Minutes of the 161st Annual Session of the American Dental Association House of Delegates

October 15-19, 2020
Chicago, Illinois

Thursday, October 15, 2020

First Meeting of the House of Delegates

Call to Order: The First Meeting of the 161st 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 9:30 a.m., Central Time, Thursday, September 15, 2020. The 161st Annual Session of the American Dental House of Delegates was convened virtually and broadcast via Zoom Webinar from the American Dental Association Headquarters in Chicago, Illinois.

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: The Pledge of Allegiance was recited led by a video presentation.

Announcements: For the benefit of the delegates and alternate delegates, the Speaker reviewed announcements regarding technology used for the virtual meeting, technical support, and a planned update from the general counsel at the conclusion of the first meeting of 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. Anthony Cuomo, New York, Committee chair, presented the Committee's report. The other members of the Committee were: Dr. Rickland G. Asai, Oregon; Dr. I. Jay Freedman, Pennsylvania; Dr. Scott L. Morrison, Nebraska; Dr. Vishruti M. Patel, Illinois; Dr. Richard D. Riddle, Jr., Connecticut; Dr. Werner W. Schneider, Arkansas; Dr. Richard A. Stevenson, Florida; and Dr. John E. Taylor, California.

Approval of Certified Delegates. Dr. Cuomo reported that a list of certified delegates and alternate delegates as of October 8, 2020, was posted on ADA Connect. Subsequent to the October 8 posting, the following requests relating to the credentialing of a new delegate and new alternate delegate were presented:

Delegate
Dr. Rudolph T. Liddell, Florida, filling vacant delegate seat

Alternate Delegate
Dr. Bradley Anderson, North Dakota, replacing Dr. Dustin Hollevoet

Dr. Cuomo 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. Cuomo moved Resolution 94 (*Supplement:*1026) as amended. Hearing no objection, the Speaker declared Resolution 94, as amended, adopted.

94H-2020. 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 2020 House of Delegates of the American Dental Association.

Dr. Cuomo reported the presence of a quorum.

Dr. Cuomo 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 2019 Session of the House of Delegates. On behalf of the Committee, Dr. Cuomo moved Resolution 95 (*Supplement:*1027). The Speaker asked if there were any corrections to the minutes; hearing none, the Speaker declared the minutes adopted.

95H-2020. Resolved, that the minutes of the 2019 session of the House of Delegates be approved.

Adoption of Agenda and Order of Agenda Items. On behalf of the Committee, Dr. Cuomo moved Resolution 96 (*Supplement:*1028).

Hearing no objection, Resolution 96 was adopted.

96H-2020. Resolved, that the agenda as presented in the *2020 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.

Special Rules of the 2020 Virtual House of Delegates. On behalf of the Committee, Dr. Cuomo moved Resolution 99 (*Supplement:*1031).

Dr. Cuomo moved to amend Resolution 99 by deleting the *Special Rule: Nominations of Officers* on page 1021, lines 10-12, of the Report of the Standing Committee on Credentials, Rules and Order, so the section on Nominations of Officers would read as follows:

~~SPECIAL RULE:~~ **Nominations of Officers:** The nominations of officers (president-elect and second vice president) will take place at the first meeting of the House on Thursday, October 15. *~~Candidates for elective office will be announced by the Speaker. The Speaker will read a brief nomination statement on behalf of each candidate.~~* Any additional nominations may be offered by a simple declaratory statement. Each candidate may give an acceptance speech not to exceed four minutes.

Hearing no objection, the proposed amendment was adopted.

Hearing no objection, Resolution 99, as amended, was adopted.

99H-2020. Resolved, that the Special Rules for the 2020 Virtual House of Delegates as identified in the Report of the Committee on Credentials, Rules and Order be adopted.

[Special Rules of the Virtual House of Delegates–as amended–are available following page 100.]

Special Order of Referral Consent Calendar. The Speaker explained that the Special Order of Referral Consent Calendar was prepared to help manage the time of the virtual House of Delegates. The Special Order of Referral Consent Calendar lists resolutions considered to be non-urgent and could be referred to the appropriate ADA agencies for report at the 2021 House of Delegates. The Speaker stated that as with any consent calendar, any delegate has the right to extract a resolution from the Referral Consent Calendar. By doing so, that resolution will be referred to the appropriate Reference Committee and be taken up at this year's House of Delegates.

97. Resolved, that the recommendation of the Speaker to refer the following resolutions to the appropriate ADA agency to be presented at the 2021 House of Delegates be adopted.

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

Resolution 40—Wisconsin Dental Association—Request that ADA Explore New Dues Structure Reflecting Evolving Dental Practice Models (*Supplement:*2001)

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

Resolution 83—First Trustee District—Policy for the Elimination of Wait Periods for Children in Dental Benefit Plans (*Supplement:*3012)

Resolution 83B—Board Substitute—Policy for the Elimination of Wait Periods for Children in Dental Benefit Plans (*Supplement:*3013)

Resolution 85—Fifteenth Trustee District—Dental Benefits Information for ADA Members (*Supplement:*3017)

Resolution 86—Fifteenth Trustee District—Improved ADA Member Assistance with Third Party Payer Issues (*Supplement:*3018)

Resolution 105—Fourteenth Trustee District—Inappropriate Recoupment Practices of Dental Benefit Companies (*Supplement:*3025)

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

Resolution 109—Fourteenth Trustee District—ADA Policy on Tooth Gems and Jewelry (*Supplement:*4028)

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

Resolution 3—Council on Government Affairs—Rescission of the Policy, Dental Focus in Federal Health Agencies (*Supplement:*5002)

Resolution 4—Council on Government Affairs—Amendment of the Policy, Use of Dentist-to-Population Ratios (*Supplement:*5004)

Resolution 5—Council on Government Affairs—Amendment of the Policy, Suggested Dental Practice Acts (*Supplement:*5005)

Resolution 6—Council on Government Affairs—Rescission of the Policy, State Regulation of Advertising (*Supplement:*5007)

Resolution 11—Council on Government Affairs—Proposed Policy, Rank and Status of Dentists in the Armed Forces, Military Reserves and Public Health Services (*Supplement:*5017)

Resolution 12—Council on Government Affairs—Amendment of the Policy, Dental Research by Military Departments (*Supplement:*5020)

Resolution 13—Council on Government Affairs—Amendment of the Policy, Legislative Delegations (*Supplement:*5022)

Resolution 13S-1—Sixteenth Trustee District—Substitute Resolution (*Supplement:*5023a)

Resolution 14—Council on Government Affairs—Amendment of the Policy, Antitrust Reform (*Supplement:*5025)

Resolution 23—Council on Government Affairs—Amendment of the Policy, Encouraging the Development of Oral Health Literacy Continuing Education Programs (*Supplement:*5029)

Resolution 24—Council on Government Affairs—Rescission of the Policy, Preventive Dental Procedures (*Supplement:*5030)

Resolution 26—Council on Government Affairs— Rescission of the Policy, High Blood Pressure Programs (*Supplement:*5034)

Resolution 28—Council on Government Affairs—Amendment of the Policy, Protection of Retirement Assets (*Supplement:*5038)

Resolution 29—Council on Ethics, Bylaws and Judicial Affairs—Amendment of Section 3.A. of the *ADA Principles of Ethics and Code of Professional Conduct* (*Supplement:*5040)

Resolution 31—Council on Ethics, Bylaws and Judicial Affairs—Amendment of the ADA Member Conduct Policy (*Supplement:*5045)

Resolution 32—Council on Ethics, Bylaws and Judicial Affairs—Amendment and Simplification of *Bylaws* Chapter I., Section 20.B. (*Supplement:*5048)

Resolution 33—Council on Advocacy for Access and Prevention—Amendment of the Policy, Limited Oral health Literacy Skills and Understanding in Adults (*Supplement:*5049)

Resolution 34—Council on Advocacy for Access and Prevention—Amendment of the Policy, Comprehensive Policy Statement on Allied Dental Personnel (*Supplement:*5050)

Resolution 34S-1—Sixteenth Trustee District—Substitute Resolution (*Supplement:*5057a)

Resolution 35—Council on Advocacy for Access and Prevention—Amendment of the Policy, Women's Oral Health: Patient Education (*Supplement:*5058)

Resolution 36—Council on Advocacy for Access and Prevention—Amendment of the Policy, Communication and Dental Practice (*Supplement:*5059)

Resolution 37—Council on Advocacy for Access and Prevention—Amendment of the Policy, Health Planning Guidelines (*Supplement:*5060)

Resolution 37S-1—Sixteenth Trustee District—Substitute Resolution (*Supplement:*5060a)

Resolution 38—Council on Advocacy for Access and Prevention—Amendment of the Policy, Non Dental Providers Notification of Preventive Dental Treatment (*Supplement:*5061)

Resolution 39—Council on Advocacy for Access and Prevention—Amendment of the Policy, Non-Dental Providers Completing Educational Program on Oral Health (*Supplement:*5062)

Resolution 42—Council on Government Affairs—Amendment of the Policy, Use of Expert Witnesses in Liability Cases (*Supplement:*5069)

Resolution 45—Council on Government Affairs—Rescission of the Policy, Professional Liability Insurance Legislations (*Supplement:*5075)

Resolution 46—Council on Government Affairs—Amendment of the Policy, Fee-For-Service Medicaid Programs (*Supplement:*5077)

Resolution 47—Council on Government Affairs—Amendment of the Policy, Medicaid and Indigent Care Funding (*Supplement:*5078)

Resolution 48—Council on Government Affairs—Amendment of the Policy, Support for Adult Medicaid Dental Services (*Supplement:*5080)

Resolution 48S-1—Sixteenth Trustee District—Substitute Resolution (*Supplement:*5080a)

Resolution 52—Council on Government Affairs—Rescission of the Policy, Availability of Dentists for Underserved Populations (*Supplement:*5088)

Resolution 52S-1—Ninth Trustee District—Substitute Resolution (*Supplement:*5089a)

Resolution 53—Council on Government Affairs—Rescission of the Policy, Misdistribution of the Dental Workforce (*Supplement:*5091)

Resolution 54—Council on Government Affairs—Amendment of the Policy, Freedom of Choice in Publicly Funded Aid Programs (*Supplement:*5093)

Resolution 55—Council on Government Affairs—Amendment of the Policy, Legislative Separation of Medicine and Dentistry (*Supplement:*5094)

Resolution 56—Council on Government Affairs—Amendment of the Policy, Limited English Proficiency (*Supplement:*5095)

Resolution 57—Council on Government Affairs—Proposed Policy, Discrimination of Benefit Payment Based on Professional Degree of Provider (*Supplement:*5097)

Resolution 58—Council on Government Affairs—Proposed Policy, Guaranteeing the Patient's Freedom of Choice of Dentist (*Supplement:*5100)

Resolution 59—Council on Government Affairs—Proposed Policy, Regulatory Definitions of Dentistry (*Supplement:*5102)

Resolution 60—Council on Government Affairs—Rescission of the Policy, ADA Assistance in Legislative Initiatives (*Supplement:*5105)

Resolution 61—Council on Government Affairs—Rescission of the Policy, Costs for the Submission of Electronic Dental Claims (*Supplement:*5108)

Resolution 63—Council on Government Affairs—Rescission of the Policy, Advocating for ERISA Reform (*Supplement:*5110)

Resolution 64—Council on Ethics, Bylaws and Judicial Affairs—Amendment of Chapter III., Section 120 of the ADA *Bylaws* (*Supplement:*5112)

Resolution 65—Council on Government Affairs—Proposed Policy, Anesthesia Coverage Under Health Plans (*Supplement:*5114)

Resolution 69—Council on Government Affairs—Proposed Policy, Provisions for ERISA Plans (*Supplement:*5116)

Resolution 74—Elder Care Workgroup—Elder Care Strategies for Continuing Education (*Supplement:*5142)

Resolution 75—Elder Care Workgroup—Elder Care Strategies on Research (*Supplement:*5145)

Resolution 76—Elder Care Workgroup—Elder Care Strategies on Increased Preparedness of Educational Institutions (*Supplement:*5146)

Resolution 77—Elder Care Workgroup—Elder Care Strategies on Public Advocacy (*Supplement:*5148)

Resolution 78—Elder Care Workgroup—Elder Care Strategies on Intra-Professional Advocacy (*Supplement:*5150)

Resolution 79—Elder Care Workgroup—Elder Care Strategies on Long Term Care Facilities (*Supplement:*5152)

Resolution 80—Elder Care Workgroup—Elder Care Strategies on Inter-Agency Advocacy (*Supplement:*5154)

Resolution 81—Elder Care Workgroup—Elder Care Strategies on Practice Management (*Supplement:*5156)

Resolution 89—Council on Government Affairs—Proposed Policy, Resources for Veterans Ineligible for VA Dental Care (*Supplement:*5161)

Resolution 103—Fourteenth Trustee District—Reexamine Council on Communication Liaison Program (*Supplement:*5180)

Resolution 104—Fourteenth Trustee District—Formulating Innovations to Address Underserved Areas (*Supplement:*5181)

Dr. Cuomo moved Resolution 97.

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

Resolution 31 removed by Dr. Michael A. Kurkowski, Minnesota
Resolution 89 removed by Dr. Phillip J. Fijal, Illinois

Hearing no objection, Resolution 97, as amended, was adopted by general consent.

97H-2020. Resolved, that the recommendation of the Speaker to refer the following resolutions to the appropriate ADA agency to be presented at the 2021 House of Delegates be adopted.

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

Resolution 40—Wisconsin Dental Association—Request that ADA Explore New Dues Structure Reflecting Evolving Dental Practice Models (*Supplement:*2001)

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

Resolution 83—First Trustee District—Policy for the Elimination of Wait Periods for Children in Dental Benefit Plans (*Supplement:*3012)

Resolution 83B—Board Substitute—Policy for the Elimination of Wait Periods for Children in Dental Benefit Plans (*Supplement:*3013)

Resolution 85—Fifteenth Trustee District—Dental Benefits Information for ADA Members (*Supplement:*3017)

Resolution 86—Fifteenth Trustee District—Improved ADA Member Assistance with Third Party Payer Issues (*Supplement:*3018)

Resolution 105—Fourteenth Trustee District—Inappropriate Recoupment Practices of Dental Benefit Companies (*Supplement:*3025)

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

Resolution 109—Fourteenth Trustee District—ADA Policy on Tooth Gems and Jewelry (*Supplement:*4028)

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

Resolution 3—Council on Government Affairs—Rescission of the Policy, Dental Focus in Federal Health Agencies (*Supplement:*5002)

Resolution 4—Council on Government Affairs—Amendment of the Policy, Use of Dentist-to-Population Ratios (*Supplement:*5004)

Resolution 5—Council on Government Affairs—Amendment of the Policy, Suggested Dental Practice Acts (*Supplement:*5005)

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Resolution 11—Council on Government Affairs—Proposed Policy, Rank and Status of Dentists in the Armed Forces, Military Reserves and Public Health Services (*Supplement:*5017)

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Resolution 29—Council on Ethics, Bylaws and Judicial Affairs—Amendment of Section 3.A. of the *ADA Principles of Ethics and Code of Professional Conduct* (*Supplement:*5040)

~~**Resolution 31**—Council on Ethics, Bylaws and Judicial Affairs—Amendment of the ADA Member Conduct Policy (*Supplement:*5045)~~

Resolution 32—Council on Ethics, Bylaws and Judicial Affairs—Amendment and Simplification of *Bylaws* Chapter I., Section 20.B. (*Supplement:*5048)

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Resolution 57—Council on Government Affairs—Proposed Policy, Discrimination of Benefit Payment Based on Professional Degree of Provider (*Supplement:*5097)

Resolution 58—Council on Government Affairs—Proposed Policy, Guaranteeing the Patient's Freedom of Choice of Dentist (*Supplement:*5100)

Resolution 59—Council on Government Affairs—Proposed Policy, Regulatory Definitions of Dentistry (*Supplement:*5102)

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Resolution 61—Council on Government Affairs—Rescission of the Policy, Costs for the Submission of Electronic Dental Claims (*Supplement:*5108)

Resolution 63—Council on Government Affairs—Rescission of the Policy, Advocating for ERISA Reform (*Supplement:*5110)

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Resolution 77—Elder Care Workgroup—Elder Care Strategies on Public Advocacy (*Supplement:*5148)

Resolution 78—Elder Care Workgroup—Elder Care Strategies on Intra-Professional Advocacy (*Supplement:*5150)

Resolution 79—Elder Care Workgroup—Elder Care Strategies on Long Term Care Facilities (*Supplement:*5152)

Resolution 80—Elder Care Workgroup—Elder Care Strategies on Inter-Agency Advocacy (*Supplement:*5154)

Resolution 81—Elder Care Workgroup—Elder Care Strategies on Practice Management (*Supplement:*5156)

~~**Resolution 89**—Council on Government Affairs—Proposed Policy, Resources for Veterans Ineligible for VA Dental Care (*Supplement:*5161)~~

Resolution 103—Fourteenth Trustee District—Reexamine Council on Communication Liaison Program (*Supplement:*5180)

Resolution 104—Fourteenth Trustee District—Formulating Innovations to Address Underserved Areas (*Supplement:*5181)

Note: For the purpose of a fully documented record, the text of the resolutions presented in Resolution 97H follows.

Special Order of Referral Consent Calendar—Resolutions Referred

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

Request that ADA Explore New Dues Structure Reflecting Evolving Dental Practice Models

40. Resolved, that the American Dental Association direct its appropriate agency to explore a new tripartite membership dues structure that more accurately reflects evolving practice models, and be it further
Resolved, that their findings be reported to the 2021 ADA House of Delegates.

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

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

83. 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.

Board Substitute Resolution

83B. 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~~.

Dental Benefits Information for ADA Members

85. Resolved, that the appropriate agency of the American Dental Association (ADA) be directed to review all current dental benefit activities conducted by the ADA. This activity inventory will include all dental benefits information available on the ADA's Center for Professional Success, ADA-created dental benefit webinars for members, and the third-party payer concierge, and be it further
Resolved, that the information inventory be summarized into an easy to read/easy to access document distributed to member dentists, and be it further
Resolved, that a report be delivered to the 2021 ADA House of Delegates including the information inventory that was disseminated to all ADA members.

Improved ADA Member Assistance with Third Party Payer Issues

86. Resolved, that the appropriate agency of the ADA be directed to review the most frequently reported third party payer issues submitted to the ADA through the third party payer concierge and the ADA's online third party complaint form and organize the issues into complaint categories to facilitate discussions with insurance carriers, and be it further
Resolved, that the appropriate agency of the ADA take the complaint categories forward and make an attempt to meet with the insurance companies, identified from the third party payer concierge and submitted ADA complaint forms, to resolve as a whole the identified insurance complaints, and be it further
Resolved, that a report be delivered to the 2021 ADA House of Delegates (HOD) summarizing the meeting(s) and including details on the elimination of claims payment abuses identified in the complaint categories. This report shall include the complaints resolved and the status of the complaints unable to be resolved before the report was prepared for the 2021 HOD meeting.

Inappropriate Recoupment Practices of Dental Benefit Companies

105. Resolved, that the ADA Council on Dental Benefits Plans (CDBP) review ADA policies regarding recoupment practices including Bulk Benefit Payment Statements (*Trans.*1990: 536, 2013:308, 2015:243); Third-Party Payers Overpayment Recovery Practices (*Trans.*1999:930, 2013:312) and Third Party Payment Choices (*Trans*.2017:265) and, be it further
Resolved, that the Council recommend a policy to encourage fair recoupment practices including reasonable time limitations and regular oversight by regulating agencies.

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

ADA Policy on Tooth Gems and Jewelry

109. Resolved, that the appropriate ADA agencies recommend a policy on tooth gems and jewelry to the 2021 House of Delegates.

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

Rescission of the Policy, Dental Focus in Federal Health Agencies

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

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

4. 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.

Amendment of the Policy, Suggested Dental Practice Acts

5. 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

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

Proposed Policy, Rank and Status of Dentists in the Armed Forces, Military Reserves and Public Health Services

11. Resolved, that flag rank(s) of dental officers should be protected and enhanced in all branches of the armed forces, military reserves and Public Health Service, 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 U.S. Army, U.S. Navy, U.S. Air Force, U.S. Public Health 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.*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

12. 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.

Amendment of the Policy, Legislative Delegations

13. 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 continue to encourage members to join and actively participate in the American Dental Political Action Committee's Grassroots Program.

Substitute Resolution

13S-1. Resolved, that the Association encourage individual ADA members to join and actively participate in the ADA Grassroots Program, and be it further
Resolved, that ADA members representing constituent and component societies 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.

Amendment of the Policy, Antitrust Reform

14. 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 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 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, Encouraging the Development of Oral Health Literacy Continuing Education Programs

23. 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.~~

Rescission of the Policy, Preventive Dental Procedures

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

Rescission of the Policy, High Blood Pressure Programs

26. Resolved, that the policy titled High Blood Pressure Programs be rescinded.

Amendment of the Policy, Protection of Retirement Assets

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

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

32. 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.~~

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

33. 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 health literacy as a significant barrier to effective prevention, diagnosis and treatment of oral disease, and be it further
Resolved, that dental offices encourage staff training in health literacy to improve health outcomes.

Amendment of the Policy, Comprehensive Policy Statement on Allied Dental Personnel

34. Resolved, that the terminology describing the Community Dental Health Coordinator provided in the "Glossary of Terminology Related to Allied Dental Personnel Utilization and Supervision" of the ADA Comprehensive Policy Statement on Allied Dental Personnel (*Trans*.1996:699; 1998:713; 2001:467; 2002:400; 2006:307; 2010:505) be amended as follows (new language underscored, deletions ~~stricken through~~):

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 duties such as screenings, fluoride treatments, placement of sealants and temporary restorations and simple 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 care from a dentist or dental hygienist. Upon graduation, they will work primarily in a public health and community settings like clinics, schools, ~~churches,~~ faith based settings, senior citizen centers, and Head Start programs in with a variety of dental providers, including clinics, community health centers, the Indian Health Service and private practice ~~dentists~~ dental offices.

Substitute Resolution

34S-1. Resolved, that the terminology describing the Community Dental Health Coordinator provided in the "Glossary of Terminology Related to Allied Dental Personnel Utilization and Supervision" of the ADA Comprehensive Policy Statement on Allied Dental Personnel (*Trans*.1996:699; 1998:713; 2001:467; 2002:400; 2006:307; 2010:505) be amended as follows (new language underscored, deletions ~~stricken through~~):

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 duties such as screenings, fluoride treatments, placement of sealants and temporary restorations and simple 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 care from a licensed dentist ~~or dental hygienist~~ and establishment of a dental home. Upon graduation, they will work primarily in a public health and community settings like clinics, schools, ~~churches,~~ faith based settings, senior citizen centers, and Head Start programs in with a variety of dental providers, including clinics, community health centers, the Indian Health Service and private practice ~~dentists~~ dental offices.

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

35. 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, Communication and Dental Practice

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

Amendment of the Policy, Health Planning Guidelines

37. 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 these objectives.

District Substitute Resolution

37S-1. Resolved, that the policy titled Health Planning Guidelines (*Trans*.1983:545; 2014:503) be amended to read as follows (additions are double ~~underscored~~; deletions are double ~~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 these objectives~~ when the objectives of said coalition are consistent with Association policy.

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

38. 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 underscored; deletions are ~~stricken~~):

Resolved, that prior to any preventive dental treatment, a dental disease risk assessment should be performed by a dentist or appropriately trained 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 dental home with a report of the services rendered given to the custodial parent or legal guardian.

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

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

Resolved, that only dentists, physicians and their properly supervised and trained designees, be allowed to provide preventive dental services 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 for this age group, and be it further

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

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

42. 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.

Rescission of the Policy, Professional Liability Insurance Legislations

45. Resolved, that the policy titled Professional Liability Insurance Legislation (*Trans.*1984:548) be rescinded.

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

46. 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

47. 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, Support for Adult Medicaid Dental Services

48. 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~~ adult dental services should be included in the federal Medicaid program, 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.

Substitute Resolution

48S-1. Resolved, that the policy titled Support for Adult Medicaid Dental Services (*Trans.*2004:327) be amended to read as follows (additions are double underscored; deletions are ~~stricken~~):

Resolved, that ~~the ADA adopt policy supporting the inclusion of~~ adult dental services should be included in the federal Medicaid program as oral health is 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, Availability of Dentists for Underserved Populations

52. Resolved, that the policy titled Availability of Dentists for Underserved Populations (*Trans.*1986:532; 2016:318) be rescinded.

Substitute Resolution

52S-1. Resolved, that the policy titled Availability of Dentists for Underserved Populations (*Trans*.1986:532; 2016:318) be amended as follows (additions are underscored; deletions are ~~stricken~~):

~~**Resolved**, that constituent societies be urged to participate in programs that encourage dentists to serve underserved populations and that offer case management resources to enable dentists to provide oral health care for institutionalized and homebound individuals, including those who are physically, emotionally and mentally disabled, and be it further~~

~~**Resolved**, that constituent societies be urged to seek fiscal resources to provide case management in support of dentists providing oral health care for these individuals, and be it further~~

~~**Resolved**, that the ADA, working with other affected organizations, review or conduct studies on the availability and scope of dental programs for the treatment of special needs populations, including physically, emotionally and mentally disabled patients.~~

Resolved, that the American Dental Association supports the development of governmental and regulatory policy at the federal, state and local levels that promotes the availability of dentists for underserved populations.

Rescission of the Policy, Misdistribution of the Dental Workforce

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

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

54. 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, Legislative Separation of Medicine and Dentistry

55. Resolved, that the policy titled Legislative Separation of Medicine and Dentistry (*Trans.*1996:715) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the American Dental Association work to assure that~~ dentistry ~~is~~ should be addressed separately from medicine in any health care reform legislation.

Amendment of the Policy, Limited English Proficiency

56. 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~~.

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

57. 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.

Proposed Policy, Guaranteeing the Patient's Freedom of Choice of Dentist

58. Resolved, that the following policy titled Guarantee Patient's Freedom of Choice of Dentist be adopted:

Guarantee 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.

Proposed Policy, Regulatory Definitions of Dentistry

59. Resolved, that the following policy titled Regulatory Definitions of Dentistry be adopted:

Regulatory Definitions of Dentistry

Resolved, that the American Dental Association's definitions of dentistry and the dental specialties should be reflected in all dental statutory and regulatory provisions to delineate the scope of dental education and training for dentistry and the dental specialties, as appropriate and feasible, and be it further

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

Rescission of the Policy, ADA Assistance in Legislative Initiatives

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

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

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

Rescission of the Policy, Advocating for ERISA Reform

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

Amendment of Chapter III., Section 120 of the ADA Bylaws

64. 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,~~ votes equal to or less than the number to be elected may be cast by each voting member, but only one vote may be cast per nominee, and the candidates receiving the greatest number of votes shall be elected.

Proposed Policy, Anesthesia Coverage Under Health Plans

65. 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.

Proposed Policy, Provisions for ERISA Plans

69. Resolved, that the following policy titled Provisions for ERISA Plans be adopted:

Provisions for ERISA Plans

The ADA 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.

Elder Care Strategies for Continuing Education

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

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

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

Elder Care Strategies on Research

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

1. pursuing translatable research on the oral health treatment of geriatric populations including medically, functionally or cognitively impaired complex patients to establish the linkage between oral health care and overall health
2. leading in the collection and dissemination of evidence-based recommendations on the oral systemic health connection

3. studying states with dual eligible Medicare and Medicaid beneficiaries to determine the financial savings, health outcomes and costs of the programs
4. studying cost savings and health outcomes from dental benefit plans
5. promoting the implementation of new treatment approaches, such as Silver Diamine Fluoride or other minimally invasive interventions, and determining the beneficial effects of the treatments on older adult patients in terms of quality of life and cost effectiveness

Elder Care Strategies on Increased Preparedness of Educational Institutions

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

1. advocating for geriatric fellowship programs; and encourage universities, the Department of Veterans' Affairs (VA), and hospitals to develop these; the fellows will play an important role in both the delivery of care, and the education of dental students
2. advocating for the inclusion of treating the elderly population, including complex cases, for pre-doctoral and relevant specialties in school curriculum
3. working with other relevant associations to develop curriculum guidelines for inter-professional education on both the oral-systemic connection and the dental management of the medically complex older adult

Elder Care Strategies on Public Advocacy

77. 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 public advocacy as priority projects, and be it further

Resolved, provide information on elder oral health matters to the public by:

1. developing educational material, targeted at the families of patients, that addresses their role in assisting in oral care and make it available on the public facing ADA website
2. supporting and evaluating community based interdisciplinary programs that bring health promotion and prevention and care to seniors where they live and congregate
3. developing a public service campaign on both the oral-systemic connection and the dental management of the medically complex older adult

Elder Care Strategies on Intra-Professional Advocacy

78. 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 intra-professional advocacy as priority projects, and be it further

Resolved, elevate the importance of oral health care in the elderly to medical professionals by:

1. advocating for the addition of teeth, gums, mucosa, tongue, and palate examination to the traditional head, ears, eyes, nose, and throat (HEENT) examination (HEENOT[1])
2. identifying, evaluating and promoting risk assessment tools for oral health care to nursing professionals
3. advocating for the US Preventive Services Task Force Guidelines to be updated to include additional and revised guidelines on oral health care

[1] Am J Public Health. 2015 Mar;105(3):437-41. doi: 10.2105/AJPH.2014.302495. Epub 2015 Jan 20.
Putting the mouth back in the head: HEENT to HEENOT.
Haber J1, Hartnett E, Allen K, Hallas D, Dorsen C, Lange-Kessler J, Lloyd M, Thomas E, Wholihan D. PMID:25602900

Elder Care Strategies on Long Term Care Facilities

79. 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 long term care facilities as priority projects, and be it further

Resolved, increase oral health care delivery in long term care facilities by:

1. developing an inventory of existing oral health training material and promote its use by care providers and accredited facilities
2. publishing this information to the public through the ADA public facing website
3. developing recommendations in cooperation with State Dental Directors as to how the oral health needs of medically, functionally, or cognitively complex patients in long term care facilities (LTC) should be addressed and include the evaluation of mobile clinics, dental chairs in the facility, teledentistry and other options
4. advocating for dental directors in all Long Term Care facilities, and improving oral health care by utilizing community dental health coordinators (CDHCs) and dental hygienists
5. promoting the educational content from the course developed through the National Elder Care Advisory Committee on working in Long Term Care facilities and making the content available to educational institutions at no charge
6. promoting inter- and intra-professional education and practice in LTC
7. advocating for Long Term Care to be included in Health Professional Shortage Areas

Elder Care Strategies on Inter-Agency Advocacy

80. 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 inter-agency advocacy as priority projects and be it further

Resolved, focus advocacy efforts to improve oral health care in seniors by:

1. hosting a periodic all-stakeholder summit to discuss issues related to oral health of the elderly
2. advocating for state, private and federally funded programs that use incentives like forgiveness of student debt in return for a work placement for specified periods of time in areas of need
3. improving communications to underserved communities through use of health literacy guidelines, patient navigators, community dental health coordinators and dental hygienists

Elder Care Strategies on Practice Management

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

Resolved, simplify practice management by:

1. developing best practices to facilitate consent for treatment from legal guardians
2. developing best practices compliant with HIPAA for information sharing with family members and dual consent
3. reducing the administrative burden of government funded plans
4. improving intercommunication and information sharing between providers of electronic health records and electronic dental record systems
5. participating in discussions with Office of the National Coordinator for Health Information Technology

Reexamine Council on Communication Liaison Program

103. Resolved, that the appropriate ADA agency examine the viability of the Council on Communication Council Liaison Program utilizing virtual meeting platforms, and be it further
Resolved, that a report be prepared for the 2021 House of Delegates.

Formulating Innovations to Address Underserved Areas

104. Resolved, that the appropriate ADA agency review and make recommendations regarding the loan forgiveness incentives available to new dentists that practice in rural and underserved areas including community health centers, FQHCs, Indian Health Service clinics and tribally-operated clinics with consideration to whether they adequately reflect increased levels of student debt, flexibility for part-time commitments and the difficulty attracting dentists to these locations and, be it further

Resolved, that the ADA assist graduating dental students to find employment opportunities in underserved areas by:

- Publishing and promoting available loan forgiveness resources
- Actively encouraging them to consult with dentists currently practicing in rural and underserved areas regarding practice opportunities
- Encouraging dentist employers in rural and underserved areas to offer flexible hours, part-time opportunities and extended tenure

Referrals of Reports and Resolutions. On behalf of the Committee, Dr. Cuomo moved Resolution 98 (*Supplement:*1030).

The Speaker announced the following withdrawn resolutions.

Resolution 7—Proposed Policy, Waiver of Patient Copayment/Overbilling—withdrawn by the Council on Government Affairs

Resolution 27—Proposed Policy, Payment by Third-Party Payers Only to Licensed Dentists—withdrawn by the Council on Government Affairs

Resolution 83BS-1—Policy for the Elimination of Wait Periods for Children in Dental Benefit Plans—withdrawn by the Eleventh Trustee District

Hearing no objection, Resolution 98 was adopted.

98H-2020. Resolved, that the list of referrals to a reference committee recommended by the Speaker of the House of Delegates be approved.

Consideration of New Business. The Speaker announced that one item of New Business was submitted:

Sixteenth Trustee District Resolution 110—2021 Dentist and Student Lobby Day (*Supplement:*2101)

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.

On vote, Resolution 110 received a majority vote to be considered.

The Speaker announced that Resolution 110 would be referred to Reference Committee A.

Dr. Cuomo 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 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.

Report of the President: Dr. Chad P. Gehani addressed the House of Delegates. He thanked the delegates, Board of Trustees and his family. He commented on the efforts that the ADA tripartite took to address the COVID-19 pandemic and applauded the efforts of ADA members stating, “I stand here before you with enormous pride in our profession for what it has done and continues to do in the presence of the pandemic.” He also said, “We are in the middle of a life-threatening crisis and that’s not a good place to be, but let’s not forget that whether it is running your office, supporting your family or dealing with health issues, the key to your character and your value to the world above all else is not how you respond to good fortune and happiness, but how you respond to adversity.” The Report of the President (*Supplement*:2102) was referred to Reference Committee A (Budget, Business, Membership and Administrative Matters) and was posted on ADA Connect.

Presentation of the Distinguished Service Award: Dr. Gehani presented the Distinguished Service Award, the highest award given by the ADA Board of Trustees, to Dr. Leo Rouse. Dr. Gehani highlighted Dr. Rouse’s accomplishments, including 24 years leading the Army Dental Corps as Commander and Chief Operating Officer of the United States Army Dental Command, as well as his career as a respected educator and his current position as professor and dean emeritus at Howard University College of Dentistry. Dr. Gehani noted that Dr. Rouse also served as the first African American president of the American Dental Education Association and is president-elect of the American College of Dentists. Dr. Gehani applauded Dr. Rouse’s kindness and mentorship. Dr. Rouse expressed his thanks and appreciation for the honor bestowed on him by the ADA Board of Trustees.

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. Billie Sue Kyger, Seventh District Trustee, presented the reports of the Board of Trustees to the House of Delegates.

Nominations to Councils and Commissions. Dr. Kyger moved Resolution 17 (*Supplement:*1002) on behalf of the Board of Trustees.

Hearing no objection, Resolution 17 was adopted by general consent.

17H-2020. 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. Kyger 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. Kyger noted that Reports 1 through 7 of the Board of Trustees to the House of Delegates were referred to the appropriate reference committees.

Dr. Kyger 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.

Point of Personal Privilege

Dr. Eva F. Ackley, Florida, thanked the leaders and staff of the Association for their quick response to the COVID-19 pandemic, especially for providing the latest information on COVID-19 to all dentists and for continued advocacy efforts on behalf of all members.

Nominations of Officers

President-elect: The Speaker called for nominations for the office of president-elect. Dr. Alejandro Aguirre, Minnesota, nominated Dr. Kenneth McDougall, North Dakota, for the office of president-elect; Dr. Andrew B. Brown, Florida, nominated Dr. Cesar R. Sabates, Florida, for the office of president-elect; and Dr. Jeannie Beauchamp, Tennessee, nominated Dr. Roy Thompson, Tennessee, 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 Monday, October 19.

Second Vice President: The Speaker called for nominations for the office of second vice president. Dr. Wendy A. Brown, Maryland, nominated Dr. Thomas a'Becket, Maryland, for the office of second vice president; and Dr. Craig S. Ratner, New York, nominated Dr. Maria C. Maranga, New York, for the office of second vice president. The Speaker asked if there were any additional nominations; there were none. Acceptance speeches were given by both second vice president candidates. The Speaker announced that the names of the candidates would be placed on the ballot for election on Monday, October 19.

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

Dr. Michael D. Medovic, West Virginia, Sixth District Trustee
Dr. Chad R. Leighty, Indiana, Seventh District Trustee
Dr. Scott L. Morrison, Nebraska, Tenth District Trustee
Dr. Gary D. Oyster, North Carolina, Sixteenth District Trustee
Dr. Rudolph T. Liddell, Florida, Seventeenth District Trustee

New Business: The Speaker announced that items of new business be submitted to the headquarters office for processing.

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 Dr. James E. Lee, Massachusetts. Hearing no objection, the Speaker declared the First Meeting of the ADA House of Delegates adjourned at 11:58 a.m., Central Time, Thursday, October 15, 2020.

Monday, October 19, 2020

Second Meeting of the ADA House of Delegates

Call to Order: The Second Meeting of the 161st Annual Session of the ADA House of Delegates was called to order at 9 a.m., Central Time, Monday, October 19, 2020, by the Speaker of the House of Delegates, Dr. W. Mark Donald.

Report of the Standing Committee on Credentials, Rules and Order: Dr. Anthony Cuomo, Committee chair, announced the presence of a quorum and read the ADA Disclosure Policy.

Voting for Elective Officers: Voting for officer elections took place electronically using the LUMI online voting platform.

The Speaker opened the vote for the office of president-elect. The candidates on the ballot, listed in alphabetical order, were as follows: Dr. Kenneth McDougall, North Dakota; Dr. Cesar R. Sabates, Florida; and Dr. Roy Thompson, Tennessee. After allowing time for votes to be cast, the Speaker closed the vote. The Speaker called for the House to stand at ease while the voting results were tallied. While the House stood at ease, a video played about the Distinguished Service Award recipient, Dr. Leo Rouse.

The Speaker announced that Dr. Cesar R. Sabates, Florida, had been elected to the office of president-elect. Dr. Kenneth McDougall, Dr. Roy Thompson and Dr. Cesar R. Sabates briefly addressed the House of Delegates.

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. Thomas a'Becket, Maryland and Dr. Maria C. Maranga, New York. After allowing time for votes to be cast, the Speaker closed the vote. The Speaker called for the House to stand at ease while the voting results were tallied. While the House stood at ease, a video message played from Dr. David Watson, chair of the American Dental Political Action Committee.

The Speaker announced that Dr. Maria C. Maranga, New York, had been elected to the office of second vice president. Dr. Thomas a'Becket and Dr. Maria C. Maranga briefly addressed the House of Delegates.

Announcements: The Speaker reminded the House of the Special Rules that had been adopted during the first meeting of the House and reviewed the process for entering the speaking queue and the procedure for raising a parliamentary inquiry.

The Speaker also announced that in the Report of Reference Committee B, Resolution 16 was placed on the consent calendar with a Committee recommendation to refer to the appropriate ADA agency for further study and report to the 2021 House of Delegates. The Speaker stated that if the motion to refer Resolution 16 is adopted, Resolutions 16S-1, 16S-2, 16S-3 and 16S-4 will go with the referral. If the motion to refer is not adopted, then Resolution 16 would be before the House for debate and disposition.

As a point of information, Dr. Steven L. Essig, New York, requested that the report titled "Annual Response to Resolution 78H-2019: Establishing a Culture of Safety in Dentistry" be distributed prior to the close of business of the 2020 House.

The Speaker responded, "We'll take that under consideration, and I'll have to talk with staff about that. …" During the third meeting of the House, Dr. Donald announced that the report referenced by Dr. Essig was part of the Council on Advocacy for Access and Prevention Annual Report posted on ADA Connect. Dr. Donald also stated, "There is no more expansive report that was submitted until after the reference committee hearings were over, and, therefore, it was not posted on the House of Delegates Connect, and it is not before the House at this time."

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

- Oral Health Care for the Elderly—Elder Care Workgroup Resolution 70 and Board of Trustees Substitute Resolution 70B (Reference Committee D)
- Financing Oral Health Care for Adults Age 65 and Older—Elder Care Workgroup Resolution 71, Ninth Trustee District Substitute Resolution 71S-1, Fourteenth Trustee District Substitute Resolution 71S-2 and Reference Committee D Substitute Resolution 71RC (Reference Committee D)
- Amendment of Policy, Summary of Recommendations, Report 5 of the Board of Trustees to the House of Delegates, on Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care—Elder Care Workgroup Resolution 82 and Reference Committee D Substitute Resolution 82RC (Reference Committee D)
- Approval of 2021 Budget—Board of Trustee Resolution 87 (Reference Committee A)
- Proposed ADA Policy Statement on Optimizing Dental Health Prior to Surgical/Medical Procedures and Treatment—Council on Scientific Affairs Resolution 21, Ninth Trustee District Substitute Resolution 21S-1 and Reference Committee C Substitute Resolution 21RC (Reference Committee C)

A motion was made by Dr. Kristi Golden, Arkansas, to limit debate on the priority items in Reference Committee D to two minutes per speaker and limit the total time in debate of these items to one hour and thirty minutes.

The Speaker noted that the motion to limit debate requires a two-thirds affirmative vote.

As a point of order, Dr. Brett Kessler, Fourteenth District Trustee, asked what would happen at the end of the hour and a half if the House has not come to consensus.

The Speaker responded, “Two things could happened. There could be a motion to extend debate, which would also be a motion with a threshold of two-thirds vote. At that point in time, if there’s no other motion, then we will vote on the resolution. So you have two options, either to vote on the resolution or extend debate at that point in time.”

The motion to limit debate was adopted by a two-thirds affirmative vote.

As a point of order, Dr. Robert M. Peskin, New York, inquired, “Did I hear you say that if there’s an appeal from the decision of the Chair; that is not debatable?”

The Speaker responded, “Yes, sir. That’s one of the Rules that we passed on Thursday morning. That’s one of the Special Rules for this House.”

The first priority agenda item was presented by Dr. Shane A. Ricci, Texas, chair, Reference Committee D.

Oral Health Care for the Elderly (Elder Care Workgroup Resolution 70 and Board of Trustees Resolution 70B): The Reference Committee reported as follows:

> The Reference Committee concurs with the Board of Trustees and supports adoption of Resolution 70B.
>
> **70B. Resolved,** that the American Dental Association supports the development of policy at the federal, state, and local levels that supports the fair, equitable, choice-driven provision of dental care to promote improved health and well-being in elderly patients.

Dr. Ricci moved Resolution 70B (*Supplement:*5132) in lieu of Resolution 70 (*Supplement:*5132) with the Committee Recommendation to Vote Yes.

Dr. Diane D. Romaine, Maryland, spoke in support of Resolution 70B, stating, “Since 1979, ADA policy, as adopted, has advocated for the prevention and control of dental disease, improved access to comprehensive

dental care for the elderly while concurrently advocating for expansion of a public and private dental benefit, reduced administrative burden and equitable reimbursement to dentists. Since 2008, and especially in recent months, as we know, health care and the foundational importance of dental care as essential care has evolved, beckoning us as leaders in the dental profession to build consensus on the issue of elder care and to take action and have the courage to define what that essential dental care is. I ask the House of Delegates to vote in favor of this overarching statement, which aligns us and moves us forward."

On vote, Resolution 70B was adopted in lieu of Resolution 70.

> **70H-2020. Resolved,** that the American Dental Association supports the development of policy at the federal, state, and local levels that supports the fair, equitable, choice-driven provision of dental care to promote improved health and well-being in elderly patients.

The second priority agenda item was presented by Dr. Shane A. Ricci, Texas, chair, Reference Committee D.

Financing Oral Health Care for Adults Age 65 and Older (Elder Care Workgroup Resolution 71, Ninth Trustee District Resolution 71S-1, Fourteenth Trustee District Resolution 71S-2 and Reference Committee D Resolution 71RC): The Reference Committee reported as follows:

> Reference Committee D supports the hard work of the Eldercare Workgroup and the exhaustive study that they performed. Based on testimony and written comments, there was a feeling that benefits at the lowest level were not comprehensive enough to provide adequate care for seniors. The Committee decided to combine levels one and two to ensure an appropriate level of care.
>
> To ensure adequate participation by providers, the committee included language promoting an appropriate provider reimbursement level.
>
> Finally, the committee reduced the top income level for eligible beneficiaries from 400% to 300% of FPL to better target those seniors most in need.

Financing Oral Health Care for Adults Age 65 and Older

71RC. Resolved, recognizing that oral health care for a large and growing segment of our population depends on acceptable and sustainable financing of that care, the ADA supports access to oral health services by providing dental benefit programs through the following mechanisms:

1. All state Medicaid programs should offer Level I benefits for adults age 65 and older whose income is at or below 100% of the Federal Poverty Level (FPL $17,420 for a two-person household in 2020);
2. A new federal program for oral health care, similar to the Children's Health Insurance Plans and providing Level I benefits, should be developed to assist adults age 65 and older whose incomes are between 100%-300% of the FPL (between $17,420 -$51,720 for a two-person household in 2020);
3. All Medicare Advantage plans should include Level I dental benefits, with optional Level II plans offered to adults age 65 and older at increased premiums;
4. The ADA should consider entering into endorsement agreements with private dental benefit plans offering ADA's designated Levels I, II or III plans to all adults age 65 and over;
5. Rather than follow the traditional approach to dental benefits, the ADA supports a different plan design for providing levels of care that would better serve the needs of adults age 65 and older;
6. To ensure adequate participation by providers, the programs should target reimbursement rates consistent with customary and usual charges as determined by the American Dental Association within geographic areas with annual review of reimbursement rates.

Level I:

Emergency treatments: Procedures to treat or relieve pain and infection, including emergent extractions

Prevention: Annual exam, diagnostic radiographic images, and at least twice a year prophylaxis
Scaling and Root Planing
Fluoride and Silver Diamine Fluoride (SDF) treatments
Direct restorative procedures
Extraction of non-restorable teeth
Pulpotomy
Removable prosthetics to restore function

Level II:
All Level I procedures
Crowns
Fixed prosthetics
Implants to support a full denture
Endodontics
Periodontal surgery

Level III:
All Level I and Level II procedures
Cosmetic Procedures
Any procedure not listed in another level

Dr. Ricci moved Resolution 71RC in lieu of Resolution 71 (*Supplement:*5137), Resolution 71S-1 (*Supplement:*5138a) and Resolution 71S-2 (*Supplement:*5138b) with the Committee Recommendation to Vote Yes.

Dr. Kevin W. Dens, Minnesota, moved to substitute Resolution 71RCS-1 for Resolution 71RC.

71RCS-1. Resolved, that the American Dental Association recognizes that oral health care for adults age 65 and older depends on acceptable and sustainable financing of that care, and be it further
Resolved, that for the purpose of presenting potential legislation that includes dental benefits for adults age 65 and over in a tax payer-funded public program such as Medicaid, CHIP, privately administered Medicare or other federal or state programs, then the ADA shall support a program that:

- Covers individuals under 300% FPL
- Covers the range of services necessary to achieve and maintain oral health
- Is primarily funded by the federal government and not fully dependent upon state budgets
- Is adequately funded to support an annually reviewed reimbursement rate such that at least 50% of dentists within each geographic area receive their full fee to support access to care
- Includes minimal and reasonable administrative requirements
- Allows freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit

and be it further,
Resolved, that the appropriate agency urge passage of legislation to enable dental offices to offer in-office membership plans to support direct care for all seniors.

As a point of order, Dr. Thomas C. Harrison, Texas, requested that debate be allowed on Resolution 71RC before proceeding to debate on substituting Resolution 71RCS-1 for Resolution 71RC.

The Speaker responded that since there was no debate on Resolution 71RC prior to the motion to substitute, he would allow a few minutes of debate related to Resolution 71RC. He stated, “Just to be clear, we are debating 71RC. I am going to give a couple of delegates [the ability] to debate this pro and con, and then we’ll move on to the resolution to substitute Resolution 71RCS-1. … Do you want to start, Dr. Dens, and I’ll bring you back. You can have a few words now, and then I’ll bring you back to debate or to start with your substitute.”

Dr. Keven W. Dens, Minnesota, spoke to his motion to substitute Resolution 71RCS-1, saying, “[The Tenth Trustee District] feels that the tiered system is complicated. I know we’ve heard of this all before. We still try to

find common ground with our colleagues. This profession and the ADA needs a solid stance to move forward. Getting into the weeds on conditions that are dental, technical, are not in the best interest of the ADA at the legislative level. Certainly this will be hammered out in legislative session, and there are so many other entities that are going to be at the table. We still need a clear and concise version. This resolution substitute puts forth hopefully more common ground. Yes, it's broad. Yes, it gives our lobbyists a lot of leeway, but that's what we need when we go to the table, is leeway. We don't need to be pigeon-holed into certain procedures. Thank you."

The Speaker said he would bring Dr. Dens up to speak to the substitute soon and clarified to the House was now speaking to Resolution 71RC.

Dr. Vincent V. Benivegna, Michigan, spoke against Resolution 71RC, stating, "Speaking in opposition to 71RC because it contains a prescriptive plan design using tiers. We believe adopting a policy adopting tiered benefit programs will create more than a legislative concept to shop on Capitol Hill. 71RC, if passed, will become Association policy that will remain long after any legislative initiative is forgotten. Plan administrators will see this as an ADA policy endorsing their plan design. A policy that endorses tiered plan design will likely migrate into the commercial marketplace and result in the proliferation of low cost PPO plans, touted to protect or provide tier 1 level benefits endorsed by the ADA. I don't want this well-intentioned initiative to provide senior's care impacting my 18 to 64 year old patients with low budget plan coverage. In the long-run, tiers will bring our members tears."

As a point of order, Dr. Kerry K. Carney, California, stated, "If we have a substitution on the floor, we don't speak in pro of the previous one. We speak in pro of substitution or against substitution. And, if you speak against substitution, then you're speaking for the one before it. I'm totally confused on how this has been stated. So could you please clarify it for me."

The Speaker responded, saying, "I will clarify. We did have Resolution 71RC that was presented by the reference committee. And immediately we had a substitute 71RCS-1 that came up. A point of order was brought to my attention that we did not have any debate on 71RC before I allowed the substitute. So, I asked the maker of the substitute if we could back up and have a few pro and con on 71RC before I move to his substitute. … The substitute will come up very soon. So right now the debate will be focused on 71RC."

As a point of order, Dr. Alan L. Felsenfeld, California, inquired "I see it, and I may be in disagreement with you. But, as I see it, we had a main motion on the floor, and a motion to substitute or amend by substitution was brought to the floor. That takes priority and has to be dealt with prior to any kind of debate on the main motion. I would like a ruling on that."

The Speaker responded, "… I will take your point of order, and it is correct. I was just trying to facilitate the business of the House in a very kind manner. I will take your point of inquiry, and we will move to the substitute at this point in time. … So before you now is going to be Resolution 71RCS-1. … Dr. Dens, you have the floor. Please continue."

In speaking to the substitute, Dr. Kevin W. Dens, Minnesota, said "As I mentioned, we're trying to find common ground here. 71RCS-1 tries to do that by being broad in giving our lobbyists the ability to move and be nimble with anything that might come up. This does not in any way advocate for Medicare. This is dealing with elder care. The 71RC, the point four advocates for endorsing third-party payers. The Council on Dental Benefits highly recommends against doing and going down this road. It has been mentioned that Bento is a third-party payer. It is not. Bento is a technology company that administers plans for self-funded plans. The Council on Dental Benefits does not want to go down this slippery slope of endorsing third-party payers. What if their plans change? It just—it's a can of worms that we just don't want to go down. We'd like to find common ground. We'd like to get something passed. I think this House owes it to the public and to its members to have a position when we go to deal with legislation."

As a point of information, Dr. Deborah S. Bishop, Alabama, inquired, "When do you want us to offer amendments? We have another amendment. Is it proper to do it now, or when does that happen?"

The Speaker responded that amendments can be offered in the Pro or Con queue, saying, "…I would ask that if you offer an amendment, do it through the Pro mic, because you would be speaking in favor of that amendment when you speak to it."

Dr. Christopher T. Gorecki, Michigan, spoke in support of the substitute resolution stating, "The proposed four program Medicaid, CHIP, Medicare Advantage and private model with four levels of benefits, one, two, three and four, called for in Resolution 70RC is excessively complex. Seniors will find it hard to navigate and will create administrative confusion and burden in our members' offices. I urge the passage of 71RCS-1 to avoid this unneeded complexity."

As a point of order, Dr. Robert J. Wilson, Jr., Maryland, stated, "Just to be clear, so I understand, I believe at this point in time our debate is on the motion to substitute …"

The Speaker responded, "It's a debate to substitute. That's correct. That's the motion Dr. Dens made; to substitute 71RCS-1 for 71RC."

As a point of order, Dr. Robert M. Peskin, New York, said, "For further clarification, and we all recognize that this is kind of challenging because of the virtual nature of this. As I understand it, if we are successfully able to substitute 71RCS-1 for 71RC, we haven't adopted it, all we've done is substitute it. The underlying resolutions then would go away and we would simply be debating the merits of whether or not we want 71RCS-1; is that correct?"

The Speaker responded, "… If the House approves the substitute, then we will debate 71RCS-1 in lieu of 71, 71S-1 and 71S-2. …"

Dr. William H. Gerlach, Texas, spoke against the substitute resolution, stating, "As a member of the Elder Care Workgroup, we put two years into this, and we also understand the angst that we have heard over the last few days regarding these levels; the levels one, two, three and four, and how they would have the possibility of pigeon-holing future ADA policy and development, especially as it comes to third-party payers. I have been in contact with the Elder Care Workgroup this morning, have received feedback from many of them. And the Elder Care Workgroup is prepared to offer language which would eliminate this tiering of what we had proposed; the levels one, two, three and four. I would respectfully request that we be allowed to present that and perhaps allay some of the fears and concerns that many of the delegates seem to be expressing."

Dr. Wallace J. Bellamy, California, moved to amend the substitute resolution by deleting the last resolving clause. The Speaker responded, "This is a motion to substitute. You will have the opportunity to amend it again once we get to the end of this motion to substitute. So I am going to call that out of order at this time, but you will have the opportunity to do that again. This is a motion to substitute. … if the House so desires to substitute, we will accept that amendment."

Dr. Bellamy spoke in support of Resolution 71RCS-1, stating, "… This resolution is very simple and would be able to track provider pools and provide adequate comprehensive care for our elderly. Our elderly adults that fall below the federal poverty level, as well as middle income adults, especially are vulnerable. There are also disparities regarding the federal poverty level regionally. I'm in favor of a dental funding for the elderly that provides an adequate level of care our seniors deserve. We need to get adequate care for our elderly passed at this House."

Dr. Diane D. Romaine, Maryland, spoke against the motion to substitute Resolution 71RCS-1 for 71RC. She said, "I oppose this substitution for three reasons. First of all, it does not fulfill the mandate of the Elder Care Workgroup, which is to develop a comprehensive implementation plan for all seniors. It only deals with those 300 percent and under. Secondly, though it has the generality of the type of range of services necessary, it fails to define courageously what those services should be to maintain health. And, thirdly, it's redundant. For example, the final item allowing freedom of choice for patients to seek care, it's already an ADA resolution, Policy 154H-1993 freedom of care—freedom of choice on section of health providers. Last week in my office in rural Pennsylvania I had a lady come in with Medicare Part C. She was so excited for her dental benefit to get a new denture, but her dental benefit didn't cover a denture. I had to tell her. She thought—she felt sunken. We need to take responsibility for more than those below 300 percent of the federal poverty level."

Dr. Judee Tippett-Whyte, California, spoke in support of the substitute resolution, stating, “The stratification of the different levels of care undermine the argument made in Resolution 84, that oral health care is essential for overall health, therefore, I support this resolution eliminating the tiers of level of care.”

Dr. Thomas C. Harrison, Texas, spoke against the substitute resolution, stating, “I would really like to see us get back to 71RC, and really for some of the reasons the prior speaker just made. We want to amend 71RC so that we can eliminate these tiers so that the delegates that are concerned about tiers would be satisfied. And we think that’s a better way. Some of these bullet points that are there in 71RCS-1, I just can’t agree with.”

As a point of order, Dr. Elizabeth A. Demichelis, California, asked if there was any way for the Speaker to provide a count of who was in line at the Pro microphone and who was in list at the Con microphone.

The Speaker responded that there were 14 delegates in line for the Pro microphone and 10 for the Con microphone.

Dr. Dens moved to appeal the decision of the Chair that amendments to Resolution 71RCS-1 were out of order at this time. Dr. Dens stated, “With all due respect Mr. Speaker, the ability to amend this, with this being on the floor, changes the effect of the vote. If it were to be able to be amended, it could change the outcome of this vote. If it’s voted down, this goes away and it loses the ability to be amended. So I would ask for a vote on the Speaker’s ruling that this cannot be amended.”

On vote, the decision of the chair was sustained.

The motion was made to vote immediately on substituting Resolution 71RCS-1 for Resolution 71RC. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, the motion to substitute Resolution 71RCS-1 for Resolution 71RC was adopted.

Dr. James A.H. Tauberg, Pennsylvania, moved to substitute Resolution 71RCS-3 for Resolution 71RCS-1.

> **71RCS-3. Resolved,** that the American Dental Association recognizes that oral health care for adults age 65 and older depends on acceptable and sustainable financing of that care, and be it further
> **Resolved,** that IF potential legislation is being developed to include dental benefits for adults age 65 and over in public programs, such as Medicaid or CHIP, the ADA shall support a privately administered program either at the state or federal level that:
>
> - Covers individuals under 200% FPL.
> - Covers a range of services necessary to achieve and maintain oral health.
> - Includes an optional, premium-based, privately administered component for those over 200% FPL that is not dependent upon government budgets.
> - Is adequately funded to support an annually reviewed reimbursement rate such that at least 50% of dentists within each geographic area receive their full fee to support access to care.
> - Includes minimal administrative requirements.
> - Allows freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit.

In speaking to the substitute, Dr. Tauberg said, “So after reviewing in our delegation in the Third District, we decided that we really felt that it would be better to offer our lobbyists great flexibility. Keep it simple; keep it broad. We noted that number for the threshold for the FPL, and we thought that we noted in the Elder Care Workgroup report that 200 percent was the threshold for improvement in oral health. So we decided that made more sense at this time. In addition, we fear that if you have something federally funded or primarily funded by federal government, then you ask for a certain degree of fees that are set by the federal government, meaning obviously Medicare type fees, which we believe would be such a situation that our general membership would be upset that their representatives to the American Dental Association would agree to lower based fees. If we ever thought we’d have a membership problem in the future, I think inviting

something like that would allow for that. I believe that our substitution offers an optional premium-based, privately administered component for those over the 200 percent FPL that is not dependent on government budgets."

As a point of order, Dr. Gary L. Glasband, California, said, "Mr. Speaker, I believe since you set a precedent already of allowing debate, even if it was corrected later, then you should follow the same precedent and allow debate on 71RCS-1. Just in fairness, otherwise we're changing the rules in the middle of debate in an ongoing situation."

The Speaker responded, "I will respectfully disagree. I did take the suggestion from my friend in California that it was out of order to allow debate, and it is proper that we follow the procedure. And it was my mistake that we did not. I was trying to be more in a sense of allowing debate to be kind and friendly, but the rules do state that amendment can be offered at this time. So I have to go with that. …we are debating 71RCS-3 substituting for 71RCS-1."

Dr. Nicholas Caplanis, California, spoke against substitution, saying, "We had various reiterations of this resolution. We believe that [Resolution 71RCS-1], as amended, is the most reasonable of the group. The levels of stratification, once again, are complex; complex for legislators, complex for patients and will be complex for providers. [Resolution 71RCS-1] removes the dependency on state budgets, which are woefully underfunded. And, yes, it will rely, or at least promote, federal funding, which is what I believe that as a body we should be wanting in this case. It provides freedom of choice for patients, and I urge my colleagues to vote yes on Resolution 71RCS-1."

Dr. Gary S. Davis, Pennsylvania, spoke in support of substituting Resolution 71RCS-3 for Resolution 71RCS-1, stating, "Many areas of our country, especially the rural areas, have seniors that are at the 200 percent to 300 percent FPL that are already visiting their dental homes regularly and are able to pay the fair fees that the dentists have. I think raising the FPL at 300 or above 300 would be a burden to many of our members that are already—have seniors that are receiving care at their offices."

Dr. Judee Tippett-Whyte, California, spoke against substituting Resolution 71RCS-3 for Resolution 71RCS-1, stating, "We have concerns in California about the FPL. I think that is going to be debated in our legislature anyway. In California, we have some of our seniors that are at the 400 FPL, so would still barely qualify for benefits. I do not think that privately administered components for these people would be prudent. And, therefore, I speak against the substitution."

Dr. Gabriel B. Holdwick, Michigan, spoke against substituting Resolution 71RCS-3 for Resolution 71RCS-1. He said, "I speak opposed to substitution and mainly because of the 200 percent FPL. I think if there's going to be a lot of people that are going to…slip through the cracks, but in all things considered, the 71RCS-1 is superior, in my opinion. And I urge the House to vote down to substitution."

Dr. Robert J. Wilson, Jr., Maryland, spoke against substituting Resolution 71RCS-3 for Resolution 71RCS-1, stating, "I don't like the bold word 'if' at the beginning. I don't think the intention was for us to sit back and wait and see what's going to happen, but try to be a driver of things to happen as we would like it to be. I'm also concerned about the 200 percent level. ...."

Dr. Prabu Raman, Missouri, spoke in support of substituting Resolution 71RCS-3 for Resolution 71RCS-1, stating, "… I serve on many committees and task forces around the specialties. So, I know that energy volunteers spend. I'm on Medicare as well. I'm on for seniors. Can you proclaim that dental care is essential and at the same time not be for dentists for different parts of Medicare? I don't think we can. This substitution would allow us to have a guidance for legislative lobbyists and yet not be getting all the way to Medicare. …"

A motion was made to vote immediately on substituting Resolution 71RCS-3 for Resolution 71RCS-1. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, the motion to substitute Resolution 71RCS-3 for Resolution 71RCS-1 was not adopted.

Dr. Vincent V. Benivegna, Michigan, spoke in support of Resolution 71RCS-1, stating, “This resolution may not fit on a bumper sticker. Still it is [easier] to understand than the others for our advocacy efforts with legislative decision makers. Being less prescriptive, 71RCS-1 may be received more favorably by other stakeholders, and we know on Capitol Hill, that partnering with other stakeholders to support our advocacy is priceless. Senior advocacy groups such as Justice and Aging and the Centers for Medicare Advocacy have already written the ADA in opposition to Resolution 71 and its tier design when it was first proposed. I urge the passage of 71RCS-1 for its simplicity to allow partnering with stakeholders to support advocacy that will be most useful in our lobbying efforts.”

A motion was made to vote immediately on Resolution 71RCS-1. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, Resolution 71RCS-1 was adopted in lieu of Resolution 71, Resolution 71S-1 and Resolution 71S-2.

> **71H-2020. Resolved,** that the American Dental Association recognizes that oral health care for adults age 65 and older depends on acceptable and sustainable financing of that care, and be it further
> **Resolved,** that for the purpose of presenting potential legislation that includes dental benefits for adults age 65 and over in a tax payer-funded public program such as Medicaid, CHIP, privately administered Medicare or other federal or state programs, then the ADA shall support a program that:
>
> - Covers individuals under 300% FPL
> - Covers the range of services necessary to achieve and maintain oral health
> - Is primarily funded by the federal government and not fully dependent upon state budgets
> - Is adequately funded to support an annually reviewed reimbursement rate such that at least 50% of dentists within each geographic area receive their full fee to support access to care
> - Includes minimal and reasonable administrative requirements
> - Allows freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit
>
> and be it further,
> **Resolved,** that the appropriate agency urge passage of legislation to enable dental offices to offer in-office membership plans to support direct care for all seniors.

The third priority agenda item was presented by Dr. Shane A. Ricci, Texas, chair, Reference Committee D.

Amendment of Policy, Summary of Recommendations, Report 5 of the Board of Trustees to the House of Delegates, on Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care (Elder Care Workgroup Resolution 82 and Reference Committee D Resolution 82RC): The Reference Committee reported as follows:

> After considering testimony and comments, the Reference Committee agreed that the resolution requires a statement of strong commitment to advocate for an adequately funded and administered dental benefit plan supporting the oral health of the elderly.
>
> In the following Resolution, additions are noted with <u>double</u> <u>underscoring</u>.
>
> **82RC. Resolved,** that the ADA policy on Recommendations to the Board on the Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care (*Trans*.1979:357, 596) be amended as follows (Additions are <u>underlined</u>, deletions are ~~stricken~~):
>
> 1. Increase Association efforts to promote the concepts of prevention within the profession and the public sector, including government.
> 2. Draw freely on the special professional abilities of dentists who are expert in practice, in public health, in research and in education.

3. Actively seek allies throughout society on specific activities that will help improve access to care for all.
4. Maintain and coordinate council and other Association activities involved in this program.
5. Maintain quality dental care in all aspects of the delivery system.
6. Seek new ways for the Association to assist state and local dental health units to strengthen themselves.
7. Speak clearly to the public and to government about their respective responsibilities with respect to dental health.
8. Recognition that the traditional form of private practice will remain the major source of dental care coupled with an understanding that other sources of care exist and should receive objective attention.
9. Press for more efficient administration of and more equitable reimbursement under Medicaid and similar programs.
10. Intensify efforts at the federal level to mandate basic dental benefits for all Medicaid recipients.
11. Explore the funding of a pilot program to obtain broader Medicaid dental care benefits at the state level.
12. Explore the use of elementary and secondary schools in providing patient education, referral and oral prophylaxis dental services to children.
13. Emphasize comprehensive dental services in addressing the need of the elderly.
14. ~~Intensify efforts to amend Medicare to include dental benefits.~~ Advocate for an adequately funded and efficiently administered dental benefit plan supporting the oral health of the elderly.
15. Seek ways to extend private group dental prepayment benefits to the elderly.
16. Develop minimal criteria that state dental societies must take to be eligible for Association assistance to provide access programs for denture care.
17. Investigate ways to improve increased opportunity for dental care for the elderly through a greater availability and effective utilization of dentists and dental auxiliaries.
18. Establish a national organization concerned with the dental health of the elderly.
19. Develop a program to provide assistance and information to state and local societies to assist dentists in caring for handicapped and disabled patients.
20. Maintain support of the Dental Lifeline Network ~~National Foundation of Dentistry for the Handicapped~~.
21. Identify and publicize other sources of care for the handicapped, institutionalized and homebound.
22. Develop a better information base on the dental health needs of the long-term homebound.
23. Help establish appropriate continuing education for practitioners and cooperate with dental educators regarding any necessary additions to the undergraduate and postgraduate dental school curricula.
24. Implement appropriate methods of providing more accessible dental care to nursing home residents.
25. Explore the potential for resolving problems of limited health manpower and capital resources in nursing homes.
26. Reexamine existing Association policy respecting the National Health Service Corps and program activity.
27. Continued support of the Health Professions Placement Network.
28. Continued support of the Dental Planning Information System to enhance its ability to provide information on care delivery in remote areas.
29. Cooperate more closely with dental health departments in states with a high number of remote area residents, including possible funding of demonstration projects.
30. Expansion of the Association's present role in stimulating the growth of dental prepayment.
31. Broaden sources of prepayment coverage beyond the workplace.
32. Support extension of group dental prepayment benefits to federal employees and military dependents.
33. Work with private and governmental groups in developing a more detailed base of information on dental prepayment.

Dr. Ricci moved Resolution 82RC in lieu of Resolution 82 (*Supplement:*5158) with the Committee Recommendation to Vote Yes.

The Speaker asked if there was any discussion on Resolution 82RC; there was none. On vote, Resolution 82RC was adopted in lieu of Resolution 82.

82H-2020. Resolved, that the ADA policy on Recommendations to the Board on the Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care (*Trans*.1979:357, 596) be amended as follows (Additions are underlined, deletions are ~~stricken~~):

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

26. Reexamine existing Association policy respecting the National Health Service Corps and program activity.
27. Continued support of the Health Professions Placement Network.
28. Continued support of the Dental Planning Information System to enhance its ability to provide information on care delivery in remote areas.
29. Cooperate more closely with dental health departments in states with a high number of remote area residents, including possible funding of demonstration projects.
30. Expansion of the Association's present role in stimulating the growth of dental prepayment.
31. Broaden sources of prepayment coverage beyond the workplace.
32. Support extension of group dental prepayment benefits to federal employees and military dependents.
33. Work with private and governmental groups in developing a more detailed base of information on dental prepayment.

The fourth priority agenda item was presented by Dr. Ioanna G. Mentzelopoulou, New York, chair, Reference Committee A.

Approval of 2021 Budget (Board of Trustees Resolution 87): The Reference Committee reported as follows:

The Reference Committee heard only con testimony regarding the 2021 budget. There were also a lot of questions posed and concerns expressed regarding spending of Reserves, about the numbers, IT and the Annual Meeting, etc. The Reference Committee is aware that running a deficit budget is not ideal and trusts that the Board will continue to be fiscally responsible as things become more certain as 2021 unfolds. Acknowledging that 2020 is a unique year and that there are still many unknowns for 2021, a majority of the Reference Committee concurs with the Board of Trustees and supports adoption of Resolution 87.

87. Resolved, that the 2021 Annual Budget of revenues and expenses, including net capital requirements be approved.

Dr. Mentzelopoulou moved Resolution 87 (*Supplement:*2077) with the Committee Recommendation to Vote Yes.

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 98 for the adoption of the final budget (Resolution 87).

The fifth priority agenda item was presented by Dr. Edmund A. Cassella, Hawaii, chair, Reference Committee C.

Proposed ADA Policy Statement on Optimizing Dental Health Prior to Surgical/Medical Procedures and Treatment (Council on Scientific Affairs Resolution 21, Ninth Trustee District Resolution 21S-1 and Reference Committee C Resolution 21RC): The Reference Committee reported as follows:

The Reference Committee heard considerable testimony on Resolution 21 and Resolution 21S-1. Testimony in favor of Resolution 21 included recognition and support of the evidentiary basis and reasoning behind the specific and narrow language of the resolution, and expressed appreciation for the thoughtful work done to address Resolution 86H-2016, which formed the basis of this proposed policy. The testimony also included requests to add the words "and treatment" into the proposed policy. After considering testimony on Resolution 21, the Reference Committee agreed with the suggestion to add "and treatment" and developed Resolution 21RC.

Testimony in support of 21S-1 included a desire to broaden the scope of the policy to include treatment during and after the management of diseases and conditions. The Reference Committee also believed that the suggested edits in Resolution 21S-1, while valuable, currently lack scientific, evidence-based support gathered and assessed by the CSA. The Reference Committee considered testimony both pro and con, as well as suggested amendments, and supports the adoption of Resolution 21RC, in lieu of Resolutions 21 and 21S-1.

21RC. Resolved, that the following ADA policy statement on Optimizing Dental Health Prior to Surgical/Medical Procedures and Treatments be adopted (additions underscored; deletions ~~stricken~~):

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

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

Dr. Cassella moved Resolution 21RC in lieu of Resolution 21 (*Supplement:*4020) and Resolution 21S-1 (*Supplement:*4019a) with the Committee Recommendation to Vote Yes.

Dr. Harold S. Jeter, Ohio, moved to amend Resolution 21RC in the first resolving clause by adding the words "when appropriate" after the word "treatment," so that the proposed policy statement would read as follows:

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

In speaking to the proposed amendment, Dr. Jeter stated, "… in the background statement of the original Resolution 21, references made to the report also initiated by Resolution 86H-2016 entitled, "Impact of Dental Treatment Prior to Cardiac Valve Surgery—Systematic Review and Meta Analysis," and the conclusion of that states, in part, that available evidence suggests that it is unclear whether dental treatment before cardiac valve surgery results in better or worse postoperative outcomes. And further, it states that a team that includes dental, medical and surgical care professionals should weigh additional case specific factors before proceeding with pre-surgical dental treatment. Mr. Speaker, we would like ADA policy to reflect that as dental consultants, we have some latitude in determining when that treatment would take place for those instances when treatment, for example, a full mouth extraction under general anesthesia prior to cardiac valve surgery would pose significant risk of morbidity or mortality if performed prior to correction of the underlying cardiac pathology."

As a point of information, Dr. Robert M. Peskin, New York, asked if the word "and" before the word "consultation" should be kept in the proposed amendment, or deleted. Dr. Jeter responded that the word "and" before the word "consultation" should be kept so that the last sentence in the proposed amendment would read as follows:

Direct communication with patients and their medical teams regarding the need for, and ability to obtain, a dental examination, ~~and~~ and consultation and treatment, when appropriate, prior to initiation of complex surgical and medical treatments is especially recommended.

Discussion in support of the proposed amendment ensued.

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 adopted.

Dr. Paul M. Mullasseril, Oklahoma, moved to further amend Resolution 21RC in the first resolving clause by inserting in two places the words “during and after” after the words “prior to” so that the proposed policy statement would read as follows:

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

In speaking to the proposed amendment, Dr. Mullasseril stated, “I feel that in order to strengthen this policy, these words need to be added to the policy. One, it’s critical to make sure that dental health is optimized prior to performance of complex medical and surgical procedures. It’s equally critical to make sure that the dental health remains in optimum state during and after these medical procedures. For example, when I see patients during radiation therapy to the head and neck area, many changes occur in the oral environment that needs the constant attention of the dentist during and after radiation. …”

As a point of order, Dr. O. Andy Elliott, Kentucky, stated, “Even though I agree with the concept that this should be a priority during and after, the actual policy has to do with optimizing dental health prior to surgical and medical procedures. So I would think that this is essentially out of order because it changes the nature of this policy.

The Speaker ruled that the proposed amendment was out of order, stating, “… the policy statement says prior to surgical, and this amendment changes the entire intent of the policy. So in that case, I will have to rule it out of order.”

A motion was made to vote immediately on Resolution 21RC, as amended. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, Resolution 21RC, as amended, was adopted.

> **21H-2020. Resolved,** that the following ADA policy statement on Optimizing Dental Health Prior to Surgical/Medical Procedures and Treatments be adopted (additions underscored; deletions ~~stricken~~):
>
> > The ADA believes that optimizing dental health prior to the performance of complex medical and surgical procedures can be an important component of clinical care. Inter-professional communication and collaboration are crucial to identifying pre-existing or underlying oral health concerns that may impact post-medical/surgical complications or healing time, particularly for patients who are immunocompromised or otherwise at greater risk of adverse medical outcomes because of underlying health problems. Direct communication with patients and their medical teams regarding the need for, and ability to obtain, a dental examination ~~and~~ and consultation and treatment, when appropriate, prior to initiation of complex surgical and medical treatments is especially recommended.
>
> and be it further,
> **Resolved,** that the appropriate ADA agency consider the feasibility of assessing the role of dental health in the management of diseases and medical conditions and report back to the 2021 House of Delegates.

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

The Report of Reference Committee A was presented by Dr. Ioanna G. Mentzelopolou, New York, chair. The other members of the Committee were: Dr. David C. Anderson, Virginia; Dr. Wendy A. Brown, Maryland; Dr. Robert E. Butler, Missouri; Dr. Matthew Cohlmia, Oklahoma; Dr. T. Brad Crump, Texas; Dr. Nancy R. Rosenthal, Pennsylvania; Dr. Steven A. Saxe, Nevada; and Dr. Lawrence A. White, Illinois.

Consent Calendar (Reference Committee A 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 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 removed and considered separately.

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

Resolution 66—(Adopt)—Council on Membership Report on Active Membership Promotion (*Supplement:*2009) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

Resolution 67—(Adopt)—Amendment of Chapter l, Section B.4.F of the Governance and Organizational Manual of the American Dental Association (*Supplement:*2010) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

Resolution 68—(Adopt)—Bylaws Amendment on Life Membership Eligibility (*Supplement:*2011) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

Resolution 101—(Adopt)—New Dentist Representation to the ADA House of Delegates (*Supplement:*2099) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

Resolution 110—(Adopt)—2021 Dentist and Student Lobby Day (*Supplement:*2100) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

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

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

Resolution 67 removed by Dr. Jeffrey A. Kahl, Colorado
Resolution 68 removed by Dr. Sarah T. Poteet, Texas
Resolution 101 removed by Dr. A. Roddy Scarbrough, Mississippi
Resolution 110 removed by Dr. Nipa R. Thakkar, Pennsylvania

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

111H-2020. Resolved, that the recommendations of Reference Committee A on the following resolutions be accepted by the House of Delegates.

Resolution 66—(Adopt)—Council on Membership Report on Active Membership Promotion (*Supplement:*2009) $: None
COMMITTEE RECOMMENDATION: Vote Yes.

~~**Resolution 67**—(Adopt)—Amendment of Chapter I, Section B.4.F of the Governance and Organizational Manual of the American Dental Association (*Supplement:*2010) $: None~~
~~**COMMITTEE RECOMMENDATION: Vote Yes.**~~

~~**Resolution 68**—(Adopt)—Bylaws Amendment on Life Membership Eligibility (*Supplement:*2011) $: None~~
~~**COMMITTEE RECOMMENDATION: Vote Yes.**~~

~~**Resolution 101**—(Adopt)—New Dentist Representation to the ADA House of Delegates (*Supplement:*2099) $: None~~
~~**COMMITTEE RECOMMENDATION: Vote Yes.**~~

~~**Resolution 110**—(Adopt)—2021 Dentist and Student Lobby Day (*Supplement:*2100) $: None~~
~~**COMMITTEE RECOMMENDATION: Vote Yes.**~~

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

Consent Calendar Resolution—Adopted

Council on Membership Report on Active Membership Promotion

66H-2020. Resolved, that the ADA *Governance and Organizational Manual*, Chapter I. MEMBERSHIP, Section B. Dues, Special Assessments and Related Financial Matters, Subsection 4. Limited Dues and Special Assessment Reduction Programs, paragraph c. Active Membership Promotion, be amended as follows (additions underscored; deletions ~~stricken~~):

c. Active Membership Promotion. The ~~ADA~~ Board of Trustees may authorize a ~~limited~~ dues reduction, up to ~~fifty~~ one hundred percent (~~50~~100%) of active member dues and any special assessment then in effect for the purpose of promoting active membership in target U.S. markets through marketing campaigns recommended by the Council on Membership. This reduction of active member dues and any special assessments shall be on a one-time only basis for these members.

Non-Consent Resolutions

Amendment of Chapter I, Section B.4.F of the Governance and Organizational Manual of the American Dental Association: (Council on Membership Resolution 67): The Reference Committee reported as follows:

There was limited testimony during the Reference Committee Hearing. There is currently one 100% Humanitarian Practitioner Waiver (rate M), along with one 100% Financial Hardship Waiver (rate T), the resolution eliminates the rate M and replaces it with the rate T. These waiver options are currently listed on the dues waiver form and each state and local uses the same form for approval, the current waiver review and approval process will remain the same, with no additional staff resources needed. The result of the proposed change is the letter of the dues rate entered into the Aptify System – instead of entering a rate M (for a Humanitarian waiver) the state society will enter a rate T (the 100% Financial Waiver).

The Committee notes that this applies to a small percentage of members. The Committee therefore concurs with the Board and the Council on Membership and recommends adoption of Resolution 67.

The Standing Committee on Constitution and Bylaws approves the wording of Resolution 67 as submitted.

67. Resolved, that Chapter I. MEMBERSHIP MATTERS, Section B. Dues, Special Assessments and Related Financial Matters, Subsection 4. Limited Dues and Special Assessment Reduction Programs, paragraph f. Full-Time Work for Humanitarian Organization, of the ADA *Governance and Organizational Manual* be amended by the deletion of subsection f in its entirety:

~~f. Full-Time Work for Humanitarian Organization. An active member who is serving the profession by working full-time for a humanitarian organization and is receiving neither income nor a salary for such humanitarian service other than a subsistence amount which approximates a cost of living allowance shall be exempt from the payment of dues and any special assessment then in effect through December 31 following completion of such service provided that such humanitarian service is being performed continuously for not less than one (1) year and provided further that such member does not supplement such subsistence income by the performance of services as a member of the faculty of a dental or dental auxiliary school, as a dental administrator or consultant, or as a practitioner of any activity for which a license to practice dentistry or dental hygiene is required.~~

Dr. Mentzelopoulou moved Resolution 67 (*Supplement:*2010) with the Committee recommendation to Vote Yes.

Dr. Jeffrey A Kahl, Colorado, moved to substitute Resolution 67S-1 for Resolution 67, by adding a second resolving clause so that the resolution would read as follows:

67S-1. Resolved, that Chapter I. MEMBERSHIP MATTERS, Section B. Dues, Special Assessments and Related Financial Matters, Subsection 4. Limited Dues and Special Assessment Reduction Programs, paragraph f. Full-Time Work for Humanitarian Organization, of the ADA *Governance and Organizational Manual* be amended by the deletion of subsection f in its entirety:

~~f. Full-Time Work for Humanitarian Organization. An active member who is serving the profession by working full-time for a humanitarian organization and is receiving neither income nor a salary for such humanitarian service other than a subsistence amount which approximates a cost of living allowance shall be exempt from the payment of dues and any special assessment then in effect through December 31 following completion of such service provided that such humanitarian service is being performed continuously for not less than one (1) year and provided further that such member does not supplement such subsistence income by the performance of services as a member of the faculty of a dental or dental auxiliary school, as a dental administrator or consultant, or as a practitioner of any activity for which a license to practice dentistry or dental hygiene is required.~~

and be it further
Resolved, that Chapter I. MEMBERSHIP MATTERS, Section B. Dues, Special Assessments and Related Financial Matters, Subsection 4. Limited Dues and Special Assessment Reduction Programs, paragraph d. Financial Hardship Waivers, of the *Governance and Organizational Manual* of the American Dental Association be amended as follows (additions underscored and deletions ~~stricken~~):

d. Financial ~~Hardship~~ or Humanitarian Waivers. Any members who have suffered a significant financial hardship that prohibits them from payment of their full dues and/or any special assessment may be excused from the payment of fifty percent (50%) or all of the current year's dues and/or any special assessment. To qualify for the Humanitarian Waiver the member must be working full-time for a humanitarian organization and must not be receiving an income or a salary for such humanitarian service other than a subsistence amount which approximates a cost of living allowance. Such member shall be exempt from the payment of all dues and any special assessment then in effect through December 31, following completion of such service. This is provided that such humanitarian service is being performed continuously, for not less than one (1) year and further, that such member does not supplement such subsistence income by the performance of services as a member of the faculty of a dental or dental auxiliary school, dental administrator or consultant, or practitioner of any activity for which a license to practice dentistry

or dental hygiene is required. Any waiver shall be ~~as~~ initially determined by ~~their~~ the members' constituents and components~~. The~~ and the constituents and components shall certify the reason for the waiver~~,~~ and ~~the constituents and components shall~~ provide the same proportionate waiver of their dues as that provided by this Association.*

* Members with disabilities who were granted dues and any special assessment disability waivers prior to the 2007 House of Delegates may continue to receive such waivers provided they are unable to practice dentistry within the definition of the Bylaws and they submit through the members' respective component and constituent, if such exist, to this Association, a medical certificate attesting to the disability and a certificate from said component and constituent, if such exist, attesting to the disability, upon request of the Association, during the exemption period.

In speaking to the proposed substitute resolution, Dr. Kahl stated, "…the Council on Membership reviewed all of the written and verbal testimony from the Reference Committee around Resolution 67. We believe that the Substitute Resolution 67S-1, while still containing the first resolving clause of [Resolution] 67, inserts the second resolving clause, which addresses all three issues that were brought up during the Reference Committee. And those are number one, the definition of the humanitarian waiver is preserved in this amendment; number two, it is clearly defined that the…local components and the states actually vet these waivers and push them forward in the national level; and then number three, it strikes the word "hardship" from the title so that now humanitarian and financial waivers will be contained under a financial or humanitarian waiver, as it was the thought of some members that hardship had a negative connotation since humanitarian waivers aren't really hardship waivers."

Dr. Thomas S. Kelly, Ohio, spoke in support of the proposed substitute resolution, stating, "I think it's important the House understands that it not only includes the first resolve clause of the resolution, which is removing the hardship waiver section of the *Governance Manual*, but it reserves that ability for us to have a humanitarian waiver. … It preserves the humanitarian waiver definition within this section of the *Governance Manual*. It defines both financial and humanitarian separately, and it includes the differences between the two in the amount that's allowed for that."

On vote, the motion to substitute Resolution 67S-1 for Resolution 67 was adopted.

Hearing no objection, Resolution 67S-1 was adopted in lieu of Resolution 67 by general consent.

67H-2020. Resolved, that Chapter I. MEMBERSHIP MATTERS, Section B. Dues, Special Assessments and Related Financial Matters, Subsection 4. Limited Dues and Special Assessment Reduction Programs, paragraph f. Full-Time Work for Humanitarian Organization, of the ADA *Governance and Organizational Manual* be amended by the deletion of subsection f in its entirety:

~~f. Full-Time Work for Humanitarian Organization. An active member who is serving the profession by working full-time for a humanitarian organization and is receiving neither income nor a salary for such humanitarian service other than a subsistence amount which approximates a cost of living allowance shall be exempt from the payment of dues and any special assessment then in effect through December 31 following completion of such service provided that such humanitarian service is being performed continuously for not less than one (1) year and provided further that such member does not supplement such subsistence income by the performance of services as a member of the faculty of a dental or dental auxiliary school, as a dental administrator or consultant, or as a practitioner of any activity for which a license to practice dentistry or dental hygiene is required.~~

and be it further
Resolved, that Chapter I. MEMBERSHIP MATTERS, Section B. Dues, Special Assessments and Related Financial Matters, Subsection 4. Limited Dues and Special Assessment Reduction Programs, paragraph d. Financial Hardship Waivers, of the *Governance and Organizational Manual* of the American Dental Association be amended as follows (additions underscored and deletions ~~stricken~~):

d. Financial ~~Hardship~~ or Humanitarian Waivers. Any members who have suffered a significant financial hardship that prohibits them from payment of their full dues and/or any special assessment may be excused from the payment of fifty percent (50%) or all of the current year's dues and/or any special assessment. To qualify for the Humanitarian Waiver the member must be working full-time for a humanitarian organization and must not be receiving an income or a salary for such humanitarian service other than a subsistence amount which approximates a cost of living allowance. Such member shall be exempt from the payment of all dues and any special assessment then in effect through December 31, following completion of such service. This is provided that such humanitarian service is being performed continuously, for not less than one (1) year and further, that such member does not supplement such subsistence income by the performance of services as a member of the faculty of a dental or dental auxiliary school, dental administrator or consultant, or practitioner of any activity for which a license to practice dentistry or dental hygiene is required. Any waiver shall be ~~as~~ initially determined by ~~their~~ the members' constituents and components~~. The~~ and the constituents and components shall certify the reason for the waiver~~,~~ and ~~the constituents and components shall~~ provide the same proportionate waiver of their dues as that provided by this Association.*

* Members with disabilities who were granted dues and any special assessment disability waivers prior to the 2007 House of Delegates may continue to receive such waivers provided they are unable to practice dentistry within the definition of the Bylaws and they submit through the members' respective component and constituent, if such exist, to this Association, a medical certificate attesting to the disability and a certificate from said component and constituent, if such exist, attesting to the disability, upon request of the Association, during the exemption period.

Bylaws Amendment on Life Membership Eligibility (Council on Membership Resolution 68): The Reference Committee reported as follows:

The Reference Committee heard limited pro and con testimony regarding removing the age requirement for life membership. The majority of the Reference Committee agrees with the Board and the Council on Membership, and supports adoption of Resolution 68.

The Standing Committee on Constitution and Bylaws approves the wording of Resolution 68 as submitted.

68. Resolved, that the ADA *Bylaws*, Chapter I. Membership, Section 20. Membership Eligibility, Subsection B. LIFE MEMBER, be amended as follows **(**deletions ~~stricken~~ and additions underlined):

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. Has been 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; and
~~b. Reached the age of at least sixty-five (65) during the previous calendar year~~;
~~c.~~b. Maintains membership in good standing in a constituent and component, if such exists, and in this Association.
~~d.~~c. 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~~.

Dr. Mentzelopoulou moved Resolution 68 (*Supplement:*2011) with the Committee recommendation to Vote Yes.

Dr. Sarah T. Poteet, Texas, moved to amend Resolution 68, by adding a second resolving clause, which reads as follows:

Resolved, that the foregoing amendment to Chapter I. Membership. Section 20. Membership Eligibility. Subsection B. Life Member, of the ADA *Bylaws* take effect at adjournment *sine die* of the 2021 ADA House of Delegates

In speaking to the amendment, Dr. Poteet stated, "The Fifteenth District supports the work done by the Council on Membership to make it easier for the ADA members to attain life membership status. This will help us ensure that more ADA members remain engaged in striving for life membership. However, changing the requirements for life membership will have a negative impact on dues revenue for some states. Given the decrease in overall membership dues faced by the ADA, its constituent state and local dental societies as a result of COVID-19, the Fifteenth District asks for additional time for states to prepare their budget forecasting to accommodate the change in life membership status. This time is needed for states and local societies to prepare for any dues reductions they may experience by having more members eligible for reduced life dues. Deferring the implementation of life membership change in Resolution 68 to the close of the ADA House of Delegates 2021 will give states the time necessary to account for changes in this membership dues category."

As a point of information, Dr. Thomas S. Kelly, Ohio, asked "…as of the close of the House 2020, there is no difference in dues between life member and full member; is that correct? … So this amendment would be moot based on—or out of order based on—that argument of two differences in dues."

At the request of the Speaker, Ms. April Kates-Ellison, vice president, Member and Client Services, responded, "I believe the question centers around whether or not the impact of dues streamlining on the active life members will have taken place at the close of 2021. The answer to that is yes; however, what I would like to add is that not all of the states have aligned with those changes, so there could be varying dues amounts taking place at the states for this particular membership category."

In response, Dr. Kelly asked, "So just to clarify again, the life membership dues rate for the ADA will be the same as active membership dues rate at the close of this House?"

Ms. Kates-Ellison responded, "For 2021; that is correct."

Dr. Jeffrey A. Kahl, Colorado, and vice chair of the Council on Membership, spoke in support of the proposed amendment, stating, "The Council on Membership reviewed this and worked with the Texas delegation. We support this, the addition of this grace period for states to work on their particular bylaws around the definition of life membership at the state and component level. It does not impact our ability to push forward the life member promotion programs that we currently have in the works."

Dr. I. Jay Freedman, Pennsylvania, and chair of the Council on Membership, spoke in support of the proposed amendment, stating, "When [the Council on Membership] developed this conclusion to the dues streamlining project, it was prior to the COVID-19 crisis. And as Dr. Kahl alluded, this gives additional time for states to align and make sure that it is an equitable treatment to allow individuals who have been committed for 30 years to the ADA to be recognized as we have our special incentives and rewards, so to speak, for life membership."

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

On vote, the proposed amendment was adopted.

The Speaker noted that adoption of Resolution 68 requires a two-thirds affirmative vote. On vote, Resolution 68, as amended, was adopted.

68H-2020. Resolved, that the ADA *Bylaws*, Chapter I. Membership, Section 20. Membership Eligibility, Subsection B. LIFE MEMBER, be amended as follows **(**deletions ~~stricken~~ and additions underlined):

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. Has been 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; and
~~b. Reached the age of at least sixty-five (65) during the previous calendar year~~;
~~c~~.b. Maintains membership in good standing in a constituent and component, if such exists, and in this Association.
~~d~~.c. 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~~.

and be it further
Resolved, that the foregoing amendment to Chapter I. Membership. Section 20. Membership Eligibility. Subsection B. Life Member, of the ADA *Bylaws* take effect at adjournment *sine die* of the 2021 ADA House of Delegates

New Dentist Representation to the ADA House of Delegates (First Trustee District Resolution 101): The Reference Committee reported as follows:

The Reference Committee heard extensive testimony on Resolution 101. Pro testimony centered on the value and unique perspective provided by the new dentist. Con testimony centered on not dictating the proportion of new dentists and encouraging efforts to the state and local components.

The Reference Committee concurs that the value of the new dentist voice is undeniable and new dentists are the future of the ADA. The Reference Committee also notes that Resolution 101 simply asks that the appropriate agencies assess the feasibility and mechanisms by which the new dentist proportion of each delegation can be increased. Therefore, the majority of the Reference Committee agrees with the Board and the Council on Membership, and supports adoption of Resolution 101.

101. Resolved, that appropriate agencies of the ADA assess the feasibility and mechanisms by which the ADA increases the proportion of each trustee delegation (delegates and alternates) who are dentists that qualify as “New Dentists” by the definition of the ADA “New Dentist” committee and reports to the 2021 House of Delegates.

Dr. Mentzelopoulou moved Resolution 101 (*Supplement:*2099) with the Committee recommendation to Vote Yes.

Dr. David Casteel, Wisconsin, spoke against Resolution 101, stating, “I am a new dentist in my second year of practice. I strongly support the concept of a demographically accurate representation including new dentists; however, the ADA has made this a priority in every facet of their level of the tripartite, including councils and committees. States choose their delegation to the ADA House best suited to represent their membership. Investigating the feasibility and mechanisms of increasing new dentist delegation representation should be handled at the appropriate level of the tripartite, the constituent state, district or territory.”

Dr. Paul Aswad, Massachusetts, spoke in support of Resolution101. He said, “I see this all about membership. The membership graph that we saw from the first meeting was really eye opening to me. It was headed straight down. We need to flatten this curve and 101 will help. It will enhance membership by bringing in a contemporary perspective. [Resolution] 101 is not a mandate, nor does it create quotas. It’s an assessment of feasibility to make this happen. To put this in perspective, the 2019 House of Delegates only had ten delegates under age 35. Only 24 were under 40 years of age out of 483 delegates. I just want to have that in perspective.”

Dr. Lauryne M. Vanderhoof, Michigan, spoke against Resolution 101, stating, “I am a new dentist in her third year of practice, a newly elected trustee at the state level and delegate for this House. And I speak here before you today because of the successful programs that the Michigan Dental Association has developed to increase new dentist participation at the state level. I support the concept of this resolution, and I strongly encourage state associations to have a delegation representative of their member body, and this includes new dentists. … Running a feasibility analysis would be a waste of time and resources, as it is the states who

> choose the delegation, not the ADA. And a policy is already in place to bring forward new dentist delegates. I stand in opposition to [Resolution] 101…because it will be a waste of ADA resources in conflict with the autonomy of the states."

Dr. Christopher M. Hasty, Georgia, spoke against Resolution 101, stating, "Representation in the House of Delegates is based on the decisions of our grassroots districts. We take issue with our national organization deciding how the individual component districts choose their appointees. Furthermore, we are against the expansion of the House of Delegates size if the Association decides to create a new category of delegate, be it a new dentist or any other subcategory of membership. This will dilute trustee district voices and create an imbalance in state representation. The Fifth District, however, strongly encourages the component, state, district societies to grow, include, mentor and ultimately promote our new dentists into leadership positions."

The Speaker announced that the virtual House of Delegates would need to recess and allow a break for the production team. The Speaker also announced that the speaking queue for Resolution 101 would remain in place when discussion on the Resolution resumed during the Third Meeting of the House of Delegates. The House of Delegates recessed at 11:59 a.m., Central Time.

Monday, October 19, 2020

Third Meeting of the ADA House of Delegates

Call to Order: The Third Meeting of the 161st Annual Session of the ADA House of Delegates was called to order at 1:00 p.m., Central Time, Monday, October 19, 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. Chad P. Gehani, president
Dr. Craig W. Herre, first vice president
Dr. W. Roy Thompson, trustee, Sixth District
Dr. Billie Sue Kyger, trustee, Seventh District
Dr. Kenneth McDougall, trustee, Tenth District
Dr. Kirk M. Norbo, trustee, Sixteenth 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. Linda K. Himmelberger, trustee, Third District
Dr. George R. Shepley, trustee, Fourth District
Dr. Jay F. Harrington, Jr., trustee, Fifth District
Dr. Susan Becker Doroshow, trustee, Eighth District
Dr. Julio H. Rodriguez, trustee, Ninth 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. Vincent U. Rapini, first vice president
Dr. Ted Sherwin, treasurer
Dr. Kathleen T. O'Loughlin, executive director

The Speaker recognized Dr. Gehani for the purpose of installing the new officers and trustees. Prior to installing these individuals, Dr. Gehani recognized the Speaker for his service.

The following new officers and trustees were introduced:

Dr. Michael D. Medovic, trustee, Sixth District
Dr. Chad R. Leighty, trustee, Seventh District
Dr. Scott L. Morrison, trustee, Tenth District
Dr. Gary D. Oyster, trustee, Sixteenth District
Dr. Rudolph T. Liddell, trustee, Seventeenth District
Dr. Maria C. Maranga, second vice president

Installation of Officers and Trustees. Dr. Gehani installed Dr. Daniel J. Klemmedson, Arizona, as ADA President; Dr. Cesar R. Sabates, Florida, as ADA President-elect; Dr. Maria C. Maranga, New York, as

second vice president; and Drs. Michael Medovic, Chad Leighty, Scott Morrison, Gary Oyster and Rudolph Liddell as trustees. Dr. Gehani extended congratulations to the new officers and trustees.

Presentation of Dr. Daniel Klemmedson: Dr. Klemmedson addressed the members of the House of Delegates. For outstanding efforts during this time of a global pandemic he thanked Dr. Gehani, the volunteer leaders of the ADA, Dr. Kathy O'Loughlin and the dedicated team at the ADA, and the Board of Trustees. Dr. Klemmedson's remarks focused on lessons learned during the COVID-19 pandemic and the opportunities these lessons can provide for the path forward. He stated, "I believe that we could be overtaken by recent events or we can be strengthened by the circumstances and the insights they have provided. Colleagues, it's all up to us."

Dr. Klemmedson commented on the challenges that dentists faced in the early months of the pandemic and the common ground amongst dentists that can create a better and stronger future for dentists and their patients with a focus on science, oral health care being essential to overall health, and the priority of patient safety. In regards to science, Dr. Klemmedson commented on the creation of the ADA Science and Research Institute, stating, "This new subsidiary will enhance our ability to produce basic and translational science for the benefit of all dentists and their patients." Commenting on oral health care being essential he said, "Any future limitations on patient care should be based on sound professional judgment, knowledge and science. Patient care for all segments of our society, in all clinical models, is essential." Lastly, in regards to patient safety he stated, "…COVID-19 has showcased the necessity of increased diligence as care providers and as employers. Diagnosis, treatment planning, procedure selection, workflow, education, monitoring, PPE and facilities were all modified effectively to protect our practice community from COVID-19. Why shouldn't we extend these safety elements to other areas of our practices?" He concluded by saying, "The COVID-19 pandemic has shown us our true nature, our strengths, our smarts, our ability to withstand the challenge and thrive within it. It has also shined a light on the work that remains. Now that we know better, we cannot waste our opportunity to do better, for ourselves, and for the generations coming after us who one day will face their own adversities and will benefit from the foundations we set today."

The installation ceremony concluded following Dr. Klemmedson's remarks.

Report of the Standing Committee on Credentials, Rules and Order: Dr. Anthony M. Cuomo, Committee chair, announced the presence of a quorum and read the ADA Disclosure Policy.

Announcements: The Speaker announced that Reference Committees A and B, during their respective hearings, ran out of time for discussion on the informational reports. He added that delegates would have an opportunity to discuss the Reference Committee A informational reports following the Report of the Reference Committee and the Reference Committee B informational reports prior to the Report of Reference Committee B.

Unfinished Business

Report of Reference Committee A (Continued)

Dr. Ioanna G. Mentzelopolou, chair, Reference Committee A, returned to the podium to present the Reference Committee's remaining items of business.

New Dentist Representation to the ADA House of Delegates (Continued) (First Trustee District Resolution 101)

Dr. Emily Mattingly, Missouri, and chair of the New Dentist Committee, spoke in support of Resolution 101, stating, "…While we have seen an increase in new dentist delegates since 2011, it is simply not enough. While states determine the composition of delegates and delegations, many states and districts need a boost to make changes. I personally have tried to propose changes to my state's delegation selection process unsuccessfully. The ADA should be the leader in new dentist involvement and leadership. Now is the time for forward thinking, and we should work together at all levels of the tripartite to strengthen our leadership pipeline. We need the diversity of the new dentist voice in this body and the inclusion of new dentists here at the national level. …"

As a point of information, Dr. Prabu Raman, Missouri, asked if Resolution 101 had a financial implication. The Speaker confirmed that the Resolution had no financial implication.

Dr. Summer K. Roark, Texas, spoke against Resolution 101. She said, "…In Texas, since the beginning of my career, I actively participated in my component society and at my state association, eventually earning a position on the Fifteenth Delegation and also chosen to represent the Fifteenth District on ADA's Membership Council. My new dentist colleagues across the nation have the same opportunities to actively participate in all levels of organized dentistry to make sure that voice of the new dentist is heard and valued. The answer is not to mandate an increase in the proportion of new dentists in each trustee district. The answer is to make sure that the branches of the tripartite embrace new dentists, mentor them and provide leadership opportunities for them. …"

Dr. James E. Lee, Massachusetts, spoke in support of Resolution 101, stating, "…There is no mandate and no one, full stop, no one will tell you how to select your delegation. Instead, this resolution is a way to identify solutions and help us do better. … This resolution allows the ADA to help others become the leaders and the mentors you are to so many. As someone who works on the front lines of these issues promoting the amazing work of this House, as someone who sees the ground truth interacting with literally hundreds of new dentists daily through our ADA initiatives, I respectfully urge you to support this resolution."

Further pro and con discussion ensued. Individuals speaking in support of Resolution 101 commented that new dentists are underrepresented in the House of Delegates and more new dentist delegates are needed to ensure that their needs are represented. These individuals also commented that to increase market share and remain relevant to new dentists, it is important that the Association include new dentists in leadership training and move them into leadership roles. Individuals speaking against Resolution 101 commented that the states and districts should study the issue and develop new dentist leaders, and that adoption of Resolution 101 could start a precedent of creating additional categories of delegation requirements.

A motion was made to vote immediately on Resolution 101. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, Resolution 101 was not adopted.

2021 Dentist and Student Lobby Day (Sixteenth Trustee District Resolution 110): The Reference Committee reported as follows:

> The Reference Committee heard testimony regarding the 2021 Dentist and Student Lobby Day. Testimony was overwhelmingly favorable and centered on the importance of advocacy to ADA members and the profession. The majority of the Reference Committee favors urging the Board to earmark funds for an in-person 2021 Dentist and Student Lobby Day from Reserves and therefore supports adoption of Resolution 110.
>
> **110. Resolved,** that the ADA Board of Trustees be urged to fund up to $650,000.00 from reserves for the in person 2021 ADA Dentist and Student Lobby Day.

Dr. Mentzelopoulou moved Resolution 110 (*Supplement:*2101) with the Committee recommendation to Vote Yes.

As a point of information, Dr. Thomas S. Kelly, Ohio, asked if Resolution 110 had a financial implication. The Speaker confirmed that the Resolution had no financial implication

Dr. Kelly also asked, "…within the budget that we currently have, is there a budgeted item for a Virtual Lobby Day?" The Speaker responded, "If you look on page 2037 of Board Report 2, you will see that the Virtual Lobby Day is mentioned. Also, in discussion with the Treasurer and our VP Mike Graham, they also mentioned that there's $50,000 in the 2021 budget for a Virtual Lobby Day. There's even some discussion of maybe having some kind of live portion of that, but that is definitely in the early stages. So the budget does reflect support of a Virtual 2021 Lobby Day."

Dr. Nipa R. Thakkar, Pennsylvania, spoke against Resolution 110, stating, "…While I deeply appreciate the advocacy efforts of this Association, we all recognize that there are very unique circumstances this year surrounding the difficult decision to defund this event. Urging the Board to fund up to $650,000 for a meeting whose fate remains uncertain for a variety of reasons–namely an ongoing pandemic–seems reckless and premature. … There are also too many questions that surround the wording of this resolution. Who decides if an in-person meeting can occur and when? What if the students still cannot travel? What if the rest of us should not travel? What if D.C. isn't allowing visitors? … Can the Board plan a meeting without this resolution if the condition of our nation changes? Can the Board decide that this is not in the best interest of this Association despite the House's ruling? We can all agree that advocacy is key to our Association's health, but isn't the health of our Association key to our ability to advocate? This resolution does not adequately address the use of this large sum of money and staff capacity, and that is not the ADA way."

A motion was made to vote immediately on Resolution110. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, Resolution 110 was adopted.

> **110H-2020. Resolved,** that the ADA Board of Trustees be urged to fund up to $650,000.00 from reserves for the in person 2021 ADA Dentist and Student Lobby Day.

Prior to the conclusion of the Report of Reference Committee A, the Speaker asked if there were any comments on the informational reports referred to Reference Committee A; there were none.

Prior to presentation of the Report of Reference Committee B, the Speaker asked if there were any comments on the informational reports referred to Reference Committee B; there were none.

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

The Report of Reference Committee B was presented by Dr. Julia K. Mikell, South Carolina, chair. The other members of the Committee were: Dr. Ensy A. Atarod, Texas; Dr. Henry B. Benson, Jr., Georgia; Dr. Kevin J. Hanley, New York; Dr. John E. Hisel, Jr., Idaho; Dr. Rachel D. Hymes, Tennessee; Dr. Jeffrey C. Ottley, Florida; Dr. Thomas E. Raimann, Wisconsin; and Dr. Peggy Richardson, Illinois.

Consent Calendar (Reference Committee B 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 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 removed and considered separately.
>
> **112. Resolved,** that the recommendations of Reference Committee B on the following resolutions be accepted by the House of Delegates.
>
> > **Resolution 15RC**—(Adopt Resolution 15RC in lieu of Resolution 15)—Proposed Policy, ADA Statement on Silver Diamine Fluoride to Arrest Carious Lesions (*Supplement*:3001) $: None
> > **COMMITTEE RECOMMENDATION: Vote Yes**
> >
> > **Resolution 16**—(Refer)—Proposed Amendment of the Comprehensive ADA Policy Statement on Teledentistry (*Supplement*:3002) $: None

COMMITTEE RECOMMENDATION: Vote Yes on Referral

Resolution 18—(Adopt)—Amendment of Policy, Dentist Selection Based on Cost (*Supplement*:3006) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 19RC—(Adopt Resolution 19RC in lieu of Resolution 19)—Amendment of Policy, Maximum Fees for Non-Covered Services (*Supplement*:3007) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 20RC—(Adopt Resolution 20RC in lieu of Resolutions 20 and 20S-1)—Temporary Expansion of Scope During Public Health Crisis (*Supplement*:3009) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 22RC—(Adopt Resolution 22RC in lieu of Resolutions 22, 90 and 90S-1)— Diagnostic Testing by Dentists (*Supplement*:3010) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 84RC—(Adopt Resolution 84RC in lieu of Resolution 84)—Review and Consideration of ADA Ad Interim Policy: Dentistry is Essential Healthcare (*Supplement*:3015) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 91RC—(Adopt Resolution 91RC in lieu of Resolutions 91 and 91B)—Proposed Policy, Vaccine Administration by Dentists (*Supplement*:3022) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 102—(Adopt Resolution 102 in lieu of Resolution 102S-1)—A System To Provide Accurate and Timely Access to a Patient's Insurance Information (*Supplement*:3024) $: 40,000
COMMITTEE RECOMMENDATION: Vote No

Resolution 106—(Adopt)—Teledentistry Legislative Principles and Ethical Considerations (*Supplement*:3026) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 108—(Adopt)—Logistics of Vaccine Administration by Dentists (*Supplement*:3027) $:198,170
COMMITTEE RECOMMENDATION: Vote Yes

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

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

Resolution 16 removed by Dr. C. Rieger Wood, III, Oklahoma
Resolution 19RC removed by Dr. David A. Schwartz, Pennsylvania
Resolution 22RC removed by Dr. Donna Thomas-Moses, Georgia
Resolution 102 removed by Dr. Scott L. Theurer, Utah
Resolution 106 removed by Dr. Michael A. Kurkowski, Minnesota
Resolution 108 removed by Dr. Ansley H. Depp, Kentucky

On vote, the amended Resolution 112 was adopted.

112H-2020. Resolved, that the recommendations of Reference Committee B on the following resolutions be accepted by the House of Delegates.

Resolution 15RC—(Adopt Resolution 15RC in lieu of Resolution 15)—Proposed Policy, ADA Statement on Silver Diamine Fluoride to Arrest Carious Lesions (*Supplement*:3001) $: None
COMMITTEE RECOMMENDATION: Vote Yes

~~**Resolution 16**—(Refer)—Proposed Amendment of the Comprehensive ADA Policy Statement on Teledentistry (*Supplement*:3002) $: None~~
~~**COMMITTEE RECOMMENDATION: Vote Yes on Referral**~~

Resolution 18—(Adopt)—Amendment of Policy, Dentist Selection Based on Cost (*Supplement*:3006)
$: None
COMMITTEE RECOMMENDATION: Vote Yes

~~**Resolution 19RC**—(Adopt Resolution 19RC in lieu of Resolution 19)—Amendment of Policy, Maximum Fees for Non-Covered Services (*Supplement*:3007) $: None~~
~~**COMMITTEE RECOMMENDATION: Vote Yes**~~

Resolution 20RC—(Adopt Resolution 20RC in lieu of Resolutions 20 and 20S-1)—Temporary Expansion of Scope During Public Health Crisis (*Supplement*:3009) $: None
COMMITTEE RECOMMENDATION: Vote Yes

~~**Resolution 22RC**—(Adopt Resolution 22RC in lieu of Resolutions 22, 90 and 90S-1)—Diagnostic Testing by Dentists (*Supplement*:3010) $: None~~
~~**COMMITTEE RECOMMENDATION: Vote Yes**~~

Resolution 84RC—(Adopt Resolution 84RC in lieu of Resolution 84)—Review and Consideration of ADA Ad Interim Policy: Dentistry is Essential Healthcare (*Supplement*:3015) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 91RC—(Adopt Resolution 91RC in lieu of Resolutions 91 and 91B)—Proposed Policy, Vaccine Administration by Dentists (*Supplement*:3022) $: None
COMMITTEE RECOMMENDATION: Vote Yes

~~**Resolution 102**—(Adopt Resolution 102 in lieu of Resolution 102S-1)—A System To Provide Accurate and Timely Access to a Patient's Insurance Information (*Supplement*:3024) $: 40,000~~
~~**COMMITTEE RECOMMENDATION: Vote No**~~

~~**Resolution 106**—(Adopt)—Teledentistry Legislative Principles and Ethical Considerations (*Supplement*:3026) $: None~~
~~**COMMITTEE RECOMMENDATION: Vote Yes**~~

~~**Resolution 108**—(Adopt)—Logistics of Vaccine Administration by Dentists (*Supplement*:3027) $:198,170~~
~~**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, ADA Statement on Silver Diamine Fluoride to Arrest Carious Lesions

15H-2020. Resolved, that the policy, ADA Statement on the Use of Silver Diamine Fluoride to Arrest Carious Lesions, be adopted as follows (additions are underscored):

ADA Statement on the Use of
Silver Diamine Fluoride to Arrest Carious Lesions

38% Silver Diamine Fluoride (SDF) is a topical antimicrobial and remineralizing agent which was cleared by the FDA as a Class II medical device to treat tooth sensitivity. In certain circumstances, SDF may be used as a non-restorative treatment to arrest carious lesions on primary and permanent teeth. The use of SDF to arrest carious lesions requires diagnosis and monitoring by a dentist.

When using SDF for caries management, the following protocols should be followed:

1. Development of a patient-specific treatment plan by the dentist.

2. Patients or their lawful guardians should be informed of all available treatment options, possible side effects, and the need for follow-up monitoring when giving informed consent.

3. The application of SDF may be delegated to qualified allied dental personnel with the appropriate training and supervision in accordance with state laws and in conjunction with the above protocols.

and be it further
Resolved, that the ADA supports SDF as a covered benefit by third-party payers, and be it further
Resolved, if the tooth treated with SDF requires further treatment, that this restorative treatment or extraction of the tooth also remain a covered benefit.

Amendment of Policy, Dentist Selection Based on Cost

18H-2020. Resolved, that the ADA policy, Administrative Practices Encouraging Dentist Selection Based on Cost (*Trans.*1995:610) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Administrative Practices Encouraging Dentist Selection Based on Cost

Resolved, that the American Dental Association ~~take appropriate legislative action to~~ oppose**s** any administrative practice or financial incentive that is utilized by benefit managers and/or administrators of dental ~~prepayment plans~~ benefit programs that force or otherwise encourage patients to select the dentist from whom they will seek care principally on the basis of cost, and be it further
Resolved, that the explanation of benefits (EOB) statement is not the appropriate document to promote the use of a dentist other than the treating dentist.
~~**Resolved,** that the appropriate agency report to the ADA House of Delegates as to the action taken to fulfill this resolution.~~

Temporary Expansion of Scope During Public Health Crisis

20H-2020. Resolved, that the ADA supports the utilization of dentists who ~~volunteer~~ choose to participate to increase medical capacity during declared local, state or federal public health emergencies to include:

1. Administering critical vaccines
2. Performing FDA-authorized diagnostic tests to screen patients for infectious diseases
3. Taking patient medical histories and triaging medical patients
4. Performing other ancillary medical procedures and activities, as requested by medical personnel, to expand the nation's surge capacity

and be it further
Resolved, that dentists should be granted immunity from personal liability and restrictions on the above listed services they provide for the duration of the emergency.

Review and Consideration of ADA Ad Interim Policy: Dentistry is Essential Healthcare

84H-2020. Resolved, that the ADA Interim Policy, "Dentistry is Essential Healthcare" be adopted.

Dentistry is Essential Healthcare

The American Dental Association supports the following policy:

1. Oral health is an integral component of systemic health.

2. Dentistry is ~~an~~ essential healthcare ~~service~~ because of its role in evaluating, diagnosing, preventing or treating oral diseases, which can affect systemic health.

3. The term “Essential Dental Care” be defined as any care that prevents ~~and~~ or eliminates infection, preserves the structure and function of teeth as well as the orofacial hard and soft tissues, and that this term be used in lieu of the terms “Emergency Dental Care” and “Elective Dental Care” when communicating with legislators, regulators, policy makers and the media in defining care that should continue to be delivered during global pandemics or other disaster situations, if any limitations are proposed.

4. Government agencies such as the Department of Homeland Security and the Federal Emergency Management Agency have acknowledged dentistry as an essential service needed to maintain the health of Americans. ~~so they can sustain their health and livelihoods and live resiliently during the COVID-19 pandemic response.~~ State agencies or officials should ~~be urged to~~ recognize the oral health workforce when designating its essential workforce during public health emergencies, in order to assist them in protecting the health of their constituents.

Vaccine Administration by Dentists

91H-2020. Resolved, that it is the position of the American Dental Association that dentists ~~have~~ with the requisite knowledge and skills should be allowed to administer critical vaccines to prevent life or health-threatening conditions ~~associated with the orofacial complex (e.g., oral cancer)~~ and protect the life and health of patients and staff at the point of care.

Non-Consent Resolutions

Proposed Amendment of the Comprehensive ADA Policy Statement on Teledentistry (Council on Dental Practice Resolution 16, Fourteenth Trustee District Resolution 16S-1, Eleventh Trustee District Resolution 16S-2 and Third Trustee District Resolution 16S-3): The Reference Committee reported as follows:

The Reference Committee heard considerable testimony regarding Resolution 16 and the substitutes. While there was no testimony given against teledentistry, there was a wide variety of comments offered on a number of technical and legal aspects contained in these resolutions. The ideological chasm was so significant that the Reference Committee did not discern a common ground upon which to reach consensus regarding the resolutions.

While deep appreciation is expressed for the efforts to date of the Council on Dental Practice, the Reference Committee supports the referral of Resolution 16 back to the appropriate ADA agency for further consideration. After consultation with the Speaker, the Reference Committee notes that referral of Resolution 16 will result automatically in the referral of the substitutes and any amendments, which includes Resolutions 16S-1, 16S-2 and 16S-3.

16. Resolved, that the Comprehensive ADA Policy Statement on Teledentistry (*Trans.*2015:244), be amended as follows (additions are underscored; deletions are ~~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:

Live video (synchronous): Live, two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology.

Store-and-forward (asynchronous): 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: ~~The treatment of patients who receive services via teledentistry must be properly documented and should include providing the patient with a summary of services. Dentists who deliver services using teledentistry must establish protocols for appropriate referrals when necessary~~. While in-person (face to face) direct examination is preferred, the ADA believes that synchronous, live-video examinations 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. Synchronous exams, as described above, can be valid and effective. 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. 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, 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.

Asynchronous teledentistry encounters have value in consultation and assessment of patient needs. Asynchronous interactions are an adjunct to live clinical exams and are valid and effective, to the extent that asynchronous data gathering through technology, for time and logistic reasons, will eventually lead to more efficient and effective live (in-person) examinations or synchronous teledentistry contacts, the asynchronous teledentistry contact has merit in the evaluation and treatment of patients.

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 using teledentistry technologies will be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's dental board.

2. Access to the licensure and board certification qualifications of the oral health care practitioner who is providing the care in advance of the visit.

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

4. That they 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. 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. That the provision of services using teledentistry technologies will be properly documented and the records and documentation collected will be provided to the patient upon ~~their~~ request.

7. 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. 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 services.

9. 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 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 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 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. Teledentistry cannot be used to expand the scope of practice or change permissible duties of dental auxiliaries. 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 encounters. Coverage for services delivered via teledentistry modalities will be at the same levels as those provided for services provided through in-person 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.

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. Mikell moved Resolution 16 (*Supplement:*3002) be referred to the appropriate ADA agency for further study and report to the 2021 House of Delegates with the Committee recommendation to Vote Yes on Referral.

Dr. C. Rieger Wood, III, Oklahoma, spoke against referral, stating, “This whole issue deserves to be addressed now and not delayed and sent back for referral. As an example, I presently sit on a university group that is working in conjunction with medical students doing teledentistry combined with telemedicine at the University of Oklahoma. It’s a pilot group that takes care of about 50 patients. Unfortunately, we need a policy so that our board of dentistry can move forward with the appropriate measures to make it legal so that our malpractice carrier can ultimately agree that the Board of Dentistry has a policy for teledentistry. Therefore, by kicking this down the road, it causes a real problem with me being able to involve the University of Oklahoma’s College of Dentistry in a teledentistry or telemedicine program in a joint study. ...”

A motion was made to vote immediately. The Speaker ruled that the motion to vote immediately was premature, stating, “…We have not had proper debate on this motion to refer. If you want to challenge my ruling, please do so. I will let the House decide. We have only had one speaker against this motion [to refer], or to speak toward the motion.”

Dr. Jeffrey A. Kahl, Colorado, spoke against referral, stating, “I am the past president of the Colorado Dental Association. Currently, teleheatlh is something that we have already addressed legislatively and through the regulatory process in Colorado. It’s an issue that continues to come up and an issue that we will most certainly talk about in our upcoming legislative session in 2021. Every time we talk about it and devoid of ADA policy on it is present, we create our own policy at the Colorado level. And I think that makes the ADA look inept in their ability to create real-time policy. So the more we deliberate on this and refer it back…the more I think that degrades the ADA’s position as the authority on oral health. I would encourage you to, again, as the last speaker pointed out, come to some sort of policy statement today and some consensus so that we can push this forward and have it as something to point at at the state level.”

Dr. Nima Aflatooni, California, moved to substitute Resolution 16S-4 (*Supplement:*3002d) for Resolution 16.

16S-4. Resolved, that the Comprehensive ADA Policy Statement on Teledentistry (*Trans.*2015:244), be amended as follows (Additions are double underscored; deletions are ~~double stricken~~).

Comprehensive ADA Policy Statement on Teledentistry

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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.

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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: ~~The treatment of patients who receive services via teledentistry must be properly documented and should include providing the patient with a summary of services. Dentists who deliver services using teledentistry must establish protocols for appropriate referrals when necessary~~. While in-person (face to face) direct examination ~~is preferred,~~ 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 ~~synchronous, live video~~ examinations performed using teledentisty 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. ~~Synchronous exams, as described above, can be valid and effective.~~ 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 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, 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.

~~Asynchronous teledentistry encounters have value in consultation and assessment of patient needs. Asynchronous interactions, are an adjunct to live clinical exams and are valid and effective, to the extent that asynchronous data gathering through technology, for time and logistic reasons, will eventually lead to more efficient and effective live (in-person) examinations or synchronous teledentistry contacts, the asynchronous teledentistry contact has merit in the evaluation and treatment of patients.~~

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1. That any dentist delivering, directing or supervising services using teledentistry technologies will be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's dental board.

2. Access to the licensure and board certification qualifications of the oral health care practitioner who is providing the care in advance of the visit.

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

4. That they 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. 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. That the provision of services using teledentistry technologies will be properly documented and the records and documentation collected will be provided to the patient upon ~~their~~ request.

7. 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. 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 services.

9. 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 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 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 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. Teledentistry cannot be used to expand the scope of practice or change permissible duties of dental auxiliaries. 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 encounters. Coverage for services delivered via teledentistry modalities will be at the same levels as those provided for services provided through in-person 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.

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.

In speaking to the substitute, Dr. Aflatooni said, "Representing the Thirteenth District, as well as serving on the Council on Dental Practice and working on updated policy on teledentistry. As subcommittee chair of policy emerging issues for the Council on Dental Practice, our goals were to update the policy with respect to the current environment and provide patient protections that will allow states and districts in their advocacy efforts against entities using teledentistry improperly. Many states are needing an updated policy now, as they need policy to refer to before their legislatures meet in 2021. We do not have time to wait. After recent testimony concerns regarding the policy, it has become abundantly clear that ADA policy should not be in the business of establishing validity or preference on practice modality. We're not here to take winners or losers. Rather, ADA policies should focus on broad principles, set a standard of care and patients' rights. ADA policy should be broad enough to allow for states and districts to develop policy based on their respective needs and views. This substitution achieves this by removing language relating to validity of that practice modality and strengthens patient protections by stating the information collected during a teledentistry exam must be equivalent to an in-person exam. The dentist is legally responsible for this. It allows for practitioners to practice based on the modality preference while holding them up to this high standard."

The Speaker reminded the House that the motion to refer was still the main motion, stating "…So if you vote to substitute [Resolution] 16S-4 with [Resolution] 16, the motion is still to refer. And, as I mentioned earlier, if the House votes to refer, then all the substitutes go along with that motion. You will have to defeat the motion to refer to take your business at the House today."

As a point of order, Dr. Bryan C. Edgar, Washington, said, "I don't quite follow this concept of substituting [Resolution] 16S-4 for [Resolution] 16, because the motion to refer has a higher order of priority than the motion to amend. …"

The Speaker responded, "The main motion coming from the Reference Committee is to refer. That is a main motion. And if you look, it follows the criteria of main motion. You can amend the main motions, so that is why I am allowing the amendment to take place. …"

Pro and con discussion on the motion to refer ensued.

As a point of order, Dr. Edgar stated that since the House needed to act on whether or not to substitute Resolution 16S-4 for Resolution 16, discussion of referral at this time would be out of order. The Speaker responded, stating, "I agree with that… The debate is related to the substitution of Resolution 16S-4 for [Resolution] 16. Let's concentrate our debate for substitution first. But we will come back to the referral at some point in time."

A motion was made to vote immediately on the motion to substitute Resolution 16S-4 for Resolution 16. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, the motion to substitute Resolution 16S-4 for Resolution 16 was adopted.

The Speaker announced that the current motion before the House was to refer Resolution16S-4 to the appropriate ADA agency for further study and report to the 2021 House of Delegates. He later stated, "So we will begin with debate on referral of Resolution [16]S-4. And before we begin debate, I just want to reiterate, if

you defeat referral, [16]S-4 will be before you. If you adopt referral, [16]S-4 and all the other resolutions will go with it, other than [Resolution] 16, which you have substituted now."

Dr. Mary Krempasky Smith, Washington, spoke against referral, stating, "I think it's clear the House is ready to vote on this. And we must defeat the referral so that we can get the resolution on the floor to discuss."

A motion was made to vote immediately on the motion to refer Resolution 16S-4. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, the motion to refer was not adopted.

Dr. Shakalpi R. Pendurkar, California, spoke in support of Resolution 16S-4, saying, "…This resolution primarily addresses issues about access to care. As a public health dentist who's worked at an FQHC for over 18 years, I can attest as to how teledentistry has greatly helped us move in the right direction. We need to send a strong message that ADA, America's leading advocate for oral health, cares about access to oral health and wants to reduce barriers to care for our most vulnerable populations."

Dr. Jeff O. Capes, Georgia, spoke against Resolution 16S-4, stating, "… To remind everyone, we have had a policy for teledentistry since 2015, and I'm in support of a new policy, but not a five-year-old policy that has fresh paint on it. This policy falls short on what is necessary as a fully comprehensive policy. The reference committee agreed it was lacking. We need a well thought out and properly constructed policy that addresses all the layers of teledentistry. It has to go beyond just the technology. To be clear, we need it to protect us, our patients and our profession, especially from unwanted and undesirable legal ramifications. … We can't live with a policy that could expose us to negative consequences. We should respect our reference committee, take a little extra time and get it right. We can't afford to take a 'let's see what happens' approach."

Dr. Mary Krempasky Smith, Washington, spoke in support of Resolution 16S-4, stating, I'm faculty with the University of Washington. The program I run is basically an outreach program in FQHC's. This is new technology, yes, but it's old–it's just standard dentistry as far as finding new ways to participate, especially in the times we've experienced with COVID."

Dr. Gary S. Davis, Pennsylvania, spoke against Resolution 16S-4, stating, "The term 'examination' versus 'assessment screening' should not be dependent upon whether the video is live, synchronous or asynchronous. The determination that an exam has been performed should be based on having a licensed person doing the exam. The comprehensiveness and accuracy of an exam in determined by having a trained person at the site to palpate the area and perform other diagnostic tests. How many time have you had a patient come in and they said, 'oh, this particular tooth hurts,' but after palpitation, percussion, hot and cold tests, you find out it's a different tooth. Having, you know, a person there live to touch the patient, to use our senses, is what determines whether an exam is comprehensive or not."

Dr. Brooke M. Fukuoka, Idaho, spoke in support of Resolution 16S-4. She said, "I practice teledentistry with patients who have special needs and geriatric patients who have Alzheimer's and dementia. And there have been so many comments saying that these exams with teledentistry are not quality exams or not equivalent to an in-person exam. But in my practice and in my world where I struggle to have a patient hold still and I struggle to see in the mouth, that camera has opened so many doors. I've seen inside the mouths of people who haven't had their mouths looked in for 20 years. I found teeth in geriatric patients that people didn't even know this patient had teeth, and it's because on that camera, there's a light, and on that light, it illuminates the mouth so that I can see. … I have done teledentistry since November in these long-term care facilities. When COVID hit, it was the only thing I could do in these long-term care facilities. I have never got paid for an exam, and it's because we don't see this as a valid exam. I have done all of it pro bono. That's because I love my patients, and I don't think I should have to be pro bono. I think this would help me in my practice and other people who are trying to expand access to care to populations that not only have a hard time with access to care, that this is the only form of care."

A motion was made to vote immediately on Resolution 16S-4. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, Resolution 16S-4 was adopted.

16H-2020. Resolved, that the Comprehensive ADA Policy Statement on Teledentistry (*Trans.*2015:244), be amended as follows (Additions are double underscored; deletions are ~~double stricken~~).

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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: ~~The treatment of patients who receive services via teledentistry must be properly documented and should include providing the patient with a summary of services. Dentists who deliver services using teledentistry must establish protocols for appropriate referrals when necessary~~. While in-person (face to face) direct examination ~~is preferred,~~ 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 ~~synchronous, live video~~ examinations performed using teledentisty 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. ~~Synchronous exams, as described above, can be valid and effective.~~ 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 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, 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.

~~Asynchronous teledentistry encounters have value in consultation and assessment of patient needs. Asynchronous interactions, are an adjunct to live clinical exams and are valid and effective, to the extent that asynchronous data gathering through technology, for time and logistic reasons, will eventually lead to more efficient and effective live (in-person) examinations or synchronous teledentistry contacts, the asynchronous teledentistry contact has merit in the evaluation and treatment of patients.~~

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 using teledentistry technologies will be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's dental board.

2. Access to the licensure and board certification qualifications of the oral health care practitioner who is providing the care in advance of the visit.

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

4. That they 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. 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. That the provision of services using teledentistry technologies will be properly documented and the records and documentation collected will be provided to the patient upon ~~their~~ request.

7. 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. 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 services.

9. 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 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 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 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. Teledentistry cannot be used to expand the scope of practice or change permissible duties of dental auxiliaries. 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 encounters. Coverage for services delivered via teledentistry modalities will be at the same levels as those provided for services provided through in-person 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.

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.

Amendment of Policy, Maximum Fees for Non-Covered Services (Council on Dental Benefit Programs Resolution 19 and Reference Committee B Resolution 19RC): The Reference Committee reported as follows:

The Reference Committee heard limited but supportive testimony of Resolution 19 from the Council on Dental Benefit Programs (CDBP). The Reference Committee heard one suggestion to amend the proposed policy by including a statement seeking adjustment of payment amounts on an annual basis in order for such amounts to not remain de minimis over time. The Reference Committee agreed with the suggestion. Therefore, the Reference Committee recommends adoption of the following resolution:

19RC. **Resolved,** that the ADA policy, Maximum Fees for Non-Covered Services (*Trans.*2010:616*)* be amended as follows (additions are double underscore):

Maximum Fees for Non-Covered Services

Resolved, that the Association opposes any third-party contract provisions that establish limits on dentists' charges ~~fee limits~~ for ~~noncovered~~ services that are not "covered services," and be it further
Resolved, that "covered service" is defined as any service for which reimbursement is actually provided on a given claim, and be it further
Resolved, that the carrier provides payment for the covered services under the patient's policy in an amount that is reasonable and not nominal or de minimis and the carrier should adjust such amounts every year to reflect inflation.
~~**Resolved,** that "non-covered service" is defined as any service for which the third-party provides no reimbursement, and be it further~~
~~**Resolved,** that the Association pursue passage of federal legislation to prohibit federally regulated plans from applying such provisions, and be it further~~

~~**Resolved,** that the Association encourage constituent dental societies to work for the passage of state legislation to prohibit insurance plans from applying such provisions.~~

Dr. Mikell moved Resolution 19RC in lieu of Resolution 19 (*Supplement:*3007) with the Committee recommendation to Vote Yes.

Dr. David A. Schwartz, Pennsylvania, moved to amend Resolution 19RC in the third resolving clause by replacing the words "is reasonable and not nominal or de minimis and the carrier should" with the words "reflects the costs of the services rendered by using the current year's averaged fee from similar geographic areas and," so that the third resolving clause would read as follows:

Resolved, that the carrier provides payment for the covered services under the patient's policy in an amount that ~~is reasonable and not nominal or de minimis and the carrier should~~ reflects the costs of the services rendered by using the current year's averaged fee from similar geographic areas and adjusts such amounts every year to reflect inflation.

In speaking to the amendment, Dr. Schwartz stated, "ADA has a policy against the use of UCR, reasonable, customary and usual by the insurance companies, and yet we use the word 'reasonable' in this resolved clause, so we thought that was not consistent with current policy and need to be removed. So we found a different way of saying that… the use of the word 'reasonable,' we tried to get the insurance companies not to use that word when they speak of fees, so we should not use it ourselves."

Dr. Marian S. Wolford, Pennsylvania, spoke in support of the proposed amendment, stating, "I think it's important to eliminate words such as 'reasonable,' 'not nominal' or 'de minimis,' because they're subjective and difficult to quantify. This amendment will allow a metric by which the services rendered can be determined at a fair market value."

Dr. Christopher J. Smiley, Michigan, spoke against the amendment, stating, "I take concern with the term 'average fee.' Although the intent of the makers of this resolution is well stated, when we talk about average fee, that can be when we're talking about averages or median fee and so forth. That can misrepresent what is actually the fair fee. We should be talking, if they wish, about percentiles rather than average fees."

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 adopted.

On vote, Resolution 19RC, as amended, was adopted in lieu of Resolution 19.

19H-2020. **Resolved,** that the ADA policy, Maximum Fees for Non-Covered Services (*Trans.*2010:616*)* be amended as follows (additions are double underscore):

Maximum Fees for Non-Covered Services

Resolved, that the Association opposes any third-party contract provisions that establish limits on dentists' charges ~~fee limits~~ for ~~noncovered~~ services that are not "covered services," and be it further
Resolved, that "covered service" is defined as any service for which reimbursement is actually provided on a given claim, and be it further
Resolved, that the carrier provides payment for the covered services under the patient's policy in an amount that ~~is reasonable and not nominal or de minimis and the carrier should~~ reflects the costs of the services rendered by using the current year's averaged fee from similar geographic areas and adjusts such amounts every year to reflect inflation.
~~**Resolved,** that "non-covered service" is defined as any service for which the third-party provides no reimbursement, and be it further~~
~~**Resolved,** that the Association pursue passage of federal legislation to prohibit federally regulated plans from applying such provisions, and be it further~~

~~**Resolved,** that the Association encourage constituent dental societies to work for the passage of state legislation to prohibit insurance plans from applying such provisions.~~

Diagnostic Testing by Dentists (Council on Dental Practice Resolution 22, Council on Government Affairs Resolution 90, Third Trustee District Resolution 90S-1 and Reference Committee B Resolution 22RC): The Reference Committee reported as follows:

Testimony was received regarding combining Resolutions 22 and 90. The Reference Committee concurs that there is a natural synergy between the two Resolutions.

The Reference Committee heard a number of comments in favor of Resolution 22. Testimony was offered in support of this Resolution as a benefit to dentists who offer hospital-based dental care, as an aid in supporting advocacy for dental practice act amendments, and as an affirmation that this is within the scope of dental practice.

The Reference Committee also heard limited testimony on both Resolutions 90 and 90S-1. Testimony in support was received regarding adding in "order and" as part of 90S-1 to facilitate navigating laboratory testing challenges. The Reference Committee appreciates this as well as the suggestion to add language regarding both federal and state requirements. Therefore, the Reference Committee recommends adoption of Resolution 22RC in lieu of Resolutions 22, 90 and 90S-1.

22RC. Resolved, that dentists have the requisite knowledge and skills to order and administer diagnostic medical tests to screen patients for chronic diseases and other medical conditions that could complicate dental care or put the patient and staff at risk, and be it further
Resolved, that point of care testing is within a dentist's scope of practice, and be it further
Resolved, that point of care testing results be communicated with the patient and the patient be referred to their physician for appropriate diagnoses and treatment, and be it further
Resolved, that dentists comply with federal and state requirements, as appropriate, to administer the tests.

Dr. Mikell moved Resolution 22RC in lieu of Resolution 22 (*Supplement:*3010), Resolution 90 (*Supplement:*3021) and Resolution 90S-1 (*Supplement:*3020a) with the Committee Recommendation to Vote Yes.

Dr. Donna Thomas-Moses, Georgia, moved to amend Resolution 22RC in the first resolving clause by replacing the word "have" with the word "with" and replacing the word "to" with the word "can," and in the second and third resolving clauses by replacing the word "testing" with the word "screening," so that Resolution 22RC, as amended, would read as follows:

Resolved, that dentists ~~have~~ with the requisite knowledge and skills ~~to~~ can order and administer diagnostic medical tests to screen patients for chronic diseases and other medical conditions that could complicate dental care or put the patient and staff at risk, and be it further
Resolved, that point of care ~~testing~~ screening is within a dentist's scope of practice, and be it further
Resolved, that point of care ~~testing~~ screening results be communicated with the patient and the patient be referred to their physician for appropriate diagnoses and treatment, and be it further
Resolved, that dentists comply with federal and state requirements, as appropriate, to administer the tests.

In speaking to the proposed amendment, Dr. Thomas-Moses, stated, "Those dentists who have requisite knowledge and training to order and administer diagnostic medical tests for screening purposes must be encouraged to do so. However, many dentists do not share the level of training and requisite knowledge. … As for amending the word 'testing' to 'screening,' the primary purpose of screening tests is to detect early disease or risk factors for disease. When an abnormal test result is obtained, it will then be necessary to refer the patient to our medical community to proceed with diagnostic testing to further guide them in establishing a proper diagnosis and treatment pathway."

As a point of information, Dr. Scott S. Hansen, Oregon, through the chair, asked for clarification from the maker of the motion, saying, "I think it's great, but is taking a blood sugar reading in an office, is that a screening or is that a test?"

At the Speaker's request, Dr. Thomas-Moses responded, "In my opinion, it's more of a screening, because you are looking at a screening outcome to know it it's high or low. And if it's found out to be abnormal, you would refer to your medical community for further diagnosis."

Dr. Richard B. Kahn, New Jersey, spoke against the proposed amendment, stating, "I'm speaking against this because there's a point here, it says the point of care is within the scope of dental practice. Isn't that determined by the state licensing boards? So we are making a regulation or a resolved clause that may not be applicable, because the state licensing board may say 'no, you can't.' I think that as dentists, as a board certified periodontist, I know what my limits are, and I feel that to go ahead and start chipping away at the greater health care pie is probably not something that we should do."

Dr. Jeff O. Capes, Georgia, spoke in support of the proposed amendment. He said, "… You know, as a dentist, we are trained and we are experts on healthy oral cavities. But we also have an opportunity to screen our patients, as was stated earlier, for medical conditions that can be affected by their oral health. You know, we take medical histories, we do blood pressures. We may weight them, BMIs, temperatures, maybe check blood sugar. You know, this is information that we can screen our patients. You know, as dentists, we can use this point of care screening process to better communicate with our patients but also our physicians, and I think this is really what this policy is getting to. We want to work more collaboratively with our physician colleagues, and we can use this process as a means to open those doors of communication, work more collaboratively. And I think ultimately we can all agree that we want what is best for our patients. And I think this resolution, as amended, conveys that information to our medical colleagues. It conveys that we understand the correlation between oral health and systemic health."

Dr. Gary S. Davis, Pennsylvania, spoke against the proposed amendment, stating, "… Just, for example, COVID-19, we do a screening before patients come in, which is a series of questions. And we want to do more than that. … We want to be able to do the testing part on several things, you know, other tests. So I speak against the word 'screening,' because I see that more as a list of questions versus testing."

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 adopted.

Dr. Ralph A. Cooley, Texas, provided information, stating, "…just for informational standpoint, and I think maybe most of the delegates know that the Code Maintenance Committee just passed last spring two new codes that are going to take place January 1, and it's DO604 and DO605. And the way those are worded is antigen testing for public health related pathogen including Coronavirus. And that's point of care testing. And the other one is antibody testing. So I'm okay with this, but just know that we're putting different words in here, 'screening.' As long as everybody understands the difference, that's fine. But the official verbiage that's coming down from the code says 'point of care testing.'"

Dr. Christopher J. Cuomo, New York, spoke against Resolution 22RC, as amended. He said, "… I do want to clarify a little bit 'testing' and 'screening.' My concern is by the change to 'screening' that we're now out of order and that we're inconsistent with our Codes Committee with the language that we're using. But we do testing all day long. It's not just screening. But blood glucose is a test. Blood pressure is a test. It is not a diagnosis. And that's what it really comes down to. We are testing all day long, but we do not come up with a diagnosis of diabetes, hypertension. We then refer off to a physician for that diagnosis. Because of that, I am opposed to the resolution with the change or the amendment of 'screening' in place of 'testing.'"

Dr. Christopher J. Smiley, Michigan, moved to reconsider the amendment to Resolution 22RC due to the new information provided by Dr. Cooley regarding new codes passed by the Code Maintenance Committee, which include the verbiage "point of care testing."

In answer to a question, the Speaker clarified that the motion is to reconsider the amendment that took place earlier.

Pro and con discussion on the motion to reconsider ensued. Individuals speaking in support of the motion to reconsider the amendment commented that following adoption of the amendment, new information had been provided, and the use of the word “tests” in the first resolving clause no longer matched up with the second and third resolving clauses where the word “screening” replaced the word “testing.” Individuals speaking against the motion to reconsider the amendment commented that the amendment was adopted by a wide margin and that the language in the first, second and third resolving clauses was consistent.

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

On vote, the motion to reconsider the amendment was adopted.

Dr. Donna Thomas-Moses, Georgia, offered a friendly amendment to the second and third resolving clauses by adding the word “test” after the word “screening”. Since Dr. Thomas-Moses was the maker of the amendment, the Speaker allowed the addition. Following a grammatical correction to change the word “test” to “testing,” the proposed amendment would read as follows:

> **Resolved,** that dentists ~~have~~ with the requisite knowledge and skills ~~to~~ can order and administer diagnostic medical tests to screen patients for chronic diseases and other medical conditions that could complicate dental care or put the patient and staff at risk, and be it further
> **Resolved,** that point of care ~~testing~~ screening testing is within a dentist’s scope of practice, and be it further
> **Resolved,** that point of care ~~testing~~ screening testing results be communicated with the patient and the patient be referred to their physician for appropriate diagnoses and treatment, and be it further

As a point of information, Dr. Monica Hebl, Wisconsin, asked if the maker of the amendment could provide explanation regarding the proposed amendments to the first resolving clause. She asked, “How do we determine which dentists have the requisite knowledge and skills?”

Dr. Thomas-Moses responded, stating, “The dentist would make that decision. Some dentists simply don’t feel comfortable doing any type of testing, yet some do. This would allow either to make the decision for their practice.”

Dr. Christopher J. Smiley, Michigan, speaking in opposition to the amendment, said, “I rise to speak against the amendments, although I would very much like to get us back to the original amendment and defeat all of this. I wonder if we can have an editorial acceptance to say ‘point of care testing to screen,’ if that would be considered editorial by the maker of this amendment, if they would be amenable to ‘point of care testing to screen.’”

At the Speakers request, the maker of the motion, Dr. Donna Thomas-Moses, accepted the editorial edit, so that the proposed amendment would read as follows:

> **Resolved,** that dentists ~~have~~ with the requisite knowledge and skills ~~to~~ can order and administer diagnostic medical tests to screen patients for chronic diseases and other medical conditions that could complicate dental care or put the patient and staff at risk, and be it further
> **Resolved,** that point of care ~~testing~~ ~~screening~~ testing to screen is within a dentist’s scope of practice, and be it further
> **Resolved,** that point of care ~~testing~~ ~~screening~~ testing to screen results be communicated with the patient and the patient be referred to their physician for appropriate diagnoses and treatment, and be it further

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 adopted.

In answer to a question, the Speaker clarified that the third resolving clause would be editorially corrected so that the words “testing to screen results” would be corrected to read “testing results.”

> A motion was made to vote immediately on Resolution 22RC, as amended. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, Resolution 22RC, as amended, was adopted in lieu of Resolution 22, Resolution 90 and Resolution 90S-1.

> **22H-2020. Resolved,** that dentists ~~have~~ with the requisite knowledge and skills ~~to~~ can order and administer diagnostic medical tests to screen patients for chronic diseases and other medical conditions that could complicate dental care or put the patient and staff at risk, and be it further
> **Resolved,** that point of care testing to screen is within a dentist's scope of practice, and be it further
> **Resolved,** that point of care testing results be communicated with the patient and the patient be referred to their physician for appropriate diagnoses and treatment, and be it further
> **Resolved,** that dentists comply with federal and state requirements, as appropriate, to administer the tests.

A System to Provide Accurate and Timely Access to a Patient's Insurance Information (Fourteenth Trustee District Resolution 102 and Sixteenth Trustee District Resolution 102S-1): The Reference Committee reported as follows:

> The Reference Committee heard testimony both in support of and against Resolution 102 and heard limited testimony on Resolution 102S-1. The Council on Dental Benefit Programs (CDBP) provided testimony in support of Resolution 102. Testimony against Resolution 102 noted the potential liability that could be created by an ADA-owned system housing protected personal health information as well as a new effort potentially duplicating the work already ongoing within the ADA's Standards Committee on Dental Informatics (SCDI). The Reference Committee acknowledges that solving the issue related to eligibility and benefits verification is important to dental offices participating in third-party payer programs. However, the Reference Committee agrees with the testimony that the SCDI is already addressing this issue and additional work could be undertaken following the completion of that effort. Therefore, the Reference Committee recommends against adoption of Resolutions 102 and 102S-1.
>
> **102. Resolved**, that the appropriate ADA agencies investigate the feasibility of developing a platform to allow third-party payers to provide the treating dentist with accurate and timely information regarding a patient's current dental benefits through a single unified system such as an online portal or app, and be it further
> **Resolved,** that the ADA prepare legislation that requires dental benefits plans to utilize fair and accurate language in the communication of limitations of coverage, and be it further
> **Resolved,** that a report with recommendations be prepared for the 2021 House of Delegates.

Dr. Mikell moved Resolution 102 (*Supplement:*3024) in lieu of Resolution 102S-1 (*Supplement:*3024a) with the Committee Recommendation to Vote No.

Dr. Scott Theurer, Utah, moved to refer Resolution 102 to the Board of Trustees with a report to the 2021 House of Delegates.

In speaking to the motion, Dr. Theurer stated, "The reference committee testimony cited three concerns: the potential liability of storing data, the affirmation that we're already working on this, and, finally, the cost. We believe that all three concerns are misplaced. First of all, the cost. We believe that Resolution 102 represents the first step in what could be a non-dues revenue generating project. Each year billions of dollars are spent by dental offices dedicating staff to track down insurance information. This project could save offices money and generate revenues from those who use the platform that we develop. The maximum value comes if the ADA is first to market. So we have to start now to develop, patent and copyright our intellectual property. The second concern was liability. If properly developed, we believe this platform would merely allow the secure exchange of data, not the storage of data and the accompanying liability. And, finally, we're already working on it. It's true that valuable work is being done by SCDI to facilitate the exchange of information. This is exactly the reason we need to be moving forward with a platform. Finding a common data language is essential, but the entity which benefits most is the one that's first to market with a data interchange. The other entities sitting at the table are in it for its financial potential or saving on expenses by their participation. The ADA shouldn't be contributing our expertise without potential for a return on our investment. This project will require partners with skill sets we may not currently have, but we need to get quickly more educated and find a way to bring this good idea to market, not just work on it until someone else finds a way to monetize it."

Dr. I. Jay Freedman, Pennsylvania, and chair of the Council of Membership, spoke in support of referral stating, "I think that this should be referred to the Board of Trustees because after advocacy, the number two concern for member dentists and potentially non-member dentists is third-party payer issues. As a result, this would allow another reason for non-members to consider ADA membership, create potential non-dues revenue; and thirdly, allow greater loyalty among our existing members."

In answer to a question, the Speaker clarified that if the House adopted the motion to refer, both Resolution 102 and Resolution 102S-1 would be referred to the Board of Trustees.

Dr. Prabu Raman, Missouri, spoke in support of the motion to refer.

A motion was made to vote immediately on the motion to refer Resolution 102. The motion to vote immediately was adopted by a two-thirds affirmative vote.

As a point of information, Dr. Randall C. Markarian, Illinois, and chair of the Council on Dental Benefit Programs stated, "This resolution as it's written is basically a referral back for a report, and the Council has also been looking into this. So without adding some funding to do more, we are at the end of what we can do. …"

In response, the Speaker confirmed that there was a $40,000 financial implication if Resolution 102 was referred.

On vote, the motion to refer Resolution 102 to the Board of Trustees for further study and report to the 2021 House of Delegates was adopted.

Subsequent to the adoption of the motion to refer, as a point of information, Dr. Christopher J. Smiley, Michigan, asked for clarification on the financial implication. He stated, "… When we were debating referral, [the] representative from the Council on Dental Benefits was clear that referring back was simply that they were already doing work on this, and the referral wouldn't come with any money, so it would add a cost center to the work of the Council without basically having the funds to do it. Mr. Speaker, then you said, no, it does come with a price tag, so you said that it does come with funding. But the funding was for the resolution itself. It was for the project in that resolution, not for giving the money to the Council on a referral. So, basically, we were not correctly informed, I believe, on clarity here that there was money to go along with the referral."

After consulting with Dr. O'Loughlin, the Speaker stated that the $40,000 went with the referral.

As a point of order, Dr. Robert M. Peskin, New York, stated, "… When we approve a resolution, we are informed of what the financial implication is, but we're not approving an amount to exceed or not to exceed until that's in the body of the resolution. The sum and substance of the resolution itself speaks for itself, and whatever implication is associated with it is estimated and just brought to our attention for informational purposes only, as I understand it."

Upon request, Dr. O'Loughlin, responded to the inquiry, stating, "Historically any resolutions that have a financial implication, as those actions are approved by the House, we will keep a running total that will be added to the coming year budget, and that will be presented to the House as a new total at the end when you do your final approval of the budget. …"

Teledentistry Legislative Principles and Ethical Considerations Fourteenth Trustee District Resolution 106): The Reference Committee reported as follows:

> The Reference Committee heard limited testimony on Resolution 106. The Reference Committee found the testimony supporting the Resolution as written to be compelling. Therefore, the Reference Committee recommends adoption of Resolution 106.
>
> **106. Resolved,** that the appropriate ADA agencies develop legislative principles for inclusion in state dental practice laws consistent with the ADA's teledentistry policies, and be it further
> **Resolved**, that the Council on Ethics, Bylaws and Judicial Affairs be requested to develop an advisory opinion regarding teledentistry guidelines for inclusion in the *ADA Principles of Ethics and Code of Professional Conduct*.

Dr. Mikell moved Resolution 106 (*Supplement:*3026) with the Committee Recommendation to Vote Yes.

Dr. Michael A. Kurkowski, Minnesota, Chair of the Council on Ethics, Bylaws and Judicial Affairs, moved to amend Resolution 106 in the second resolving clause as follows:

> **Resolved**, that the Council on Ethics, Bylaws and Judicial Affairs be requested to develop ~~an advisory opinion regarding~~ ethical guidance on teledentistry ~~guidelines for inclusion in~~ consistent with the *ADA Principles of Ethics and Code of Professional Conduct*.

In speaking to the amendment, Dr. Kurkowski stated, "The last line of the background statement for Resolution 106 includes a misstatement that the current ADA Code of Ethics does not address the ethics of Teledentistry and, as such, gives no guidance on its appropriate use. In fact, the Principles of Ethics and Code of Professional Conduct does, just as it addresses all facets of providing care to patients. The Code does this by focusing on the conduct of the practitioner rather than the delivery method of care employed. By focusing on the practitioner's conduct, the Principles and Code can be concisely set forth and explained. … Members of the House, rest assured that CEBJA has been and will continue to monitor the ongoing development of Teledentistry and is prepared to provide ethical analysis as needed. … So this amendment broadens the options or avenues by which our Council may be enlisted to provide guidance."

Dr. Michael Maihofer, Michigan, spoke in support of the amendment, saying, "I was against the second resolving clause in the first one directing CEBJA to develop an advisory opinion on teledentistry. I'm confident that from my over 20 years' experience adjudicating ethics cases, that the five guiding principles of ethics found in our Code adequately over any type of ethical infraction that this new mode of dental practice would require."

Dr. Richard B. Kahn, New Jersey, spoke against the amendment, saying, "Earlier we approved teledentistry as a way to deliver care. We are now saying that we need to form some ethical guidance on how to do this. …as members of the American Dental Association, haven't we sort of agreed that we would practice ethically according to our State Dental Practice Act? … Haven't we agreed that we're going to do everything ethically? Why are we going to add this in there? I think that's a redundant thing. I think this is something that is part and parcel of being an ADA member, so I speak against this motion.'

Dr. Alma J. Clark, California, spoke in support of the amendment, saying, "Advisory opinions, by definition, are interpretations that apply to Code of Professional Conduct to specific fact situations. They, in general, address a problem and remind the public of that. There's no problem yet. Teledentistry is a new area. It's developing. In my mind, it's premature to formulate an advisory opinion. Right now we would use a more flexible tool as we work around telehealth. Again, this is an evolving area. Let teledentistry grow. Every section of what we do in teledentistry is what we do in the practice of dentistry. Teledentistry with morph and grow. Again, a white paper may provide the background and rationale or perhaps a longer, scholarly journal response in the beginning, but CEBJA believes interpretation of the Code of Professional Conduce is needed."

Dr. Robert J. Wilson, Jr., Maryland, spoke in support of the proposed amendment.

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 adopted.

The Speaker asked if there was any discussion regarding the Resolution; there was none. On vote, Resolution 106, as amended, was adopted.

> **106H-2020. Resolved,** that the appropriate ADA agencies develop legislative principles for inclusion in state dental practice laws consistent with the ADA's teledentistry policies, and be it further

Resolved, that the Council on Ethics, Bylaws and Judicial Affairs be requested to develop ~~an advisory opinion regarding~~ ethical guidance on teledentistry ~~guidelines for inclusion in~~ consistent with the *ADA Principles of Ethics and Code of Professional Conduct*.

Logistics of Vaccine Administration by Dentists (Fourteenth Trustee District Resolution 108): The Reference Committee reported as follows**:**

The Reference Committee heard only favorable testimony regarding Resolution 108. Following careful consideration of the financial implication which is necessary to develop educational materials and procedures, along with the potential member benefit, the Reference Committee recommends adoption of Resolution 108.

108. Resolved, that the ADA develop legislative principles for inclusion in state regulations allowing appropriately trained dentists to administer vaccines, and be it further
Resolved, that the ADA develop educational materials and procedures supporting the use and administration of vaccines by dentists, and be it further
Resolved, that the appropriate ADA agency develop guidance on protocols to communicate with patients and access reimbursement mechanisms related to administering vaccines.

Dr. Mikell moved Resolution 108 (Supplement:3027) with the Committee Recommendation to Vote Yes.

Dr. Ansley H. Depp, Kentucky, moved to amend Resolution 108 by deletion of the second and third resolving clauses so that Resolution 108 would read as follows:

Resolved, that the ADA develop legislative principles for inclusion in state regulations allowing appropriately trained dentists to administer vaccines~~, and be it further~~
~~**Resolved**, that the ADA develop educational materials and procedures supporting the use and administration of vaccines by dentists, and be it further~~
~~**Resolved**, that the appropriate ADA agency develop guidance on protocols to communicate with patients and access reimbursement mechanisms related to administering vaccines~~.

In speaking to the amendment, Dr. Depp said, “On behalf of the Sixth District, I would like to amend by deletion Resolution 108. While we recognize the merits of the amendment brought to the House by the Fourteenth District, we believe that the investment required to bring this amendment as written is not a good use of our budget dollars at this time. We believe most dentists would be happy to assist in ending this pandemic by administering vaccines; however, if we are involved in vaccine delivery, the setting most likely would be dictated by the federal government, as illustrated by the administration of the polio vaccine of the 1950’s. We may be called upon as volunteers or perhaps paid per diem to administer vaccines in a staged setting such as a gym, church or parking lot tent. The government protocols for dentist to administer vaccines in a private office and to try to obtain reimbursement would be difficult at best. In the absence of vaccine administration in a private office setting, the responsibility of the ADA to develop training materials and reimbursement protocols comes into question. …”

Dr. James A.H. Tauberg, Pennsylvania, spoke against the amendment, saying, “One of the things they talk about in dentistry that is so important is HPV vaccinations. In our states, I know it’s a big priority for our Department of Health Dentistry Service and it’s something we should be able to do. It’s disconcerting to watch that we cannot do a flu vaccine or COVID vaccines in the future. Instead, we go to the pharmacist and a pharmacist gets to do it, not a doctor, not a dental doctor. I am against this. I believe that it is appropriate for dentist to provide appropriate vaccinations, especially HPV. And if you can do an HPV, why can’t you do a flu or a COVID.”

As a point of information, Dr. Mark M. Johnston, Michigan, asked is the amendment would change to financial implication.

In response, the Speaker stated that the cost would go to zero.

Dr. Monica M. Hebl, Wisconsin, spoke in support of the amendment, saying, “I’m in favor of the deletion and the elimination of the financial [implication]. We’re in a tough year. I don’t think we need to create CE at this point. …”

As a point of information, Dr. Depp offered clarification to the Sixth District's amendment. She said, "The first line, we are not—I am not saying that we don't want to do vaccinations. We are just trying to reduce the cost by the deletion."

Dr. Thomas E. Raimann, Wisconsin, spoke against the amendment, saying, "I think this defeats the purpose of the resolution. We need to ADA to help us to move forward in administering, not just COVID vaccine, but other vaccines, in our offices. As other people have stated, I can go to the pharmacy and get other vaccinations. And I would like to see the ADA moving forward to help us do that."

Dr. Vincent V. Benivegna, Michigan, speaking in support of the amendment, said, "I believe that these deletions work really well, and I totally agree with taking out the financial implication of this. I don't think it really changes to spirit of this much. It just kind of puts it on the states, because once dentists are allowed…legally to administer vaccines, you know, it will be put on the state to train us, and approve it. So it takes the ADA out, but still allows it."

As a point of information, Dr. Maria L. Geisinger, Alabama, stated, "When the Council on Scientific Affairs worked on developing background information for HPV vaccination alone, it was costly, and it was done after the legislative piece."

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 adopted.

A delegate spoke in support of Resolution 108, as amended.

A motion was made to vote immediately on Resolution 108, as amended. The motion to vote immediately was adopted by a two-thirds affirmative vote.

A delegate spoke in support of the amended resolution.

The Speaker asked if there was any further discussion regarding the Resolution; there was none. On vote, Resolution 108, as amended, was adopted.

> **108H-2020. Resolved,** that the ADA develop legislative principles for inclusion in state regulations allowing appropriately trained dentists to administer vaccines~~, and be it further~~
> ~~**Resolved**, that the ADA develop educational materials and procedures supporting the use and administration of vaccines by dentists, and be it further~~
> ~~**Resolved**, that the appropriate ADA agency develop guidance on protocols to communicate with patients and access reimbursement mechanisms related to administering vaccines~~.

As a point of information, Dr. Jennifer L. Enos, Arizona, asked the Speaker if, when Resolution 16S-4 replaced Resolution 16, did that make 16S-1, 2, 16S-2, 16S-3 moot or if they could be brought back to the House for consideration.

The Speaker responded by saying, "That made those resolutions moot. If you will remember, the resolution was for referral, and it was substituted. [Resolution] 16 was substitute for 16S-4. When 16S-4 passed, that made the rest—it was not an 'in lieu of' motion, so it made the other resolutions go away."

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

The Report of Reference Committee C was presented by Dr. Edmund A. Cassella, Hawaii, chair. The other members of the Committee were: Mary Jane Hanlon, Massachusetts; Bradley W. Hester, Oregon; Paul A Lindauer, North Carolina; Melanie E. Mayberry, Michigan; Louvenia A. Rainge, Georgia; Philip L. Schefke, Illinois; and Kaitlin Small, New Jersey.

Non-Consent Resolutions

Review of ADA Policies: Dentistry and Dentistry as an Independent Profession (Council on Dental Education and Licensure Resolution 1, Board of Trustees Resolution 1B and Reference Committee C Resolution 1RC). The Reference Committee reported as follows:

The Reference Committee heard no testimony on Resolution 1 and limited testimony on Resolution 1B. The Committee agrees with the Board of Trustees, changing the term "maxillofacial" to "craniomaxillofacial" (double underscored) in the first resolving clause. The Reference Committee also agreed with testimony adding the term "essential" to both resolving clauses and adding the phrase "which may be" in the second resolve (double underscored and highlighted in yellow) Accordingly, the Reference Committee recommends the adoption of Resolution 1RC in lieu of Resolutions 1 and 1B.

1RC. Resolved, that the ADA policy *Dentistry* (*Trans*.1997:687; 2015:254) be amended as follows (additions underscored and double underscored; deletions ~~stricken~~):

Resolved, that the profession of dentistry is essential and defined as the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, craniomaxillofacial area and/or the adjacent and associated structures and their impact on the human body, provided by ~~a dentist~~ dentists, within the scope of ~~his/her~~ their education, training and experience, in accordance with the ethics of the profession and applicable law, and be it further

Resolved, that dentistry is essential and should remain an independent health care profession that safeguards, promotes and provides care for the health of the public which may be in collaboration with other health care professionals.

and be it further

Resolved that the policy *Dentistry as an Independent Profession* (*Trans*.1995:640) be rescinded.

Dr. Cassella moved Resolution 1RC in lieu of Resolution 1 (*Supplement*:4001) and Resolution 1B (*Supplement*:4001) with the Committee Recommendation to Vote Yes.

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

1H-2020. Resolved, that the ADA policy *Dentistry* (*Trans*.1997:687; 2015:254) be amended as follows (additions underscored and double underscored; deletions ~~stricken~~):

Resolved, that the profession of dentistry is essential and defined as the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, craniomaxillofacial area and/or the adjacent and associated structures and their impact on the human body, provided by ~~a~~ ~~dentist~~ dentists, within the scope of ~~his/her~~ their education, training and experience, in accordance with the ethics of the profession and applicable law, and be it further

Resolved, that dentistry is essential and should remain an independent health care profession that safeguards, promotes and provides care for the health of the public which may be in collaboration with other health care professionals.

and be it further

Resolved, that the policy *Dentistry as an Independent Profession* (*Trans*.1995:640) be rescinded.

Special Needs Dentistry (Second Trustee District Resolution 100 and Second Trustee District Resolution 100S-1). The Reference Committee reported as follows:

The Reference Committee received testimony in support of and opposed to pursuing a feasibility study for developing an accreditation process and standards for advanced education programs in special care dentistry by the Commission on Dental Accreditation (CODA). The American Academy of Pediatric Dentistry submitted written comment in opposition. General practice residency programs and pediatric dentistry programs also provide this type of training. Others testifying in opposition appreciated the intent of Resolution 100 and 100S-1, but believed that the special needs practice and education communities should work together rather than the Council on Dental Education and Licensure (CDEL) conducting a feasibility study.

Those testifying in support of the resolution recognized that it is necessary to further explore the issue of providing dental care for America's special needs population. CDEL provided comment noting that it would be pleased to explore the feasibility of requesting an accreditation process by CODA for advanced education programs in special needs dentistry. The Council completed a similar feasibility study related to geriatric dentistry programs for the 2019 House of Delegates.

The Reference Committee noted that Resolution 100 also calls for the Council to address actionable strategies to enhance and expand pre-doctoral training; to develop and promote continuing education programs for existing practitioners; and to investigate advanced educational opportunities with a $100,000 financial implication due to costs related to developing continuing education programs. Resolution 100S-1, also submitted by the Second Trustee District, calls for the development of a feasibility study, eliminating the actual development and promotion of CE activities at this time. CDEL provided written testimony in support of eliminating the financial implications for the resolution. The Reference Committee agrees and supports adoption of Resolution 100S-1 in lieu of Resolution 100.

100S-1. Resolved, that the ADA Council on Dental Education and Licensure (CDEL) explore through a survey with other appropriate communities of interest, the feasibility of requesting the development of an accreditation process and accreditation standards for advanced education programs in special care dentistry by the Commission on Dental Accreditation (CODA), and be it further

Resolved, that CDEL address actionable strategies to:

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

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

Dr. Cassella moved Resolution S-1 (*Supplement*:4023a) in lieu of Resolution 100 (*Supplement*:4023) with the Committee Recommendation to Vote Yes.

In response to a point of order, the Speaker clarified that Resolution 100S-1 had no financial implication.

In response to further inquiry and at the request of the Speaker, Dr. Anthony Ziebert, senior vice president, Education and Professional Affairs, confirmed that Resolution 100S-1 had no financial implication, saying "So, in Resolution 100, there was a directive to develop continuing education programs. As you can see in 100S-1, there are just actionable strategies to develop continuing education programs. So that is why there's no longer a cost."

Dr. Rhoda H. Sword, Georgia, moved to substitute Resolution 100S-2 for Resolution 100S-1. Resolution 100S-2 reads as follows:

100S-2. Resolved, that because all dentists can treat special needs patients, the ADA Council on Dental Education and Licensure (CDEL) explore through a survey to the 12 dental specialties recognized by the

National Commission on Recognition of Dental Specialties and Certifying Boards, the AGD, and Special Care Dentistry Association (SCDA), the feasibility of the following, concerning Special Care Dentistry:

1. enhancing and expanding pre-doctoral training;
2. developing and promoting continuing education programs for existing practitioners; and
3. exploring how each organization/program, through advanced educational opportunities, are educating and preparing dentists to best address the needs of this population, and be it further

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

In speaking to the substitution, Dr. Sword said, "While the District agrees with the intent of 100S-1, that special care patients need to be further addressed, we believe that the existing educational system should be examined and improved prior to creating advanced education training programs in special care dentistry. Therefore, the Fifth would urge the communities of interest surveyed in this process to include the 12 ADA specialties, the AGD, as well as Special Care Dentistry Association. As a dentist with private practice experience and now a full-time educator, I have never learned from, talked to, or taught a dentist who does not genuinely care about special care patients. We offer this amendment in support of better treating this special population, and as a call to action for our dental schools, specialty programs and fellow general dentists alike. …"

Dr. Brooke M. Fukuoka, Idaho, spoke in opposition to Resolution 100S-2, saying, "…this takes out the survey to possibly develop a postdoctoral program in special care. When I graduated from dental school, I wanted to treat this population … and I did a five-week externship in a special care clinic. And you know what, that wasn't enough. … As a new dentist right out of school, I should not have to make up my own curriculum. … I urge you to consider voting against this amendment so that people like me out of school don't have to keep looking for programs to supplement our GPRs or our AGDs. Yes, there are some programs that exist, but there is not enough. … CDEL said they would be happy to look at this. There is no price tag on it, and there is absolutely no reason for us to not do a survey …"

Dr. Anthony C. Caputo, Arizona, moved to amend Resolution 100S-2 by adding a fourth bullet, so that the amended resolution would read as follows:

100S-2. Resolved, that because all dentists can treat special needs patients, the ADA Council on Dental Education and Licensure (CDEL) explore through a survey to the 12 dental specialties recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards, the AGD, and Special Care Dentistry Association (SCDA), the feasibility of the following, concerning Special Care Dentistry:

1. enhancing and expanding pre-doctoral training;
2. developing and promoting continuing education programs for existing practitioners; and
3. exploring how each organization/program, through advanced educational opportunities, are educating and preparing dentists to best address the needs of this population, and
4. exploring opportunities to reduce barriers to this population, such as obtaining access to outpatient care facilities, and be it further

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

In speaking to the proposed amendment, Dr. Caputo said, "To begin with, we are fully supportive of the intent of this resolution to explore through a survey this opportunity to improve the care and treatment of this vulnerable patient population. We have identified through our caucus that one of the challenges that exists for dentists is taking patients to the operating room or other outpatient care facilities as indicated. And so the opportunity for us was to explore that to see where we might be able to improve access to such treatment facilities for dentists."

Dr. Robert M. Peskin, New York, spoke against the amendment, saying, “I think I understand what the Fourteenth is trying to do in adding the laundry list in this first resolved clause by exploring opportunities, but this really goes against the intent of the original Resolution 100 and 100S-1, which was to request development of an accreditation process and an accreditation standard for advanced education programs in special care dentistry. … I would respectfully request if Dr. Ziebert could explain the difference between an accreditation process for a specialty and an accreditation process for an advanced general dental program in general dentistry.”

In response and at the Speaker’s request, Dr. Anthony Ziebert, senior vice president, Education and Professional Affairs, said, “There’s actually no difference in the accreditation process itself. Generally speaking, the discipline or sponsoring organization would apply to CODA to accredit the programs, and CODA would develop an accreditation process. And if the discipline met the criteria for that, then CODA would approve that and begin to develop standards within that discipline.”

Dr. Amber P. Lawson, Georgia, speaking in support of the amendment to Resolution 100S-2, said, “I’m a general dentist who has the privilege to treat special needs patients. This population makes up about 20 percent of my practice, and it is the most rewarding to treat. I was trained in a GPR program, which included hospital dentistry. Most of these patients cannot be examined or treated in a dental setting. These patients are usually seen in an operating room. Most need various types of sedatives even before an I.V. can be started. … I support this amendment, and I feel that we need to bring all programs, all specialties and programs to the table to identify the weaknesses that are there and make improvements to provide quality dental treatment for these special need patients who are dear to my heart. …”

Dr. Jonathan D. Shenkin, Maine, speaking against the proposed amendment, said, “I rise to oppose the substitution of 100S-2 in this scenario. And it’s really important that people understand the very small population of institutionalized adults that none of us ever see in our practices. I did a residency, a GPR in Stony Brook Dental School in the VA, and it’s one of, I think, only two programs left in the country that has one of these programs still to this day. And I treated [at] the University of Iowa pediatric dentistry program where we treated developmentally disabled adults. And the difference between how we treated adults in those two programs was vast. We examined everybody and did as much treatment as we possibly could in an outpatient or in a dental school setting and not in an operating room under general anesthesia. The direction of this resolution and this amendment takes away from an opportunity to expand a very special group of dentists that want to take care of a population of adults that few are trained to and few want in their practices. So I implore you to vote down this amendment and this substitution.”

Dr. Deborah S. Bishop, Georgia, spoke in support of the amendment, adding, “… Although not specifically mentioned in our resolution, we would like for the appropriate agencies to explore training models based on fellowships that have served our medical colleagues so well. Creating more specialty programs will only serve to dilute the existing postgraduate programs. …”

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.

As a point of information, Dr. James M. Boyle, III, Pennsylvania, said, “…past chair of CDEL, current chair of Specialty Recognition Commission. I just wanted to offer some insight and follow-up to what Dr. Ziebert had said. And, that is, eventually the sponsoring organization will need to pursue whatever avenue they see fit, even if it’s petitioning CODA on whatever their standards for advanced education might be. So, for example, during my term at CDEL, operative dentistry asked, requested, when through the process of becoming an area of special interest in dentistry. But, again, it was that organization. So at some point, the Special Care Dentistry Association will need to take whatever the survey results is, should this pass, but eventually they will need to take it to whatever level they chose to.”

The Speaker opened debate on the motion to substitute 100S-2 for Resolution 100S-1.

Dr. Harold S. Jeter, Ohio, speaking in support of substitution, said, "… there's no disagreement regarding the need for adequate and timely access to treatment for all facets of society, especially those we deem vulnerable, such as pediatric, geriatric, and special needs. And the education to do so needs to be there. My support for this amendment, rather, is based on the opinion that optimizing and enhancing and expanding education through Predoctoral curriculum, existing postgraduate residencies, such as pediatrics, GPR, AEGD, as well as the potentially coming specialty in geriatric dentistry, and even continuing education opportunities are the appropriate avenues to meet the educational and experiential requirements sought by this resolution. …"

Dr. Shakalpi R. Pendurkar, California, speaking in opposition to the proposed substitute, said, "…This resolution speaks about all dentists can treat special needs patients, but the reality is that all dentists do not treat special needs patients because we don't feel comfortable doing so. I oppose this amendment because it eliminates doing the study that looks at the very possibility of developing advanced education programs in special care. This is a very underserved population, and I think any ideas as to improved care for them should at least be explored. …"

Dr. Mark Feldman, former president, New York, spoke against Resolution 100S-2, saying, "… I think we can all agree that both resolutions speak to the urgent need to develop programs for this very in-need population. I think it is unfortunate that you cannot get the two resolutions side by side. Because [Resolution] 100S-2 just misses the mark on what we were really looking to accomplish with [Resolution] 100S-1. If you take a look at the very beginning, they speak about doing this survey with a laundry list of select groups; dental specialties, the certifying voice, the AEGD special care dentistry. They leave out, notably, some very important groups, such as ADEA, hospital dentistry, public health dentists. These all need to be included, and our [Resolution] 100S-1 just listed communities of interest. And, most important, the clause number three talking about just developing from the survey in [Resolution] 100S-2 a list of what these different organizations are currently doing to educate and prepare dentists leaves out the need to develop new and innovative concepts, which is what [Resolution] 100S-1 speaks about. So the choice is basically look to the future or look for just what's being done right now, which is what [Resolution] 100S-2 addresses. …"

The Speaker stated the time at 5:55 p.m. (CDT) and announced that the House would recess until 6:30 p.m. (CDT) in order to provide a 30-minute break for the production crew and others supporting the Virtual Meeting of the House of Delegates in the Chicago Headquarters Office.

After a 30-minute recess, the Speaker called the third meeting of the House of Delegates back to order. Debate continued of the motion to substitute Resolution 100S-2 for Resolution 100S-1.

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

On vote, the motion to substitute Resolution 100S-2 for 100S-1 was not adopted.

Speaking in support of Resolution 100S-1, Dr. Shakalpi R. Pendurkar, California, stated, "This resolution addresses actionable strategies for enhancing and promoting education programs for practitioners to meet the needs of our underserved population. …"

Dr. Alayna L. Schoblaske, Oregon, spoke in support of Resolution 100S-1 saying, "… One of our biggest focuses in Oregon where I am from is to always know what question we are asking before we propose the answers, and this is a feasibility study to find out what questions we are asking. We will partner with the appropriate parties to identify the issues at hand and then propose at the next year's House the appropriate answers to those questions. …"

A motion was made to vote immediately on Resolution 100S-1. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, Resolution 100S-1 was adopted in lieu of Resolution 100.

> **100H-2020. Resolved,** that the ADA Council on Dental Education and Licensure (CDEL) explore through a survey with other appropriate communities of interest, the feasibility of requesting the development of

an accreditation process and accreditation standards for advanced education programs in special care dentistry by the Commission on Dental Accreditation (CODA), and be it further

Resolved, that CDEL address actionable strategies to:

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

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

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

The Report of Reference Committee D was presented by Dr. Shane A. Ricci, Texas, chair. The other members of the Committee were: Dr. Mark E. Bronson, Ohio; Dr. Xerxez M. Calilung, California; Dr. Thomas Isbell, Arkansas; Dr. Ben W. Jernigan, Jr., Georgia; Dr. James Lee, Massachusetts; Dr. Rachel A. Maher, Delaware; Dr. Mitchell D. Mindlin, New York; and Dr. Heather A. Willis, Alaska.

Consent Calendar (Reference Committee D Resolution 113) The Reference Committee reported as follows:

The appended Resolution 113 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 113, 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 removed and considered separately.

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

Resolution 2—Adopt—Review and Consideration of ADA Ad Interim Policy on E-Cigarettes and Vaping (*Supplement*:5000) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 8—Adopt—Amendment of the Policy, National Practitioner Data Bank Self-Generated Inquiries (*Supplement*:5011) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 9—Adopt—Proposed Policy, National Practitioner Data Bank Statute of Limitations (*Supplement*:5012) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 10—Adopt—Proposed Policy, Support for Deployed Dentists (*Supplement*:5014) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 25—Adopt—Proposed Policy, Guidelines for Medicaid Dental Reviews (*Supplement*:5032) $: None

COMMITTEE RECOMMENDATION: Vote Yes

Resolution 31—Adopt—Amendment of the ADA Member Conduct Policy (*Supplement*:5045) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 41—Adopt—Proposed Policy, Tobacco Use, Vaping, and Nicotine Delivery Products (*Supplement*:5064) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 44—Adopt—Proposed Policy, Limits on Non-Economic Damages (*Supplement*:5073) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 49—Adopt—Proposed Policy, Federal Medicaid Funding (*Supplement*:5081) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 50—Adopt—Proposed Policy, Tax Incentives for Medicaid Participation (*Supplement*:5083) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 51—Adopt—Proposed Policy, Support for the Children's Health Insurance Program (*Supplement*:5085) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 89—Adopt—Proposed Policy, Resources for Veterans Ineligible for VA Dental Care (*Supplement*:5161) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 92—Adopt—Proposed Bylaws and Governance Manual Revisions on Declaring an Extraordinary Emergency (*Supplement*:5169) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 93—Adopt—Proposed Bylaws Provisions to Take Effect When a Time of Extraordinary Emergency is Declared (*Supplement*:5172) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 107—Adopt—Availability of ADA Community Water Fluoridation Webinar Series (*Supplement*:5182) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Dr. Ricci moved Resolution 113 with the Committee Recommendation to Vote Yes.

Seeing no one in the queue, Resolution 113 was adopted by general consent.

113H-2020. Resolved, that the recommendations of Reference Committee D on the following resolutions be accepted by the House of Delegates.

Resolution 2—Adopt—Review and Consideration of ADA Ad Interim Policy on E-Cigarettes and Vaping (*Supplement*:5000) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 8—Adopt—Amendment of the Policy, National Practitioner Data Bank Self-Generated Inquiries (*Supplement*:5011) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 9—Adopt—Proposed Policy, National Practitioner Data Bank Statute of Limitations (*Supplement*:5012) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 10—Adopt—Proposed Policy, Support for Deployed Dentists (*Supplement*:5014) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 25—Adopt—Proposed Policy, Guidelines for Medicaid Dental Reviews (*Supplement*:5032) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 31—Adopt—Amendment of the ADA Member Conduct Policy (*Supplement*:5045) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 41—Adopt—Proposed Policy, Tobacco Use, Vaping, and Nicotine Delivery Products (*Supplement*:5064) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 44—Adopt—Proposed Policy, Limits on Non-Economic Damages (*Supplement*:5073) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 49—Adopt—Proposed Policy, Federal Medicaid Funding (*Supplement*:5081) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 50—Adopt—Proposed Policy, Tax Incentives for Medicaid Participation (*Supplement*:5083) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 51—Adopt—Proposed Policy, Support for the Children's Health Insurance Program (*Supplement*:5085) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 89—Adopt—Proposed Policy, Resources for Veterans Ineligible for VA Dental Care (*Supplement*:5161) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 92—Adopt—Proposed Bylaws and Governance Manual Revisions on Declaring an Extraordinary Emergency (*Supplement*:5169) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 93—Adopt—Proposed Bylaws Provisions to Take Effect When a Time of Extraordinary Emergency is Declared (*Supplement*:5172) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Resolution 107—Adopt—Availability of ADA Community Water Fluoridation Webinar Series (*Supplement*:5182) $: None
COMMITTEE RECOMMENDATION: Vote Yes

Note: For the purpose of a fully documented record, the text of the resolutions presented in Resolution 113H follows.

Consent Calendar Resolutions—Adopted

Review and Consideration of ADA AD Interim Policy on E-Cigarettes and Vaping

2H-2020. **Resolved**, that the following statement on E-Cigarettes and Vaping be adopted ADA policy.

E-CIGARETTES AND VAPING

That the American Dental Association (1) strongly supports regulatory, legislative, and/or legal action at the federal and/or state levels to ban the sale and distribution of all e-cigarette and vaping products, with the exception of those approved by the FDA for tobacco cessation purposes and made available by prescription only; and (2) advocate for research funding to study the safety and effectiveness of e-cigarettes and vaping products for tobacco cessation purposes and their effects on the oral cavity.

Amendment of the Policy, National Practitioner Data Bank Self-Generated Inquiries

8H-2020. Resolved, that the policy titled National Practitioner Data Bank Self-Generated Inquiries (*Trans.*1993:706; 2015:272) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the Association seek appropriate federal action to prohibit an entity~~ entities not otherwise authorized to query the National Practitioner Data Bank should be prohibited from coercing a provider to provide a self-query as a requirement for employment or to participate in a health insurance plan or for professional liability coverage~~, and be it further~~

~~**Resolved,** that the Association seek appropriate federal action to prohibit providers from being required to assign their rights of self-query to third parties~~.

Proposed Policy, National Practitioner Data Bank Statute of Limitations

National Practitioner Data Bank Statute of Limitations

9H-2020. **Resolved**, that National Practitioner Data Bank malpractice payment entries involving dentists should be expunged after seven years, provided a further incident has not been reported, and be it further

Resolved, that the policy titled Statute of Limitations (Trans.1997:708) be rescinded.

Proposed Policy, Support for Deployed Dentists

Support for Deployed Dentists

10H-2020. **Resolved**, that the American Dental Association give its utmost support to its members who may be called to active duty, and be it further

Resolved, that the ADA encourages dentists to volunteer to help maintain the practices of dentists who are temporarily activated into military service by practicing in the deployed dentist's office and treating their patients, and be it further

Resolved, that it is the ADA's position that military deployment is a learning experience that provides opportunities to treat complex cases, sometimes under difficult circumstances, and be it further

Resolved, that deployed military dentists who are serving on active duty should be eligible to have their continuing education requirements waived, and be it further

Resolved, that dentists who reopen their practices following a period of military deployment should be exempt from having their unemployment insurance premiums increased or incurring any other financial

penalties due to unemployed staff having drawn unemployment benefits during the period of office closure, and be it further

Resolved, that the policies titled Exemption From Unemployment Insurance Liability for Active Duty Dentists (Trans.2004:321), Deployed Dentists and Mandatory Continuing Education Requirements (Trans.2004:314), and Support for Dentists Temporarily Called to Active Service (Trans.2012:496) be rescinded.

Proposed Policy, Guidelines for Medicaid Dental Reviews

25H-2020. Resolved, that the American Dental Association encourages state dental associations to work with their respective state Medicaid agency to adopt such guidelines for Medicaid Dental Reviews and/or in States that use a managed care model to incorporate such guidelines into their request for proposal (RFP) to third-party payers interested in managing the dental benefit:

Guidelines for Medicaid Dental Reviews

The Auditor/Reviewer shall demonstrate adherence, not only to individual State Board regulations and requirements, but also an understanding, acceptance and adherence to Medicaid State guidelines and specific specialty guidelines as applicable. In addition, the Auditor/Reviewer shall demonstrate experience in treatment planning specific patient demographic groups and/or unique care delivery sites that influence treatment planning being reviewed.

It is recommended that entities, which conduct Medicaid Dental reviews and audits, utilize auditors and reviewers who:

1. Have a current active license to practice dentistry in the State where audited treatment has been rendered and be available to present their findings.

2. Are of the same specialty (or equivalent education) as the dentist being audited.

3. Document and reference the guidelines of an appropriate dental or specialty organization as the basis for their findings, including the definition of *Medical Necessity* being used within the review.

4. Have a history of treating Medicaid recipients in the state in which the audited dentist practices.

5. Have experience treating patients in a similar care delivery setting as the dentist being audited, such as a hospital, surgery center or school-based setting, especially if a significant portion of the audit targets such venues.

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

1. Stating a reasonable period of time in which an audit can proceed before dismissal can be sought.

2. Defining the reasonable use of extrapolation in the initial audit request.

Amendment of the ADA Member Conduct Policy

31H-2020. Resolved, that the Member Conduct Policy (Trans.2011:530) be amended as follows (additions underscored, deletions ~~stricken through~~):

ADA Member Conduct Policy

1. Members' ~~should communicate respectfully in all~~ discussions, social media activities, communications and interactions with other dentists, dentist members, Association officers, trustees and staff should be respectful and free of demeaning, derogatory, offensive or defamatory language.

2. Discussions and communications relating to modes of practicing dentistry should be courteous and professional, and members should be respectful of the practice choices of their colleagues.

~~2~~3. Members should abide by and respect the decisions and policies of the Association ~~and must not engage in disruptive behavior in actions with other members, Association officers, trustees and staff~~. Any criticism or challenges to existing Association policies or decisions shall be undertaken in a professional manner.

~~3~~4. Members have an obligation to be informed about and use Association policies for communication and dispute resolution.

~~4~~5. Members are expected to comply with all applicable laws and regulations, including but not limited to antitrust laws and regulations and statutory and common law fiduciary obligations.

~~5~~6. Members must respect and protect the intellectual property rights of the Association, including any trademarks, logos, and copyrights.

~~6~~7. Members must not use Association membership directories, on-line member listings, or attendee records from Association-sponsored conferences or CE courses for personal or commercial gain, such as selling products or services, prospecting, or creating directories or databases for these purposes.

~~7~~8. Members must treat all confidential information furnished by the Association as such and must not reproduce materials without the Association's written approval.

~~8~~9. Members must not violate the attorney-client privilege or the confidentiality of executive sessions conducted at any level within the Association.

~~9~~10. Members must fully disclose conflicts, or potential conflicts, of interest and make every effort to avoid the appearance of conflicts of interest.

Proposed Policy, Tobacco Use, Vaping, and Nicotine Delivery Products

41H-2020. Resolved, that the following policy titled Tobacco Use, Vaping, and Nicotine Delivery Products be adopted:

Tobacco Use, Vaping, and Nicotine Delivery Products

Dentist's Role in Preventing Tobacco Use

Resolved, that dentists should be fully aware of the oral and maxillofacial health risks that are causally associated with tobacco use, including higher rates of tooth decay, receding gums, periodontal disease, mucosal lesions, bone damage, tooth loss, jaw bone loss and more, and be it further

Resolved, that dentists should routinely screen patients for tobacco and non-tobacco nicotine use and provide clinical preventive services, such as in-office cessation counseling, to prevent first-time tobacco use and encourage current users to quit, and be it further

Resolved, that the dentists and health organizations should provide educational materials to help prevent first-time use and encourage current users to quit, and be it further

Resolved, that these educational materials should be developed or provided by credible and trustworthy sources with no ties to the tobacco industry or its affiliates, and be it further

Cessation Counseling and Nicotine Replacement Therapies

Resolved, that aside from the intended use of approved tobacco cessation products and nicotine replacement therapies, the American Dental Association discourages the use of all nicotine products made with or derived from tobacco, and be it further

Resolved, that dentists should be fully informed about nicotine cessation interventions and routinely apply those techniques to help patients stop using tobacco, and be it further

Resolved, that third-party payers should cover professionally administered cessation products and services (e.g., cessation counseling, prescription medications, etc.) as an essential plan benefit, and be it further

Modified Risk Tobacco Products

Resolved, that the American Dental Association does not consider the concept of "modified risk"—which is allowing some tobacco and other nicotine products (e.g., snus, electronic nicotine delivery systems) to be marketed as having a reduced or modified health risk compared to others (e.g., cigarettes)—to be a viable public health strategy to reduce the death and disease associated with tobacco use, and be it further

Resolved, that modified risk tobacco product (MRTP) applications should include extensive data examining the comparative impact on oral and maxillofacial health, both to the individual and the population as a whole, and the data should be made publicly available, and be it further

Regulation of Tobacco Products, Vaping Devices, and Other Nicotine Delivery Systems

Resolved, that the American Dental Association recognizes nicotine as an addictive chemical and supports its regulation as a controlled substance, and be it further

Resolved, that the ADA supports state and federal authority to investigate and strictly regulate nicotine and nicotine-containing products, including those made or derived from tobacco, and be it further

Resolved, that these nicotine-containing products include, but are not limited to:

- Cigarettes.
- Cigars (both premium and non-premium).
- Pipe tobacco.
- Hookah (also called waterpipe tobacco).
- Roll-your-own tobacco.
- Smokeless tobacco (e.g., chewing tobacco, moist snuff, snus, etc.).
- Dissolvables (e.g., nicotine lozenges, strips, sticks, etc.).
- Nicotine gels (absorbed through the skin).
- Electronic nicotine delivery systems (e.g., e-cigarettes, e-hooka, e-cigars, vape pens, advanced refillable personal vaporizers, e-pipes, etc.).

and be it further

Resolved, that the ADA supports strict regulation of these and other nicotine-containing products by (but without being limited to):

- Prohibiting product sales in all venues, including through vending machines and the internet.
- Levying significant taxes on these products.
- Setting age restrictions to purchase and receive these products.
- Requiring oral health warning statements, graphic images and ingredient disclosures on product packaging.
- Restricting the addition of added flavors (including menthol) and other ingredients and ingredient levels (including nicotine).
- Regulating second hand exposure to environmental smoke and vapor.
- Banning all forms of advertising and marketing (including bans on free sampling, product giveaways, promotional items, event sponsorships, etc.).
- Imposing licensure requirements for product wholesalers and retailers.
- Prohibiting the use of these products on and around public and private property, including government buildings and school campuses.

and be it further

Resolved, that the policy titled Policies and Recommendations on Tobacco Use (*Trans.*2016:323) be rescinded.

Proposed Policy, Limits on Non-Economic Damages

44. Resolved, that the following policy titled Limits on Non-Economic Damages be adopted:

Limits on Non-Economic Damages

Resolved, that medical liability reform legislation should not override state limits on non-economic damages, and be it further

Resolved, that the policy titled ADA Support for Medical Injury Compensation Reform (*Trans.*2005:342) be rescinded.

Proposed Policy, Federal Medicaid Funding

49H-2020. Resolved, that the following policy titled Federal Medicaid Funding be adopted:

Federal Medicaid Funding

Resolved, that the federal Medicaid match for dental care should be enhanced to 90/10 or better, and be it further

Resolved, that the policy titled Increase Federal Medicaid Funding (*Trans.*2002:409) be rescinded.

Proposed Policy, Tax Incentives for Medicaid Participation

50H-2020. Resolved, that the following policy titled Tax Incentives for Medicaid Participation be adopted:

Tax Incentives for Medicaid Participation

Resolved, that dentists should be allowed to claim a tax credit for the first $10,000 of services provided under the Medicaid program, and be it further
Resolved, that the tax credit should be based upon the most recent Code on Dental Procedures and Nomenclature (CDT) codes and credited at a rate consistent with the most recent ADA Survey of Dental Fees for that region or state, and be it further
Resolved, that the policy titled Federal Tax Credit/Voucher for Medicaid Dentist Providers (*Trans.*2003:383; 2014:499) be rescinded.

Proposed Policy, Support for the Children's Health Insurance Program

51H-2020. Resolved, that the following policy titled Support for the Children's Health Insurance Program be adopted:

Support for the Children's Health Insurance Program

Resolved, that that the American Dental Association supports the Children's Health Insurance Program (CHIP), and be it further
Resolved, that funds dedicated to the program should be used to provide medical and dental care to children with family income less than or equal to 200 percent of the federal poverty level before any expansion to children in families above that level, and be it further
Resolved, that decisions to cover children beyond 200 percent of the federal poverty level continue to be made on a state-by-state basis, and be it further
Resolved, that the policy titled Reauthorization of the State Children's Health Insurance Program (*Trans.*2007:451) be rescinded.

Proposed Policy, Resources for Veterans Ineligible for VA Dental Care

89H-2020. Resolved, that the following policy titled Resources for Veterans Ineligible for VA Dental Care be adopted:

Resources for Veterans Ineligible for VA Dental Care

Resolved, that the American Dental Association supports the federal authorization of administrative support resources within the Veterans Administration Medical Centers to assist veterans to identify and utilize dental services offered by federally qualified health centers, not for profit dental care facilities, and volunteer dental professionals, and be it further

Resolved, that the ADA supports the work of component and constituent dental associations, dental organizations, societies and dentists to develop new programs with outreach strategies to assist veterans with unmet dental treatment needs, and to serve as a resource in finding dental homes for veterans.

Proposed Bylaws and Governance Manual Revisions on Declaring an Extraordinary Emergency

92H-2020. Resolved, that Chapter III., Section 60. of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

CHAPTER III. HOUSE OF DELEGATES

*** * ***

Section 60. OPERATION DURING AN EXTRAORDINARY EMERGENCY.

A. TRANSFER OF POWERS AND DUTIES OF THE HOUSE OF DELEGATES: The powers and duties of the House of Delegates, except the power to amend, enact and repeal the *Constitution and Bylaws* or the *Governance Manual*, and the duty of electing the elective officers and installing the

members of the Board of Trustees, may be transferred to the Board of Trustees of this Association in time of extraordinary emergency~~, as set forth in the *Governance Manual*~~.

B. DECLARATION OF EXTRAORDINARY EMERGENCY AND WITHDRAWAL OF SUCH A DECLARATION. The existence of a time of extraordinary emergency may be declared and withdrawn as follows:

a. By the House of Delegates. A time of extraordinary emergency may be declared by mail vote of the current members of the House of Delegates on recommendation of at least four (4) of the elective officers.* A mail vote to be valid shall consist of ballots received from not less than twenty-five percent (25%) of the current members of the House of Delegates. A majority of the votes cast within fourteen (14) days after the date declared for the commencement of the balloting shall decide the vote.

b. By the Board of Trustees A time of extraordinary emergency may be declared by a three-fourths affirmative vote of the members of the Board of Trustees present and voting at a regular or special session of the Board of Trustees pursuant to CHAPTER V., Section 70.D. of these *Bylaws*.

c. Withdrawal of a Declaration of Extraordinary Emergency. A declaration of extraordinary emergency may be withdrawn by the House of Delegates by mail vote on recommendation of at least two (2) of the elective officers consisting of ballots received from not less than twenty-five percent (25%) of the current members of the House of Delegates or by a majority vote of the Board of Trustees present and voting at a regular or special session of the Board of Trustees pursuant to CHAPTER V., *Section 70.D*. of these *Bylaws*.

* As used with respect to the declaration of an extraordinary emergency, the term "mail ballot" shall mean any vote permitted pursuant to Illinois law, including an electronic vote.

and be it further

Resolved, *that CHAPTER V., Section 70.D. of the ADA Bylaws be amended as follows (additions underscored, deletions ~~stricken through~~):*

CHAPTER V. BOARD OF TRUSTEES

*** * ***

Section 70. POWERS. The Board of Trustees shall be the managing body of the Association, vested with power to:

* * *

D. By ~~unanimous consent~~ a three-fourths affirmative vote of the members of the Board of Trustees present and voting at a regular or special session, declare the existence of a time of extraordinary emergency.

and be it further

Resolved, that Chapter III., Section A. of the *Governance and Organizational Manual of the House of Delegates* be amended as follows (additions underscored, deletions ~~stricken through~~):

CHAPTER III. HOUSE OF DELEGATES

A. Convening Sessions of the House of Delegates.

1. ~~Declaration of Extraordinary Emergency. The existence of a time of extraordinary emergency may be declared by mail vote of the current members of the House of Delegates on~~

~~recommendation of at least four (4) of the elective officers.* A mail vote to be valid shall consist of ballots received from not less than twenty-five percent (25%) of the current members of the House of Delegates. A majority of the votes cast within thirty (30) days after the mailing of the ballot shall decide the vote. The existence of a time of extraordinary emergency may also be declared by the Board of Trustees pursuant to the provisions set forth in the Governance Manual.~~

~~2.~~ Special Sessions. A special session of the House of Delegates shall be called by the President on a three-fourths (3/4) affirmative vote of the members of the Board of Trustees or on written request of delegates representing at least one-third (1/3) of the constituents and not less than one-fifth (1/5) of the number of officially certified delegates of the last House of Delegates. The time and place of a special session shall be determined by the President, provided the time selected shall be not more than forty-five (45) days after the request was received. The business of a special session shall be limited to that stated in the official call except by unanimous consent.

~~3.~~2. Official Call of Sessions of the House of Delegates.

a. Annual Session. The Executive Director of the Association shall direct that an official notice of the time and place of each annual session be published in The Journal of the American Dental Association. The Executive Director of the Association shall also send an official notice of the time and place of the annual session to each member of the House of Delegates at least thirty (30) days before the opening of such annual session.

b. Special Session. The Executive Director of the Association shall send an official notice of the time and place of each special session and a statement of the business to be considered to every officially certified delegate and alternate delegate of the last House, not less than fifteen (15) days before the opening of such special session.

Proposed Bylaws Provisions to Take Effect When a Time of Extraordinary Emergency is Declared

93H-2020. Resolved, that the CHAPTER III. *Section 60*. of the ADA *Bylaws* be amended by the addition of a new subsection B., as follows (additions underscored):

Section 60. OPERATION DURING AN EXTRAORDINARY EMERGENCY.

A. TRANSFER OF POWERS AND DUTIES OF THE HOUSE OF DELEGATES: The powers and duties of the House of Delegates, except the power to amend, enact and repeal the *Constitution and Bylaws* or the *Governance Manual*, and the duty of electing the elective officers ~~and installing the members of the Board of Trustees,~~ may be transferred to the Board of Trustees of this Association in time of extraordinary emergency, as set forth in the *Governance Manual*. To the extent not inconsistent with any provision of *Bylaws* CHAPTER III., Section 60.B., Emergency Bylaws, provisions of the *Bylaws* and *Governance Manual* shall remain in effect during the duration of the extraordinary emergency. Upon the conclusion of the declaration of the time of extraordinary emergency adopted by the House of Delegates or Board of Trustees, the emergency bylaws set forth in CHAPTER III, *Section 60.B*. of these *Bylaws* shall cease to be effective.

B. Emergency Bylaws. In the event that a time of extraordinary emergency is declared pursuant to Chapter III.A.1. of the *Governance Manual*, the provisions of this *Section 60.B*. of the ADA *Bylaws* shall be implemented and continue in effect until such time as the declaration of extraordinary emergency is withdrawn.

a. Provisions if the Annual Session of the House of Delegates Convenes During an Extraordinary Emergency. In the event the House of Delegates is convened during the period when an extraordinary emergency has been declared, the following provisions shall apply:

1. Agenda. The Speaker, in consultation with the President, may limit the agenda to matters that require the attention of the House of Delegates.

2. Quorum. A quorum for the transaction of any business at any meeting of the House of Delegates convened during a time declared as an extraordinary emergency shall be the same as stated in CHAPTER III, *Section 80*. of the *Bylaws*.

3. Delegates. Delegations may substitute new delegates for any unavailable delegates, based upon feasibility, as determined by the Speaker. The Speaker may subsequently determine that alternate delegates will not be certified.

4. Suspended Elections**.** Any elections to be held during a session of the House of Delegates during the period that an extraordinary emergency has been declared may be suspended by the Board of Trustees upon a two-thirds affirmative vote of the voting members of the Board of Trustees present and voting at a regular or special session of the Board of Trustees. In the event the elections are suspended, the terms of office of the President and the trustees shall end on the date previously scheduled for the adjournment *sine die* of the House of Delegates. Vacancies in the offices of President, President-elect, First Vice President, Second Vice President, Speaker of the House of Delegates and Treasurer shall be filled in accordance with the provisions of CHAPTER VI, *Section 80*. of these *Bylaws*. The outgoing President shall install the President and any incoming trustees who have been elected by their districts. If a district has not elected a trustee to fill an expiring position, the incumbent trustee shall remain in office until a successor is duly elected and installed. All other ADA office holders in office immediately prior to commencement of the meeting of the House of Delegates shall remain in their respective offices until the first-session of the House of Delegates following the withdrawal of the declaration of an extraordinary emergency.

b. Suspension of the Annual Session of the House of Delegates. An annual session of the House of Delegates scheduled to occur during a period where an extraordinary emergency has been declared may be suspended by the Board of Trustees for good cause upon a two-thirds affirmative vote of the voting members of the Board of Trustees present and voting at a regular or special session of the Board of Trustees. If an annual session of the House of Delegates is so suspended, the following provisions shall apply.

1. Alternative Elections by Ballot without a Meeting. Regardless of whether or not the House of Delegates annual session is suspended, the Board of Trustees may direct the Speaker to arrange for some or all contested elections to be conducted electronically outside the annual session of the House of Delegates.

(a). Any such election shall be valid provided that the certified delegates are duly notified, are given an opportunity to vote, and the number of certified delegates casting votes would constitute a quorum as defined in Chapter III, Section 80, of these *Bylaws*.

(b). The method for such elections set forth in CHAPTER III, *Section 120*, of these *Bylaws* shall govern.

(c). Announcement of the election results shall be provided to the House of Delegates by the Speaker.

(d). Any candidates elected pursuant to this provision shall be installed as soon as practical after their election, provided that such installation is no sooner than the previously scheduled adjournment of the House of Delegates.

2. Incumbent Trustees. In the event that a district has not elected a trustee to fill an expiring trustee office, the incumbent trustee shall remain in office until a successor is duly elected and installed.

3. Extension of Tenure. Except as otherwise provided in these Emergency *Bylaws*, limitations on tenure of officers, trustees, council, committee and ADA commission members shall not apply during an extraordinary emergency.

4. Approval of Association Budget and Active Member Dues. If the annual session of the House of Delegates is suspended during an extraordinary emergency, the Board of Trustees shall have the authority to approve a final annual budget and active member dues for the succeeding year so long as the active member dues do not exceed the prior year's dues. Any such budget approved by the Board shall be presented to the House for ratification if the House convenes following the end of the emergency with more than six months remaining in the fiscal year for which the budget has been established.

c. Scientific Session. If it is determined that holding the scientific session required by Chapter XVIII. of the *Governance Manual* is impossible or infeasible due to the existence of an extraordinary emergency, the Board of Trustees may suspend the holding of the scientific session upon a two-thirds affirmative vote of the voting members of the Board of Trustees present and voting at a regular or special session of the Board of Trustees.

Availability of ADA Community Water Fluoridation Webinar Series

107H-2020. Resolved, that the American Dental Association's 75th Anniversary of Community Water Fluoridation Webinar Series be made available, in digital format, at no cost to the public, and be it further

Resolved, that nonmembers seeking to earn continuing education credit upon completion of the courses be charged appropriate fees.

Non-Consent Resolutions

Amendment of Chapter XII., Section A of the Governance and Organizational Manual of the American Dental Association (Council on Ethics, Bylaws and Judicial Affairs Resolution 30). The Reference Committee reported as follows:

The Reference Committee received testimony that supported making installment dues payments available to all members, and not just active life and retired members, in order to simplify the *Governance Manual*. However, certain member classifications, such as pre- and post-doctoral students have dues levels ($5 and $30, respectively) that would make annual installments impractical. For this reason, the Reference Committee supports adoption of Resolution 30 as submitted.

The Standing Committee on Constitution and Bylaws approves the wording of Resolution 30 as submitted.

30. Resolved, that Chapter XII., Section A. of the Governance and Organizational Manual of the American Dental Association be amended as shown below (additions underscored, deletions ~~stricken through~~):

CHAPTER XII. FINANCIAL MATTERS

A. Installment Payments of Dues and Special Assessments. Any constituent or component may establish a plan for the installment payment of dues and special assessments for active, life, retired and provisional members. This Association may establish a plan for the installment payment of dues and special assessments for active, ~~and~~ life and retired members who are direct members of the Association. Any such installment plan shall require:

1. Monthly installment payments that conclude with the current dues and any special assessment amount being paid by December 15.

2. The expeditious transfer of installments of member dues and any special assessments collected to this Association and any applicable constituent or component.

3. Any installment plan adopted under this provision of the *Governance Manual* may impose a reasonable transaction fee upon the member. Transaction fees collected shall be prorated between this Association and the constituent and component, if any, based on the amount of dues and special assessment collected on each organization's behalf.

Dr. Ricci moved Resolution 30 (*Supplement*:5043) with the Committee Recommendation to Vote Yes.

Seeing no one in the queue, Resolution 30 was adopted by general consent.

30H-2020. Resolved, that Chapter XII., Section A. of the Governance and Organizational Manual of the American Dental Association be amended as shown below (additions underscored, deletions ~~stricken through~~):

CHAPTER XII. FINANCIAL MATTERS

A. Installment Payments of Dues and Special Assessments. Any constituent or component may establish a plan for the installment payment of dues and special assessments for active, life, retired and provisional members. This Association may establish a plan for the installment payment of dues and special assessments for active, ~~and~~ life and retired members who are direct members of the Association. Any such installment plan shall require:

1. Monthly installment payments that conclude with the current dues and any special assessment amount being paid by December 15.

2. The expeditious transfer of installments of member dues and any special assessments collected to this Association and any applicable constituent or component.

3. Any installment plan adopted under this provision of the *Governance Manual* may impose a reasonable transaction fee upon the member. Transaction fees collected shall be prorated between this Association and the constituent and component, if any, based on the amount of dues and special assessment collected on each organization's behalf.

Proposed Policy, Principles for Tort Reform (Council on Government Affairs Resolution 43 and Reference Committee D Resolution 43RC). The Reference Committee reported as follows:

Reference Committee D heard testimony from one delegate requesting a verbiage change. The Reference Committee concurs with the delegate's recommendation and offers the following substitute.

43RC. Resolved, that the following policy titled Principles for Tort Reform be adopted (additions underscored):

Principles for Tort Reform

Resolved, that the American Dental Association supports tort reform that should include, among other things, legislation that includes, but is not limited to:

1. mandatory periodic payments of substantial awards for damages;
2. a ceiling on non-economic damages;
3. mandatory offsets of awards for collateral sources of recovery;
4. limits on attorneys' contingency fees;
5. a statute of limitations on health care-related injuries; and
6. state duties concerning alternative methods of resolving disputes.

and be it further
Resolved, that the policy titled Federal Tort Reform Legislation (*Trans.*1993:708) be rescinded.

Dr. Ricci moved Resolution 43RC in lieu of Resolution 43 (*Supplement*:5071) with the Committee Recommendation to Vote Yes.

On vote, Resolution 43RC was adopted in lieu of Resolution 43.

43H-2020. Resolved, that the following policy titled Principles for Tort Reform be adopted (additions underscored):

Resolved, that the American Dental Association supports tort reform ~~that should include, among other things,~~ legislation that includes, but is not limited to:

1. mandatory periodic payments of substantial awards for damages;
2. a ceiling on non-economic damages;
3. mandatory offsets of awards for collateral sources of recovery;
4. limits on attorneys' contingency fees;
5. a statute of limitations on health care-related injuries; and
6. state duties concerning alternative methods of resolving disputes.

and be it further
Resolved, that the policy titled Federal Tort Reform Legislation (*Trans.*1993:708) be rescinded.

Note. Subsequent to the adoption of Resolution 43H, it was noted by Council on Government Affairs Chair, Dr. Phillip Fijal, Illinois, that language in the second resolved clause was inadvertently left in the final Reference Committee Resolution. Dr. Fijal requested an editorial correction be made to strike the words, "that should include, among other things." Hearing no objection, the Speaker accepted editorial correction, which is reflected in 43H above.

Modifying the Existing Medicare Dental Coverage: Statutory Dental Exclusion (Elder Care Workgroup Resolution 72 and Reference Committee D Resolution 72RC). The Reference Committee reported as follows:

The Reference Committee heard testimony that the phrase "for cancer care" should be eliminated from the second bullet point in the original resolution as IV bisphosphonate therapy can be used to treat conditions other than cancer. Consequently, the Reference Committee recommends the adoption of the following Reference Committee Resolution (deletions ~~stricken~~).

72RC. Resolved, that the appropriate ADA agencies should consider conducting a review of the current scientific evidence that would support expanding the oral health services provided to medically frail recipients prior to major medical or surgical treatments available through Medicare in order to determine next steps for modifying the Medicare statutory exclusion, with the recommendation that the review include but not be limited to the following:

- head and neck radiation therapies
- IV bisphosphonate therapy ~~for cancer care~~
- organ transplants
- cancer chemotherapy including hematopoietic cell transplantation
- joint replacement
- cardiac valve replacement

Dr. Ricci moved Resolution 72RC in lieu of Resolution 72 (*Supplement*:5140) with the Committee Recommendation to Vote Yes.

Dr. Steven A. Saxe, Nevada, move to amend Resolution 72RC by addition of a second resolving clause that would read as follows:

Resolved, that the ADA encourage the universal adoption of the definition of medically necessary care contained in the current ADA policy titled "Medically Necessary Care" (*Trans*.1990:537).

In speaking to the amendment, Dr. Saxe said, “Currently, the definition of medical necessity is clouded from state to state, and medical insurance company or dental benefit companies have different definitions. This allows these companies to regularly deny claims and not pay dentists for services rendered based on subjective definitions of what is considered to be medically necessary. As a leader of the dental industry, the ADA should clearly identify what we have already adopted as our definition of medical necessity for the past 30 years to share with legislators, both federal and state, to Health and Human Services and to all medical insurance and dental benefit companies that promote fair reimbursements for services rendered for dentists who perform medically necessary services for their patients.”

Dr. Deborah S. Bishop, Georgia, speaking against the proposed amendment, said, “I believe that this amendment takes away from the intention of this resolution. [Resolution 72RC] is just for the science to study these particular maladies to see if they could be included in medically necessary. We don’t need a laundry list. I really would like to see everything taken out, because all this does is give the coalitions in Washington who would like to see us in Medicaid Part B, ammunition to say, okay, we want this, this and this. …”

As a point of information, Dr. Maria Geisinger, Alabama, and chair of the Council on Scientific Affairs, said, “The amendment as written does not link back up to the body of the resolution with regard to the science and the consideration for management of these diseases with concomitant dental care.”

On vote, the proposed amendment to Resolution 72RC was not adopted.

Dr. Alan L. Felsenfeld, California, moved to amend Resolution 72RC, saying, “Speaking as an individual. In my career as an oral and maxillofacial surgeon in an academic medical center, starting when this first hit the fan a number of years ago, I have had the opportunity to treat scores of patients with bisphosphonate types of problems. But we’ve also learned in the past that there are other types of medications that have implications with respect to osteonecrosis. I would like to suggest that on the second bullet point, instead of saying IV bisphosphonate therapy, I would like it to say osteoclast inhibitor therapy.” So the second bullet would be amended as follows:

- ~~IV bisphosphonate~~ osteoclast inhibitor therapy ~~for cancer care~~

In speaking further to the amendment, Dr. Felsenfeld said, “… And while this might not make a lot of sense to a lot of people, the people on the appropriate ADA agency will understand all of this. There are monoclonal antibodies and other types of drugs that have impact as well. We have reported cases of that, so that’s something to be considered. And also, the oral bisphosphonates are something we need to think about as well with osteonecrosis. So there’s the reason for that.”

As a point of information, Dr. Maria Geisinger, Alabama, said, “… If this is referred to the Council on Scientific Affairs, the [Council] will consider all pharmacologic therapy in relation to cancer care, et cetera, here. So I don’t think we need to necessarily wordsmith this in this fashion. I think this will be investigated.”

The Speaker clarified that the debate was not on referral.

Dr. Richard Kahn, New Jersey, as a point of inquiry, said, “You’re talking about approving treatment on these frail people. What level of treatment would be considered necessary? What would be considered appropriate? And since we’re dealing with Medicare, what would the fee schedule be and what is the time frame? At a hospital where I teach in a general practice residency, it is routine for the dental residents to be called in the night before a patient is scheduled for an organ transplant. Many times the organ is already on the airplane coming to New Brunswick, New Jersey, and they’re calling the dental resident to give them clearance. I think that there needs to be some language in here to determine what would be the appropriate treatment and what would be the timeframe. And, of course, since we do need to get paid, what would be the amount of reimbursement? Can anybody provide me that information?”

At the Speaker’s request, Dr. Marcelo Araujo, chief science officer, responded by saying, “… This resolution talks about the review of the science behind the conditions listed below. It’s not a request to look into cost. If

referred to the appropriate agencies, the focus of this work will be on the science only and not related to any costs for treatment."

Dr. Brooke M. Fukuoka, Idaho, speaking in support of the amendment, said, "I support this amendment to add the osteoclast inhibitor. … This is really important in our special needs population. My first case of osteonecrosis was in somebody who had pituitary dwarfism and they were taking an oral bisphosphonate. And I feel like it would be very valuable to … our members that treat these medically complex patients that have more knowledge on oral bisphosphonates and other osteoclast inhibitors. …"

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 to Resolution 72RC was adopted.

A motion was made to vote immediately on Resolution 72RC, as amended. The motion to vote immediately was adopted by a two-thirds affirmative vote.

On vote, Resolution 72RC, as amended, was adopted in lieu of Resolution 72.

> **72H-2020. Resolved,** that the appropriate ADA agencies should consider conducting a review of the current scientific evidence that would support expanding the oral health services provided to medically frail recipients prior to major medical or surgical treatments available through Medicare in order to determine next steps for modifying the Medicare statutory exclusion, with the recommendation that the review include but not be limited to the following:
>
> - head and neck radiation therapies
> - ~~IV bisphosphonate~~ osteoclast inhibitor therapy ~~for cancer care~~
> - organ transplants
> - cancer chemotherapy including hematopoietic cell transplantation
> - joint replacement
> - cardiac valve replacement

National Elder Care Advisory Committee Review (Elder Care Workgroup Resolution 73). The Reference Committee reported as follows:

> The Reference Committee concurs with the Elder Care Workgroup and supports adoption of the following Resolution.
>
> > **73. Resolved,** that the appropriate ADA agency should consider reviewing the funding, mandate, reporting structure and composition of the National Elder Care Advisory Committee to assist the ADA in accomplishing elder care strategies.

Dr. Ricci moved Resolution 73 (*Supplement*:5141) with the Committee Recommendation to Vote Yes.

On vote, Resolution 73 was adopted.

> **73H-2020. Resolved,** that the appropriate ADA agency should consider reviewing the funding, mandate, reporting structure and composition of the National Elder Care Advisory Committee to assist the ADA in accomplishing elder care strategies.

Unfinished Business (Continued)

Report of Reference Committee A (Continued)

Dr. Ioanna G. Mentzelopolou, chair, Reference Committee A, returned to the microphone to present the Reference Committee's remaining items of business.

Approval of the 2021 Budget (Board of Trustees Resolution 87)

The Treasurer, Dr. Ted Sherwin, reported that the current deficit budget for the 2021 budget was $5,963,000.00. He reminded the House that the 2021 budget includes an $8 dues increase.

On vote, Resolution 87 was adopted.

> **87H-2020. Resolved,** that the 2021 Annual Budget of revenues and expenses, including net capital requirements, be approved.

Establishment of Dues Effective January 1, 2021 (Board of Trustees Resolution 88): The Reference Committee reported as follows:

> The Reference Committee heard no testimony regarding the 2021 dues. The majority of the Reference Committee supports the proposed Resolution.
>
> **88. Resolved,** that the dues of ADA active members shall be $573.00, effective January 1, 2021.

Dr. Mentzelopolou moved Resolution 88 (*Supplement:*2078) with the Committee Recommendation to Vote Yes.

Resolution 88 required a sixty percent affirmative vote.

Dr. Karin Irani, California, speaking in support of Resolution 88, said, "Event though I speak in favor of the resolution, I would like to strongly urge our ADA leaders, our Finance Committee, and our Treasurer, whom I greatly respect, to reevaluate our expenses for the coming year. We cannot, and I emphasize, we cannot justify raising dues without developing member specific value propositions and without cutting expenses."

Dr. Prabu Raman, Missouri, speaking in opposition, said, "I know it's a long day. We want to get it over with. Eight dollars isn't much, but the optics doesn't look good, right after COVID and people are just getting out of it, to even have a dues increase, even a tiny amount, just doesn't sound right to me."

After further pro and con testimony, Dr. Brittany S. McCarthy, Ohio, requested a point of order, saying, "What effect does the $8 dues have on our $5M deficit?"

At the Speaker's request, Dr. Sherwin responded, "It's roughly $800,000. For every dollar dues increase, it's about $104,000. So it's a little over $800,000."

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

On vote, Resolution 88 was adopted.

> **88H-2020. Resolved,** that the dues of ADA active members shall be $573.00, effective January 1, 2021.

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.

Point of Personal Privilege

The Speaker thanked the members of the House of Delegates, saying, “As I began the training sessions for this Virtual House of Delegates, I asked for patience. And I want to thank you, the members of the House of Delegates, for extending patience to me and all the members of this body as we went through this virtual journey together.” He thanked the many staff who worked behind the scenes to make this meeting run smoothly. In closing, Dr. Donald said, “I want to share a concept from Mac Barnes that I’ve applied to my life. Many of you may be familiar with this concept, but it’s worth repeating, and I am going to quote his words: ‘*At 211 degrees, water is just hot. As 212 degrees it boils. And with boing water comes steam, and steam can power a locomotive. That one extra degree makes all the difference.*’ A simple analogy reflects the ultimate definition of excellence. Because it’s one extra degree of effort in business or life, that can separate one from good to great. The team has put in the extra degree of effort and gone from good to excellent.”

Adjournment

Dr. Emily D. Hobart, Washington, moved to adjourn the 161st Annual Session of the ADA House of Delegates. Without objection, the Speaker declared the 161st Annual Session of the ADA House of Delegates adjourned *sine die* at 7:37 p.m., Central Time, on Monday, October 19, 2020.