relevant symptoms or comorbidities.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
Resolution 43

Report: N/A
Date Submitted: June 2021

Submitted By: Council on Dental Practice
Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None
Net Dues Impact: 

Amount One-time Amount On-going

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

How does this resolution increase member value: See Background

PROPOSED ADA POLICY STATEMENT ON THE USE OF AUGMENTED INTELLIGENCE IN DENTISTRY

Background: Healthcare augmented intelligence (AI) concepts are being increasingly applied to the practice of dentistry and have had a significant impact on the delivery of patient care. AI algorithms have been developed for use in visual perception, speech recognition, decision-making, and forecasting future outcomes, behaviors, and trends.

As a healthcare policy leader, the American Dental Association has a unique opportunity to ensure that the integration of AI in dentistry is beneficial to patients, dentists and the dental workforce. It must be utilized in ways that will promote quality of care, minimize adverse consequences, support the clinical skills training and development of dentists, dental students, and dental team members or have the potential to reduce barriers to equitable access to oral health care.

Resolution 43

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.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
NOTES
Resolution No.  54 ___________________________ New
Report:    N/A ___________________________ Date Submitted:  June 2021
Submitted By:  Council on Dental Practice
Reference Committee:  B (Dental Benefits, Practice and Related Matters)
Total Net Financial Implication:  None ___________________________ Net Dues Impact:  _____________
Amount One-time  _____________ Amount On-going  _____________

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

How does this resolution increase member value: See Background

RESCISSION OF POLICY, INDIVIDUAL PRACTICE ASSOCIATION


The current dynamics of Individual Practice Associations have changed significantly in the 30 years since it was adopted. The Council found no added value in maintaining a definition that is no longer relevant to current situation.

Resolution

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

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
Individual Practice Association (*Trans.1990:540*)

Resolved, that the following definition of Individual Practice Association be adopted:

A legal entity organized and governed by individual participating dentists for the primary purpose of collectively entering into contracts to provide dental services to enrolled populations.
Resolution No. 55

Report: N/A Date Submitted: June 2021

Submitted By: Council on Dental Practice

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

Total Net Financial Implication: None Net Dues Impact: 

Amount One-time Amount On-going 

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

How does this resolution increase member value: See Background

**RESCISSION OF POLICY, SUPPORT FOR INDIVIDUAL PRACTICE ASSOCIATIONS**


The Individual Practice Associations have changed significantly in the 30 years since this policy was adopted. The Council determined that Support for Individual Practice Associations was no longer relevant to the current situation.

**Resolution**


**BOARD RECOMMENDATION:** Vote Yes.

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

Resolved, that the American Dental Association provide information to members and plan purchasers about dental individual practice associations (IPAs) that includes legal and regulatory limitations on the uses of IPAs.
Resolution No. 63 Resolved, that the American Dental Association supports the elimination of wait periods for treatment, including orthodontic treatment, for children from dental benefit plans.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
2020 Resolution 83—First Trustee District—Policy for the Elimination of Wait Periods for Children in Dental Benefit Plans and 2020 Resolution 83B—Board Substitute

83-2020. Resolved, that the American Dental Association supports the elimination of wait periods for treatment for children from dental benefit plans, and be it further

Resolved, that the American Dental Association shall support legislative efforts to eliminate treatment wait periods for children in the United States on the state and federal levels.

83B-2020. Resolved, that the American Dental Association supports the elimination of wait periods for treatment for children from dental benefit plans, and be it further

Resolved, that the American Dental Association shall support legislative efforts to eliminate treatment wait periods for children in the United States on the state and federal levels.
Resolution 71

AMENDMENT OF THE POLICY, THIRD-PARTY PAYERS OVERPAYMENT RECOVERY PRACTICES

Background: In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar, which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each Referred Resolution, Resolution 105-2020 was reviewed by the Council.

Dental offices have reported receiving requests for alleged overpayments by dental insurance companies sometimes up to 3-4 years after a claim has been paid. This puts the dental office in an awkward collections position as these patients may no longer be patients of record with the treating dentist. Resolution 105-2020 directed the Council to review ADA policies regarding recoupment practices.

Resolution 105-2020 is appended to this report.

The Council reviewed the policies cited in Resolution 105-2020 and would like to address the issue of recoupment practices by amending existing policy, Third-Party Payers Overpayment Recovery Practices (Trans.1999:930; 2013:312) with the proposed revisions for consideration by the 2021 House of Delegates.

Resolution

71. 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.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
2020 RESOLUTION 105—FOURTEENTH TRUSTEE DISTRICT—INAPPROPRIATE RECOUPMENT
PRACTICES OF DENTAL BENEFIT COMPANIES


Resolved, that the Council recommend a policy to encourage fair recoupment practices including reasonable time limitations and regular oversight by regulating agencies.
COUNCIL ON DENTAL PRACTICE REPORT 1 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 28H-2019, PEDIATRIC SCREENING FOR SLEEP-RELATED BREATHING DISORDERS

Background: The 2019 House of Delegates adopted the following resolution:

Resolution 28H-2019 Pediatric Screening for Sleep-Related Breathing Disorders

Resolved, that the American Dental Association, through its appropriate agency or agencies, develop and promote a screening tool/protocol for pediatric airway issues for use by dentists.

The proposal for this resolution was to collaborate with other specialty groups and stakeholders to produce a protocol or screener that will serve as the consensus tool for the profession to identify children at risk of breathing disorders.

The Council on Dental Practice (The Council/CDP) convened an advisory group of experts to discuss various existing tools and to assess the work done to date by the Children’s Airway Screener Taskforce (CAST) on a screening tool and to gain an understanding of their future validation intentions. The CDP advisory group held its first meeting virtually in April 2021.

The CDP discussed the work of CAST at the Council’s May 2021 meeting. The Council elected to continue to engage with and monitor the work of CAST in the creation and validation of a screening tool. The validation process will be based on a variety of program evaluation criteria measuring specificity, sensitivity and spectrum bias. The intent of the validation process will be to generate statistically relevant data that will ultimately support a screening tool/protocol. The findings will be reported at a future meeting of the House of Delegates.

Resolution

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
Resolution No. 74  
Report: N/A  
Date Submitted: August 2021  
Submitted By: Council of Dental Benefit Programs  
Reference Committee: B (Dental Benefits, Practice and Related Matters)  
Total Net Financial Implication: None  
Net Dues Impact: 
Amount One-time 
Amount On-going 
ADA Strategic Plan Objective: Public Goal Obj-10: Dental benefit programs will be sufficiently funded and efficiently administered.  
How does this resolution increase member value: See Background  

PROPOSED POLICY, DENTAL BENEFITS WITHIN AFFORDABLE CARE ACT MARKETPLACE AND A PUBLIC OPTION  

Background: The emerging issue of federal “public option” legislation began in earnest in the previous 116th Congress when several bills were introduced that would expand the role of public programs in health care and it continues be addressed in healthcare reform bills in the 117th Congress. A “public option” could refer to several different policy proposals including but not limited to:  
- A Medicare buy-in option for older individuals not yet eligible for the current Medicare program.  
- A Medicaid buy-in option that states can elect to offer to individuals through the ACA Marketplace.  
- A new public plan option that would be offered to individuals through the ACA Marketplace.  
The ADA’s position on plans offered though the Affordable Care Act Marketplaces including any government-administered plan remains unclear.  
The dental industry has not seen very large impacts since the ACA was enacted in 2012. Over 90% of enrollees are between ages of 18--64 years of age. Of the approximately 11.4 million consumers enrolled in a Marketplace plan during the 2020, only 1.76 million purchased a Stand Alone Dental Plan (SADP) within the Marketplace in 2020. Pediatric dental benefits are considered “Essential Health Benefits” and are available to the limited number of children enrolled in Marketplace plans either through SADP’s or within medical plans (Qualified Health Plans). Seventy percent of current Marketplace enrollees are under 250% of the Federal Poverty Level (FPL), with over 90% of enrollees below 400% FPL.  
Under a public option introduced within the ACA Marketplaces, the government could create a public financing system potentially administered by the Centers for Medicare & Medicaid Services (CMS). That system would likely be available to all consumers as a choice to purchase through the ACA Marketplaces. Private plans being sold in the Marketplaces would compete with a government plan to attract enrollees.  

Resolution

74. 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.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)
NOTES
The following resolution was submitted by the New York State Dental Association and transmitted on August 24, 2021, by Dr. Mark Feldman, executive director, New York State Dental Association.

**Background:** There are many instances when knowing the manufacturer of a previously placed endosseous implant (including type and size) would provide valuable information for a subsequent-treating dentist. New patients can present to dental practices with loose, failed, or failing implant prostheses where good integration of the implant exists. In addition, there are times when an existing fixed partial denture (FPD) needs to be modified or expanded by the placement of additional fixtures. Attempting to identify a particular implant can be a daunting (and, perhaps, embarrassing) undertaking, especially with the vast assortment of implants that historically have been made available to dentists (some of which may no longer be available). Relying solely on a radiograph or fixture mount is often insufficient. However, being able to access details about an existing implant(s) would, undoubtedly, facilitate treatment.

A national registry of all implant placements would benefit dentists and patients alike. The registry can track patients, implant manufacturer, type, size, and location and be a valuable resource for the profession. In addition, establishing potential trends, such as implant failure associated with a given manufacturer or implant type, would provide useful data for analysis. Such a database would improve care well into the future. Accordingly, the following resolution is submitted for consideration.

**Resolution**

**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.
**BOARD COMMENT:** The Board appreciates the intent of Resolution 79 submitted by New York State Dental Association. However, the Board believes that establishing a new endosseous implant registry at this time is duplicative, costly and poses significant cybersecurity risks for the Association to manage.

Per House Resolution 25H-2018, the ADA is in the process of developing a comprehensive oral health clinical data warehouse through the newly launched (July 2021) [ADA Dental Experience and Research Exchange](https://www.ada.org) (DERE) program. This is a multi-year, multi-million dollar effort. DERE aims to connect with practice management software systems to automatically extract clinical data from participating dental practices into a centralized data warehouse.

Part of the clinical data that could potentially be extracted is information regarding implants available within the patient record. However, most practice management software systems do not capture the Unique Device Identifiers (UDI) on implant product labels as structured data within the patient chart. Feasibility of acquiring UDI information in common formats under these circumstances needs to be explored. The ADA Technical Report No. 1081 on UDI’s developed through the Standards Committee on Dental Informatics provides more information on technological challenges associated with UDI implementation at the point of care. Without a means of acquiring this data automatically from patient management software or the FDA, dentists would need to voluntarily enter data into a registry with each surgical placement, separately from all other data entry into their own system. Indications to date are that dentists resist separate data entry in addition to their current workflow.

In establishing DERE, the ADA has already gained much of the experiential knowledge this investigation would produce. Significant challenges include cybersecurity risks associated with extracting and storing identifiable patient data and the need for every participating dental office to seek consent from each patient before the data could be transmitted to the ADA. Note that the DERE program is specifically designed around a limited data set (as defined by HIPAA), meaning the data is de-identified. Housing identifiable patient data is a risk the ADA determined it did not want to take when establishing DERE.

While the resolution only seeks an investigation into the establishment of an endosseous registry, we believe that the knowledge gained through the establishment of DERE already exposes known concerns. Therefore, we cannot support additional time and financial resources to assess feasibility of the proposed project.

**BOARD RECOMMENDATION:** Vote No.

**Vote:** Resolution 79
Resolution No. 85

Report: N/A Date Submitted: August 2021

Submitted By: Indiana Dental Association

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

Total Net Financial Implication: $150,000 Net Dues Impact: $1.50

Amount One-time Amount On-going $150,000

ADA Strategic Plan Objective: Membership Obj-1: Increase membership market share of lagging demographics by 2% per year.

How does this resolution increase member value: See Background

ADDRESSING THE DENTAL TEAM WORKFORCE SHORTAGE

The following amendment was submitted by Mr. Doug Bush, executive director, Indiana Dental Association and transmitted on August 26, 2021.

Background: Dentistry is facing a workforce crisis. A shortage of dental hygienists, dental assistants and dental office administrative staff that existed prior to COVID-19 appears to have been exacerbated by the pandemic, as some staff members did not return to the profession after COVID-related dental office shutdowns.

According to a May 17, 2021 study by the ADA Health Policy Institute, 35.8% of owner dentists were recruiting assistants; 28.8% were seeking hygienists and 26.5% were seeking administrative support staff. The same study reported hiring struggles: 86% of dentists reported hygiene recruitment efforts as “extremely” or “very” challenging; and 83% reported assistant recruitment efforts as “extremely” or “very” challenging.

While COVID is partially to blame, the American Dental Education Association (ADEA) Snapshot of Dental Education 2019-20 (page 4) data indicates that the problem has been developing for many years. According to ADEA, from 2007 through 2017, the average number of dentists graduating from CODA-accredited educational programs each year increased from 4,714 to 6,238 (32.3%). During the same 10-year period, the average number of hygienist graduates from CODA-accredited programs increased modestly from 6,652 to 7,294 (9.7%), and the average number of assistants from CODA accredited programs actually decreased from 6,097 to 4,852 (-20.4%), partially the result of the increase in unaccredited assisting programs. Clearly the number of graduating dental team members is not keeping pace with the number of graduating dentists.

There is no single solution to this growing workforce shortage. A kneejerk reaction may be to increase class sizes, but some schools report declining applications and enrollment. The problem is not just a need for larger classrooms, but a need for a larger applicant pool. Dentistry needs to be more aggressive in attracting young people to dentistry, hygiene and assisting careers.

The ADA Mission is to “help dentists succeed and support the advancement of the health of the public.” It is imperative that dentists be supported by an adequate, well-trained dental team workforce. This is a critical element in access to care and the financial viability and sustainability of dental practices. This can
best be achieved by recruiting and training an adequate workforce, while also taking steps to increase employee tenure by helping establish a safe and nurturing workplace environment.

Resolution

85. Resolved, that the appropriate ADA agency publicize the availability of existing print and social media communications materials that members and state and local dental societies can use to promote and encourage 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 burnout 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 conduct 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.

BOARD COMMENT: The Board completely understands the workforce concerns that are shared across our Association. This issue would appear to be in the purview of ADEA and their constituents in education. Additionally, the lack of impact measures influenced the Board's decision.

BOARD RECOMMENDATION: Vote No.

Vote: Resolution 85

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Addressing the Dental Team Workforce Shortage

The following amendment to Resolution 85 (worksheet: 3021) was submitted by the Third Trustee District and transmitted on September 23, 2021 by Mr. Ward Blackwell, executive director, Pennsylvania Dental Association.

Background: The Third District supports the objectives of Resolution 85. This is a critical issue that is having among the most profound impacts of all the challenges for the profession in the course of the pandemic. Any reasonable possibility for improvement that is both significant and reasonably expeditious would seem worth exploring. And, existing dental education institutions would seem to be best positioned in terms of experience and resources to effect meaningful improvement in a reasonable time frame (even though we acknowledge that a “reasonable” time is a fairly subjective metric). Accordingly, the Third District would offer an amendment to Resolution 85 that supplements the original language with additional strategies for evaluation. (Additions are underscored; deletions are stricken.)

Resolution

85S-1. Resolved, that the appropriate ADA agency publicize the availability of existing print and social media communications materials that members and state and local dental societies can use to promote and encourage 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 burnout 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 conduct 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(ies) investigate financial incentives, such as possible
tax abatements and grants, to motivate existing dental educational institutions to create, or
expand existing, dental hygiene and dental assisting programs in order to expedite the resolution
of the workforce issue.

BOARD COMMENT: Received after the September 2021 Board of Trustees Meeting.
The following substitution was submitted by Mr. Doug Bush, executive director, Indiana Dental Association and transmitted on September 28, 2021.

Background: Dentistry is facing a workforce crisis. A shortage of dental hygienists, dental assistants and dental office administrative staff that existed prior to COVID-19 appears to have been exacerbated by the pandemic, as some staff members did not return to the profession after COVID-related dental office shutdowns.

According to a May 17, 2021, study by the ADA Health Policy Institute, 35.8% of owner dentists were recruiting assistants; 28.8% were seeking hygienists and 26.5% were seeking administrative support staff. The same study reported hiring struggles: 86% of dentists reported hygiene recruitment efforts as “extremely” or “very” challenging; and 83% reported assistant recruitment efforts as “extremely” or “very” challenging.

While COVID is partially to blame, American Dental Education Association (ADEA) Snapshot of Dental Education 2019-20 (page 4) data indicates that the problem has been developing for many years. According to ADEA, from 2007 through 2017, the average number of dentists graduating from CODA-accredited educational programs each year increased from 4,714 to 6,238 (32.3%). During the same 10-year period, the average number of hygienist graduates from CODA-accredited programs increased modestly from 6,652 to 7,294 (9.7%), and the average number of assistants from CODA accredited programs actually decreased from 6,097 to 4,852 (-20.4%), partially the result of the increase in unaccredited assisting programs. Clearly the number of graduating dental team members is not keeping pace with the number of graduating dentists.

There is no single solution to this growing workforce shortage. A kneejerk reaction may be to increase class sizes, but some schools report declining applications and enrollment. The problem is not just a need for larger classrooms, but a need for a larger applicant pool. Dentistry needs to be more aggressive in attracting young people to dentistry, hygiene and assisting careers.

The ADA Mission is to “help dentists succeed and support the advancement of the health of the public.” It is imperative that dentists be supported by an adequate, well-trained dental team workforce. This is a critical element in access to care and the financial viability and sustainability of dental practices. This can best be achieved by recruiting and training an adequate workforce, while also taking steps to increase employee tenure by helping establish a safe and nurturing workplace environment.
The author of the resolution offers the following substitute resolution to clarify several aspects of the proposal, including the collaboration of ADEA in studying optimal hygiene and assisting program enrollment recommendations. (Additions are underscored; deletions are stricken.)

Resolution

85S-2. Resolved, that the appropriate ADA agency publicize the availability of distribute existing print and social media communications materials that members and to state and local dental societies can 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 burnout 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.

BOARD COMMENT: Received after the September 2021 Board of Trustees Meeting
Reinstatement of ADA Third Party Payer Concierge Service

The following resolution was submitted by the Fourteenth Trustee District and transmitted on August 30 by Dr. Julius N. Manz, Director, Dental Hygiene Program, San Juan College.

Background: In 2020, the American Dental Association (ADA) decided to end its third-party dental insurance concierge service. The service assisted ADA members who used it with insurance disputes they had with third-party insurance companies. Numerous state dental associations have stated that the members using the service found it to be of significant benefit and value. The ADA explained that its decision to terminate the service was based on the costs for the service, which the ADA indicated only had about 5,000 calls from ADA members per year. To that end, numerous supporters of the service responded that it was not heavily promoted by the ADA (perhaps explaining its low usage) and yet, even at 5,000 calls per year, that far exceeded the usage of other services that the ADA has invested in and continues to invest in.

Moving forward, the ADA suggested that third-party insurance issues be handled by the individual states, but if the ADA’s centralized service had low turnout (5,000 calls per year), then spreading those services out over 50 states would only seem to result in even higher overhead for less usage (in just spreading out 5,000 calls over 50 states, each state would need someone (so 50 people compared to the ADA’s 5 people) to handle on average 100 calls per year). Given the significant member value that this service provided for those who used it and the efficiencies and cost-savings that can be achieved by providing it at the ADA level rather than the state level, are reasons enough to reinstate this program. Moreover, any issues of underuse hopefully could be resolved by increasing the promotional efforts for the service to all ADA members.

Resolution

88. 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 benefit.

Board Comment: Delivered to the House of Delegates absent Board of Trustees evaluation, recommendation or comment due to inadequate process time of resolution.
Resolution No. 89

Report: N/A Date Submitted: August 2021

Submitted By: Indiana Dental Association

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

Total Net Financial Implication: None Net Dues Impact: __________

Amount One-time __________ Amount On-going __________

ADA Strategic Plan Objective: Membership Obj-1: Increase membership market share of lagging demographics by 2% per year.

How does this resolution increase member value: See Background

ADDRESSING THIRD PARTY DENTAL REIMBURSEMENT RATES

The following amendment was submitted by Mr. Doug Bush, executive director, Indiana Dental Association and transmitted on August 26, 2021.

Background: Dentistry is facing a workforce crisis. A shortage of dental hygienists, dental assistants and dental office administrative staff that existed prior to COVID-19 appears to have been exacerbated by the pandemic, as some staff members did not return to the profession after COVID-related dental office shutdowns.

According to a May 17, 2021, study by the ADA Health Policy Institute, 35.8% of owner dentists were recruiting assistants; 28.8% were seeking hygienists and 26.5% were seeking administrative support staff. The same study reported hiring struggles: 86% of dentists reported hygiene recruitment efforts as “extremely” or “very” challenging; and 83% reported assistant recruitment efforts as “extremely” or “very” challenging.

This workforce shortage is leading to substantial increases in staffing costs for dentists. This inflation is further exacerbated by increasing personal protection equipment (PPE) and other infection control costs created by the COVID pandemic. Rising costs will ultimately be reflected in rising dental fees.

Third party payers should recognize these increases in dental office overhead and make appropriate adjustments to dental reimbursement rates.

Resolution

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.

BOARD COMMENT: Delivered to the House of Delegates absent Board of Trustees evaluation, recommendation or comment due to inadequate process time of resolution.
DEVELOPING SAFEGUARDS TO PROTECT EMPLOYEE DENTISTS

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

**Background:** As dental practice models evolve, concerns arise with regard to the role of dentists working as employees. One area of particular concern is the issue of billing claims made to third party payers done under the employee dentist’s NPI number and signature on file but without the employee dentist’s approval. Use of the employee dentist’s NPI and signature on file directly indicates that the employee dentist has authorized the claim and accepts liability for the accuracy of that claim.

When such claims are inaccurately or inappropriately submitted without the employee dentist’s approval, it exposes the employee dentist to allegations of fraud.

This is less of an issue with third party payers, and more of an issue pertaining to employment. There is growing evidence that this type of misappropriation of employee dentist’s information is occurring in a wide variety of different practice settings where a dentist is employed.

Dentists should therefore be made aware of the risks that they accept when entering into business relationships. In order to help facilitate this, the ADA should develop guidelines to protect its member dentists who are employee dentists. Such guidelines will help employee dentists in safeguarding their personal information and will help minimize the risk of a fraudulent claims being submitted under the employee dentist’s name.

Although the ADA currently has policy (Statement Regarding Employment of a Dentist (Trans.2013:353; 2018:357; 2019:251)) which states that employers should make certain that proper business practices, including billing, are followed, no guidelines currently exist which would assist the employee dentist in either avoiding these pitfalls or addressing them with their employer should they occur.

**Resolution**

93. Resolved, that the appropriate ADA agency develop guidelines off of the existing policy which would be aimed at assisting the employee dentists to assure the accuracy of claims and communications to other parties on their behalf.

**BOARD COMMENT:** Delivered to the House of Delegates absent Board of Trustees evaluation, recommendation or comment due to inadequate process time of resolution.
Resolution No. 107

Report: N/A

Submitted By: Sixteenth Trustee District

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

Total Net Financial Implication: None

Net Dues Impact: 

Amount One-time 

Amount On-going 

ADA Strategic Plan Objective: Public Goal Obj-10: Dental benefit programs will be sufficiently funded and efficiently administered.

How does this resolution increase member value: See Background

STANDARD FORM FOR CONSOLIDATING DENTAL IMPLANT AND IMPLANT RESTORATION DATA

The following resolution was submitted by the Sixteenth Trustee District and transmitted on October 6, 2021 by Mr. Phil Latham, executive director, South Carolina Dental Association.

Background: Replacing and repairing existing implant restorations is becoming increasingly difficult and complicated due to lost data regarding implant and abutment details. This resolution offers a simple and non-intrusive way to establish a standard form to assist dentists and patients affected by failing implant restorations. The following resolution addresses both of these.

Resolution

107. 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.

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