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Annual Reports and Resolutions

133rd Annual Session

Orlando, Florida

October 17-21, 1992

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Table of Contents

Special Note

Copies of the 1992 *Annual Reports and Resolutions* have been mailed to both delegates and alternate delegates. Please bring your copy to the meetings of the House of Delegates.

Notes

Notes

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Notes

Reports of Councils and Commissions

Divisions of Conference and Meeting Services, and Membership and Marketing Services

Council on ADA Sessions and International Relations

Commission on the Young Professional

Notes

Council on ADA Sessions and International Relations

Brewster, James E., California, 1992, chairman
Divack, Morton L., New York, 1994
Goodman, William E., Oklahoma, 1993
Grothaus, Bernard J., Illinois, 1995
Harrell, James A., Sr., North Carolina, 1992
Hudgins, John O., Illinois, 1994
Kunik, Burton J., Texas, 1994
Lee, John G., Florida, 1992, *ex officio*
Leshgold, Richard D., Washington, 1995
McDermott, Bernard K., District of Columbia, 1993
Morawa, Arnold P., Michigan, 1992
Passantino, Frank R., California, 1993, *ex officio*
Scures, Chris C., Florida, 1995
Jeske, Edward T., director
Cherrett, Helen McK., manager, international relations
Stiegel, Marsha P., manager, program development

Meetings: The Council met January 27-28, 1992 in Orlando at the Walt Disney World Dolphin Hotel and May 14-15 at the Headquarters Building in Chicago.

Activities: During 1991-92, the Council on ADA Sessions and International Relations continued serving as the program coordinating body for the annual session as well as acting as the committee to formulate and recommend policies related to the Association's role in international affairs and serving as its liaison to the world dental community. The Council, in its January meeting in Orlando, primarily discussed planning for the 1992 and 1993 annual sessions, but it also included update reports on the status of the Council's international programs. Association president Dr. Geraldine Morrow and Dr. Heber Simmons, Jr., Fifth District trustee and the Board of Trustee's liaison to the Council, also attended that meeting.

At its May meeting, the Council finalized plans for the 1992 session and pursued plans for the 1993 meeting. The Council also considered the international matters that are its responsibility. Also attending the May meeting were Dr. Francis Serio, chairman of the ADA/HVO Steering Committee, and committee members, Dr. Hugh Cooper and Dr. Richard Nieusma who updated the Council on activities related to the ADA/HVO Dentistry Overseas Program. During the May meeting the Council also initiated activities to develop a strategic plan for the annual session and produced a "vision statement" of what they would want the annual session to be in five years.

1991 Annual Session: The 1991 annual session was the first time that the ADA met in Seattle. The site of the 1991 Annual Scientific Session was the Washington State Convention and Trade Center in the heart of Seattle. This facility provided accommodations for the technical exhibition and certain scientific programs. Due to the limitation in size of the center, three downtown hotels had to be utilized also for scientific programs. Total registration was 28,389, including 9,566 dentists of which 618 were internationals. Both the exhibits and the scientific programs were well attended during the four-day meeting.

1991 ADA/Dentsply Student Clinician Program: This student program, which celebrated its 33rd anniversary at the 1991 annual session, is conducted annually by the Council on ADA Sessions and International Relations and is financially supported by Dentsply International, Inc., York, Pennsylvania.

Outstanding student clinicians representing 54 accredited dental schools in the United States including Puerto Rico, presented table clinics on Monday afternoon at the Washington State Convention and Trade Center. On Tuesday morning the winning students presented their clinics.

Winning students in Category I, Clinical Application and Technique, were: Vincent Kim-Thy Chee, Loma Linda University, first place; Laurel Rae Leslie, University of Colorado, second place; and Wilma Luquis-Aponte, University of Puerto Rico, third place.

Winning students for Category II, Basic Science and Research, were: Jean S. McGill, Northwestern University, first place; Dwayne E. Karateew, Columbia University, second place; and Nancy A. Montgomery, Ohio State University, third place.

The first place winners in each category were awarded a travel prize to present their winning table clinics at the Chicago Dental Society Midwinter Meeting. Second and third prize winners in each category received awards of $500 and $250, respectively.

Judges for Category I were: John Olmsted, Greensboro, North Carolina, chairman; Cordell S. Fisher, San Pedro, California; Brenda J. Harman, Seattle; Arthur D. Hunger, Jr., York, Pennsylvania; Keith V. Krell, Iowa City, Iowa; and Dan Middaugh, Seattle.

Judges for Category II were: Richard C. Tatum, Columbia, Maryland, chairman; Steven Abel, Mount Kisco, New York; Gordon Christensen, Provo, Utah; Thomas Emmering, Wheaton, Illinois; Theresa Madden, Rochester, New York; Mirdza E. Neiders, Buffalo, New York; Roger Stambaugh, Los Angeles; Barbara Tatum, Columbia, Maryland; and Thomas Van Dyke, Atlanta.

1991 Technical Exhibits: The Washington State Convention and Trade Center in Seattle was the site for 830 technical exhibit booths, representing 456 exhibiting companies. More

than 100 different classifications of products were displayed in dental therapeutics, materials, instruments, equipment and services.

1991 Scientific Exhibits and Informational Tables: There were 23 scientific exhibits and 20 informational tables at the 1991 annual session. Informational tables relate to continuing education opportunities, alumni or membership activities or professional service opportunities, and educational and scientific exhibits present scientific information relating to dentistry.

1991 Scientific Program: Ninety courses were offered in 1991 using the convention center, the University of Washington and three downtown hotels. These gave attendees a wide selection of topics from which to choose. Audience attendance was generally good and program evaluations submitted by attendees attest to the relevance and quality of the programs offered. Four courses, which were the live clinical demonstrations, were videotaped and most other courses were audiotaped. These tapes were available for purchase at the meeting and afterwards. In addition to these programs, more than 100 table clinics were presented during the meeting on a variety of topics and these presentations were also well received.

A full schedule of registered clinics including live clinical demonstrations, lectures and workshops was offered during the annual session in Seattle. These programs covered a variety of topics including anesthesia and sedation, endodontics, implantology, operative dentistry, periodontics, temporomandibular joint dysfunction, bonding and a number of other clinical and practice management courses. The nine registered clinics included courses on periodontics, endodontics, practice management, esthetics and oral surgery. These clinics had an attendance of about 3,000. Participation workshops included a course on radiography for dental assistants, crown and bridge temporization, cosmetic imaging, endodontics, implants and periodontal surgery. Workshops had about 400 participants. General interest programs included discussion of the history, culture, geography and foods of the northwest and managing stress and change.

Certificate of Recognition for Volunteer Service in a Foreign Country: At its May meeting, the Council awarded 101 dentists in 21 states the Certificate of Recognition for Volunteer Service in a Foreign Country. Since the program was initiated in 1975, 1,316 Certificates have been awarded to individuals in 45 states and the District of Columbia. This year an article about the program appeared in the *ADA News*; a news release was included in the *Update for Dental Editors* and in *Dental Society Update*; and a mailing was sent to constituent and component dental societies, which has resulted in the processing of 112 applications. The discrepancy in the number of applications presented and the number of certificates awarded is generally because of lack of adequate documentation.

This program continues to be well received throughout the profession, as evidenced by the number of nominations, publicity in dental journals and presentation of the Certificates at dental society meetings. It also assists the Council in locating the increasing number of volunteer programs that use dental personnel.

International Subscription Program: Since this program was revised in 1982, subscriptions have been sent to dental school libraries and dental organizations in Africa, Asia, Europe and the Middle East, as well as Central America and South America. This year the Council registered 73 subscriptions to *Dental Abstracts* and one other U.S. dental periodical of choice. All new recipients are now encouraged to select from Association publications for both their periodicals. Providing current professional journals to dental school libraries in lesser developed countries has proved to be one of the most effective and least costly ways of helping to raise standards and improve the dental health of these countries' citizens. The many letters of appreciation received by the Council attest to the valuable contributions the journals make to dental educational programs.

National Council for International Health (NCIH): The purpose of the NCIH is to improve health worldwide by strengthening the U.S. response to international health needs. Its emphasis is on information, education/training, job opportunities, policy and technical cooperation. The NCIH is currently the only organization in the United States that functions as a coordinating council and provides information to leading private and voluntary health organizations. Established 21 years ago, this organization, of which the ADA is a founding member, is flourishing and serves a broad segment of the international health community. The Association participates actively through its representative, Dr. Morton L. Divack, who is a member of the governing board. He attends the annual conference, which is held in Washington, D.C. This meeting acts as a forum to facilitate information sharing, identify trends and focus on future health programs.

ADA/HVO Voluntary Service Program: In 1989 the Board of Trustees adopted a resolution that established an ADA Voluntary Service Program under the auspices of Health Volunteers Overseas (HVO). The program is managed by a special steering committee, composed of five consultants and one member of the Council to act as the liaison. Dr. Bernard J. Grothaus is the liaison, and Drs. Hugh Cooper, Raymond A. Flanders, Dick H. Nieusma, Jr., Francis G. Serio and Richard G. Topazian were appointed to serve on the committee for terms ending with the 1992 annual session.

The committee met on January 22, 1992 in Washington, D.C. and appointed Dr. Serio as chairman. At this meeting the committee reviewed current programs in Grenada, Jamaica, St. Lucia and Trinidad. On May 13 the committee met in Chicago to review potential new programs in Malawi, Africa; Sartarem, Brazil; Ludhiana, India; and Bluefields, Nicaragua, and to assess the current "in country" activities. Additionally, as part of the annual session scientific program, the ADA/HVO program "Dentistry Overseas" was updated for the members and an educational forum was presented to help dentists prepare to volunteer overseas.

With increased support, the Steering Committee has also agreed to help the Council review and address the numerous requests for assistance being received by the Association, primarily from Eastern Europe and the Commonwealth of Independent States.

ADA Quatercentenary Celebration of Trinity College, Dublin—July 19-24, 1992: In 1992, Trinity College, University of Dublin celebrates its 400th anniversary, and in honor of this occasion the school of dentistry invited the ADA to hold a major international dental meeting in Trinity College as part of the College's quatercentenary celebrations. In accepting this invitation, it was determined that the meeting would be sponsored by the ADA, the Irish Dental Association, the Association for Dental Education in Europe and the School of Dental Science at Trinity College, Dublin.

The Council appointed Dr. Bernard McDermott to serve as the program chairman and approved eight speakers for the scientific portion of the meeting designed for the general practitioner. The second half of the meeting focuses on dental education. At the time of writing, the Council is finalizing the logistics for the scientific program, including a special program for auxiliaries, general interest courses and special events, which include a final banquet at the College. An official program is being developed and printed in the United States. Pre- and post-convention tours and a golf tournament have also been established. The preliminary program was made available in October 1991 and an intensive promotional campaign has been undertaken in cooperation with the four meeting sponsors.

1992 Annual Session: Orlando, Florida is the site of the Association's 133rd Annual Session. The Orange County Convention/Civic Center is the location for the technical exhibits, table clinics, and all of the scientific program as well as other related activities. The scientific program schedule will offer courses on an array of topics including temporomandibular joint dysfunction, implants, removable prosthetics, gerontology, endodontics, esthetics, periodontics, sedation, practice management, orthodontics, infection control, dental materials and prosthodontics. Seven participation workshops, ten registered clinics and four limited attendance clinics are being offered in addition to the open lectures. A four-day symposium by the L. D. Pankey Institute faculty will celebrate the 20th anniversary of the Institute.

Strategic Planning Activities: At its January meeting, the Council agreed to pursue the development of a strategic plan for the annual session and appointed a committee consisting of Drs. Kunik, Leshgold and McDermott and instructed it to meet just prior to the Council's May meeting to begin developing this plan and report to the full Council. This committee met and drafted a preliminary "Vision Statement" of what they would want the annual session to be in five years for discussion by the full Council. The entire Council and staff were involved in this discussion and the statement that resulted was unanimously adopted by the Council. This Vision Statement reads as follows:

The American Dental Association Annual Session should be:

- the premier international dental meeting
- highly profitable to the ADA
- a major reason to be an ADA member
- an opportunity for all to voice their opinion, be informed and be involved
- the number one meeting at which dental trades exhibit
- the meeting where new technology is introduced
- the cutting edge of continuing dental education, the best programs are always available and the newest programs are introduced
- the best opportunity to get continuing education credits
- the meeting which offers opportunities that no other offers
- the most fun dental meeting.

With this vision statement as a motivating force, the Council will continue its strategic planning activities by setting goals and objectives and developing strategies and tactics to meet them and thereby produce action to achieve the vision.

Acknowledgments: The Council wishes to express its sincere appreciation to Dr. John G. Lee, general chairman of the 1992 Committee on Local Arrangements, who leaves the Council after this year's annual session. The Council also wishes to thank those who so capably assisted Dr. Lee: Dr. Roger Nofsinger, committee vice-chairman; Dr. Neil Powell, chairman of the Program Coordinating Committee; Dr. Richard Altman, chairman of the Committee on Special Services; and Dr. Carter Greear and Mrs. Beverly Greear, chairpersons of the Committee on Social Activities.

The Council also wishes to recognize the contributions of those members who will be leaving the Council after the 1992 annual session: Dr. James E. Brewster, 1992 Council chairman; Dr. James A. Harrell, Sr.; and Dr. Arnold P. Morawa.

Resolution: This report is informational in nature and no resolutions are presented.

Commission on the Young Professional

Hinkle, R. Alan, Virginia, 1993, chair
Doerfler, Andrew C., Texas, 1992, vice-chair
Bigelow, Tod A., Colorado, 1993
Castagna, Daniel M., California, 1994
Crete, Michael J., Michigan, 1992
Donatelli, David P., Pennsylvania, 1994
Feinberg, Edward, New York, 1993
Isaacson, Richard, New Jersey, 1994
Kell, Kathryn A., Iowa, 1992
Messina, Matthew J., Ohio, 1995
Parolin, Karen K., Vermont, 1995
Platt, George B., Arkansas, 1995
Thompson, Timothy E., Idaho, 1994
Thompson, Wm. Roy, Tennessee, 1992
Unger, Joseph G., Illinois, 1993
Winston, Mollie A., Georgia, 1995
Shuck, J. Vincent, director
Peebles, John N., manager

Organization: The Commission became operational following the 1987 House of Delegates to address the special concerns of young members. The Commission recommends policy and programs in the following areas: (1) recruitment and retention; (2) needs and concerns of young, women and minority dentists; and (3) leadership involvement.

Meetings: The Commission met on August 7-8, 1991 at the Marriott Rivercenter in San Antonio and on February 21-22, 1992 at the Headquarters Building in Chicago. It is scheduled to meet again on August 12-13, 1992 in San Francisco prior to the Sixth National Conference on the Young Dentist. Four subcommittees of the Commission facilitate activities through conference calls and meetings in conjunction with regularly scheduled Commission meetings. These subcommittees include: Conference Activities; Emerging Trends in Dentistry; Leadership and Dental Society Liaison; and Recruitment and Retention.

Dr. William S. TenPas, Eleventh District trustee served as Board Liaison in 1991. Dr. James H. Gaines, Sixteenth District trustee, currently serves in that capacity.

Acknowledgments: The Commission and staff extend their appreciation for the active participation and dedication of the following members upon completion of their tenure of service: Dr. Andrew C. Doerfler; Dr. Michael J. Crete; Dr. Kathryn A. Kell and Dr. Wm. Roy Thompson. It is especially significant to note that these four individuals were originally appointed to the Special Committee on Young Dentists in 1986 and continued to serve the Association with distinction through their tenure on the Commission.

Election of Chair and Vice-Chair: In accordance with the authority contained in the Association's *Bylaws* (Chapter XIV, Section 40, Paragraph D), the Commission elected Dr. R. Alan Hinkle to serve as chair. Dr. Andrew C. Doerfler was elected as vice-chair. The elections for the 1992-93 terms are scheduled to occur during the Commission's August 1992 meeting.

Recruitment and Retention of Young Dentists: The national market share of young dentists was 67.8% as of December 31, 1991. This represents a decline of 1.3% since 1990. In its efforts to help address this decline, the Commission undertook a number of efforts in recruitment and retention activities in conjunction with other Association agencies. The Commission participated in a special effort with the Department of Membership Development and Services (DMDS) to contact 4,705 recent graduate non-renewing members. This activity resulted in 642 renewed memberships. The Commission also participated in the 1991-92 Young Dentist Campaign that has elicited over 100 responses to an interactive software program that promotes membership. As a new program for 1992, Commission members participated in four pilot "Transition Programs" with DMDS staff at selected dental schools in an effort to recruit more dental student members.

The Commission contacted constituent and component dental societies to market the Dues Payment Program. This option enables young dentists, during their first five years after graduation, to pay tripartite dues over a six-month period, interest-free. Over 2,100 young dentists have participated to date.

The Commission also sent a letter to dental society staff promoting the use of the Commission's new member orientation program. In addition, the Commission implemented a plan to encourage young dentist committees to provide students a more active role in area dental society meetings and activities. The Commission's efforts in the development of strategies that address the membership needs of women and minority dentists are discussed later in this report.

Additional recruitment and retention activities in which the Commission participated during the year include: participation in meetings to promote Association membership; open forum at the 1991 annual session; recruitment workshops; articles in dental society publications and the Commission's *Leadership Focus* newsletter; mentor program activities; promotion of dental faculty membership; and distribution of materials to the Commission's network of over 80 young dentist committees.

Women and Minorities in Organized Dentistry: The Commission has devoted substantial time and resources addressing issues of concern to women and minority dentists who constitute a growing percentage of graduates. Among younger dentists, one in three is a member of a minority group and one in five is female. The demographic shift in dental school enrollment has significantly impacted the profile of young dentists entering practice. Nearly 80% of all women dentists are under age 40, and almost 50% of minority dentists identified in the membership files have graduated from dental school in the last ten years. This significant market growth of young women and minority dentists presents a formidable challenge for increasing future Association membership since these groups have historically held lower membership market share.

The Commission was created to address the needs of young dentists and to help the Association in responding to the decline in membership among this group. Research has confirmed that young dentists frequently view the tripartite structure as unresponsive to their needs, unrepresentative of their interests and unwilling to extend opportunities for leadership participation. The Commission determined that these perceptions must be addressed in a proactive manner to demonstrate the importance of Association membership. The following actions have been taken to address these emerging issues:

1. Development of a comprehensive report, *Portrait of Minority and Women Dentists*, that depicts demographic trends related to the profession and identifies the impact these trends could have on the ADA.
2. Completion of focus group research on minority and women dentists.
3. Increased liaison with special interest groups, such as the National Dental Association, Hispanic Dental Association, Society of American Indian Dentists and American Association of Women Dentists.
4. Identification and utilization of women and minority consultants for the preparation of conference programs and Commission agendas.
5. Presentation of special workshops at the 1991 and 1992 National Conferences on the Young Dentist.
6. Amendment of Association guidelines on the appointment of council and commission members encouraging the appointment of young, women and minority dentists.
7. Submission of resolutions that generated House support for the inclusion of young, women and minority dentists in leadership positions.
8. Submission of recommendations to the Strategic Planning Committee on the involvement of young, women and minority dentists in leadership positions.
9. Assistance in the development of publicity that reports on young, women and minority issues.
10. Assistance to the ADA Field Service Representatives during the development of special recruitment activities for young, women and minority dentists.

The Commission recognizes that the Association must adapt many of its programs and develop new programs if it is to be viewed as a viable, responsive organization by young, women and minority dentists who will shape the future of the profession. Based on its current *Bylaws* responsibilities, the momentum it has created with its ongoing program activities and its unique understanding of women and minority issues, the Commission intends to continue serving as a catalyst for the Association's efforts related to these membership segments. In this regard, the following plans are being implemented by the Commission and pursued through the 1993 budget process:

1. Support and encourage the ongoing focus by the Association on this expanding membership market.
2. Accept responsibility for managing the recommendations initiated by the Task Force on Women and Minority Dentists.
3. Place cultural diversity information before component and constituent dental societies as well as ADA leaders.
4. Recommend the development or adaptation of ADA services and programs to address the needs of women and minority dentists.
5. Seek corporate funding for women and minority programs.
6. Promote role models from these membership segments to demonstrate the Association's commitment to change.
7. Obtain ethnicity data for use in comparing membership information.
8. Involve more young, women and minority dentists in leadership positions throughout the tripartite system.
9. Evaluate the changes in the market share of young, women and minority dentists as well as the increase in the number of these groups in leadership positions in order to determine when the Commission has completed its responsibilities.
10. Review the present Commission name and decide whether a change should be recommended.

The Commission reviewed the progress being made by the Association's Strategic Planning Committee and noted that many of the issues being addressed relate to these young dentist membership groups. In addition, the Commission/Board of Trustees Task Force was convened in January to determine the most effective means of impacting the Association's direction as it relates to young, women and minority dentists. The Task Force agreed that substantive action must be taken now to integrate young dentists into organized dentistry. Effectively adapting the Association to the needs of tomorrow's practitioners requires action on the part of every Association agency as well as current and future leaders. Opportunities are present now, but could be lost in the future. Although most, but not all women and minority dentists are under age 40, the Commission views its role as advisory in nature to encourage appropriate agencies to address relevant issues. The Commission's initiation and support of efforts to develop reliable standards for evaluating clinical competency (*Supplement 2*, 1990:395) illustrates the effective nature of its advisory role on important young dentist issues that, in reality, benefit dentists of all ages.

Leadership and Dental Society Liaison Activities: In keeping with its *Bylaws* responsibilities, the Commission evaluates participation of young dentists in leadership positions and pursues activities for additional involvement. In the 1991 House

of Delegates, 5.3% were under age 40. Although this represents a 1% increase over the previous year, it still does not sufficiently represent the 31.7% of Association members under age 40. The 1990 House of Delegates adopted Resolution 72H-1990 (*Trans.*1990:567), which encourages constituent societies to consider young dentists when electing delegates and alternates to the ADA House of Delegates. The Commission continues to encourage young dentist committees to become knowledgeable about delegate selection practices in their states and seek to remove barriers that may exist. Information has been provided through workshops, mailings, articles in *Leadership Focus* and personal contacts by Commission members to identify opportunities for qualified young dentists to serve throughout the tripartite structure.

The Commission also recommended that the Strategic Planning Committee consider reviewing the representation of the House of Delegates, including the manner in which delegates are apportioned and the demographic composition. In addition, input was offered on the following: the need for cultural diversity training for current leaders; uniform democratic election procedures for ADA delegates; increased liaison with special interest group dental organizations; leadership training for young, women and minority dentists; dissemination of role model information; and development of seminars.

In order to provide leadership growth for young dentists, the Commission conducted skills development activities at conferences throughout the tripartite structure, continued quarterly publication of the *Leadership Focus* newsletter, promoted the national Young Dentist Leadership Award, continued circulation of the *Guidelines for Young Dentist Committees* and revised the workbook for the Young Dentist Committee Workshop. The workshops provide young dentist committees with an intensive one-day session to facilitate effective planning and implementation of activities. Eleven workshops were conducted in 1991. Four have been conducted in the first quarter of 1992 and others are pending. Follow-up activities are conducted at each site to provide support to the committees and to identify problems with selected activities. Associateship Resource Programs were conducted in conjunction with the Council on Dental Practice SUCCESS Programs at selected dental schools. The program helps to link graduates with those practices that are seeking an associate. Local young dentist committees are provided with support to conduct the activity and implement a follow-up mechanism.

The Commission assisted the Council on Dental Practice in the development of a Seminar for Recent Graduates and identified several young dentists who could participate as presenters. The Commission also developed guidelines for dental student liaison activities and a suggested list of strategies to enhance Association membership among faculty. Young dentist committees are provided assistance to implement a student contact program with dental schools in their local area.

The Commission contacted members of Congress to support passage of legislation that would restore the tax deductibility of interest on student loans and conducted a successful campaign to encourage young dentist committees to participate in the legislative contact process. Although the bill which contained a tax deduction provision was vetoed by the President, the Commission intends to redirect its efforts with Congress at the appropriate time.

Licensure Issues: The 1991 House of Delegates adopted Resolution 36H-1991 (*Trans.*1991:600), which directed the Council on Dental Education to implement a plan to develop a comprehensive document promoting the minimum common core of clinical requirements for licensure among licensing jurisdictions. The Commission supports the efforts of the Council on Dental Education to develop a quality examination and has encouraged the Council to continue the momentum created as a result of recent House actions. The Commission has also requested the Council to determine how the minimum common core requirements could be pilot tested among one or more licensing jurisdictions in order to demonstrate how these elements could be used by all licensing authorities. The Commission continues to assess initiatives that support acceptance of licensure by credentials by licensing authorities throughout the United States.

Conference on the Young Dentist: With continued corporate support from Chesebrough-Pond's USA, the Commission will conduct the Sixth National Conference on the Young Dentist in San Francisco on August 13-15, 1992. The Conference provides continuing education from a young dentist's perspective on practice management, periodontics, cosmetic dentistry and financial planning, as well as opportunities for leadership development, interaction with Association leaders on policy issues and networking opportunities. The Commission is planning for the Seventh National Conference to be held in the Washington, D.C. area during 1993.

Response to Assignments from the 1991 House of Delegates:

Mentor Programs. The 1991 House of Delegates adopted Resolution 138H-1991 (*Trans.* 1991:600), which encourages appropriate agencies of the Association to continue support and promotion of the mentor program. The Commission developed a promotional brochure and a resource packet to assist dental societies in implementing a mentor program. Following promotional efforts, over 40 constituent and component dental societies have requested and received these materials. The Commission will continue to encourage young dentist committees to consider developing mentor programs and provide information and assistance upon request.

Resolutions: This report is informational in nature and no resolutions are presented.

Division of Dental Practice

Council on Community Health, Hospital, Institutional and Medical Affairs

Council on Dental Care Programs

Council on Dental Practice

Joint Report of the Council on Dental Care Programs and Council on Dental Practice

Commission on Relief Fund Activities

The ADA Endowment and Assistance Fund, Inc.

Notes

Council on Community Health, Hospital, Institutional and Medical Affairs

Romeo, Frank J., Maryland, 1992, chairman
Harris, David J., Indiana, 1992, vice-chairman
Adams, Samuel H., Texas, 1994
Allen, J. David, Georgia, 1992
Barry, Victor J., Washington, 1995
Bonofiglo, Eugene L., Michigan, 1993
Calderone, James J., New Mexico, 1993
Daniel, Thomas M., Florida, 1992, American Medical Association
Donlon, William C., California, 1993
Fallon, Michael W., New York, 1995
Fridley, John S., Pennsylvania, 1995
Hanson, Paul, New York, 1992, American Hospital Association
Haught, Wm. Richard, Oklahoma, 1994
Jabbour, Richard E., South Carolina, 1994
Kalil, Joseph G., Massachusetts, 1995
Melnick, Harry J., Illinois, 1992
Murphy, James C., Kentucky, 1994
Tempero, Richard M., Nebraska, 1993
Klyop, John S., director
Marshall, James Y., manager

Organization: The Council works to broaden the scope of oral health care within the total health care system and to advance preventive dentistry and the delivery of oral health care in the community. Areas of program activity include: (1) medical and dental interface, (2) access and community health, and (3) dental disease prevention and health promotion. The Council recommends policy and directs programs in the aforementioned areas.

Meetings: The Council met in the Headquarters Building on September 20-21, 1991 and January 31-February 1, 1992. It is scheduled to meet again September 11-12, 1992. Three subcommittees, Access to Dental Care, Preventive Dentistry and Institutional Dental Care, meet in conjunction with regularly scheduled Council meetings.

Personnel: At the February meeting of the Council, Dr. David J. Harris was unanimously elected vice-chairman.

Liaison Activities: In addition to other activities described in this report, Council members and staff maintain liaison with various health associations and governmental agencies. These liaison activities provide opportunities to present the profession's perspective on matters of interest and to monitor and report on related activities.

National Conference on Special Care Issues in Dentistry: A major element of the Council's access programming has been sponsorship of conferences or scientific programs on access and special patient care issues. In cooperation with the Federation of Special Care Organizations in Dentistry, the Council presented the Fourth Annual National Conference on Special Care Issues in Dentistry, April 3-5, 1992. Over 300 clinicians, researchers, educators, dental auxiliaries and public health dentists attended. The program addressed special patient care issues from several perspectives including: diagnostic and treatment modalities; financial considerations; delivery options; and legal, legislative, regulatory and ethical issues. Dr. Harald Löe, director, National Institute of Dental Research and U.S. Representative Ron Packard, 43rd District, California, presented the keynote addresses. Welcoming remarks were given by Association president, Dr. Geraldine Morrow and Dr. Martin Lebowitz, chairman of the Federation of Special Care Organizations in Dentistry. The Conference also featured numerous full- and half-day sessions on a wide variety of special care issues. Among them was the Council-sponsored annual Hospital Dental Directors Workshop, which is discussed in this report (see page 22). The Council appreciates the corporate contributions received from the Burroughs Wellcome Company, Warner-Lambert Company, Laclede Professional Products, MGI Pharma and Fixodent Fasteeth Procter & Gamble Oral Care. The 1993 Fifth Annual National Conference on Special Care Issues in Dentistry is tentatively scheduled for April 1-3, 1993.

National Foundation of Dentistry for the Handicapped: The Council continues to function as the Association's primary liaison with the National Foundation of Dentistry for the Handicapped, an affiliate of the Association. The Foundation's executive director, Dr. Larry Coffee, is a Council consultant and regularly reports to the Council. The Foundation sponsors special care programs in 11 states and serves over 35,000 individuals annually through the ongoing Campaign of Concern, the Dental House Call program and the Donated Dental Services program.

The Foundation has been actively marketing the sale of a dental product coupon book called DentaCheques as a fund-raising activity. This activity is finishing its second year and is realizing success. The Foundation is planning to offer the DentaCheques coupon book again next year.

Nonclinical Dental Career Information: The Council continues to provide information and guidance to dentists who are interested in pursuing a nonclinical or nontraditional dental

career. A packet of materials is provided which discusses in general terms, the issues and factors dentists need to take into account when considering a nonclinical career. Each year the Council office receives 400 to 500 requests for this information.

Institutional and Interprofessional Affairs

Related Activities of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO): In 1992, Dr. John F. Helfrick assumed the Association's seat on the JCAHO Board of Commissioners, succeeding Dr. Charles A. McCallum. Dr. Helfrick is in private practice in Houston specializing in oral and maxillofacial surgery. Prior to becoming a Commissioner, Dr. Helfrick served as the Association's representative on the Joint Commission's Hospital Accreditation Program Professional and Technical Advisory Committee (PTAC).

In addition to being on the Board, Dr. Helfrick also serves on the JCAHO's Executive Committee, the Finance and Audit Committee, the Research and Development Committee, the Standards and Survey Procedures Committee and the Accreditation Committee. He attended the Council's meeting in January and reported on JCAHO activities of interest.

The Association continues to be well represented on numerous Joint Commission committees and task forces. Currently, Dr. John Kelly is on the Hospital Accreditation Program PTAC; Dr. Terrance J. Thines serves on the Long Term Care Accreditation Program PTAC; Dr. Roseann Mulligan serves on the Ambulatory Accreditation Program PTAC; and Dr. Linda Niessen is on the Home Care Accreditation Program PTAC. Additionally, Dr. James J. Crall continues to serve on the Quality Improvement Task Force; Dr. John A. Yagiela continues on the Medical Use Task Force; John A. Molinari, Ph.D., serves on the Infection Control Task Force; and Thomas W. Evans, Jr., serves on the Task Force on Overcrowded Conditions in Emergency Departments.

JCAHO Surveyor Training. The Council continues to sponsor a half-day seminar for new Joint Commission surveyors on the role of dentistry and dental departments in the operation of health care facilities. Particular attention is devoted to how JCAHO standards apply to dentistry. Faculty for this seminar includes Dr. Peter Hurst of Northwestern Memorial Hospital, Chicago, and Dr. Malcolm Lynch, of the University of Pennsylvania School of Dental Medicine, Philadelphia.

Focus Group Meeting. During the Fourth Annual National Conference on Special Care Issues in Dentistry a focus group meeting was organized to provide feedback to representatives of the Joint Commission relative to the JCAHO survey process, its surveyors and the standards themselves. For the past 18 months, the Joint Commission has been holding such sessions with various physician groups. The American Dental Association, as a corporate member of the JCAHO, proposed holding a similar session with dentists who have had first hand experience with accreditation of their hospitals.

JCAHO Board Composition. Corporate members of the Joint Commission agreed to expand the size of the Board of Commissioners by four seats this year. Three of these seats will be made available to public members and one to a representative of the nursing profession. This action responds to the Joint Commission's commitment to becoming more broadly representative of the public and to health professions impacted by its functions. The 28-member board now includes seven members from the American Medical Association, seven from the American Hospital Association, three from the American College of Physicians, three from the American College of Surgeons, one from the American Dental Association, six public members and one who shall be an at-large representative of nursing.

Hospital Bylaws Issues: The Council continues to monitor and respond to problems related to medical staff membership and/or privileges based on inappropriate bylaws language. An ongoing effort is aimed at identifying and correcting, where possible, discriminatory bylaws language in individual hospitals or in sets of model bylaws maintained by state medical societies. As part of its liaison activities with the American Medical Association (AMA), the Council has provided input to the revision of an AMA document which discusses the nature and scope of hospital bylaws. When necessary, the Association's Department of Legal Affairs assists in helping individual dentists resolve adverse situations.

Oral Health Care Guidelines Development: The Council proposed the development of a new set of Oral Health Care Guidelines to address the chemically dependent patient. This project will be coordinated with the Council on Dental Practice which manages the Association's response to addiction and substance abuse issues. The new document is titled Oral Health Care Guidelines for the Chemically Dependent Patient.

Hospital Dental Directors Workshop: The Council sponsored the fifth Hospital Dental Directors Workshop on April 3, 1992. For the past four years this meeting has been held in conjunction with the National Conference on Special Care Issues in Dentistry. The over 50 attendees heard a presentation on managing substance abuse and chemical dependency issues in their institutions, involving either patients or dental department staff. Additionally, the half-day session addressed the issue of faltering General Practice Residency (GPR) programs in various locations around the country. Strategies for strengthening GPR programs were discussed.

Liaison with National Organizations: Council staff maintains liaison with various health care organizations in an effort to present and promote the interests of the profession. Council staff attends both the Annual and Interim meetings of the American Medical Association's House of Delegates and Hospital Medical Staff Section. Dr. Lewis S. Earle serves as an official observer at these meetings. Council staff also attends the American Association of Oral and Maxillofacial Surgeons' annual meeting and the American Hospital Association's annual convention. Dr. David A. Whiston officially represents the Association at the American Hospital Association's House of Delegates meeting. Further, the Council works with the American Association of Hospital Dentists through the Federation of Special Care Organizations in Dentistry.

Access and Community Health

Access Program Promotion: The Council continually works to develop and provide professional and patient resource materials. This year, the Council, in collaboration with the Department of Public Information and Education and the Salable Materials Program, is developing and marketing an oral health promotion resource kit for use in health promotion activities targeting older adults. It is anticipated that the resource materials, including a videotape, patient education materials and a scripted presentation would be used by dental professionals and lay persons in oral health promotion talks in settings such as senior centers, adult day care facilities and health fairs. The kit, to be sold through the Salable Materials Program, will be available by the end of 1992.

The Council collaborated with the Department of Public Information and Education in the development of the brochure, *Dental Care for Special People*, a 16-page brochure that helps parents and others care for the oral health of individuals with special needs. The brochure is included in the *ADA Catalog* and is available for purchase through the Salable Materials Program.

The Council responded to numerous requests for access related information reflecting increased interest by individual members and dental societies for information on special patient care. In response to requests, Council staff has presented access program information at national meetings.

Access Recognition Program: In 1989, the Council launched an ongoing program designed to honor individuals who have shown particular leadership and inspiration in the establishment of local access programs. To date, 23 individuals from 11 states and Puerto Rico have received recognition. Recipients in 1991 were: Drs. Albert L. Anderson and Barry D. Kinney of California, Dr. George H. Vail of Indiana, Dr. Donald Gambrall of Kentucky, Dr. Katherine M. Morgan of Massachusetts, and Drs. Bernard Unger and Ernest Mendeloff of Connecticut. These individuals received a certificate from the Association and were mentioned in various Association publications. In February, the Council once again asked constituent dental societies to recommend names of outstanding individuals to be recognized in 1992. A number of nominations have been submitted since that time.

Annual Session Program: The Council will sponsor a scientific program, "Meeting the Oral Health Needs of Older Patients," at the Association's 1992 annual session in cooperation with the Federation of Special Care Organizations in Dentistry. The program will provide the private practitioner with contemporary approaches to treatment planning for the oral health needs of older adults. The use of new products and techniques in caring for older adults will also be highlighted.

Liaison with National Advocacy Organizations: The Council is concluding a fourth two-year term on the executive committee of the National Volunteer Organizations for the Independent Living of the Aging, a membership unit of the National Council on the Aging (NCOA). This unit is composed of over 200 voluntary organizations nationwide that have an interest in the well being of the aging. In addition to participating in the executive committee meetings, Council staff attended the NCOA's Annual Conference May 9-13, 1992. Through its participation in NCOA activities, the Association gains valuable insight, input and visibility on geriatric issues.

Council staff continues to communicate with the American Association of Retired Persons (AARP) in an effort to promote oral health awareness among its vast membership. The Council continues to encourage constituent dental societies to explore ways in which the importance of oral health care can be communicated through AARP.

The Association, through the Council, has maintained liaison with the National Commission on Correctional Health Care (NCCHC) and is one of its supporting organizations. Dr. William J. Byland is the Association's representative to the Board of Directors of the NCCHC. The NCCHC provides health care accreditation services for interested correctional facilities nationwide.

The Association, through the Council, has also maintained liaison with the National Alliance for Oral Health. The second annual meeting of the Alliance was held on June 15, 1992. Council staff sits on the Board of Directors as chair of the nominating and membership committee. The Alliance office, located in the office of the American Association of Dental Schools, is now staffed with a part-time staff person to respond to requests for information and perform administrative functions. The Alliance looks forward to future growth in membership and hopes to have a positive effect on the oral health needs of special population groups.

Caring Program for Children: In February, the Board of Trustees endorsed the Association's participation in the Caring Program for Children. At that time, the Board placed responsibility for the coordination of the Association's role in this access activity with the Council.

The Caring Program, designed to provide access to dental care for underserved children, is directed to the eight million children of the working poor. The Program is a multi-year partnership between the American Dental Association, Procter & Gamble and the Caring Program for Children, a group of non-profit charitable foundations that fund health care for the children. Although, as of May, the Caring Program provided medical care to underserved children through 20 programs in 18 states, constituent dental societies are working to expand health care services offered through the Program to include dental care.

A pilot dental program is being conducted in Ohio in collaboration between Procter & Gamble, the Caring Program for Children in Ohio and the Ohio Dental Association. Over 700 dentists volunteered to participate in the pilot program by providing care for to up to three eligible children annually.

Official announcement of the Program occurred in May when letters from Association president, Dr. Geraldine Morrow, were sent to constituent dental societies encouraging their participation. Specifically, Iowa, Maryland, Missouri and Pennsylvania were asked to consider developing a dental component in their state during 1992.

The long-term vision of the Program is to implement the dental component of the Program nationally over a three-year period. The Council appreciates the assistance of the Division of Communications, the Division of Legal Affairs and the Council on Dental Care Programs for their help in laying the foundation for future expansion of the Caring Program's dental component.

Fluoridation and Preventive Health

Fluoridation Activities: The Council continues to support community water fluoridation and acts as a resource to the profession and the public on this issue. During the past year, the Council provided educational materials and assisted active campaigns to initiate or retain fluoridation in 116 communities in 33 states. According to data obtained from the Association of State and Territorial Dental Directors, city government actions resulted in new authorizations for fluoridation in 53 communities, and public referenda were successful in two communities, while one community voted against fluoridation. At the present time, significant fluoridation campaigns are underway in ten cities in seven states.

National Fluoridation Advisory Committee (NFAC): The NFAC, composed of consultants to the Council, met via a conference call on May 4, 1992. The Association appointed the following members to serve a one-year term on the NFAC: Drs. Richard Tempero, chairman, Joel M. Boriskin, Stephen Corbin, Robert Faine, P. Jean Frazier, Kim Cowles, Herschel Horowitz, Elaine Neenan, Ernest Newbrun and Mr. John Small. This Committee continues to serve the important role of advising the Council concerning national fluoridation promotion and maintenance activities. In this regard, the NFAC assists the Council in monitoring trends associated with the state/local community water fluoridation initiatives and provides the Council with valuable input in the development and/or revision of fluoride/fluoridation education materials. Currently, the NFAC is in the process of revising *Fluoridation Facts*, the Association's most comprehensive resource on the safety and effectiveness of water fluoridation.

Task Force on Fluoride: In a continuing effort to effectively manage the Association's response to inquiries from the profession, the media and the public, regarding the safety and effectiveness of fluoridation and fluorides, Council staff continues to coordinate the activities of an internal Task Force on Fluoride. In this regard, the Task Force assisted the Division of Communications with the development of a patient education brochure titled *Facts About Fluoride* and developed a reproducible fact sheet on fluoride that was published in the August 1991 issue of *The Journal of the American Dental Association*. The Task Force will continue to monitor and assess a variety of research issues and national trends relative to fluoridation and fluorides and will serve as a resource to Association agencies on this topic.

Management Conference: As part of the 1991 ADA Management Conference, Council staff participated in a panel presentation given by the chairs of the Association Task Forces on HIV/Infection Control, Amalgam and Fluoride. Fluoride issues that were highlighted included a review of the key recommendations and conclusions of the U.S. Public Health Service Report on Fluoride, the role of systemic and topical fluorides in caries prevention and an overview of state fluoridation activities.

During the 1992 ADA Management Conference, the Council sponsored a workshop titled, "Achieving Community Visibility: Team Building for Success." Participants included Mr. Roger Weiss, executive director, Missouri State Dental Association; Dr. Dean Perkins, director, Missouri Bureau of Dental Health; and Robert Marshall, Ph.D., chief, Applied Research Section, National Cancer Institute. The workshop focused on strategies to enhance the working relationships between constituent and component dental societies and state dental public health programs.

Fluoridation Commemorative Stamp: The Council remains supportive of the West Michigan Dental Society's (WMDS) effort to procure a national stamp commemorating the 50th anniversary of water fluoridation in Grand Rapids, Michigan in 1995. Accordingly, the Council has been working with members of the WMDS Fluoride Commemorative Stamp Committee to develop strategies for obtaining endorsements for a fluoridation commemorative stamp from key national dental and health related organizations. The Council will continue to provide the WMDS with technical assistance related to this activity on an as needed basis.

Caries Prevention Guide for Health Practitioners: The Council is coordinating the final phase of a project, initiated in 1990, that has resulted in the development of a Caries Prevention Technical Assistance Guide for Health Practitioners. This resource document, which covers a broad spectrum of caries prevention modalities, their rationale and appropriateness, was developed by an ad hoc committee that consisted of the following members: Dr. James Calderone, chairman; Dr. Durward Collier; Alice Horowitz, Ph.D.; Dr. David Johnsen; Dr. James Jones; Dr. Gary J. Newman; Dr. Mark Siegal; and Dr. Jane Weintraub. Over the past year, the Committee reviewed and discussed the comments it received from over 100 field reviewers and finalized the Guide for publication. Production of the Guide, which is dependent on corporate sponsorship, is anticipated late in 1992.

Healthy Mothers/Healthy Babies Coalition (HMHB): The Council continues to represent the Association as a member of HMHB, which consists of more than 90 national organizations. The Council is also a member of the Coalition's Oral Health Subcommittee. While the problem of Baby Bottle Tooth Decay continues to be a major focus of this group, the Subcommittee has been developing strategies to address some of the other oral health care issues facing high-risk mothers, infants and children. Increasing advocacy at the state and local levels, on behalf of this population, is one of several action plans under development for accomplishing this goal.

Maternal and Child Oral Health: The Council is committed to programmatic activities aimed toward improving the oral health status of mothers and children. The Council continues to monitor regional and state follow-up activities associated with the Regional Maternal and Child Oral Health Conferences that occurred in 1991. The Council has become increasingly involved with national activities aimed toward developing strategies for improving the oral health of mothers and children via the removal of barriers to care to improve access. In this regard, Council staff represented the Association at the Surgeon General's Healthy Children: Ready to Learn Conference, held in February 1992. As an organizational co-sponsor of this Conference, the Association had an opportunity to highlight its commitment to improving the oral health of

children and their families for the benefit of the predominantly non-dental participants attending the conference.

Additionally, Council staff was invited to participate in the development of a Model Oral Health Needs Assessment Instrument for use by state/local Maternal and Child Health Title V Block Grant Programs. This project, which is being coordinated by the Association of State and Territorial Dental Directors, is being funded through a grant provided by the U.S. Public Health Service Maternal and Child Health Bureau. The Council anticipates being involved with this project through 1994.

National Health Education Consortium: In March 1992, the American Dental Association accepted an invitation to become a formal member of the National Health Education Consortium. The Consortium was created by the National Commission to Prevent Infant Mortality and the Institute for Education Leadership in response to the growing awareness of the connection between children's health and their ability to learn. The purpose of the Consortium is to effectively integrate health and education programs for children throughout the United States. Through the Consortium, leaders from over 50 national health and education associations, with combined memberships of nearly 11 million members, are regularly brought together to develop strategies to link health and education at national, state and community levels. The Council, in keeping with its mission to work to broaden the scope of oral health care within the total health system and the delivery of health care in the community, will serve as the focal point for this liaison activity within the Association.

Nutrition Screening Initiative: Recognizing that proper nutrition is an important determinant of good oral health in the elderly, the Council made a recommendation, during its September 1991 meeting, to support a new initiative aimed toward improving the nutritional status of the elderly. This project, the Nutrition Screening Initiative, is a five-year national effort being sponsored by three partner organizations: the American Academy of Family Physicians, the American Dietetic Association and the National Council on Aging, Inc. An additional 30+ organizations comprise a Blue Ribbon Advisory Committee, of which the American Society of Geriatric Dentistry (ASGD) is a member. The Council is coordinating the Association's involvement with this project, in concert with ASGD.

Sports Dentistry: The Council remains committed to promoting a greater awareness of sports dentistry issues and encourages widespread use of oral/facial protectors. The U.S. Olympic Committee has a Dental Advisory Committee composed of Dr. Robert Biddington, chairman, Dr. Jack Nichols and Mr. Nikolaj Petrovic. The Committee met in October 1991 and is scheduled to meet again in October 1992. Council staff represented the Association at the Academy of Sports Dentistry meeting in May 1992.

Hypertension: Dr. Brodie Secrest, Jr., Council consultant, is a member of the National High Blood Pressure Education Program Coordinating Committee. The issue of hypertension and its relevance to dentistry continues to be monitored by the Council.

Liaison with National Agencies: Liaison with national organizations continues to be an integral part of the Council's preventive health activity. Staff represented the Council at two major public health meetings in 1992, the annual meeting of the American Public Health Association and the American Association of Public Health Dentistry. Staff also attended and participated in the National Oral Health Conference in April 1992. The Conference was cosponsored by the Centers for Disease Control and the Association of State and Territorial Dental Directors. The Conference focused on methods for effectively addressing the oral health needs of children and their families and on strategies for improving access to oral health care services for underserved populations.

Outreach Activities with Allied Health Care Groups: As part of an ongoing effort to effectively interface with allied health care groups to promote the concept of oral health in relation to an individual's general health and well being, in November 1991, Council staff co-presented a lecture titled "Putting Teeth Into Your Physical Exam" during the Academy of Family Physicians' 13th Annual Conference on Patient Education. The Conference on Patient Education, which was attended by over 325 physicians, family practice residents, nurses and allied health personnel, is noted for its emphasis on interdisciplinary interaction, team development and practical information to enhance the patient education efforts of health care professionals. The Council, in cooperation with the Oral Health Division of the Centers for Disease Control, has submitted a proposal for a poster board presentation on the physician's role in the early detection of oral cancer for the 1992 Conference.

Pit and Fissure Sealants: The Council continues to promote the availability of the Dental Sealant Resource Kit, a joint effort with the Council on Dental Materials, Instruments and Equipment (CDMIE). The kit is available on request. The concept of dental sealants as a priority caries prevention regimen for the pits and fissures of permanent teeth has been comprehensively addressed in the Caries Prevention Guide for Health Practitioners discussed earlier. Additionally, the Council plans to collaborate with CDMIE to publish a revised Association Report on dental sealants in *The Journal of the American Dental Association*. The report is likely to address a variety of issues related to sealant utilization by dentists. The last Association Report published in *The Journal* on the topic of sealants was jointly prepared by the Council and CDMIE in 1987.

Smokeless Tobacco: The Council believes that appropriate federal regulation of this product and its advertising are needed and commends the Federal Trade Commission for taking steps to enforce the ban on advertising provisions contained in the 1986 Smokeless Tobacco Act. As a result of the American Dental Association's commitment to this issue, the Council was invited by the National Cancer Institute and the National Institute of Dental Research to join a newly created Steering Committee on Spitting Tobacco and Baseball. The purpose of this group, which held its first meeting in January 1992, is to develop a combination of educational strategies to attempt to break the link between smokeless tobacco and baseball. Opportunities for involving constituent and

component dental societies in promoting and delivering these educational messages to youngsters playing in park districts, Little League and school baseball leagues are being considered. Additionally, the Council continues to promote its Smokeless Tobacco Resource Kit, which is available on request.

Smoking Cessation: The Council has become increasingly involved with promoting the dental professional's role in tobacco use intervention and continues to monitor programs designed to utilize dentists in smoking cessation efforts. During its September 1991 meeting, the Council reviewed a draft manuscript of a clinical guide developed by the National Cancer Institute (NCI) and the National Institute for Dental Research titled "Tobacco Effects in the Mouth." This guide, which will be targeted to dentists and physicians, was endorsed in principle by the Council.

Additionally, over the past year, the Council has communicated with constituent dental societies regarding NCI's American Stop Smoking Intervention Study (ASSIST), a nationwide initiative being launched to fight tobacco-related cancers. In October 1991, the Department of Health and Human Services announced that 17 states will receive contracts totalling more than $7 million in the first year to participate in the ASSIST initiative. Those states include: Colorado, Indiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New Mexico, New York, North Carolina, Rhode Island, South Carolina, Virginia, Washington, West Virginia and Wisconsin. Federal and non-federal resources for this project will approximate $115 million and will affect at least 91 million individuals.

In response to recommendations made by the Council and the Council on Dental Practice, a letter jointly signed by the Council chairmen was sent to constituent dental society leadership in designated ASSIST contract states encouraging them to become involved with this project, particularly during its initial planning phase. Both Councils will continue to monitor the ASSIST initiative and will continue to provide organized dentistry's perspective during the planning and implementation phases of this project through its liaison with the National Dental Tobacco Free Steering Committee, a group charged with advising NCI on dental related tobacco issues. The Council continues to promote the availability of its Smoking Cessation Resource Packet, which contains informational materials on smoking cessation and tobacco intervention programs suitable for implementation in a dental office setting. This packet is available on request.

Tobacco Cessation Intervention Training: At its September 1991 meeting, the Council considered revising existing American Dental Association policy and recommendations regarding tobacco use to encourage dentists to become knowledgeable in tobacco cessation intervention techniques via the continuing education process. In an effort to adequately prepare the profession for an anticipated increase in demand by consumers for tobacco cessation intervention counseling in dental office settings, the Council, in conjunction with the Council on Dental Practice, prepared the following amendment to existing Association policy and recommends its adoption by the 1992 House of Delegates.

1. Resolved, that the Association's current Policy and Recommendations regarding Tobacco (*Trans.*1988:489; 1990:533) be amended by the addition of a new paragraph 7 to read as follows.

7. The American Dental Association urges its members to become fully informed about tobacco cessation intervention techniques to effectively educate their patients to overcome their addiction to tobacco. This information should include techniques for primary prevention of tobacco use.

and be it further
Resolved, that the current paragraph 7 be renumbered paragraph 8.

National Health Objectives for the Year 2000: The Association has been an active member of the consortium of organizations participating in the development of the National Health Objectives since 1987. The Council remains committed to identifying opportunities through which organized dentistry can impact specifically on the compendium of National Oral Health Objectives. In 1991, the Council sponsored Resolution 108 (*Supplement 2*, 1991:428), which endorses and supports the oral health objectives contained in Chapter 13 of the "Year 2000 Objectives for the Nation" document. These 16 highlighted objectives challenge both the private and public sectors to meet the oral health needs of targeted high-risk populations. Ways to enhance public and private collaborative efforts to meet these goals will continue to be an important focus of the Council in the decade ahead.

Healthy People 2000 Tobacco Work Group: As a demonstration of its support for the "Year 2000 Objectives for the Nation," and its commitment to educating the public about the hazards associated with tobacco use, the Council represents the Association as a member of the Healthy People 2000 Tobacco Work Group. Council staff attended the first meeting of the Tobacco Work Group in January 1992. This committee, which is composed of representatives from a variety of national health, education and governmental agencies, has been charged with developing strategies to effectively achieve the tobacco objectives outlined in the "Healthy People 2000" document. A long-term commitment by the Council to this activity is anticipated.

Community Preventive Dentistry Award: The Community Preventive Dentistry Award, funded by the Johnson & Johnson Dental Care Company and administered by the Council, recognizes those who have created and implemented significant preventive dentistry programs. Four programs were recognized for outstanding achievement during 1991, the 19th year of the program. An award of $2,000 was presented to Dr. Guilleromo C. Vicuna for "Su Salud - Your Health." This project, conceived in 1978 by its founder, Dr. Vicuna, is dedicated to assisting members of the Stockton, California area Spanish-speaking community obtain primary health care services. Su Salud is a volunteer organization intended to provide free diagnostic health screening, disease prevention awareness, tutoring and access opportunities for the poor. Over 1,300 volunteers from a

variety of health care fields donate their talents and abilities to this yearly health fair event. In 1991, approximately 14,000 people obtained dental and medical care through the efforts of the volunteers affiliated with this comprehensive program.

Awards of merit were granted to: the Greater Milwaukee Dental Association for its entry "Smile Day - There's Magic in Your Smile," a one-day dental health event that attracted over 5,000 individuals, and was conducted in collaboration with the Auxiliary to the Greater Milwaukee Dental Association, the Dental Hygiene Society and members of the Marquette University Dental School; to Ms. Marley Tobian, assistant professor, Department of Dental Hygiene, University of Nebraska Medical Center College of Dentistry, for the entry "Preventive Dental Program for the Children of the Winnebago and Omaha Tribes," an outreach program that provided preventive dental services to over 250 American Indian Children; and to the USA DENTAC at Fort Bragg, North Carolina for its entry "From Prenatal to Geriatric: Fort Bragg's Preventive Dentistry Programs," a U.S. Army Dental Activity program that provides comprehensive oral health education to the entire army base community in an innovative and positive way.

Geriatric Dental Health Care Award: The Geriatric Dental Health Care Award, funded through a grant from the Warner-Lambert Company Consumer Health Products Group, recognizes those individuals and organizations that have improved the oral health care of the elderly through innovative research and health care delivery projects. The 1991 Geriatric Dental Health Care Award was presented to Ms. Theresa A. Dolan, assistant professor, University of Florida College of Dentistry, for the entry "Partnerships in Oral Health: The University of Florida Geriatric Dental Demonstration Project." This innovative program, developed to improve access to dental care for underserved elderly, was developed in collaboration with community agencies and local dental practitioners to assist older adults living in the Jacksonville, Florida area overcome common barriers associated with obtaining dental care. In addition to providing over 900 area residents and their care givers with oral health education programs, the project has assisted 1,360 participants obtain a variety of services, including transportation to dental appointments, oral health assessments, dental cleanings and referrals for subsidized comprehensive care.

Merit awards were granted to the West Michigan Dental Society (WMDS) for its entry "West Michigan Dental Society Nursing Home Dental Program," a collaborative effort of the WMDS, the West Michigan Dental Health Foundation and the Michigan Academy of Dentistry for the Handicapped (the program assists long-term care institutions meet the oral health needs of their residents); to the Albuquerque District Dental Society for its "Senior Citizens Dental Program," an outreach program to improve the accessibility of oral health services for low-income seniors that was developed in collaboration with the New Mexico Health and Environment Department and the Albuquerque/Bernalillo County Office of Senior Affairs; and to the West Virginia University School of Dentistry (UWVSD), Department of Community Dentistry, for its "Oral Care for the Dependent Patient" program, an educational videotape developed in cooperation with the UWVSD Dental Hygiene, Geriatric and Biomedical Communication Departments that promotes the concept that the maintenance of oral health is not optional, but rather, is an essential element of basic quality care for medically and physically compromised patients.

National Fluoridation Award: The National Fluoridation Award for Outstanding Achievement in Water Fluoridation honored two fluoridation initiatives in April 1992 during the National Oral Health Conference. Plaques of recognition were presented to Dr. Donald Crow, Texas state dental director, honoring the accomplishments of the Texas Department of Health to fluoridate the largest number of consecutive water systems in that state during 1991. In addition, a plaque of recognition was presented to members of the Snohomish County, Washington "Citizens for Better Oral Health" for their efforts in bringing the benefits of water fluoridation to over 350,000 citizens residing in the Everett, Washington area. The National Fluoridation Award is sponsored by the Centers for Disease Control, in cooperation with the American Dental Association and the Association of State and Territorial Dental Directors. This annual award will continue to be presented during this National Conference to recognize the efforts of states and/or individuals in promoting community water fluoridation.

Response to Assignments from the 1991 House of Delegates

Approval of Guidelines for Hospital Dental Services: Resolution 1H-1991 (*Trans.*1991:618) revised Association policy relating to hospital dental departments. The guidelines are useful in an advisory sense and are included in resource packets distributed to the communities of interest.

Rescission of Policies Related to the Hospital Dental Service Accreditation Program: Resolution 2H-1991 (*Trans.*1991:618) rescinded all Association policy related to the hospital dental service accreditation program.

Revision of Policy on Physical Examinations by Dentists: Resolution 3H-1991 (*Trans.*1991:618) revised the policy on physical examinations by dentists. Association documents relating to physical exams were revised to contain the new policy.

Revision of Policy on National Health Service Corps Scholarships: In 1991 the Council proposed a resolution to the House of Delegates that would amend existing policy regarding the National Health Service Corps Scholarship Program. In order to improve clarity and intent, the House elected to send Resolution 4-1991 (*Trans.*1991:619) back to the Council for additional work.

It is the intent of the Council to have the House of Delegates adopt policy clearly stating that the Association favors the use of federal funds for dental education loan repayment programs that would be available to dentists in return for service in underserved communities. Therefore the Council offers the following resolution for adoption by the House of Delegates:

2. Resolved, that the American Dental Association supports the use of federal funds to provide loan repayment grants to dentists in return for service in recognized underserved communities or population groups.

Approval of Policy Statement on Dental Care in Nursing Homes: Resolution 5H-1991 (*Trans.*1991:619) consolidated and revised Association policy related to dental care in nursing homes. Association documents on nursing homes were revised to contain the new policy.

Support for Healthy People 2000 Report: Resolution 108H-1991 (*Trans.*1991:618) endorsed and supported the oral health objectives contained in the U.S. Public Health Service Report "Healthy People 2000" and urged constituent and component dental societies to work with their respective state health departments toward achievement of the oral health objectives. Recognizing that this assignment requires the development of a variety of strategies and action plans for implementation at the national, state and local levels, the Council reviewed and discussed several options for involving constituent and component dental societies in this process during its January 1992 meeting. Future activities targeted to the accomplishment of these goals include the identification of opportunities for constituent and component dental society involvement with this process. The Council is prepared to provide technical assistance to state and local dental societies interested in cultivating state/local public and private partnerships in an effort to identify and promote successful model efforts. A survey of constituent and staffed component dental societies is planned for 1992, which will assist the Council in identifying state/local dental society programs that are supportive of the Year 2000 Objectives. At the national level, the Council represents the Association on several multi-agency work groups that have been charged with developing strategies to accomplish key oral health related objectives contained within the "Healthy People 2000" document.

Coalition Building: Resolution 126-1991 (*Trans.*1991:628) urged the American Dental Association to work cooperatively with all state constituent dental societies, medical societies and appropriate non-profit associations to demonstrate the Association's deep concern for issues pertaining to the disadvantaged and underserved population groups. The resolution further encouraged the Association to build the necessary coalitions to ensure that there are the funds and services necessary to make available a level of support for disadvantaged citizens who are being denied access to dental care and other essential human necessities. The Association has long been committed to addressing the oral health needs of underserved population groups. An excellent example of the Association's commitment is the Association's participation in the Caring Program, discussed earlier in this report (page 23). Coalition building is the cornerstone of this activity, because the success of the Caring Program depends on the collaboration of state dental societies, corporate sponsors and charitable organizations.

Additionally, as discussed earlier in this report (page 23), the Council has liaison responsibility with a number of advocacy organizations to build coalitions to promote oral health awareness among their membership. The Council continues to support the Association's commitment to increasing access to dental care for underserved population groups by, among other things, building coalitions.

Summary of Resolutions

New Policy/Directive:

2. Resolved, that the American Dental Association supports the use of federal funds to provide loan repayment grants to dentists in return for service in recognized underserved communities or population groups.

Amendment/Rescission of Current Policy:

1. Resolved, that the Association's current Policy and Recommendations regarding Tobacco (*Trans.*1988:489; 1990:533) be amended by the addition of a new paragraph 7 to read as follows.

7. The American Dental Association urges its members to become fully informed about tobacco cessation intervention techniques to effectively educate their patients to overcome their addiction to tobacco. This information should include techniques for primary prevention of tobacco use.

and be it further
Resolved, that the current paragraph 7 be renumbered paragraph 8.

Council on Dental Care Programs

Kirchner, George A., Pennsylvania, 1992, chairman
Geraci, Timothy F., California, 1993, vice chairman
Corns, Alan E., Indiana, 1995
Craddock, Patricia S., Nevada, 1995
Dubowsky, Scott M., New Jersey, 1992
Duncan, Terry L., Kansas, 1994
Georges, Ramon P., Illinois, 1993
LaCoste, Roger R., Massachusetts, 1992
Lippert, Jacob J., Missouri, 1993
McCaslin, Alston J., V., Georgia, 1995
McClure, G. Jerry, Texas, 1993
Pudwill, Myron L., Nebraska, 1994
Schutze, H. John, New York, 1994
Straka, Edward A., Jr., Oregon, 1992
Tankersley, Ron L., Virginia, 1994
Woolley, Carl T., Michigan, 1995
Feldman, Marye C., director
Hoffmann, Rita M., manager
Narcisi, Jean P., manager
Todd, Kathleen M., manager, Contract Analysis Service

Meetings: The Council met on December 13-15, 1991 and April 10-12, 1992. The Council's liaison from the Board of Trustees, Dr. Richard D'Eustachio, trustee, Fourth District, attended the December 1991 and the April 1992 Council meetings.

The Chairman appointed three subcommittees of the Council to focus on major areas of activity. These subcommittees met as follows:

Purchaser Information Service	January 24-25, 1992
Third-Party Issues	February 7-8, 1992
Peer Review	February 21-22, 1992

Representatives of the American Association of Dental Consultants, American Association of Preferred Provider Organizations, Blue Cross and Blue Shield Association, the Health Insurance Association of America and the National Association of Prepaid Dental Plans met with the Council on April 10, 1992.

The Council also met with representatives of national dental organizations on April 10, 1992. In attendance were representatives of the Academy of General Dentistry, American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons and the American Association of Public Health Dentists.

Personnel: At the December 1991 meeting, the Council elected Dr. Timothy F. Geraci as vice-chairman for the 1991-92 year.

The close of the 1992 annual session brings to an end the terms of four valued members of the Council: Dr. George A. Kirchner, who has served as chairman of the Council for 1991-92, Dr. Scott M. Dubowsky, Dr. Roger R. LaCoste and Dr. Edward A. Straka, Jr. These members have made great contributions to the work of the Council and have given unselfishly of their time and energy on behalf of the profession. Their efforts are acknowledged by the Council with great appreciation.

Future Conference: The Council has approved a format for the next Dental Benefits Conference scheduled for July 1993.

Federal Programs: The Council continues to monitor the dental component of the Medicaid and Medicare programs and of the Military Dependents Dental Plan. With respect to the Council's efforts in Medicaid, the annual survey of constituent dental societies and state Medicaid agencies will be conducted again in 1993, and every other year thereafter, to comply with budget cuts. The results of this survey will include information for fiscal year 1992. The 1991 survey was divided into four sections targeting dental expenditures under the program, available dental services, program administration and Medicaid dental providers. The report of the survey of the dental component of state Medicaid programs is available from the Council upon request.

The results of the 1991 survey indicate that in 42 states dental benefits are available to all eligible beneficiaries of Medicaid, adults and children; in eight states and the District of Columbia, dental benefits are offered only to children under the Early and Periodic Screening, Diagnosis and Treatment program. Of the 42 states which provide dental benefits to adults, eight limit these benefits to emergency care, denture services or both.

According to survey results, nearly $712 million was spent on dental claims under the Medicaid Program in fiscal year 1990. This represents a $66 million increase from fiscal 1989. Using a total of 44 state responses, there are approximately 77,500 dentists enrolled as providers in the Medicaid program. This figure represents the fourth consecutive increase since fiscal year 1987.

Pending legislation is addressed in detail in the annual report of the Council on Governmental Affairs and Federal Dental Services.

Health Maintenance Organizations (HMOs): The Council continues to monitor the status and progress of the dental component of the HMO industry. The Council has compiled

data from various sources to create an informational package of HMOs that offer some level of dental services as part of their programs.

According to data available as of January 1992, there were a total of 483 HMOs that had a total of 33 million enrollees. Approximately three-fourths, or 371, of those HMOs are federally qualified while the remainder are Competitive Medical Plans (CMPs). An additional 12 HMO and four CMP applications are pending.

Of the total respondents to a recent survey conducted by the Group Health Association of America, 86% of HMOs with plans over three years old cover dental/accidental injury. Forty percent of those plans cover dental/accidental injury without limits or copayments. Forty-three percent of the respondents' plans cover temporomandibular joint treatment, 23% cover preventive dental care and 13% cover restorative dental care. Eighty-five percent of self-funded plans offer a dental component to their HMOs.

Purchaser Information Service: This Service continues to be the authority and primary resource for plan sponsors and patients in need of dental benefit plan information. The main activities of the Service are to promote direct reimbursement and other dental benefits plan models in accordance with the policies of the American Dental Association, to increase the number of individuals covered by a dental benefits plan and to improve currently existing dental benefits plans where the level of benefits and extent of coverage is less than optimal.

To best assist patients in understanding their dental plan coverage and options, the Council has combined its patient resources into one revised brochure, *Understanding Your Dental Benefit Plan*. This brochure is available through the Association's Department of Salable Materials.

To most effectively reach plan sponsors, the Service disseminates information to the press (and subsequently to the public) through its Dental Benefits Databook. The Databook is a three-ring binder that contains fact sheets about such topics as The Difference Between Dental Care and Medical Care and Policies on Dental Care Programs, and it also contains press releases about the activities of the Council and dental plan issues. It serves as a vehicle for press releases as well as a permanent reference for editors and reporters who need information about topics relating to dental care programs. Installments are sent, on a regular basis, to over 50 popular press and human resource trade publications.

In the past year, as a result of the Databook, articles on direct reimbursement, the Purchaser Information Service, as well as the Association's perspective on dental benefit issues in a broader benefits article, have been printed in the following publications:

—April 1992, *Employee Benefit News*
—April 1992, *Risk & Insurance*
—March 1992, *Medical Benefits*
—February 1992, *Business & Health*
—February 1992, *Managed Healthcare News*
—February 1992, *Business & Insurance*
—February 1992, *Key* (a publication of the Auxiliary to the American Dental Association)
—January 1992, *Small Business Reports*
—January 1992, *Employee Benefit Plan Review*
—November 1991, *The American School Board Journal*
—October 1991, *ADA News*
—October 1991, *Business & Health*
—September 1991, *Association Management*
—September 1991, *Employee Benefit News*
—August 1991, *American School & University*
—June 1991, *The Fact Finder*

The Council promotes the information and services of the Purchaser Information Service by well-placed advertisements in national benefits publications including: *Business & Health; Employee Benefit News, Inc.; The American School Board Journal; HR (Human Resource) Magazine; Hospitals; Personnel Journal; and Employee Benefit Plan Review*. Employer responses to these ads have been the source of 31% of the Purchaser Information Service requests for information.

Employers and other plan sponsors who contact the Service receive information on direct reimbursement and other fee-for-service, freedom of choice dental plans as well as information about alternative dental plan concepts. The Council has recently completed a guide for employers, which discusses the issues in dental plan design. The guide will be available to employers through the Purchaser Information Service.

Since October 1991, a total of 1,270 employers have requested direct reimbursement and dental benefit information from the Purchaser Information Service. Based on responses to a follow-up survey sent to those who requested direct reimbursement materials, over 25% of those responding have adopted a direct reimbursement dental plan in the past year and an additional 35% are strongly considering the direct reimbursement option.

For the past five years, the Council has provided actuarial cost estimates to companies interested in implementing a direct reimbursement plan. These estimates have often been the convincing factor for companies in choosing a dental plan. One-third of those groups requesting a cost estimate have actually implemented a direct reimbursement plan with a majority of the remaining groups considering a plan for the future.

Staff of state and local dental societies who were trained on the actuarial formula continue to provide estimates to purchasers in their respective areas along with Association staff providing estimates at a national level. This broad network of expertise has greatly increased the turnaround time of cost estimates to purchasers and has enabled the Purchaser Information Service to furnish estimates to more employers.

In 1991-92, the Council again offered an incentive program to encourage direct reimbursement campaigns and other purchaser contact efforts at the constituent and component dental society levels. This project was first undertaken in 1987 with a project fund being set aside to assist in the costs of relevant projects. There are guidelines established by the Council that enable a dental society to obtain up to $3,000 in assistance by submitting a detailed plan and budget where the society itself contributes at least two-thirds of the cost of the program.

In the last year, incentive funds have been provided to projects sponsored by the Kansas Dental Association, the New Mexico Dental Association, the San Joaquin Dental Society (California), the California Dental Association, the Maryland State Dental Association and the Utah Dental Association. The societies provide updates on the status of the programs to the Council.

Most dental societies have the dual goals of promoting quality

dental benefits and educating the membership on dental plan models. Education of the membership is also a goal of the Council. For this reason, the Council, through its Purchaser Information Service Subcommittee, developed a 25-minute videotape for dental students entitled "Dental Benefits Delivery Systems: Third-Party Payment."

The videotape was sent to every state dental society and every dental school in the country. Students now have access to information they will need after they graduate and begin to make decisions regarding their relationship with third-party payers. Dental schools are aware that Council members are available to speak to dental classes and discuss the issues covered in the videotape.

A second videotape is currently being developed. This videotape will track the "life" of a dental claim, so that members can learn more about topics such as predetermination, explanations of benefits, waiver of copayment, electronic claims, assignment of benefits and utilization review. The video will be completed in late 1992.

The Council has taken Guidelines on the Coordination of Benefits, adopted by the 1991 House of Delegates (*Trans.* 1991:635), to the National Association of Insurance Commissioners (NAIC) for incorporation into its model legislation. The NAIC has placed the topic on its 1993 agenda. The Service also presents information on coordination of benefits and other issues to plan sponsors.

Exhibiting resource materials, services and information at human resources and benefits conventions continues to be an important activity for the Council. An additional exhibit booth was purchased this year to keep up with the demand from constituent and component dental societies who use the Council booths to exhibit at state and local shows. In the past year, a number of constituent or component societies have used these booths at a total of 19 meetings of dentists or employers.

Additionally, the Council has exhibited dental benefits information and encouraged the adoption of dental benefits plans at the following annual exhibitions or conventions: the Annual Session of the American Dental Association, the Society of Human Resource Executives, the American Management Association, the American Association of School Administrators, the National School Boards Association, the American Hospital Association and *Personnel Magazine*'s Best of America.

Pre-show mailings and targeted advertising alert convention attendees to the presence of the Purchaser Information Service at these shows and allow the attendees to seek out the Council's booth for information and materials.

In addition to talking to convention attendees, Council members and staff have given presentations at numerous meetings of interested employers and benefits managers such as personnel conventions, employer luncheons hosted by dental societies, and Chamber of Commerce and service club meetings. These presentations emphasize the differences between dental and medical care and payment which result in differences in effective techniques to "manage" that care and cost. They explain the ramifications of some of the more common, troublesome exclusions and limitations placed on dental programs under the guise of cost-containment.

Employers sometimes wish to make changes in coverage for an already-existing plan or wish to know if their plan is in keeping with Association policy. For this reason, the Council reviews dental plans for employers, commenting on plan language as well as on the scope and level of coverage as it relates to Association information and policy. These plan reviews have resulted in continued or improved dental benefits for major employers including Baxter International Corporation and Armstrong World Industries.

One of the recurring issues in plan design is the exclusion coverage for treatment identified by the plan administrator as "experimental." The Council is concerned with the potential for arbitrary designations of treatment as "experimental." Because dental technology is an evolving field, procedures that were once "experimental," may now be a professionally accepted standard procedure. Identification of this professional acceptance should be in the hands of the profession. For this reason the Council recommends adoption of the following resolution:

3. Resolved, that the appropriate agencies of the Association study the feasibility of establishing a technological assessment process within the American Dental Association that would qualify dental procedures as "experimental" or "non-experimental" and report their findings back to the 1993 House of Delegates.

Individual Practice Associations (IPAs): One of the trends in cost-containment of medical plans is for a large company or a coalition of companies to contract directly with a group of providers to offer care (physician, hospital or dental) to its patient base. The Council continues to monitor the extent to which this phenomenon will spread into the dental benefit arena. To gather information on this area, the Council has revised its guidelines for the Association's Contract Analysis Service, on a provisional basis, to permit the Service to analyze contracts offered by a group purchaser to a dentist or group of dentists. If the concept of direct provider contracting becomes significant in dentistry, the Council will consider recommending expansion of its role in the encouragement of state or local dental society-sponsored IPAs. The Council currently provides copies of its booklet on developing an IPA at no charge to requesting dental societies and employers.

"Current Dental Terminology," Second Edition, (CDT-2): The 1995 code revision process began in January 1992 with a meeting of the Council's Advisory Committee on the *Code on Dental Procedures and Nomenclature*.

This first meeting of the Advisory Committee was both informational and educational. Issues and topics that are important to the 1995 code revision process were discussed, including: Resolution 74H-1990 (*Trans.*1990:542), which directed consideration of development of diagnostic codes to establish and define dental disease classifications; and Resolution 50H-1991 (*Trans.*1991:640), which directed the Council to revise its Guidelines to Changes to the Code to include compliance with state and federal regulations and to compile all available data to determine what impact compliance with state and federal regulations relating to infection control, OSHA, etc., is having on the cost of practicing dentistry.

The Advisory Committee received presentations on the guidelines from the Centers for Disease Control, the new OSHA regulations, the Americans With Disabilities Act, electronic data interchange (EDI), condition of the oral cavity and diagnostic coding.

The deadline for requests for new codes from the state dental

societies, national dental organizations and third-party payers is September 1, 1992.

As part of the Association's *Code* activities the Council reaches out to other major coding systems, including attendance at the ICD-9-CM Coordination and Maintenance Committee meetings and representation on the American Medical Association's Current Procedural Terminology Advisory Committee.

The Health Care Financing Administration's (HCFA) Common Procedural Coding System has adopted the ADA's *Code*, 1990 and is completing its code update project. HCFA has notified state Medicaid programs that it is using the 1990 version of the ADA's *Code* and many of the state Medicaid agencies are now working with the Council to bring the state Medicaid programs coding up to date.

The Council was informed that the Blue Cross and Blue Shield Plans are switching over to the Association's *CDT-1*.

Electronic Claims Processing: The Council has continued to monitor the growth of electronic claims processing and participated in the March 1992 meeting of the Dental Electronic Technology Advisory Group (DETAG). The Council's staff has worked with the American National Standards Institute X12n subcommittee which is charged with the responsibility of developing standards for claims submission, eligibility, enrollment and claims payment.

The Council, along with the Council on Dental Practice (CDP), jointly conducted a work group called DETAG. A joint report and accompanying resolutions are being submitted by the Council and CDP separate from each Council's annual report (see page 49).

As reported to the House in 1991 (*Reports* 1991:61), the Council has worked with vendors of electronic claims processing software to try and ensure that the programs members purchase contain the most recent version of the ADA's Dental Claim Form and *Code*. This has been accomplished by offering a Licensing Agreement for purchase by software vendors. Members are encouraged to look for the ADA's License Agreement number on programs they are considering for their offices.

Peer Review: The Council continues to monitor the status of the Data Bank and reviewed the Association's decision to appeal the Court's ruling that Data Bank regulations are consistent with the language and purpose of the Health Care Quality Improvement Act. This judgment indicates that fee refunds are reportable to the Data Bank if they are made in response to a written request. Information has been distributed to state dental societies indicating that the "interim" agreement, which the Association has worked out with the Health Resources and Services Administration is still in effect.

The Council also reviewed the possibility of the Data Bank establishing a threshold below which no payments would be reportable. The ADA and other associations are lobbying for a reportable floor.

The Council reviewed the statistics compiled from the 1991 National Peer Review Reporting System survey. The Council noted with interest that even with fewer states reporting, there was a greater number of peer review cases nationwide. Also, the average turnaround time for peer review cases has decreased over the past few years.

The Council discussed the current program schedule for the 1992 peer review assistance programs. The programs conducted at the time of this report include a combined program for New Hampshire/Vermont, Texas and Wyoming. A program is scheduled for Louisiana in June 1992. Priority for peer review assistance workshops will be given to those states that reinstate their peer review programs. The nine constituent societies suspended peer review due to the regulations imposed by the Data Bank: Alabama, Arkansas, Arizona, Connecticut, District of Columbia, Kansas, Louisiana, Oklahoma and Utah. However, in the past year Connecticut and Alabama have reinstated their peer review programs, and as of this writing, Louisiana is in the process of reinstating its peer review program.

The Council reviewed the proposal for the Association-sponsored regional mediation workshops in 1992. The Council has arranged for two professional mediators to conduct two workshops. The first workshop will be in Washington, D.C. in June 1992, and the second will be at Association Headquarters in November 1992.

Several states have sought alternative funding sources for their own mediation programs. The Council directed staff to review this alternative funding source for future ADA-sponsored programs.

As part of the revision of peer review resource materials, the Council also developed guidelines for resolving dentist-to-dentist consultant complaints for inclusion in the Peer Review Manual. The guidelines read as follows:

Sequence for Resolution of Dentist-to-Dentist Consultant Disputes

1) The treating dentist should review the records of the patient.
2) The treating dentist should submit a letter to the chief dental consultant of the third party requesting a review of the claim.
3) The treating dentist should file a complaint with the constituent society's Council on Dental Care Programs using the Claim Resolution Form or other appropriate report.
4) The treating dentist should submit the case to dental society peer review either in his/her own state, or, in those constituents where peer review is not available, the case should be submitted to the constituent of record of the dentist consultant.

The Council also reviewed and recommended revisions to the following peer review materials:

—the National Peer Review Reporting Form;
—the brochure, *Peer Review: Communication is the Key*; and
—the manual, *Peer Review in Focus*.

Changes are necessary to these materials to conform to changes in Association policy as well as federal regulations.

Current peer review policy includes guidelines for handling third-party cases for review, but not for dentist-to-dentist (or in the case of a third-party review, dentist-to-dentist consultant) complaints. The Council established the need for the above stated criteria for handling dentist-to-dentist (dentist consultant) complaints and felt that the Association should have

specific policy regarding this matter. Therefore, the Council recommends adoption of the following resolution:

4. Resolved, that disputes concerning dental treatment provided under dental benefits programs be referred to the treating dentist's constituent dental society peer review process, and be it further

Resolved, that in those constituents where peer review is not available, the review should be conducted by the peer review committee based in the third-party payer's and/or the dentist consultant's state of record.

Third-Party Issues: The Council reviewed the issue of hold harmless clauses. The Association had been contacted by two state dental societies asking for assistance in addressing this problem. The complaints have stemmed from dentists who have received letters from payers stating that the insurance company/payer will defend and indemnify the patient if the doctor attempts to collect the difference between the full fee and the amount reimbursed by the insurer.

To help curb this problem, the Council recommended that members need to be informed that, before treatment is begun, they should obtain written agreements from their patients that the patient will pay the dentist's full fee regardless of any third-party reimbursement amount.

The Council also offered assistance to state societies to meet with plan purchasers and negotiate the possibility of obtaining voluntary agreement to stop using the clause in their contracts with the employers.

The Council also developed a letter for use by state societies which will explain the hold harmless issue and how to prevent interference through appropriate communication. The letter will also suggest that state societies publish articles in their respective journals regarding the issue.

The Council is fully committed to building a data base of third-party problems through its Claims Resolution pilot project which involves ten states. The Council reviewed the information received from the state societies involved in the pilot project. Some of the states were not actively participating and have hesitated, for various reasons, to initiate the program. Although the ten states involved had agreed to send staff to participate in the pilot, they have been reluctant to follow through with the program because of monetary, staff and time limitations. The Council recommended that the pilot project test period be extended to July 1993 instead of July 1992 in order to provide the Council with an adequate amount of data to evaluate.

The Council continues to monitor fraud and abuse among government agencies, private insurance carriers and health care providers. It maintains a liaison relationship with the National Health Care Anti-Fraud Association. Although fraud among third-party carriers and health care providers continues to be a concern, these issues remain relatively insignificant for dentistry.

Utilization Review Organizations: In its annual report to the 1991 House of Delegates (*Reports* 1991:62), the Council stated that it had found utilization review agencies represented a rapidly growing new industry in the health care field and that this industry is largely unregulated.

The major bills being considered by the Congress as possible solutions to the country's health care problems include sweeping protection for the concepts of managed care and utilization review. The federal proposals include provisions to pre-empt state laws that hinder utilization review. The Council believes that utilization review is being treated by legislators and business leaders as an inseparable part of managed care. In fact, utilization review and managed care are both administrative processes and should not be included in the debate on health care reform measures.

The Association, through its Washington Office, has expressed its concern on this issue to the appropriate sponsors of health care legislation.

Most dental utilization review conducted by third-party payers is statistically based. Its purpose is to identify what the insurance industry calls "over utilization." Unfortunately, this has the effect of challenging treatment decisions based on cost and not on the dental needs of patients.

Currently, most utilization review agencies are not regulated and those states that do regulate them do not do so based on standards that would establish qualifications for those who perform utilization review. Without regulation based on uniform, professional standards, utilization review will challenge state medical and dental practice acts in determining who can practice medicine and dentistry.

Unregulated utilization review agencies will encourage the practice of medicine and dentistry by unlicensed and unqualified individuals where the only intent is to cut costs. Any one of the major proposals before Congress, if passed into law with utilization review protection intact, could have the effect of putting a federal stamp of approval on removing the final treatment decision regarding patient care from the only people qualified to give it.

The Council does not believe that the minimum national standards proposed by the Utilization Review Accreditation Commission (URAC), sponsored by the American Managed Care and Review Association, are anywhere near sufficient. URAC's process does not include on-site review but consists of a paper application and review process for which the applicant pays a $9,500 fee. While the paper review process may be very thorough, the Council does not believe it to be complete. Nor does the Council believe that accreditation of utilization review organizations should be a voluntary activity.

For all of the above reasons, the Council recommends that the following Guidelines on Professional Standards for Utilization Review Organizations be adopted:

Guidelines on Professional Standards for Utilization Review Organizations

Utilization review is a rapidly growing new industry that has yet to prove its effectiveness in containing costs without harming patient care. Because utilization review has the effect of influencing benefit plan design based on least costly procedures rather than positive treatment outcomes, the Association believes that utilization review organizations should be licensed by the appropriate state agency. The Association also believes that compliance with professional standards for licensing should not be voluntary.

In the interest of assuring that where utilization review programs exist, they should be conducted as efficiently and effectively as possible and there should be minimal disruption to the delivery of health care. The following guidelines are recommended to achieve uniformity in the structure and operation of utilization review programs:

1. Utilization review organizations (UROs) should be financially solvent and in compliance with applicable federal and state laws. While utilization review programs may play an important role in promoting an efficient distribution of health care resources, the decision as to what health care treatment an individual patient actually receives must remain the prerogative of the practitioner and his/her patient or the patient's representative.
2. All incentives, financial and otherwise, for practitioners, hospitals and third-party payers to manipulate the provision of treatment to patients should not, in any manner or form, be a part of the utilization review process and should be eliminated from all existing programs.
3. Utilization review organizations should be legally responsible and liable for any adverse outcomes based on their treatment decisions.
4. Staff should be properly licensed, trained, qualified and supervised. Physicians, dentists and other health professionals conducting reviews of health care services, and other clinical reviewers conducting specialized reviews in their area of specialty, should be currently licensed or certified by an approved state licensing agency.
5. In conducting utilization reviews, only the information necessary to certify a procedure, treatment, admission or length of stay should be collected. Data requirements should be limited to the following elements:

Patient Information
Name
Address
Date of Birth
Sex
SS Number or Patient ID Number
Name of Payer(s) or Plan
Plan ID Number

Enrollee Information
Name
Address
SS Number or Employee ID Number
Relation to Patient
Employer
Health Benefit Plan
Group Number/Plan ID Number
Other Coverages Available (including Workers Comp, Auto, CHAMPUS, Medicare, etc.)

Attending Practitioner Information
Name
Address
Phone Numbers
Degree
Specialty/Certification Status
Tax ID or SS Number

Diagnosis/Treatment Information
Diagnoses
Proposed Procedure(s) or Treatment(s) (with associated CDT, CPT or ICD codes if available)
Proposed Procedure Date(s), Admission Date(s) or Length of Stay

Clinical/Treatment Information
Sufficient for support of appropriateness and level of service proposed
Contact person for detailed clinical information

Facility Information
Type (such as office/clinic, inpatient, outpatient, special unit, SNF, rehab)
Status (licensure/certification status, etc.)
Name
Address
Phone Number
Tax ID or Other ID Number

Concurrent (Continued Stay) Review Information
Additional Days/Services/Procedures Proposed
Reasons for Extensions (including clinical information sufficient for support of appropriateness and level of service proposed)
Diagnoses (same/changed)

For Admissions to Facilities Other than Acute Medical/Surgical Hospitals
Additional information:
History of Present Illness
Patient Treatment Plan and Goals
Prognosis
Staff Qualifications
24 Hour Availability of Staff

For Special Situations
Additional information necessary for the treatment of the patient's condition such as discharge planning or catastrophic case management

6. Written procedures should be in place to assure that reviews are conducted in a timely manner.
   a. Certification determinations should be made within two working days of receipt of the necessary information on a proposed service or admission requiring a review determination.
   b. Protocol for review of emergency care must be clearly defined.
   c. Ongoing inpatient stays may be reviewed, but routine daily reviews should not be conducted on all such stays.
   d. The same procedural codes, code modifiers and a common practitioner tax ID number to assist practitioners in dealing with multiple health benefit plans in their service areas should be used.
   e. Health care providers, patients and their representatives should be informed of URO policies relating to denial of claims based on lack of or failure to provide necessary information for review.
7. Procedures should be adopted for appeals of determinations not to certify an admission, procedure, service or extension of stay. The right to appeal should be available to the patient or enrollee and to the attending practitioner. If the determination is denied after review by the UROs' appropriate practitioner advisor, the patient, enrollee or attending practitioner should have the right to a review by another medical consultant or peer review body.

8. There should be written procedures for assuring that patient information obtained during the process of utilization review will be:

   a. kept confidential in accordance with applicable federal and state laws;
   b. used solely for the purposes of utilization review, quality assurance, discharge planning and catastrophic case management; and
   c. shared with only those agencies who have authority to receive such information.

5. Resolved, that the Guidelines on Professional Standards for Utilization Review Organizations (UROs) be adopted as policy of the American Dental Association, and be it further
Resolved, that organizations who subcontract to provide utilization review services for licensed UROs must be equally licensed and meet the same standard as the contracting UROs, and be it further
Resolved, that the appropriate Association agencies seek federal legislative or regulatory actions to have these Guidelines integrated into laws, rules and regulations governing utilization review organizations and their activities.

Third-Party Liaison Activity: The Council maintains continual liaison with the dental benefits industry through its representation to national carrier associations as well as direct dialogue with representatives of individual carriers, service corporations and other third-party payers.

Council representatives to these associations are: Health Insurance Association of America, Dr. Scott M. Dubowsky; Delta Dental Plans Association, Dr. George A. Kirchner; Blue Cross and Blue Shield Association, Dr. Ramon P. Georges; National Healthcare Anti-Fraud Association, Dr. Scott M. Dubowsky; Self Insurance Institute of America, Dr. G. Jerry McClure; International Classification of Diseases (ICD-9), Dr. George A. Kirchner; Group Health Association of America, Dr. Edward A. Straka; National Association of Prepaid Dental Plans, Dr. Ron L. Tankersley; American Association of Preferred Provider Organizations, Dr. Ramon P. Georges; American Association of Dental Consultants, Dr. George A. Kirchner; and National Association of Insurance Commissioners, Dr. G. Jerry McClure.

Council representatives frequently attend, and give presentations to, carrier meetings and conferences. Among others, council members attended the annual meeting of Delta Dental Plans Association and were featured speakers at annual meetings of the Dental Insurance Consultants, Inc., the American Association of Dental Consultants and the California Association of Prepaid Dental Plans.

Contract Analysis Service: As of December 1991, the Contract Analysis Service had eliminated the backlog of requests for contract analyses from constituent and component dental societies. A backlog of 30 requests from individual members remained. The demand for analyses is growing. The Service currently receives about 30 requests per month or more than one request per working day. This is up from an average of 24 requests per month in 1991. The Service continues to give first priority to requests from state and local dental societies. Approximately two-thirds of all requests fall in this category. The remaining requests are from individual members.

Reacting to recent litigation, dental benefit organizations have increased their efforts to screen applicants for participating dentist status. Cases against managed care organizations involving negligent selection of participating providers date back to the late 1980s. However, the immediate impetus for dental benefit organizations is probably the lawsuits brought by Kimberly Bergalis and others against Cigna Dental Health of Florida, Inc. alleging, among other things, that Cigna was negligent in failing to properly credential Dr. David Acer to participate in Cigna's preferred provider organization. Examples of questions that have recently appeared on applications for participating dentist status are:

—Have you ever been reported to the National Practitioner Data Bank?
—Do you, or any member of your staff, have an infectious disease that would interfere with your ability to provide patient care?
—Do you comply with OSHA?

In its analyses, the Service points out to dentists the legal implications for them of answering questions like these.

Recommendations for Policy Revisions: Reviewing policies is an integral part of the Council's work each year. The following policies have been identified for recommended action.

Statement on Preventive Coverage in Dental Benefits Plans. The Council currently has policy on the recommended language for third parties to use when limiting benefits for certain services to twice in a calendar year. However, there is no Association policy recommending that specific preventive services such as examinations and prophylaxes be covered at least twice a year. Since recent articles have created considerable confusion among plan purchasers as to whether preventive care should be covered more than once a year, the Council agreed that the following proposed policy, which combines the current Statement on Preventive Coverage in Dental Benefit Plans with a Benefits Frequency Limitations policy, should be submitted to the House. Therefore, the Council recommends adoption of the following resolution:

6. Resolved, that preventive dentistry refers to the procedures in dental practice and health programs which aid in the prevention of oral diseases, and be it further
Resolved, that the American Dental Association recognizes the importance of implementing preventive oral health practices as a means of affording optimal oral health to all individuals, and be it further
Resolved, that the ADA urges third-party payers to include the following preventive procedures as covered services:

—prophylaxis (at least twice in a calendar [contract] year);
—topical fluoride applications (at least twice in a calendar [contract] year);
—application of pit and fissure sealants;
—fixed and removable space maintainers;
—construction of mouth protectors for use in contact sports;
—prescription or use of supplemental dietary or topical fluoride for home use; and
—in-office patient education, i.e., oral hygiene instruction and dietary counseling, with regard to the promotion of good oral health (at least twice in a calendar [contract] year).

and be it further
Resolved, that the Council on Dental Care Programs continue to recommend to insurance firms, service plans, prospective purchasers and policyholders that, where considered necessary and appropriate, contract limitations on frequency of providing benefits for certain services be stated as "twice in a calendar (or contract) year" rather than "once in every six months," and be it further
Resolved, that the Statement on Preventive Coverage in Dental Benefits Plans (*Trans.*1991:631) be rescinded.*

Preauthorization of Benefits. The Association currently has policy opposing the denial or reduction of dental benefits solely on the basis of a lack of preauthorization of the treatment plan (*Trans.*1990:539). The Council felt that opposition might lead members to feel that they should not or do not have to comply with a request for predetermination from a plan administrator. However, recent court decisions have indicated that, if such a provision is clearly in a contract, the plan has the right to deny or reduce benefits for failure to submit a predetermination. Therefore, the Council agreed to clarify this policy by specifying that the Association's opposition is to the inclusion of such a clause and that policy should not oppose its legal enforcement in the event such a clause is clearly specified in the contract. Therefore, the Council recommends adoption of the following resolution:

7. Resolved, that the American Dental Association is opposed to any dental benefit clause that would deny or reduce payment to the beneficiary, to which he/she is normally entitled, solely on the basis of lack of preauthorization, and be it further
Resolved, that Resolution 14H-1990 (*Trans.*1990:539), Preauthorization Requirements, be rescinded.*

Dental Benefits for Federal Employees. The Council reviewed the policy on Dental Benefits for Federal Employees developed in response to HR6077 (*Trans.*1980:582), and it agreed that the language of the policy was outdated and its purpose unclear. That policy, which was developed in 1980 (*Trans.*1980:582) and revised in 1986 (*Trans.*1986:530) to include direct reimbursement and exclude payment to hygienists, encourages legislation enabling the purchase of stand-alone dental plans as a benefit for federal employees.

Federal employees do not currently have the option of stand-alone dental coverage. Some receive coverage through their medical plan. For example, the Blue Cross and Blue Shield Association's standard medical package includes a minimal schedule of benefits for dental procedures such as prophylaxes and fillings in order to encourage enrollment in the standard plan instead of the richer medical plan coverage. Most federal employees are eligible for dental benefits as part of their union benefits. Apparently, a federal employee can join any federal union (e.g., an IRS employee can buy an associate membership in the Postal Workers' Union) and be eligible for that union's benefits. As a result, government unions could not oppose dental benefit legislation, but would not actively support it since employees would lose a major incentive for becoming union members.

After consultation with the Washington Office, the Council decided that the policy should remain in place, with the only changes being those to bring the language and references of the policy up-to-date. Therefore, the Council recommends adoption of the following resolution:

8. Resolved, that in recognizing that federal employees may receive employment benefits that are comparable to those received by employees in private industry, the American Dental Association supports legislation authorizing the purchase of comprehensive dental benefits from private sources or the funding of direct reimbursement dental benefits for federal employees, and be it further
Resolved, that in dealing with such authorizing legislation the appropriate agencies of the Association be instructed to apply the policies contained in the Statement on Dental Benefit Plans (*Trans.*1988:481) and Standards for Dental Benefit Plans (*Trans.*1989:547), and be it further
Resolved, that direct payments from these programs be made only to employees or their attending dentists, and be it further
Resolved, that the policy on Dental Benefits for Federal Employees (*Trans.*1980:582; 1986:530) be rescinded.*

Dentistry's Position in a National Health Program. The policy entitled Guidelines for Dentistry's Position in a National Health Program (*Trans.*1979:624) was withheld from the Council's 1991 revision process because of the work of the Association's Task Force on Access, Health Care Financing and Reform. Since the Task Force has completed its white paper and will be reporting its recommendations to the Board of Trustees the Council sees no reason for the Association to retain the Guidelines that were developed in 1979. Therefore, the Council recommends adoption of the following resolution:

9. Resolved, that the Guidelines for Dentistry's Position in a National Health Program (*Trans.*1976:908, 914; 1977: 919, 920; 1978:511; 1979:631; 1981:584, 585; 1982:528, 529; 1983:549) be rescinded.*

The Council continues to support policy which directs it to monitor proposals on national dental care programs and to oppose those sections which are contrary to Association policy (*Trans.*1978:508). However, this current policy is narrow in scope and focuses on specific plans to have been submitted to the federal government for review. In order to make it applicable to all current and future third-party proposals for national dental care programs, the Council recommends revision of this policy. Therefore, the Council recommends adoption of the following resolution:

10. Resolved, that appropriate agencies of the American Dental Association evaluate and monitor proposals for national dental care submitted by third-party payers to government agencies, and be it further
Resolved, that appropriate agencies of the American Dental Association vigorously oppose proposals for national dental care that are contrary to Association policy, and be it further
Resolved, that appropriate agencies of the American Dental Association communicate and disseminate information about these proposals to the profession, and be it further
Resolved, that Resolution 57H-1978 (*Trans.*1978:508), Evaluation and Monitoring of Proposals for Administration of Federal Dental Care Programs, be rescinded.*

*Note: As the volume of policy being proposed for rescission is significant, this report will only provide the appropriate citations. Copies of the policies to be rescinded will be provided to the House of Delegates prior to its meeting and to all other individuals upon request.

Dental Medicaid Benefits. In 1977, the House of Delegates adopted policy to seek legislation to include dental benefits under Medicaid (*Trans.*1977:912). The intent of the Association was clarified in 1989 with policy calling for this expansion of Medicaid benefits only after the Association seeks uniform benefits, adequacy of payments and voluntary practitioner participation (*Trans.*1989:561). The 1977 policy which sought coverage, without further stipulation, for all Medicaid-eligible persons, is superseded by the 1989 policy. Therefore, the Council recommends adoption of the following resolution:

11. Resolved, that Resolution 17H-1977 (*Trans.*1977:912), Dental Care in State Medicaid Programs for Indigent, be rescinded.*

Federal Dual Choice Legislation. In 1980, the House of Delegates adopted policy to seek federal legislation requiring employers to offer a fee-for-service program where Health Maintenance Organizations (HMO) or capitation programs are the only options offered (*Trans.*1980:582). This position is also stated in the Association's Guidelines for Dental Components of Health Maintenance Organizations (*Trans.*1988:476). In order to eliminate redundancy, the Council recommends adoption of the following resolution:

12. Resolved, that Resolution 21H-1980 (*Trans.*1980:582), Legislation to Require Fee-for-Service Dental Program Where HMO or Capitation Programs are Only Options, be rescinded.*

Peer Review and Third Parties. In 1975, the House of Delegates adopted policy stating that organized dentistry opposes attempts by prepayment plans to pre-empt dental society review functions (*Trans.*1975:658). This position, with stronger language regarding peer review and third parties, was affirmed in 1990 (*Trans.*1990:534). Therefore, the Council recommends adoption of the following resolution:

13. Resolved, that Resolution 21-1975-H (*Trans.*1975:658), Review of Dental Practice by the Profession, be rescinded.*

Peer Review Guidelines. In 1987, the House of Delegates adopted Guidelines on the Structure, Functions and Limitations of the Peer Review Process (*Trans.*1987:502).

During the past year, the Council has been reviewing all of the Association's peer review materials including the manual, *Peer Review in Focus,* the brochure *Peer Review: Communication is the Key* and the peer review reporting forms. In order to be consistent with current policies and revisions to materials, the Council has made revisions to the Guidelines on the Structure, Functions and Limitations of the Peer Review Process. Therefore, the Council recommends adoption of the following revised guidelines:

Guidelines on the Structure, Functions and Limitations of the Peer Review Process

The function of a peer review committee is to review matters regarding the appropriateness of care and/or quality of treatment. Peer review committees also may, acting in an advisory capacity, provide for the appropriate review of fees.

Dental societies should establish peer review committees which provide for the review of differences of opinion between a dentist and a patient, or a dentist and a third-party agency. Third-party agencies may include insurance carriers, dental service corporations, dentist consultant, administrators of health and welfare trusts, alternative benefit plans, government agencies, and employers who have implemented self-funded and self-administered dental plans.

Requests submitted by a dentist for review of treatment rendered by another dentist should be channeled to that agency, which the constituent or component society has determined should review allegations of gross or continual faulty treatment by a dentist. This could be the judicial committee or committee on ethics, or some combination thereof. It could also be the state board of dentistry.

In all instances, the peer review committee should carry out its responsibilities within a reasonable period of time that makes its efforts effective.

To guide dental societies in establishing peer review committees, consideration of the following is recommended:

Directives

1. The constituent society is responsible for establishing peer review committees.
2. The committee membership should be composed primarily of general practitioners who have the qualifications and experience to render a considered opinion as to the dental standards of the community.
3. The committee should consider problems submitted by patients, dentists and third-party agencies.
4. The committee will not review any case without access to the treatment records.
5. The committee is not vested with disciplinary authority, but should provide recommendations for remedial action where appropriate.
6. The committee should utilize standard procedures and forms in obtaining data required for adequate evaluation.
7. Constituent dental societies should develop standardized review criteria for use by peer review committees during the clinical examination stage of the peer review process.
8. The committee may not consider cases in litigation.
9. The committee should have a clearly outlined process for dealing with repeat adverse decisions against a practitioner and for handling requests for appeal.
10. Constituent societies should have appropriate liability insurance to protect all members of peer review committees, as well as the societies sponsoring the peer review activity.
11. Constituent societies should have appropriate statutory protection for immunity from liability for all members of peer review committees, the societies sponsoring the peer review activity and for confidentiality of records.

Recommendations

12. Review of problems involving practicing dentists who are not members of the dental society is encouraged.

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13. The committee should establish a policy that parties appearing before it do not have the right to be represented by an attorney.
14. Information on the purpose, function and availability of the peer review process should be communicated to dental society members, the public and other interested agencies.

The following guidelines are suggested to assist dental societies in implementing the foregoing principles.

Organization: The peer review committee should be a permanent committee of the dental society with appropriate status and liaison with related committees. It could be a freestanding committee, or subcommittee of the Committee, or Council on Dental Care Programs or other body charged with the responsibility for managing issues regarding dental benefit plans.

Composition: The committee membership should be composed primarily of general practitioners who have the qualifications and experience to render a considered opinion as to the dental standards of the community. Terms on the committee should be staggered to ensure continuity of experience. The appointment of a lay person to serve on the peer review committee is encouraged.

The committee should have specialists as resources who can be appointed if the dentist being reviewed is a specialist and requests a committee composed of like specialists. If the committee feels the need for additional expertise, other members may be appointed on an ad hoc basis.

Submission Procedures: All requests for peer review will be submitted in writing, accompanied by supporting records and other appropriate consent forms and pertinent information, to the constituent or component dental society. All parties to a peer review case should be asked to agree in writing to abide by the peer review committee's recommendation.

In cases involving a third-party payer, the payer should first have made an attempt to contact the dental office for clarification on a clerical or claim reporting problem, or to have had its dental consultant contact the dentist on issues involving professional judgment or contract interpretation.

The payer should notify the patient of a delay in payment of a claim, with further explanation that the case has been submitted for review.

Constituent dental societies are urged to cooperate in every appropriate way to resolve peer review cases in which the parties involved reside in different states or in different jurisdictions within the same state.

Mediation: The component peer review committee chairman should appoint a committee member to serve as mediator. All contacts made by the mediator should be carefully documented. The mediator submits a written report to the chairman stating only the facts of the case. The mediator will advise whether mediation was successful. The mediator's role is advisory and does not involve a clinical examination of the patient.

Review Panel: The committee chair will appoint a minimum of three members to review the case. Panel members should have the opportunity to evaluate the specifics of the case, individually conduct a clinical examination if necessary, and make final recommendations to the committee chairman reflecting the collective opinion of the panel members. Panel members must not discuss the findings amongst themselves or in any way appear to collaborate in the decision.

Communications and Recordkeeping: The chairperson of the committee shall report the decision and recommendations to all parties within 60 to 90 days from initiation of the review. While original documents and records should be returned, copies of all documents and records obtained during the review process, including the decision and any recommendations, must remain confidential and should be immediately forwarded to the constituent society executive offices. An attorney should be consulted to determine individual state provisions for retention of case records.

Appeal Mechanism: Within 30 days of receipt of a component dental society's peer review committee decision, all parties have the right to appeal, in writing, to the constituent dental society peer review committee which generally serves as the appellate body. An appeal can only be considered if it is shown that (a) proper procedure was not followed, (b) information previously unavailable at the time of review has become available or (c) the decision was perceived to have been contrary to any evidence and testimony presented. The decision of the appellate body is final within the peer review context.

Considerations for Peer Review and Dental Plans: The quality of the dental treatment provided under dental plans is the logical concern of the dental profession and questions regarding that quality are within the purview of the peer review process.

Review of the dental treatment provided under a dental plan should include a determination that the services were performed and that the treatment was appropriate and rendered in a satisfactory manner.

In the course of peer review function, specific deficiencies or problems prevalent in a particular plan may become evident. General information regarding the administrative or other aspects of the plan should be communicated, as appropriate, to the constituent society body vested with the responsibility for monitoring dental benefit plans.

14. Resolved, that the Guidelines on the Structure, Functions and Limitations of the Peer Review Process be adopted, and be it further

Resolved, that Resolution 78H-1987 (*Trans.*1987:502), Guidelines on the Structure, Functions and Limitations of the Peer Review Process, be rescinded.*

Dental Benefit Plan Terminology. The Association has adopted two policies encouraging standardization of dental plan terminology (*Trans.*1973:668; 1991:631). Both policies urge use of standard language and definitions, but the newer also

*__Note:__ As the volume of policy being proposed for rescission is significant, this report will only provide the appropriate citations. Copies of the policies to be rescinded will be provided to the House of Delegates prior to its meeting and to all other individuals upon request.

cites the Association's *Current Dental Terminology* (*CDT*) as the source for proper use. To eliminate the redundancy of two policies with the same purpose, the Council recommends adoption of the following resolution:

15. Resolved, that Resolution 32-1973-H (*Trans.*1973:668), Dental Prepayment Terms, be rescinded.*

Response to Assignments of the 1991 House of Delegates:

Least Expensive Alternative Treatment Clauses. Resolution 6H-1991 (*Trans.*1991:634) created a new policy, which has been incorporated into the Council's publication entitled *Policies on Dental Care Programs* and other materials produced by the Council.

Pre-Existing Condition Exclusion. Resolution 7H-1991 (*Trans.*1991:634) created a new policy which has been incorporated into the Council's *Policies on Dental Care Programs* and other materials produced by the Council. Further information on the legislative aspects of this resolution can be found in the annual report of the Council on Governmental Affairs and Federal Dental Services (see page 112).

Inclusion of Radiographic Examinations in Dental Benefits Programs. Resolution 8H-1991 (*Trans.*1991:634) created a new policy to replace Resolution 40H-1989 (*Trans.*1989:555) which was rescinded. The new policy has been incorporated into the Council's *Policies on Dental Care Programs* and made available to third-party payers and plan purchasers.

Age of "Child." Resolution 9H-1991 (*Trans.*1991:635) created a new policy, which has been incorporated into the Council's *Policies on Dental Care Programs* and other materials produced by the Council. Further information on the legislative aspects of this resolution can be found in the annual report of the Council on Governmental Affairs and Federal Dental Services (see page 112).

Approval of Guidelines on Coordination of Benefits. Resolution 10H-1991 (*Trans.*1991:635) created a new policy and rescinded Resolution 52H-1987 (*Trans.*1987:506) entitled Birthday Rule for Coordination of Benefits (COB). The new policy has been incorporated into the Council's *Policies on Dental Care Programs*. It has been submitted to the National Association of Insurance Commissioners for its consideration in developing new model legislation on COBs. The Guidelines have also been made available to third-party payers. Further information on the legislative aspects of this resolution can be found in the annual report of the Council on Governmental Affairs and Federal Dental Services (see page 113).

Approval of Statement on Utilization Management Review. Resolution 11H-1991 (*Trans.*1991:631) created a new policy, which has been incorporated into the Council's *Policies on Dental Care Programs* and other materials produced by the Council.

Regulation of Utilization Management Organizations. Resolution 12H-1991 (*Trans.*1991:636) created a new policy, which has been incorporated into the Council's *Policies on Dental Care Programs* and shared with the Department of State Government Affairs. Further information on the legislative aspects of this resolution can be found in the annual report of the Council on Governmental Affairs and Federal Dental Services (see page 113).

Approval of "Statement on Determination of Usual, Customary and Reasonable Fees." Resolution 13H-1991 (*Trans.*1991:631) created a new policy, which has been incorporated into the Council's *Policies on Dental Care Programs* and discussed with both the Washington Office and the Department of State Government Affairs. Further information on the legislative aspects of this resolution can be found in the annual report of the Council on Governmental Affairs and Federal Dental Services (see page 113).

Reporting of "Dental Procedures to Third Parties." Resolution 14H-1991 (*Trans.*1991:637) created a new policy to replace Resolution 59H-1986 (*Trans.*1986:515) entitled Reporting of Dental Procedures to Carriers.

ADA's Dental Claim Form. Resolution 15H-1991 (*Trans.*1991:631) created a new policy to replace Resolution 89H-1976 (*Trans.*1976:861), Uniform Acceptance of Claim Form, and Resolution 30-1973-H (*Trans.*1973:663), Use of Claim Form.

Rescission of Policies on Inclusion of Sealants in Dental Benefits Plans and Preventive Dentistry in Public and Private Dental Care Programs. Resolution 16H-1991 (*Trans.*1991:631) rescinded Resolution 92H-1982 (*Trans.*1982:527) and Resolution 51-1970-H (*Trans.*1970:485).

Approval of Revised Statement on Preventive Coverage in Dental Benefits Plans. Resolution 17H-1991 (*Trans.*1991:631) created a new policy to replace Resolution 42H-1988 (*Trans.*1988:480). The new policy has been incorporated into the Council's *Policies on Dental Care Programs* and other materials produced by the Council.

Rescission of Policy on Supporting the Concept of Cost Containment in Dental Care Programs and Delivery Systems. Resolution 18H-1991 (*Trans.*1991:631) rescinded Resolution 68H-1984 (*Trans.*1984:528) since the intent of the policy is incorporated in other Association policy.

Liaison Relationships. Resolution 19H-1991 (*Trans.*1991:638) created new policy to replace Resolution 38-1973-H (*Trans.*1973:678) entitled Third-Party Liaison and Problems. The new policy has been incorporated into the Council's *Policies on Dental Care Programs* and made available to third-party payers.

Safeguards for Medicare's Health Maintenance Organizations. Resolution 20H-1991 (*Trans.*1991:638) created new policy to replace Resolution 72H-1985 (*Trans.*1985:606). The new policy has been incorporated into the Council's *Policies on Dental Care Programs*. Further information on the legislative aspects of this resolution can be found in the annual report of the Council on Governmental Affairs and Federal Dental Services (see page 113).

Timely Payment of Dental Claims. Resolution 21H-1991 (*Trans.*1991:639) created new policy to replace Resolution 85H-1979 (*Trans.*1979:629), Reimbursement Time Limits for

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***Note:** As the volume of policy being proposed for rescission is significant, this report will only provide the appropriate citations. Copies of the policies to be rescinded will be provided to the House of Delegates prior to its meeting and to all other individuals upon request.

Federal Programs and Resolution 64H-1988 (*Trans.*1988:498), Timely Payment of Dental Benefits Carriers. The new policy has been incorporated into the Council's *Policies on Dental Care Programs* and shared with the Department of State Government Affairs. Further information on the legislative aspects of this resolution can be found in the annual report of the Council on Governmental Affairs and Federal Dental Services (see page 113).

Qualifications of Participating Dentists. Resolution 23H-1991 (*Trans.*1991:639) created a new policy to replace Resolution 38-1966-H (*Trans.*1966:347), Qualifications of Participating Dentists, as amended by Resolution 120H-1976 (*Trans.*1976:865). The new policy has been incorporated into the Council's *Policies on Dental Care Programs* and other materials produced by the Council.

Rescission of Policy on Determination of Fees. Resolution 25H-1991 (*Trans.*1991:631) rescinded Resolution 14H-1975 (*Trans.*1975:646).

Rescission of Policy on Elimination of Differentiation in Patient Benefits. Resolution 26H-1991 (*Trans.*1991:631) rescinded Resolution 34H-1977 (*Trans.*1977:912). The old policy was a duplication of existing policy.

Dental Benefit Plan Terminology. Resolution 27H-1991 (*Trans.*1991:631) has been incorporated into the Council's *Policies on Dental Care Programs* and made available to third-party payers.

Infringement on Dentists' Judgment. Resolution 28H-1991 (*Trans.*1991:631) created new policy to replace Resolution 43H-1986 (*Trans.*1986:518).

Rescission of Policy on Inclusion of Dentists in Health Legislation and Programs. Resolution 29H-1991 (*Trans.*1991:631) rescinded Resolution 44-1971-H (*Trans.*1971:524).

Procedure Code for Preparation of Dental Operatories/Disposable Supplies. The House directed the Association to collect data regarding the cost of compliance with federal and state regulations on infection control, barrier techniques, etc. Through Resolution 50H-1991 (*Trans.*1991:640), the House also directed the Council to expand the Guidelines on Changes to the *Code* to include compliance with state and federal regulations, which was accomplished by the Council at its meeting in December 1991.

Prior to the first meeting of the Council's Advisory Committee on the *Code*, the Council contacted the Advisory Committee's third-party payer representatives and requested information on increases in dental fees that might be attributed to the costs associated with compliance with the Centers for Disease Control and ADA guidelines on infection control and to the new OSHA regulations. The Blue Cross and Blue Shield Association conducted a survey of its plans and stated that dentists had raised their fees approximately 8%. The Delta Dental Plans Association's experience was the same. The figures from both organizations corresponded with those collected by the Association's Bureau of Economic and Behavioral Research, which indicate that between 1988 and 1990 dentists raised their fees between 7% to 8%.

There is no way to specifically attribute the data on increased fees to compliance with infection control and OSHA regulations. Therefore, the Council has included in its 1993 budget a recommendation to fund a comprehensive survey to determine the cost of compliance with state and federal regulations on infection control, the OSHA regulations and the Americans With Disabilities Act.

The reasons for this survey follow:

a. to inform the public and legislators precisely of the increases in the cost of dental care that are due to the compliance with new state and federal regulations;
b. to provide the insurance industry with accurate information so that these increased costs will be reflected in renegotiated contracts with plan purchasers; and
c. to identify costs associated with regulations that the Association deems inapplicable to the dental profession.

The Council has received many calls from members who were confused about the purpose of OSHA regulations. It must be emphasized that OSHA regulations are not patient-driven. OSHA's regulations speak only to the safety of health care workers, not their patients. In this regard, compliance with OSHA is considered a cost of doing business.

The Blue Cross and Blue Shield Association, the Delta Dental Plans Association and the Health Insurance Association of America have stated that they consider infection control and compliance with OSHA a cost of doing business and not a dental procedure. They will not cover separate charges for infection control.

The Association does not have a policy on whether dentists should increase their fees as a result of increased costs for infection control or on whether dentists should bill the increased costs to their patients. This is considered a business decision that dentists must make in accordance with their practice policies.

In its 1988 annual report to the House of Delegates (*Reports* 1988:48), the Council urged members to build such costs immediately into their business overhead. The Council remains adamant that dentists should not bear these costs.

Dentists who wish to charge a separate fee for infection control should do so. Some members are using the 0999 codes, although the Council has learned that this will delay the claims process. Claims with 0999 codes are automatically separated out for specific review and reimbursement is delayed accordingly.

At this time, the Council is aware of two consumer groups/patient advocates that are opposing separate charges for infection control. One group is urging patients to challenge their dentists or even to refuse paying that portion of the bill.

To assist members in making appropriate decisions for their dental practices on whether to build the increased costs into their business overhead or whether to bill patients for the full cost of infection control, the following points are provided for members' consideration:

1. If dentists choose to bill patients for the full cost of infection control it should be recognized that, while patients may not object initially, they may eventually resent the fact that they are bearing the full, financial brunt of their dentists' costs of compliance with infection control standards, the OSHA regulations and the Americans With Disabilities Act.

2. There is already concern expressed by dentists who have built the increased costs into their overhead. Customary fees are calculated by zip code so, for example, if 60% of the dentists in that geographic area have raised their fees and 40% have not, the reimbursement levels will be held down by the 40% who prefer to bill their patients separately for the full cost of infection control.
3. In keeping with good business practices, dentists should refile their fee profiles regularly, and as frequently as third-party payers permit. Through this process, third-party payers will be able to more quickly identify the increased costs associated with infection control guidelines, OSHA Standards and Americans With Disabilities Act.
4. If an infection control procedure is reported on a claim, it is likely that the rejection and the reason for the rejection will be indicated on the "explanation of benefits statement" to the patient. Dentists who elect not to include the increased costs in their office overhead, may need to explain their reasons to their patients in order to avoid any misunderstanding or negative reaction.
5. Dentists who are in contractual relationships must be careful about any restrictions concerning fees. If a contract prohibits dentists from charging patients for additional costs and/or services, then dentists will need to determine whether a separate infection control fee would be included in those restrictions.

The Council, with the assistance of the Bureau of Economic and Behavioral Research, will continue to identify and review studies conducted by outside entities relating to the directives contained in Resolution 50H-1991.

Identifying Types of Dental Plans and How They are Regulated and Controlled. Resolution 105-1991 (*Trans.*1991:641) was referred to the Council by the House of Delegates. The resolution directed the Council to study the issue of providing members with steps involved in pursuing a claim; how to identify the various entities governing dental plans (ERISA, state insurance commissioners, federal statutes, etc.); and options and alternatives for dealing with these entities when pursuing dental claims.

The Council discussed the resolution and identified several projects related to Resolution 105-1991. The Council made the following recommendations:

1. The Washington Office should keep the Council informed of its discussions with the Department of Labor regarding ERISA and request amendments to ERISA legislation if necessary.
2. The Purchaser Information Service materials for employers should include a recommendation that employers identify in the employee plan booklet whether the dental plan is self-funded.
3. The Council's new videotape on third-party payment and dental claims provide dentists with information on types of plans and steps in claims submission and processing. The audience for the videotape has been identified as senior dental students, recent dental school graduates, dental society staff and any dentist who may be unfamiliar with third-party issues.
4. The Council also recommended that a companion booklet to the videotape be produced to explain some of the third-party issues in greater detail.
5. Finally, the Council's Claim Resolution Program will assist state dental societies in identifying problems with payers.

Summary of Resolutions

New Policies/Directives:

3. Resolved, that the appropriate agencies of the Association study the feasibility of establishing a technological assessment process within the American Dental Association that would qualify dental procedures as "experimental" or "non-experimental" and report their findings back to the 1993 House of Delegates.

4. Resolved, that disputes concerning dental treatment provided under dental benefits programs be referred to the treating dentist's constituent dental society peer review process, and be it further
Resolved, that in those constituents where peer review is not available, the review should be conducted by the peer review committee based in the third-party payer's and/or the dentist consultant's state of record.

5. Resolved, that the Guidelines on Professional Standards for Utilization Review Organizations (UROs) be adopted as policy of the American Dental Association, and be it further
Resolved, that organizations who subcontract to provide utilization review services for licensed UROs must be equally licensed and meet the same standard as the contracting UROs, and be it further
Resolved, that the appropriate Association agencies seek federal legislative or regulatory actions to have these Guidelines integrated into laws, rules and regulations governing utilization review organizations and their activities.

Amendment/Rescission of Current Policies:

6. Resolved, that preventive dentistry refers to the procedures in dental practice and health programs which aid in the prevention of oral diseases, and be it further
Resolved, that the American Dental Association recognizes the importance of implementing preventive oral health practices as a means of affording optimal oral health to all individuals, and be it further
Resolved, that the ADA urges third-party payers to include the following preventive procedures as covered services:

—prophylaxis (at least twice in a calendar [contract] year);
—topical fluoride applications (at least twice in a calendar [contract] year);
—application of pit and fissure sealants;
—fixed and removable space maintainers;
—construction of mouth protectors for use in contact sports;
—prescription or use of supplemental dietary or topical fluoride for home use; and
—in-office patient education, i.e., oral hygiene instruction and dietary counseling, with regard to the promotion of good oral health (at least twice in a calendar [contract] year).

and be it further
Resolved, that the Council on Dental Care Programs continue to recommend to insurance firms, service plans, prospective purchasers and policyholders that, where considered necessary and appropriate, contract limitations on frequency of providing benefits for certain services be stated as "twice in a calendar (or contract) year" rather than "once in every six months" and be it further
Resolved, that the Statement on Preventive Coverage in Dental Benefit Plans (*Trans.*1991:631) be rescinded.

7. Resolved, that the American Dental Association is opposed to any dental benefit clause that would deny or reduce payment to the beneficiary, to which he/she is normally entitled, solely on the basis of lack of preauthorization, and be it further
Resolved, that Resolution 14H-1990 (*Trans.*1990:539), Preauthorization Requirements, be rescinded.

8. Resolved, that in recognizing that federal employees may receive employment benefits that are comparable to those received by employees in private industry, the American Dental Association supports legislation authorizing the purchase of comprehensive dental benefits from private sources or the funding of direct reimbursement dental benefits for federal employees, and be it further
Resolved, that in dealing with such authorizing legislation the appropriate agencies of the Association be instructed to apply the policies contained in the Statement on Dental Benefit Plans (*Trans.*1988:481) and Standards for Dental Benefit Plans (*Trans.*1989:547), and be it further
Resolved, that direct payments from these programs be made only to employees or their attending dentists, and be it further
Resolved, that the policy on Dental Benefits for Federal Employees (*Trans.*1980:582; 1986:530) be rescinded.

9. Resolved, that the Guidelines for Dentistry's Position in a National Health Program (*Trans.*1976:908, 914; 1977:919, 920; 1978:511; 1979:631; 1981:584, 585; 1982:528; 1983:549) be rescinded.

10. Resolved, that appropriate agencies of the American Dental Association evaluate and monitor proposals for national dental care submitted by third-party payers to government agencies, and be it further
Resolved, that appropriate agencies of the American Dental Association vigorously oppose proposals for national dental care that are contrary to Association policy, and be it further
Resolved, that appropriate agencies of the American Dental Association communicate and disseminate information about these proposals to the profession, and be it further
Resolved, that Resolution 57H-1978 (*Trans.*1978:508), Evaluation and Monitoring of Proposals for Administration of Federal Dental Care Programs, be rescinded.

11. Resolved, that Resolution 17H-1977 (*Trans.*1977:912), Dental Care in State Medicaid Programs for Indigent, be rescinded.

12. Resolved, that Resolution 21H-1980 (*Trans.*1980:582), Legislation to Require Fee-for-Service Dental Program Where HMO or Capitation Programs are Only Options, be rescinded.

13. Resolved, that Resolution 21-1975-H (*Trans.*1975:658), Review of Dental Practice by the Profession, be rescinded.

14. Resolved, that the Guidelines on the Structure, Functions and Limitations of the Peer Review Process be adopted, and be it further
Resolved, that Resolution 78H-1987 (*Trans.*1987:502), Guidelines on the Structure, Functions and Limitations of the Peer Review Process, be rescinded.

15. Resolved, that Resolution 32-1973-H (*Trans.*1973:668), Dental Prepayment Terms, be rescinded.

Council on Dental Practice

Chaput, Ronald M., Massachusetts, 1993, chairman
van Dyk, William, California, 1992, vice-chairman
Amundson, Vernon L., Minnesota, 1992
Baker, Robert W., Sr., New York, 1994
Grubb, Richard V., Maryland, 1993
Hall, Charles R., Alabama, 1994
Harrison, Thomas C., Texas, 1993
Hearon, Donald L., Washington, 1992
Kort, William, Illinois, 1995
Occhionero, Ronald, Ohio, 1995
Ogawa, Amy A., Hawaii, 1994
Prevost, Gibbs M., Sr., Tennessee, 1992
Sniderman, Marvin, Pennsylvania, 1993
Van Miller, James L., Wisconsin, 1994
Watson, David F., South Carolina, 1995
Young, Stephen F., Kansas, 1995
Bramson, James B., director
Kiser, Anthony L., assistant director
Lienau, Kathryn A., manager

Meetings: The Council met in the Headquarters Building on November 7-9, 1991 and April 30-May 2, 1992. Dr. William Booth, Third District trustee, serves as the Board of Trustees liaison to the Council.

The Council is organized into two subcommittees to facilitate its work activities. These subcommittees are the Subcommittee on Dental Team Members and Practice Management Publications (Committee A) and the Subcommittee on Special Projects (Committee B). The subcommittees met in conjunction with regularly scheduled Council meetings immediately prior to the plenary sessions.

Personnel: At the November meeting of the Council, Dr. William van Dyk was unanimously re-elected vice-chairman for 1991-92. The 1992 annual session will mark the retirement of Dr. William van Dyk, 1990-92 Council vice-chairman, Dr. Vernon Amundson, Dr. Donald Hearon and Dr. Gibbs M. Prevost, Sr. The Council wishes to express its appreciation to these individuals for their thoughtful, determined leadership and for many contributions during their tenure. During the year, Mr. S. William Oberg retired after 21 years of service to the Association, the most recent six years of which he served as the Manager of Dentists' Well Being Programs.

Response to Assignments from the 1991 House of Delegates:

Definitions of "Active" and "Inactive" Dental Patients of Record. The 1991 House of Delegates approved Resolution 30H (*Trans.*1991:621). This policy statement is incorporated into the revisions of the Council's Success Library publication dealing with practice valuation. The Council has also begun development of a directory of practice appraisers. Once completed, this policy will be mailed with copies of the directory to each of the listed appraisers.

Statement on Dental Care and Recovery from Chemical Dependency. The 1991 House of Delegates approved Resolution 72H (*Trans.*1991:618). This resolution called for changing the name of the Association policy statement on dental care and chemical dependency to more accurately reflect the intended meaning and purpose of the statement. It is now named the ADA Policy Statement on Provision of Dental Care for Patients Who Are or Have Been Chemically Dependent. This new language has been incorporated into the chemical dependency information that is available from the Council upon member request. It is also noted in the revised and updated *Directory of Chemical Dependency Help Programs.*

SUCCESS 91-92: Completing its ninth successful year of operation, the SUCCESS Program has continued to grow in both popularity and impact. In 1991, the Program was retitled SUCCESS to more accurately reflect the current content of the Program. Formerly known as OPTIONS, the Program now concentrates on the items and issues that a pending graduate would face as he/she enters private practice. Response from corporate sponsors, dental students, dental schools and organized dentistry continues to be extremely positive. Senior dental students throughout the United States and Puerto Rico benefited through the efforts of SUCCESS 91-92. The representatives of the American Student Dental Association (ASDA) were involved in promoting student attendance at the seminar in their respective schools and assisted in the distribution of materials at the seminar site. This has proven to be a tangible benefit of organized dentistry and is enhancing both ASDA's and the Association's images among students and faculty. The American Fund for Dental Health was again able to secure corporate funding to make the Program a reality.

SUCCESS 91-92 continued to focus upon the business needs and concerns of junior and senior dental students approaching graduation and faced with career and business decisions. The Program conveyed this information to the students in two ways: First, the Association's publication, *The Successful Dental Practice: An Introduction*, was distributed to approximately 4,400 senior dental students. This comprehensive 120-page manual includes chapters on choosing a practice location, buying a practice, dental office design, office staffing, records systems, benefit plans, insurance for the dentist and several other sections on office practice management. Corporate sponsorship was appropriately recognized in this publication on the inside front cover.

Second, a one-day practice management seminar, "Starting Your Dental Practice," was scheduled at 27 dental school campuses in 1991-92 and reached students from 28 different dental schools. This concentrated seminar covers such topics as management decisions, practice leadership, locating a practice, purchase of a practice, personnel and staffing decisions, office communications, the cost of doing business, insurance processing, billing and collections, appointment scheduling and marketing strategies. A comprehensive seminar manual was distributed to all seminar attendees to use as an ongoing reference and as a gift from the corporate sponsors and organized dentistry.

Corporate Sponsors. The following corporate sponsors contributed the resources to conduct the Program: A-dec, Inc.; American Academy of Dental Practice Administration Endowment and Memorial Foundation; American Dental Trade Association; CIGNA; Colwell Systems, Inc.; Dentsply International, Inc.; The Equitable Life Assurance Society of the United States; GC International Corporation; Great-West Life Assurance Company; Healthco International; Poe and Associates, Inc.; Procter & Gamble Company Oral Health Group; SmithKline Beecham Consumer Brands; THERMAFIL; 3M Dental Products; and the Warner-Lambert Company.

It should be noted that several of the above sponsors have been supportive of the SUCCESS Program since its inception in 1983. The American Dental Association is appreciative of their generous involvement on behalf of organized dentistry.

Sponsor Recognition. Corporate sponsors received the following benefits and recognition: a feature article in the August 19, 1991 *ADA News* distributed to approximately 140,000 dentists and subscribers; a feature article in the November 1991 issue of *ASDA News* distributed to 14,000 American Student Dental Association members throughout the United States; formal acknowledgment on the inside front cover of the publication, *The Successful Dental Practice: An Introduction*, distributed to senior dental students; acknowledgment on the inside front cover of the seminar manual, "Starting Your Dental Practice," distributed to the junior and senior dental students participating in the seminar; distribution of sponsor literature to all seminar participants via a dossier in which interested corporate sponsors placed a promotional flyer, usually with a business reply card; opportunities for sponsors to send representatives to student seminars; and a formal plaque in recognition by the American Dental Association.

Seminar Site Selection. SUCCESS 91-92 seminars were presented on the dates indicated below (the first school listed after each date is the seminar site and students from the listed neighboring schools also attended): October 1, 1991, University of Missouri; October 16, University of Alabama; October 17, Oregon Health Sciences University; October 18, University of Nebraska; October 22, University of Saskatchewan; October 24, Baylor College of Dentistry; October 25, University of Texas-San Antonio; October 26, University of Michigan and the University of Detroit; October 29, West Virginia University; November 2, University of Western Ontario; November 12, SUNY-Stony Brook; November 13, Louisiana State University; November 14, SUNY-Buffalo; November 26, University of Medicine and Dentistry of New Jersey; December 4, University of Iowa; December 11, Boston University; January 8, 1992, University of Tennessee; January 9, University of Mississippi; January 10, University of Puerto Rico; January 11, University of Washington; January 21, Ohio State University; January 23, University of Texas-Houston; January 25, University of North Carolina; January 27, Medical University of South Carolina; February 1, University of Florida; February 3, Meharry Medical College; and February 5, Indiana University.

Seminar Presenters. Instructors were selected by the Council based upon recognized expertise in practice management. In addition, representatives of the respective constituent societies were invited to discuss the important role of organized dentistry. Changes to certain sections of the Program required the Council to host a limited orientation session for those speakers who presented those sections. This was held in Chicago in August 1991. Program revisions, speaker background material and improved audiovisuals were used to illustrate the changes in the Program.

At the April 1991 Council meeting, two new presenters were recommended for inclusion in the Program and three speakers retired. Each seminar included three professionals from the following group: Dr. George L. Bletsas, former chairman, Council on Dental Practice, Michigan; Dr. James B. Bramson, director, Council on Dental Practice, American Dental Association; Ms. Kay A. Branz, director, Department of Marketing and Seminar Services, American Dental Association; Mr. Randall K. Berning, attorney, California; Dr. Carl M. Caplan, consultant, Maryland; Dr. Christine Dumas, private practice, California; Dr. David C. Hansen, private practice, Iowa; Dr. Thomas C. Harrison, member, Council on Dental Practice and private practice, Texas; Ms. Kathryn A. Lienau, manager, Practice Management Projects, Council on Dental Practice, American Dental Association; Dr. Rand T. Mattson, private practice, Utah; Ms. Diane E. Noskin, manager, Department of Marketing and Seminar Services, American Dental Association; Ms. Paula Perich, assistant executive director, Division of Membership and Marketing Services, American Dental Association; Dr. Michael L. Perich, assistant executive director, Division of Dental Practice, American Dental Association; Dr. Terryl Propper, private practice, Tennessee; Dr. William van Dyk, vice-chairman, Council on Dental Practice and private practice, California; and Dr. Emmett Zimmerman, private practice, Louisiana.

SUCCESS 91-92 Program Revisions: Each year the Program is reviewed in light of the changing dental practice environment and student needs. As an enhancement, a number of modifications took place this past year; the most notable was the restructuring of the seminar agenda. Because most graduates typically enter into an associateship arrangement, it was believed that the agenda should be reoriented to present "associateships" at the beginning of the Program. An additional revision integrated a discussion about various office systems into the section on management and leadership.

A coupon distribution for a free copy of a volume from the Success Library was done this year. This coupon was given to those students in attendance at the conclusion of the Program. Over 1,200 requests from this coupon have been honored. Corporate sponsors were presented with Cheshire labels of all coupon redeemers.

With continued corporate support, this Program will again be offered to dental schools throughout the United States and continue to grow in its Program offerings. Overall goals remain the same—to make available a quality practice management experience to junior and senior dental students in dental schools throughout the nation.

Shortages of Dental Office Staff Manpower: The 1987 House of Delegates approved Resolution 92H (*Trans.*1987:514) directing the appropriate agencies of the Association to study several issues related to dental office staff manpower. A joint report of the Council on Dental Practice and the Council on Dental Education was developed and presented to the 1988 House of Delegates in response to Resolution 92H-1987 (*Reports* 1988:117).

As part of Resolution 92H-1987, the Council continues to distribute the *Guide to Enhancing the Availability and Retention of Dental Team Members*, especially when a state task force is being organized and designed. *Dental Teamwork* articles have been published in the past year on shortages of dental team members and various office benefit programs. Council staff assisted in the content development, review and comment on these articles. To assist with the growing issue of employees with family concerns, the Council continues to investigate the applicability of flexible spending and dependent care accounts as a possible office employee benefit.

With the passage of Resolution 117H-1991 (*Trans.*1991:603), the Council on Dental Practice and the Council on Dental Education (CDE) began to further investigate innovative, flexible methods and means to promote educational programs that could deliver qualified students and meet demand. A joint report of both Councils, in response to Resolution 117H, is presented in a separate report to the 1992 House of Delegates (see page 84).

In an effort to address shortages of dental assistants, the Council, in cooperation with the CDE and researchers at the University of Kentucky, have been involved in the development and planning of a formal correspondence course. This course, with accompanying clinical exercises, is planned for acceptance as an accredited program. The Council, along with CDE and the Association's Board of Trustees, has given support to this program, known as the University of Kentucky-Independent Dental Education for Assistants Program (UK-IDEA). Fund-raising for the development of this project is ongoing. A summary of this program is also found in the joint Councils' report regarding Resolution 117H.

The Council continues to assist researchers in North Carolina regarding the Dental Office Team Survey (DOTS). This survey was funded and supported, in part, by the Association's Board of Trustees. One of the survey instruments was designed for dental hygienists who have left the field, asking why they left and what factors would encourage them to re-enter. A series of dental team-building workshops and seminars are planned as an outgrowth of this research. Areas where the Council can cooperatively work with the DOTS researchers are being explored.

Resolution 73H-1989 (*Trans.*1989:534) directed appropriate agencies to develop a plan to provide direct assistance to states who were interested in developing responses regarding shortages of allied dental health personnel. This was jointly assigned to the Council on Dental Practice and the Council on Dental Education.

To implement this resolution, a survey of the constituent dental societies resulted in three pilot projects for development. These pilot projects were in Massachusetts, Pennsylvania and Virginia. The Council on Dental Practice worked primarily with the Massachusetts Dental Society (MDS) project since it designed a program to survey licensed dental hygienists through a cooperative effort with the state dental board. During licensure renewal, a survey instrument was inserted as a companion piece, which requested information about the licensee's employment status. Approximately 1,200 surveys were returned out of the 6,000 licensed hygienists in Massachusetts. About 250 of these were from hygienists who were licensed, but not working in dentistry. The Council assisted MDS in tabulating and reviewing the responses from these inactive dental hygienists and in the development of a statistical review of the survey findings.

Chemical Dependency Issues: The Council nominated the following nine members to its Advisory Committee on Chemical Dependency Issues (ACCDI) for 1991-92: Drs. Vernon Amundson, chairman, Minnesota; Thomas Harrison, vice-chairman, Texas; Thomas Derosier, Massachusetts; Gale Kloeffler, California; Edward E. Linsell, Jr., Michigan; Theresa E. Madden, New York; Dennis R. Miers, Louisiana; Patrick J. Sammon, Ph.D., Kentucky; and Harry D. Simpson, Jr., Virginia.

The Council co-sponsored the Second Regional Conference on Chemical Dependency on November 1-2, 1991 in Williamsburg, Virginia. Council staff continued liaison with the executive director and executive committee of the Auxiliary to the American Dental Association, the American Student Dental Association and the American Association of Dental Examiners concerning chemical dependency activities. Staff also interfaced with other health professionals concerned with chemical dependency at meetings of the International Doctors in Alcoholics Anonymous and the Society for Professional Well-Being.

The Council also sent a letter of support to Dr. David Webster, and other researchers from the University of Kentucky, who seek to conduct a study of psychoactive substance abuse use among dentists. This study is being submitted as a grant proposal to the National Institutes for Drug Abuse and other similar governmental agencies. It is hoped that Council support may assist in securing a grant to conduct such research since, at present, the incidence and prevalence of drug abuse among dentists is subject to speculation.

A Chemical Dependency Help-Information Center was staffed by volunteers and Association staff at the 1991 annual session in Seattle and additional educational materials were distributed at the Health Screening Program. A full-day scientific program on chemical dependency in dentistry was sponsored by the Council. Open meetings of Alcoholics Anonymous and Al-Anon Family Groups held during the annual session were well-attended.

The Council and its ACCDI have been concerned about the issues of dental management in active and/or recovering chemically dependent (alcohol and other drug dependent) patients. A growing interest on the part of dental practitioners about the management of active and/or recovering chemically dependent patients has been evidenced by: (1) inquiries for information on the subject based on the "Drug-Free America"

ads which have appeared in dental publications since 1987, (2) the appearance of articles on the subject in dental publications, and (3) telephone inquiries received in the Council office. The Council continues to distribute, in response to the "Drug-Free America" ad series, copies of the ADA Policy Statement on Provision of Dental Care for Patients Who Are or Have Been Chemically Dependent. As of March 1992 nearly 2,000 inquiries were received.

At its November 1988 meeting, the Council directed that the University of Utah School on Alcoholism and Other Drug Dependencies Dental Section be designated as the primary "training resource" for members of the dental family seeking either basic or advanced education concerning chemical dependency and assistance in starting and developing dental society chemical dependency help programs. The Fourth Dental Section, conducted in 1991, drew an attendance of approximately 46 persons from 21 states and 16 dental schools. These included dentists, dental hygienists, dental school administrators, faculty members and dental students. Mr. S. William Oberg, former CDP manager, Well Being of Dentists, was a member of the School Planning Committee and continues to serve as its Section Leader. Dr. Patrick Sammon was the designated faculty member. The 1992 Utah School Dental Section is scheduled for June 21-26 in Salt Lake City.

Oral Health Care Guidelines for Treating Chemically Dependent Patients: The Council, in conjunction with Council on Community Health, Hospital, Institutional and Medical Affairs (CCHHIMA), has approved the development of oral health care guidelines for treating chemically dependent patients. These will be similar in nature to the guideline documents that CCHHIMA has produced on other treatment considerations. The Council expects this document to be completed by the end of 1992 and offered to the membership through the Salable Materials Department.

"Code" Amendment Regarding Chemical Dependency: At the January 1992 meeting of the Council on Ethics, Bylaws and Judicial Affairs (CEBJA), it considered an amendment to the *ADA Principles of Ethics and Code of Professional Conduct* regarding references to impairment resulting from chemical dependency. A separate issue also considered was the duty of a dentist with knowledge that a colleague suffers such an impairment.

The Council on Dental Practice reviewed the proposed *Code* amendment at its May 1992 meeting. This amendment is being presented to the House by CEBJA (see page 111) for consideration. Copies of this proposed *Code* amendment are also planned for review and comment by the Council's Advisory Committee on Chemical Dependency Issues in August 1992. The Council on Dental Practice highly supports CEBJA's efforts in this matter and endorsed the general concept of addressing chemical dependency issues in the Association's *Code*. The Council was also strongly supportive of the amendment references to refer such matters to state chemical dependency help committees. The Council suggests that definitions of "impairment" be added to the background material.

Forensic Dentistry Issues: The Council, in response to Resolution 98H-1990 (*Trans.*1990:546), has assimilated information to act as a clearinghouse for information on forensic dental programs in state and local areas and distributes this upon member request. The Council also continues to distribute the *Proceedings: First National Conference on Dentistry's Role and Responsibility in Mass Disaster Identification.*

Emerging Electronic Technology: The Council has become increasingly involved in the emerging issues of electronic technology and how it can be used in dental offices. This technology ranges from the practice administrative considerations of using computers in the office to the various clinical computer uses.

The Council, along with the Council on Dental Care Programs (CDCP), jointly conducted a work group called the Dental Electronic Technology Advisory Group. A joint report and accompanying resolutions are being submitted by the Council and CDCP separate from each Council's annual report (see page 49).

Americans With Disabilities Act Panel: The Council has submitted, jointly with the CCHHIMA, a proposal to present a two-person panel at the 1992 annual session in Orlando. This program is targeted to help explain the implementation of the Americans With Disabilities Act and how it affects dentists.

Smoking Cessation Issues: In September 1991, CCHHIMA noted that the Association's tobacco policies did not contain language regarding dentists' continuing education on tobacco cessation practices. With the advent of several smoking cessation pharmacological agents and the growing awareness of the effects of smoking on oral tissues, CCHHIMA sought support from the Council to amend the Association's existing tobacco policies.

A draft policy statement was approved by the Council and CCHHIMA at their spring 1992 meetings. Concomitantly, the Board of Trustees asked the Council on Dental Therapeutics (CDT) to comment on the appropriateness of dentists prescribing nicotine patches. CDT reviewed the activities of the Council and CCHHIMA and agreed that policy language should be developed.

As a result, the Council and CCHHIMA are submitting a joint resolution to amend Association policy on tobacco (*Trans.*1988:489; 1990:533). This resolution appears in CCHHIMA's annual report (see page 26) for consideration.

Council Publications: Of the nine revenue-producing materials developed by the Council, *The Successful Dental Practice: An Introduction, Building Successful Associateships, Successful Valuation of a Dental Practice* and *Handbook of Dental Letters*, continued to be the most popular sellers during 1991-92.

Building Successful Associateships and *Successful Valuation of a Dental Practice* were the first two publications to be revised as part of the Council's newly introduced Successful Dental Practice Library. Each publication is to be revised once every three years, if needed. During the year, the Council completed work on two more volumes in the Success Library—*Building a Financial Foundation for Your Practice* and *Computers in the Dental Practice*. This results in a total of seven volumes in the Council's Success Library.

"Planning for Successful Growth: Partnerships and Group Arrangements," "Planning for Successful Retirement," "Successful Financial Arrangements" and "Successful Office Design" are all under development. Eventually, 11 volumes are planned for the practice management Success Library.

Seminar Programs: The Council developed the following new seminars in 1991-92:

1. The Council approved a second generation program for young dentists based on the student SUCCESS Program. A full-day program is planned which highlights those sections of SUCCESS that would be most applicable to recent graduates and adds new sections on practice financing, practice productivity measures and multiple-doctor practice environments. The Council is seeking corporate sponsorship in order to allow the program, "Preparing for Ownership," to be offered at a reduced rate through established young dentists' committees and networks.
2. The Council has developed the seminar "The Smart Office: How to Hire and Train a Computer" by Dr. Barry Freydberg. This program discusses the basics of computer operations in the dental office and gives practical advice about the selection of computer systems.
3. The Council has approved the development of a seminar on pediatric dentistry done in conjunction with the American Academy of Pediatric Dentistry. Dr. William Waggoner, Ohio, has been selected to present this course.
4. The Council continues to refine an outline and seminar presentation materials for a program in conjunction with the Federation of Prosthodontic Organizations and the American College of Prosthodontists.
5. The Council has also approved the development of seminars on implant dentistry, dealing with difficult patients and geriatric dental care.

In an effort to review and evaluate the practice management seminar offerings and based on bookings and member interest, the Council elected to sunset six seminar programs, preferring instead to possibly offer them on audiocassettes. The six seminars that have been discontinued follow: "Treating the Chemically Dependent Patient," "Financial Planning for the Young Professional," "Buying/Selling/Associating—Learn How," "Financial Independence: Make It a Reality," "Build a Top Dental Team in a Tight Market" and "Managing Your Patients for Practice Growth."

Practice Listing Services: The Council routinely receives telephone inquiries regarding placement of associates in dental offices. In 1988, the Council published the results of a survey conducted by David Born, Ph.D., University of Minnesota. In 1991, a follow-up survey was done by the Council to update the *Directory of Dental Placement Services in the United States*. It was determined that the addition of proprietary listing services and those that operate to place dental hygienists, should be included in the *Directory*. As a result of this recommendation, the Council surveyed all existing hygiene education programs and known proprietary firms. The resulting *Directory* is substantially more complete and has been well received by the users. Single copies of this *Directory* are available from the Council's offices to members on request. It is estimated that over 1,200 requests for this are received annually by the Council. An *ADA News* article was done to promote this *Directory* to the membership.

As a companion document to the *Directory*, the Council published Guidelines for Establishing a Dental Placement Service. These Guidelines are designed to serve as a step-by-step aide to those organizations operating a placement service.

Liaison with the Dental Laboratory Industry: The Council continues to maintain formal liaison activities with the dental laboratory industry to allow for discussion of mutual concerns. A representative from the National Association of Dental Laboratories (NADL) was in attendance at the Council's November 1991 meeting. The Council Chairman and staff will attend the annual session of NADL, June 17-21, 1992.

NADL has agreed to assist in the partial funding of a brochure on veneers that is planned as part of the Adult Awareness Campaign. Further, the Council continues to annually implement 1987 House of Delegates Resolution 28H (*Trans.*1987:496) regarding recognition for certified dental technologists. With assistance from NADL, the Association communicates with each of the certified dental technologists reaching their 25th anniversary. NADL annually provides the Council with these names.

The Council also forwarded to the laboratory organizations the revised laboratory section of the document "Infection Control in the Dental Office and Dental Laboratory" for review and comment.

Liaison with the American Dental Hygienists' Association (ADHA): The Council met with representatives of the ADHA during its November 1991 meeting. Several project ideas surfaced that included continued communication to state dental boards about gathering information on licensed, non-working dental hygienists and developing a generic survey instrument for such information gathering. A joint letter was sent in September from the then presidents of ADA and ADHA to the state dental boards. This letter urged the boards to begin gathering data regarding hygienists who were licensed, but not working clinically. A follow-up letter is planned in order to audit the states' responses. Sample survey instruments are also under development.

Liaison with the American Dental Assistants Association (ADAA): Representatives of the ADAA met with the Council in April-May 1992. The Council continues its collaboration with the ADAA regarding Dental Assistants Recognition Week (DARW), which occurred March 8-13, 1992. The Council worked in cooperation with the Association's Salable Materials Department to promote DARW recognition buttons and certificates. The Council also distributed institutional advertising "slicks" to over 600 dental editors nationwide through the *Dental Editor's Update* mailing in cooperation with the Division of Communications. These ads appeared in both *The Journal of the American Dental Association* and *ADA News*.

The Association is also a participant in an ADAA task force on mandatory credentialing for dental assistants. This ADAA task force met January 17-18, 1992 and has planned a second meeting on June 26-27, 1992. The Association is represented by three individuals on this task force: Drs. James Clark,

trustee, Tenth District; T. Arthur Babineau, Maine, member Council on Dental Education; and Thomas Harrison, Texas, member Council on Dental Practice. The first meeting was spent primarily developing a task force mission statement and defining some of the task force's major goals and objectives.

The Council also received and noted the ADAA's 1991 policy statement on HIV and infection control realizing that many of the components of a successful office infection control system are dependent on duties delegated to dental assistants.

Practice Management Articles/Topics: The Council is actively involved in identifying and developing articles and topics relevant to current needs on practice management. Several practice management-related articles appeared in the *ADA News* or *The Journal of the American Dental Association*. These articles covered, among others, computers, electronic claims processing, implementation of the Americans With Disabilities Act and the Clinical Laboratory Improvement Act this past year.

Resource Files: The Council continues to maintain and update resource files on over 30 practice management topics. Approximately 200 telephone inquiries and written requests are processed monthly.

Resolutions: This report is informational in nature and no resolutions are presented.

Joint Report of the Council on Dental Care Programs and the Council on Dental Practice

Electronic Data Interchange

Background: For the past six years, the Association has been involved in various aspects of the emerging field of electronic data interchange (EDI). This technology has been manifested in the dental marketplace, most notably in the area of electronic dental claims submission.

The Council on Dental Practice (CDP) and the Bureau of Economic and Behavioral Research continue to monitor the growth of dental office computerization. In response to this growth, CDP has developed the following educational resource materials:

—a seminar on computers in the dental office;
—a soon to be released publication from the Success Library series, entitled *Computers in the Dental Office*;
—Guidelines for Selecting Office Computers, published in the January and February 1991 issues of *The Journal of the American Dental Association* and;
—a "Guide on Selecting Electronic Claims Vendors."

Current and future involvement of CDP is in practice management systems, the development of computer-based patient records and diagnostic and treatment applications of new technology.

The Council on Dental Care Programs (CDCP) has worked vigorously to ensure the integrity of the ADA's *Code on Dental Procedures and Nomenclature* and Dental Claim Form by contacting vendors who develop and/or sell office management software programs to dental practices to see that the latest code and claim form data are included in their software programs. The Council is also a participant in the American National Standards Institute X12 insurance subcommittee, which is charged with developing standards for electronic claims transmission, eligibility, enrollment and reimbursement.

Current and future involvement of CDCP is in the possible development of diagnostic coding, gaining access to utilization data, and representing the interests of members in the development, growth and implementation of all aspects of electronic claims transmission.

In 1991, the importance of EDI became clear, especially its potential for having a detrimental impact on the dental profession if, in fact, the profession's perspective was not reflected in the standards for this new technology. As a result of these concerns, the Department of Information Science, in the Division of Dental Practice, was created.

This new department is charged with identifying groups and organizations responsible for the introduction, promotion and growth of any technology, application of technology or the development of any standard, that involves or will involve the practice of dentistry, including education, science, clinical practice and administration/management. The Association is represented by the Department of Information Science at all important, decision-making meetings of those groups and organizations identified to date.

Recognizing that this new field is advancing rapidly, the Board of Trustees, at its February 1992 meeting, approved a meeting of a working group called the Dental Electronic Technology Advisory Group (DETAG) consisting of a member of the Board as Chairman, representatives from CDP and CDCP (the representative from the Council on Dental Education was unable to attend) and three outside consultants.

Dr. George Kirchner, chairman of CDCP, and Dr. David Watson, member of the CDP, together with the director of each of the two Councils, attended the meeting. Staff from the Bureau of Economic and Behaviorial Research, the Council on Dental Materials, Instruments and Equipment and the Council on Education also attended the meeting.

The first meeting of DETAG took place on March 20-21, 1992, and its purpose was to discuss the future direction in EDI and how the Association could position itself to represent the dental profession.

During the DETAG meeting it became obvious that the Association has no policy directly associated with EDI that could guide the Association's activities in representing members' interests in the growth of electronic claims transmission and no policy directing the Association to gain access to aggregate data bases.

These data will provide opportunities to further enhance dental school curricula, scientific research, epidemiologic studies, health services research and other areas. Such policy voids could prove harmful if the Association is not in a position to represent the best interests of the profession in a timely manner.

To this end, CDP and CDCP agreed that these policy voids should be filled. Therefore, the Councils recommend that the following resolutions be adopted by the 1992 House of Delegates.

Resolutions

New Policies/Directives:

16. Resolved, that the American Dental Association represent the interests of the dental profession in all aspects of the development, growth and implementation of electronic technologies with administrative and clinical applications in dentistry, computer-based patient records, practice management systems, and diagnostic and treatment applications of new technology.

17. Resolved, that the American Dental Association be actively involved at the policy-making levels of national organizations responsible for developing standards in electronic data interchange (EDI) that will affect the clinical, administrative, scientific and educational components of dentistry.

18. Resolved, that the American Dental Association facilitate the development of electronic dental patient records through involvement with appropriate organizations and efforts to resolve legal, legislative and regulatory barriers to the evolution of this application of electronic technology.

19. Resolved, that the American Dental Association, through appropriate means, seek to gain access to aggregate data bases relating to dental treatment, patient care, epidemiology, scientific research, education, practice management, health services research and other areas.

Commission on Relief Fund Activities

Hinkle, Robert C., Ohio, 1992, chairman
Passantino, Frank R., California, 1992, vice-chairman
Brett, George W., Pennsylvania, 1993
Fleckenstein, Leo J., West Virginia, 1995
Long, John Q., Jr., Texas, 1994
Olson, A. Miles, Iowa, 1994
Ramirez-Brunet, Rafael, Puerto Rico, 1995
Reitinger, Charles G., Colorado, 1993
Bramson, James B., director
Mountz, Marsha L., manager

Meetings: The Commission met in the Headquarters Building on August 1-2, 1991 and on February 21, 1992. Dr. Frank H. Stevens, Sixth District trustee and ADA Board of Trustees liaison, attended the August 1-2, 1991 meeting. A meeting of the Commission is scheduled for August 6-7, 1992. Dr. Gary J. Newman, Twelfth District trustee currently serves as the Commission's trustee liaison for 1992.

Election of Chairman and Vice-Chairman: The 1989 ADA House of Delegates approved Resolution 44H (*Trans.*1989:557), which amended the *Bylaws* to allow the Commission on Relief Fund Activities to elect its chairman. Dr. Robert C. Hinkle was elected chairman and Dr. Frank R. Passantino was elected vice-chairman at the August 1-2, 1991 meeting.

Response to Assignments from the 1991 House of Delegates: *Amendment Provisions of the ADA Relief Fund "Indenture of Trust."* Since the adoption of the Relief Fund *Indenture of Trust* 43 years ago, the laws regarding taxation and non-profit organizations have changed significantly and at times require the Fund to make amendments in a timely manner. The Commission proposed through Resolution 31-1991 (*Reports* 1991:104) to amend the section of the *Indenture of Trust,* which describes the amendment provisions. The Commission believes that a two-thirds (⅔) majority vote without prior years notice rather than a unanimous vote should be the procedure used to amend the *Indenture*. This resolution was referred to the 1992 House of Delegates by the Speaker since it proposed an amendment to the *Indenture of Trust*.

Modifications to the ADA Relief Fund "Rules": The Commission directed legal counsel to research the term "dependents" and its applicability to the Relief Fund *Rules*. A significant change in the ADA Relief Fund *Rules* has been made to clarify and strengthen the criteria for determining eligibility. This was approved by the Commission and the ADA Board of Trustees. This change includes specific language which defines and determines the lineage of a dependent.

The Commission defines "dependents" in the following manner:

> Dependents are limited to a dentist's current spouse and blood-related or legally adopted children under the age of 18. A deceased dentist's spouse, if married at the time of death, is also considered a dependent. If a deceased dentist's spouse remarries, he/she is no longer eligible for Relief Fund grants.

Financial Operations: As of December 31, 1991, the ADA Relief Fund contributions generated by the 1990-91 annual fund-raising campaign amounted to $377,095, of which $325,369 was rebated to constituent society relief funds. The Commission established a base of $250,000 to determine each state's campaign quota.

From the ADA Relief Fund, $367,498 was disbursed in the form of grants to recipients during the fiscal year. For calendar year January 1 through December 31, 1991, the Commission, in cooperation with constituent and component dental society relief funds, provided monthly financial assistance to 146 eligible recipients compared with 77 recipients for fiscal year 1990. The grant awards in 1991 have almost doubled in number when compared with awards given in 1990. Other expenses for the fiscal year were general and administrative, $183,696; investment and bank fees, $26,362; professional audit and accounting fees, $27,300; and solicitation campaign expenses, $61,547.

Investment Activities: Since June 1985, Lake Shore National Bank of Chicago has managed the portfolio of the Relief Fund in accordance with guidelines adopted by the Commission members. The market value of the portfolio was $6,521,810 as of December 31, 1991. The portfolio generated $367,650 in annual income and provides a yield at book of approximately 7.1%.

As of December 31, 1991, the return on fixed-income investments comprised of government bonds, cash equivalents and high grade corporate securities was 8.3%. This segment of the portfolio represents about 46% of the total investments in the Relief Fund. The equity portion of the portfolio constitutes approximately 54% of total assets. The number of issues owned is 31, with total equity assets distributed over ten major industries. For the year ended December 31, 1991, the equity portfolio was valued at approximately $3,518,448 with a total return of 23.4%. The return generated by the Standard & Poor's 500 Stock Index was 30%. The diversification of assets of the fixed income and equity segments of the portfolio provides income from interest and stock dividends needed by the Commission to meet annual administrative, fund-raising and grant expenses.

For the year ending December 31, 1991, interest and dividends amounted to $440,543 as compared to $479,480 the previous year. In addition, as a matter of policy, the investment manager is prohibited from purchasing securities in any corporation that manufactures, fabricates, processes, sells or furnishes dental supplies, machinery, equipment and materials, dentifrices or other agents related to oral hygiene or tobacco products.

As of June 1991, PaineWebber Inc. evaluates the performance of the Relief Fund's investment advisor and compares the portfolio performance of the Fund with that of 2,000 similar money managers. Quality of service and knowledge of the Commission's investment strategies were not affected with the change from Merrill Lynch to PaineWebber Inc. In August 1991, the Commission developed with the assistance of PaineWebber the Master Statement of Investment Policy and Objectives, which are specific investment guidelines that address the portfolio holdings and further define the framework within which the manager will invest the Relief Fund's portfolio. The management structure of the portfolio is being reviewed with regard to having a manager for the fixed-income segment and a manager for the equity index of the portfolio.

Revision of Relief Fund Application Form: The Commission has revised the Relief Fund application to more clearly identify the assets and liabilities of the applicant's financial statement, which are required for appropriate review of grant requests. These revisions include the listing of retirement funds and personal property, as well as detailing credit card debts, and they will be incorporated in the next printing of the Relief Fund application forms for distribution to component and constituent dental societies.

1991-92 Relief Fund Campaign: The Commission conducts an annual campaign to solicit charitable contributions on behalf of the Relief Fund. The fund-raising campaign consists of three mailings, the first of which was sent in November 1991. Previous years' donors were the target audience of the follow-up letters. Total contributions through May 1, 1992 amounted to $318,150. There have been changes in the campaign which have proven cost-effective and result oriented, which include development of new copy for fund-raising letters and reduction in the overall production and distribution costs of the mailings. The Commission appreciates the continued support of those members of the dental community who, through their contributions, have helped those less fortunate dentists and their families improve their quality of life.

HIV-Infected Dentists: The Commission on Relief Fund Activities provided financial assistance for daily living expenses to four individuals who are HIV positive. These applications were handled with strict confidentiality as stipulated in the Relief Fund *Rules*.

Constituent Society Relief Funds: In November 1991, the Commission was asked to consider the effects of grant requests on those states that have been depleting financial resources and are active in terms of providing assistance to dentists and their dependents. There are several states that fall into this category. The Commission is evaluating the Relief Fund Campaign Quota System and the redistribution of campaign donations to those states that actively use their relief fund monies for relief purposes.

Resolutions: This report is informational in nature and no resolutions are presented.

The ADA Endowment and Assistance Fund, Inc.

Hinkle, Robert C., Ohio, 1992, chairman and president
Passantino, Frank R., California, 1992, vice-president
Brett, George W., Pennsylvania, 1993
Fleckenstein, Leo J., West Virginia, 1995
Long, John Q., Jr., Texas, 1994
Olson, A. Miles, Iowa, 1994
Ramirez-Brunet, Rafael, Puerto Rico, 1995
Reitinger, Charles G., Colorado, 1993
Bramson, James B., secretary/treasurer

Meetings: The Board of Directors of The ADA Endowment and Assistance Fund, Inc. (Endowment Fund) met in the Headquarters Building on August 2, 1991 and on February 21, 1992. A meeting of the Board of Directors is scheduled for August 7, 1992.

Board of Directors Election of Officers: The Endowment Fund Board of Directors, at its August 2, 1991 meeting, elected the following officers: Dr. Robert C. Hinkle, president and Dr. Frank R. Passantino, vice-president.

Annual Member Meeting: At the August 8, 1991 annual Member meeting of The ADA Endowment and Assistance Fund, Inc., the Member was informed of a $10,000 grant given to the Endowment Fund by the Commission on Relief Fund Activities for the establishment of an Ad Hoc Work Group on HIV-Infected Dentists. The purpose of this group was to identify and/or investigate new programs or proposals to counsel, support and potentially assist in the retraining of dentists who voluntarily restrict their dental activities or who are faced with resignation due to HIV infection. The election of Directors by the Member was deferred until October 10, 1991 in order to coincide with the ADA House of Delegates' appointment of members to the Commission on Relief Fund Activities.

Shareholder Meetings of The Endowment Fund Board: At the October 10, 1991 shareholder's meeting, the ADA Board of Trustees, as sole Member of the Fund, elected the following individuals appointed to the Commission on Relief Fund Activities as Directors of the Endowment Fund: Dr. Leo J. Fleckenstein, West Virginia, and Dr. Raphael Ramirez-Brunet, Puerto Rico, to replace Dr. Robert T. Ragan and Dr. William R. Capps who were retiring.

Financial Operations: The financial statements of the Endowment Fund were reviewed for the year ended December 31, 1991. Assets totaled $2,084,201, which included a grant from the Relief Fund in the amount of $1,210,001. Liabilities of $4,725 were due to the ADA General Fund, resulting in a Fund balance of $2,079,476. Revenues for the year were $5,108 from loan interest and $72,306 from investment earnings. Expenses for 1991 totaled $54,455.

Investment Activity: The Endowment Fund portfolio is managed by Lake Shore National Bank. The portfolio is comprised of short-term liquid investments to insure the immediate availability of funds for program activity. Portfolio assets held as of December 31, 1991 totaled $1,716,561. Approximately 35% of the total assets are guaranteed by the U.S. Government or agencies of the U.S. Government. Short-term investments constitute 36% of invested monies and currently yield 5%. The equity segment of the portfolio is comprised of 13 issues distributed over nine major industry categories with a compounded return of 7.1%.

PaineWebber Incorporated evaluates the performance of the Endowment Fund's investment advisor and provides the Board of Directors with pertinent information regarding changes in economic trends that might affect investment results. In August 1991, the Board of Directors, in concert with PaineWebber, developed the Master Statement of Investment Policy and Objectives which addresses the Fund's portfolio holdings and defines guidelines for investment of the Fund's resources by the portfolio manager. The management structure of the Endowment Fund's portfolio is being reviewed with regard to having a manager for the fixed-income segment and a manager for the equity index of the portfolio.

Development of Program Activity: The programs of the Endowment Fund comprise four areas of charitable activity which include: (1) scholarship programs for dental, minority dental and allied dental health students; (2) loans for expenses associated with chemical dependency in-patient medical treatment; (3) loans for educational support to facilitate certain retraining of disabled individuals; and (4) loans to victims of disasters to maintain or restore availability of dental care in affected areas.

Dental and Allied Dental Health Scholarship Programs: The Endowment Fund established scholarship programs for dental, minority dental and allied dental health students to encourage them to seek or continue to pursue careers in dentistry, hygiene, assisting and laboratory technology. The American Fund for Dental Health has had a scholarship program in dental laboratory technology, which in March 1992 was combined with the Endowment Fund's allied program to streamline the application process for students and to unify the administrative structure of the program. The Endowment Fund has developed and distributed application forms to financial aid officials and admissions advisors of dental schools and program directors of accredited allied health programs. Screening committees for scholarship review were established by the Endowment Fund to rate applicants prior to final submission to the Board of Directors. The Fund appointed the following individuals to serve a one-year term on the dental student scholarship screening committee: Dr. Robert C. Hinkle, president of the Endowment Fund; Dr. William E. Hoskins, associate dean, University of California at San Francisco; and Ms. Carole Busch, director of financial aid, Indiana University School of Dentistry. This committee will meet on June 26, 1992

to nominate up to 25 scholarship candidates. The maximum annual award for the dental student scholarship is $2,500.

The screening committee for the allied dental health program is comprised of the following appointed members: Dr. Robert C. Hinkle or his appointee from the Endowment Fund; Ms. Carol Brobst, assistant administrator of curriculum and programs, Hawkeye Institute of Technology, Waterloo, Iowa; Ms. Kathleen Hinshaw, director of dental hygiene/assisting, Indiana University Northwest, Gary, Indiana; and Mr. Frank Loffredo, former director of dental laboratory technology program, Triton College, River Grove, Illinois. This committee will meet on July 31 to August 1 to nominate candidates for dental hygiene, dental assisting and dental laboratory technology scholarships. The allied dental health program will award up to 25 scholarships per discipline with $1,000 being the maximum annual award per scholarship.

Financial need, academic achievement, personal and professional goals and letters of reference are the established criteria used in evaluating the Endowment Fund's scholarship applicants. The selection process is based on rating the criteria for eligibility and the scoring mechanism used in evaluating the criteria. The slate of candidates chosen by the screening committees will be sent to the Board of Directors for approval. Notification of awards will be sent to recipients and respective schools and programs on July 30, 1992 for dental students and August 30, 1992 for allied students.

Minority Dental Student Scholarship Program: The Endowment Fund, with support from Colgate-Palmolive, established a scholarship program for minority dental students. Concurrently, the American Fund for Dental Health (AFDH) has had a minority dental student scholarship program, which is supported by several foundations and groups. Both programs were combined for joint support and to facilitate the application process for the student.

The criteria for eligibility and the candidate selection process mirror that of the dental student program. The members appointed to the dental student scholarship screening committee will comprise the minority committee along with additional members: Dr. Yolanda Bonta, Colgate-Palmolive liaison to the Fund and Dr. Juliann S. Bluitt, AFDH representative and associate dean of student affairs, Northwestern University. The screening committee will meet June 27, 1992 to nominate candidates for the minority dental student scholarships. Notification of these awards will be sent to recipients and dental schools on July 30, 1992.

Chemical Dependency Loan Program: The Endowment Fund has a loan program for chemically dependent dentists who require in-patient medical treatment. The application form is in the process of being revised to more clearly define the program's criteria for eligibility. The goal of the Fund is to implement this program by September 1992.

Educational Retraining Program: The Endowment Fund has developed a loan program for educational support of those dentists who have become disabled and thus require retraining for employment. The Fund has had three inquiries from HIV-positive individuals and one from a dentist who suffered an accident and does not have the use of his hands. An interim application will be provided to those dentists who require immediate assistance.

Disaster Loan Assistance Program: The Endowment Fund's Disaster Loan Assistance Program provides financial assistance to those dentists who are victims of disasters to assist in the restoration, repair or reconstruction of their practice facility and to ensure that dental care is provided in the affected community. Two disaster assistance loans were provided by the Fund in 1991-92.

Resolutions: This report is informational in nature and no resolutions are presented.

Division of Education

Council on Dental Education and Commission on Dental Accreditation

Special Report of the Council on Dental Education

Joint Report of the Council on Dental Education and the Council on Dental Practice

Joint Commission on National Dental Examinations

Notes

Council on Dental Education
Commission on Dental Accreditation

*Barker, Ben D., North Carolina, 1992, chairman, American Association of Dental Schools
*Warren, Robert E., Alaska, 1993, vice-chairman, American Association of Dental Examiners
Aquilino, Steven A., Iowa, 1993, Federation of Prosthodontic Organizations
*Babineau, T. Arthur, New Hampshire, 1992, American Dental Association
*Cherrick, Henry M., California, 1995, American Association of Dental Schools
*Ferris, Robert T., Florida, 1995, American Dental Association
Harris, Sandra, Tennessee, 1992, public member
*Hasler, John F., Maryland, 1993, American Association of Dental Schools
Helfrick, John F., Texas, 1992, American Association of Oral and Maxillofacial Surgeons
*Horwitz, W. Kenneth, Texas, 1994, American Dental Association
*Hunt, Lindsay M., Jr., Virginia, 1994, American Association of Dental Schools
Mescher, Kay, Iowa, 1995, American Dental Hygienists' Association
Muhlstein, Denis, Michigan, 1993, student member
Mumolo, F. Alan, New York, 1993, National Association of Dental Laboratories
Novak, Darlene, Kentucky, 1992, American Dental Assistants Association
Ramirez de Arellano, Annette B., New York, 1994, public member
*Roberson, Peter D., Illinois, 1993, American Dental Association
*Williams, Lewis H., Georgia, 1994, American Association of Dental Examiners
*Yaple, Newell H., Ohio, 1995, American Association of Dental Examiners
*Yeager, Arthur L., New Jersey, 1992, American Association of Dental Examiners
Santangelo, Mario V., director
Bellanti, Neal D., assistant director
Davenport, Cynthia A., manager
Nix, Judith A., assistant director
Schuhrke, Lois L., assistant director

Meetings: The Council met in the Headquarters Building, Chicago, on December 6, 1991 and May 8, 1992. The Commission conducted its meetings on December 5, 1991 and May 7, 1992. Standing and advisory review committees, which provide comments and recommendations on policy and accreditation matters, met immediately prior to the scheduled meetings of the Council and Commission.

Personnel: The Council and Commission acknowledged with appreciation the many significant contributions made by Drs. T. Arthur Babineau, Ben D. Barker and Arthur L. Yeager upon completion of their terms as Council and Commission members. Commendation and appreciation were also extended to Dr. John Helfrick, Ms. Sandra Harris and Ms. Darlene Novak who served as Commission members.

Commission on Dental Accreditation

Summary of Accreditation Actions: The Commission's accreditation actions from May 1991 through May 1992 are summarized in Table 1 (see page 58). At the December 1991 and May 1992 meetings, 326 accreditation actions were taken. These actions were based on site visit reports, progress reports submitted by educational institutions detailing the degree to which specific recommendations included in previous evaluation reports had been implemented, and applications for initial evaluation of education programs. As indicated in Table 2 (see page 58), the total number of educational programs currently accredited is 1,292, representing a decrease of six programs from the previous reporting period. The Commission *Rules* stipulate that when the Commission anticipates denial or withdrawal of accreditation, it must inform the institution of its right to appeal the proposed action prior to final action being taken. There were no such appeals during the reporting period. Because accreditation is voluntary, accreditation may also be discontinued at any time during the process upon written request of the sponsoring institution.

Enrollment: Enrollment in accredited dental and dental-related educational programs during the 1991-92 academic year and the number of 1991 graduates are reported in Table 3 (see page 58). In 1991, a total of 3,794 first-year students entered dental school representing a 1% increase from the 3,754 new students in 1990. When students who are repeating their first-year studies are added, the 4,047 students enrolled in first-year dental school in 1991 constitute a 1.15% increase over the 4,001 first-year students enrolled in dental school in 1990. This increase represents the second increase reported in predoctoral first-year students in the past 11 academic years. The number of 1991 dental school graduates decreased by 5.6% from 4,233 to 3,995 during the previous year. The first-year enrollments in dental assisting, dental hygiene and dental laboratory technology increased by 4.6%, 1.2% and 2.6% respectively. There was a 1.9% increase in dental specialty first-year enrollment and a 3.1% increase in general practice residency program first-year enrollment. The total number of students enrolled in advanced education programs in general dentistry increased 8.3% from the previous reporting period. Currently, 38,436 students are enrolled in accredited dental and dental-related education programs in the United States. This represents an increase of 1.2% from the previous academic year.

*Council on Dental Education Member

Table 1

Accreditation Actions
May 1991 - May 1992

Classification	Dental	Advanced Dental Specialties	General Practice Residency	General Dentistry	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Accreditation Eligible		6				6		12
Preliminary Provisional Approval			4	4	1			9
Approval	7	91	40	14	27	24	5	208
Conditional Approval	2	19	12	1	12	8	2	56
Provisional Approval	1	6	3		1	2	1	14
Accreditation Denied				1				1
Accreditation Withdrawn Discontinued Program		5	4	2	11	1	3	26
Number of Accreditation Actions	10	127	63	22	52	35	9	326

Source: ADA Department of Educational Surveys

Table 2

Number of Accredited Programs: May 1992

Accreditation Classification	Dental	Advanced Dental Specialties	General Practice Residency	General Dentistry	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Accreditation Eligible		16				7		23
Preliminary Provisional Approval			14	13	6			33
Approval	54	384	226	60	217	193	43	1,177
Conditional Approval	1	12	12	1	12	7	2	49
Provisional Approval		6	2		1	2	1	12
Number of Programs	55	418	254	74	236	209	46	1,292

Source: ADA Department of Educational Surveys

Table 3

Enrollment and Graduate Summary: October 1991

	Dental	Advanced Dental Specialties	General Practice Residency	General Dentistry	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
1st Year Enrollment	4,047	1,259	903	366	6,162	5,487	932	19,156
Percent Change	1.1	1.9	3.1	5.5	4.6	1.2	2.6	2.6
Total Enrollment	15,882	3,121	934	443	6,365	10,193	1,498	38,436
Percent Change	-0.4	2.8	-2.5	8.3	3.7	3.7	0.1	1.2
Number of Graduates	3,995	1,141	877	352	3,999	4,229	655	15,248
Percent Change	-5.6	2.1	0.2	20.5	1.4	7.0	9.9	1.6

Source: ADA Department of Educational Surveys

Third Interim Report to the Council on Postsecondary Accreditation (COPA) Submitted: As previously reported (*Reports* 1989:95; 1990:101; 1991:113), COPA in 1989 took action to continue recognition of the Commission. At that time, the Commission was required to submit an annual interim report on the revision of the accreditation standards for dental hygiene education programs. The third interim report was submitted in November 1991. It was reviewed by COPA's Committee on Recognition and the COPA Board. In April 1992, the Commission was notified that COPA had accepted the interim report as "satisfactory and responsive to its concerns." The Commission will not be required to submit any additional reports prior to the next regularly scheduled re-recognition review scheduled for January 1994.

Revision of Accreditation Standards: In accordance with its *Bylaws* authority, the Commission has undertaken several activities related to the development and revision of accreditation standards during the previous year. In May 1992, based on a documented need, revised accreditation standards for advanced education programs in periodontics were adopted with a July 1, 1994 implementation date. The major changes in the document include incorporation of increased specific levels of knowledge and skill in numerous basic and biological science and in clinical content areas in the curriculum, including implant dentistry. Another major change is the expansion of the minimum length of the program from two academic years to three academic years with a minimum of 30 months of instruction.

As was previously reported (*Reports* 1989:96; 1990:101; 1991:113), in 1990 the Commission initiated comprehensive revisions of the accreditation standards for dental assisting, dental hygiene and dental laboratory technology education programs. Following a lengthy process that provided opportunities for input by the profession through three written comment periods and three open hearings for each discipline, the Commission took final action on the standards in December 1991. The implementation date for all three revised standards documents is January 1, 1993.

Major changes in the dental assisting standards included a merger of the separate standard on advanced functions into the curriculum standards, more flexible provisions for independent study programs and increased specificity of the standard on required curriculum content. Significant revisions to the dental hygiene standards included more specifically required curriculum content in clinical dental hygiene and the addition of a new standard on patient care. Dental laboratory technology standards were revised to increase the specificity of the required curriculum content and recast the curriculum standards as competency-based statements, clarify the required program director and faculty qualifications, and delete the separate standard for evening programs. In response to Resolution 90H-1990 (*Trans.*1990:555), the standards for all three disciplines now incorporate new language to explicitly highlight the flexibility afforded to educational institutions in designing innovative programs to improve access for nontraditional students.

The Commission also initiated several revisions in the accreditation standards that are pertinent to all 14 accredited disciplines, in an effort to maintain standards that are current and relevant to the needs of education and practice. The Commission considered a proposed addition to the standards that would require all students, faculty and staff who are involved in the direct provision of patient care to be recognized (certified) in basic life support procedures. At its May 1992 meeting the Commission directed that this proposed new standard be circulated to the communities of interest for review and comment; it is anticipated that final action will be taken in December 1992. Because of the importance of this issue to patient protection in clinical settings, the projected implementation date is January 1993.

As previously reported (*Reports* 1991:113), in 1991 the Commission considered adoption of a general standard for all disciplines that would provide guidance to accredited programs on dealing with the public health issues related to bloodborne infectious diseases. At its May 1992 meeting the Commission reviewed a draft standard that incorporated comments provided following the December 1991 meeting. This proposed standard would require accredited programs to integrate appropriate content related to bloodborne infectious diseases throughout their curriculums and to implement policies related to patients, students, faculty and staff having such diseases. The Commission directed that the draft standard be disseminated to the communities of interest for review and comment. Further, an open hearing will be held during the March 1993 meeting of the American Association of Dental Schools. It is anticipated that the Commission will take final action in May 1993; the new standard would become effective on January 1, 1994. Finally, because of the urgency with which the Commission views this issue, the Commission adopted that portion of the proposed standard related to required curriculum content as interim policy, pending completion of the usual review process.

Revised "Outcomes Assessment" Document Distributed: During 1991 the Commission revised information related to the assessment of educational outcomes and provided the revised "Outcomes Assessment" document to accredited programs with the January 1992 issue of *Communications Update*. The material was revised to provide more guidance to accredited programs as they comply with the Commission's standard on outcomes assessment. Adoption of this standard and the initial development of informational material was previously reported to the House (*Reports* 1986:37; 1987:88). The revised material promotes the concept that successful programs consider assessment as an ongoing process that has inherent values apart from accreditation, use a variety of internal and external measures and have plans that are comprehensive in nature. The new material reflects the thesis that assessment must take place within the framework of the competencies, functions, procedures or patient-care services contained in the discipline-specific accreditation standards. When multiple dental or dental-related programs are sponsored by one institution, the importance of developing a single, overall comprehensive plan is stressed.

"Competence Assessment" Document to be Developed: The Commission's increased emphasis on outcomes rather than the process of education requires programs to document that their students have learned what was described in the institution's mission and goals statements. This emphasis is reflected in the accreditation standards for all disciplines, which include a specific standard that requires outcomes assessment as part of determining the quality of educational programs (*Reports* 1986:37). The Commission has also indicated that evaluation

of the quality of educational programs should be based on whether the graduates have an appropriate well-defined level of skill and knowledge as specified in the standards for the specific discipline.

Assessment of student competence is central to the Commission's mission of quality improvement and is integral to the intent of the standards in all accredited disciplines. The Commission has historically provided assistance to programs in this area. For these reasons, the Commission determined that it would develop a draft of a generic "Competence Assessment" document. The document is intended for use by educational programs in all disciplines and would provide accredited programs with guidance and examples on competence assessment. The Commission will review the draft document in December 1992. At that time, the appropriateness of the document to each discipline will be assessed. When the document has been approved by the Commission, it will be distributed to all accredited programs.

Calibration, Orientation and Training of New Consultants, Committee, Commission and Council Members: To ensure consistency in all stages of the accreditation process, the Commission undertook a series of calibration activities in 1990 (*Reports* 1991:114) and continued them in 1991. These efforts will also assist the Commission in demonstrating the reliability of its accreditation procedures to both the Council on Postsecondary Accreditation and the U.S. Department of Education (USDOE) during the next re-recognition reviews. The Commission is paving new ground in the accreditation community with this endeavor, which has already shown a positive impact on the accreditation process. Calibration exercises have been conducted by each of the Commission's standing committees during the previous three Commission meetings. In addition, guidelines were developed to delineate the documentation required from programs to demonstrate compliance with Commission recommendations. These guidelines have been provided to accredited programs and used by all standing committees at the two most recent meetings. The guidelines will continue to be revised based on the results of the calibration activities to be conducted at all future Commission meetings. In May 1992 the Commission adopted a protocol to ensure continued calibration efforts.

Calibration efforts were expanded during 1991 to include more specific efforts to orient and train new members of the standing committees, Commission and Council. A formal orientation meeting was held with new members in December 1991. Because the Commission has a minimum of 25% new members each year, such formal orientation sessions will continue.

Consultants continue to be calibrated and trained through the Commission's consultant training workshops. Since 1984, the Commission has conducted 22 workshops in various disciplines. During the past year, two advanced education workshops were conducted. In May 1991 a workshop was held for pediatric dentist consultants; in October 1991 a workshop was held for advanced general dentistry consultants. Workshops for endodontics, oral and maxillofacial surgery, predoctoral and allied dental education consultants are scheduled for 1992.

Efforts to Reduce the Cost of Accreditation: The Commission has been concerned about the cost of the accreditation process to dental schools. In attempts to minimize these costs, the Commission has revised the *Self-Study Guide*, provided documents on computer disks and provided staff assistance to understand the process. The revised *Self-Study Guide for the Evaluation of a Dental Education Program in the United States* was adopted and transmitted to dental education programs being site visited in 1994. Also, dental education programs being site visited in 1993 were provided a copy of the revised *Self-Study Guide* and given the option of changing from the previous version. In revising the *Self-Study Guide*, the Commission has made efforts to eliminate redundancy, streamline the content and provide better guidance regarding appropriate documentation to demonstrate compliance with accreditation standards. These revisions are intended to decrease time and cost to institutions in preparation of their self-study. Additional guidance in establishing the length of time allotted to the self-study process was also included. To save time and effort in wordprocessing, the Commission has provided the schools with computer disks containing the *Self-Study Guide* and its tables and the suggested site visit schedule. Further, Commission staff have attempted to increase contacts with institutional personnel in order to establish communications and provide assistance during the self-study process.

During the past year the Commission has also revised all advanced education self-study documents to reflect a combined format for institutions that sponsor multiple programs. The documents were revised to reflect the institutional perspective related to common areas in the standards for all dental-related programs. These revised documents are intended for the following: to reduce institutional costs when preparing for site visits; to streamline the process and content of the self-study; to eliminate redundancies; to provide clearer guidance to individuals responsible for completing the documents; and to reduce the amount of paperwork that institutions prepare for a site visit. Use of these documents will be phased in with advanced education programs being reviewed after July 1, 1992.

The Commission will monitor use of these documents to ensure that they successfully accomplish their intended purpose to assist institutions by streamlining the accreditation process with the intent of reducing costs to the institution. Further, the Commission continues to study other ways in which it can reduce accreditation preparation costs to the institution.

Adjustments to the Standards Revision Process: During the recent revision of the allied dental education accreditation standards, the Commission followed its policy and procedures for revising the accreditation standards related to all 14 disciplines. The revision of the dental hygiene standards prompted the Florida Dental Association (FDA) to raise some questions regarding the Commission's procedures.

The FDA proposed that final adoption of the revised allied dental education standards be postponed to allow an additional comment period. However, the Commission determined that the revision process and timetable had been widely published and included significant opportunities for comment. For these reasons and because the Commission believed that timely action on the revised standards was important to many of the communities of interest, the Commission followed its published timetable and took final action on the revised standards in December 1991.

The FDA also suggested that the Commission distribute all drafts of proposed revised standards in a format that would highlight proposed additions and deletions. In addition, the Reference Committee on Dental Education and Related Matters heard testimony on this issue during the 1991 annual session, which was referred to the Commission for consideration (*Trans.*1991:603). At its December 1991 meeting, the Commission concurred with this suggestion and directed that all draft standards documents henceforth be circulated with recommended deletions and additions appropriately highlighted. The Commission also directed that all Commissioners attending future open hearings on standards revisions be introduced and, if possible, seated at a head table to enhance their visibility to participants. Finally, in December the Commission requested that a detailed report be developed to explore the cost impact and related implications of several other suggestions offered by the FDA.

In May 1992, the Commission reviewed this report and determined that future open hearings on revised standards will be tape recorded. Copies of the tape recordings will be made available upon request for a fee sufficient to cover the cost of duplication and use of the tapes will be monitored as the next two standards are revised. The Commission believed that this method would assure the Commission and hearing participants that the testimony presented at open hearings is accurately reported to the Commission, without substantially increasing the costs of conducting hearings.

Defaults on Student Education Loans by Graduate Dentists: The Commission has monitored the increasing interest shown in the loan default rates of individual educational institutions by the U.S. Department of Education. In order to determine if accredited dental and dental-related educational programs were in danger of loss of eligibility for federal funds, the Commission obtained the USDOE report, "Cohort Default Rates for Guaranteed Student Loan Programs, FY 1987, FY 1988, and FY 1989 Loss of Eligibility Report, June 1991." In analyzing the data, the Commission found that only one dental-related education program was in danger and that program had appealed its status. In addition, dentistry had a satisfactory record related to the Health Profession Student Loan program. The Commission has found no correlation between defaults on student education loans and the accreditation of educational programs. However, the Commission is continuing to monitor reports of student loan defaults.

Development of Curriculum Information on Career Advancement Programs: The 1991 House adopted Resolution 117H-1991 (*Trans.*1991:603), which directed the Council on Dental Education (CDE), with input from the Council on Dental Practice (CDP), to develop curriculum guidelines for dental assisting and dental hygiene career advancement programs. Actions taken to address this resolution and the specific strategies recommended by the councils are described in detail in a separate joint report from CDE and CDP to the 1992 House (see page 84).

In direct response to Resolution 117H, the councils determined that information describing examples of innovative career advancement programs should be developed for dissemination to the communities of interest. In May 1992 the Commission reviewed examples of curriculum sequences and curriculum content for several types of nontraditional dental assisting and dental hygiene programs. This material was based on currently accredited allied dental education programs, which are designed to ease access for nontraditional students and support articulation between career fields. The Commission determined that a program curriculum structured along the lines suggested by the examples would be consistent with the accreditation standards on curriculum content. Therefore, the Commission informed the Council of its support for inclusion of the curriculum examples for innovative programs in a Council publication for distribution to educational institutions and dental organizations.

Length of Dental Hygiene Programs: Also in May 1992, the Commission reviewed an informational report of current data on the instructional time students spend in dental hygiene education programs. The report noted that the average number of instructional hours required in dental hygiene education programs equates to approximately 2.25 academic years. This number is only slightly higher than the two-year minimum length specified by the accreditation standards. The perception that the length of accredited dental hygiene programs exceeds two years appears to stem from two facts. The vast majority of students enter dental hygiene with college coursework that exceeds the programs' requirements for admission. And many programs require coursework beyond that specified by the accreditation standards—often to meet state or institutional mandates. Finally, the report noted that the number of associate degree dental hygiene programs has risen steadily while the number of baccalaureate degree programs has remained the same during the past five years. Of the 209 accredited programs, 183 grant a certificate or associate degree. The Commission believed that this report presented information that was both timely and important, and directed that it be disseminated to educational institutions and constituent societies, as well as published in appropriate national publications.

Exploration of Reciprocal Accreditation for U.S. and Canadian Dental Assisting Programs: At its May 1992 meeting the Commission considered a request received from the Dental Assisting National Board, Inc. regarding establishment of a reciprocal agreement between the ADA Commission on Dental Accreditation and the Commission on Dental Accreditation of Canada for dental assisting education programs. The ADA and the Canadian Dental Association's Commission on Dental Accreditation have for some years had reciprocal agreements for predoctoral dental education, advanced dental specialty education and dental hygiene education programs. The Commission determined that it would approach the Commission on Dental Accreditation of Canada about pursuing a comparability study of both agencies' accreditation standards to assess the feasibility of establishing reciprocity for dental assisting accreditation.

Commission Comments on Resolution 111H-1991: As part of its May 7, 1992 meeting, the Commission on Dental Accreditation reviewed the preliminary draft report of the 111H-1991 Ad Hoc Committee to Study the Structure of the Council on Dental Education (*Trans.*1991:598). The second clause of that resolution asks the Commission to consider and comment on the Ad Hoc Committee's preliminary report

during the Commission's May 1992 meeting. All members of the Commission were present during the discussion. Members of the Ad Hoc Committee present included: Dr. Richard E. Bradley; Dr. William TenPas, trustee, District 11; and Dr. Ben D. Barker, Commission chairman. Dr. Clifford H. Miller, assistant executive director, Education, was also present.

The Commission offered a number of comments related to the preliminary draft report as indicated below:

- misuse of the phrase "representing the practicing dentists" to refer exclusively to members of the ADA;
- belief that separation of the meetings and staff of the Council from the meetings and staff of the Commission would have significant ongoing cost with little, if any, tangible benefit to be gained; concern that the ADA has more to lose than gain from this proposed change;
- belief that separation of the staff of the Council from the staff of the Commission would be a significant communications loss and would not improve the effectiveness of either body and has serious implications for the quality of work of both bodies;
- belief that it is appropriate to have a higher rather than a lower percentage of educators on a body that is charged with reviewing educational issues and policy for the Association;
- belief that, because the Council's *Bylaws* duties frequently require mediation between conflicting points of view, the charge of nonresponsiveness is not related to structure and will continue even if a different structure is approved;
- belief that the current procedures related to nomination and election of AADE and AADS members must be maintained;
- belief that carefully fostered cooperative relationships (e.g., between practice, education and licensure) could be damaged;
- belief that the current procedures related to nomination and election of the individual to serve as Council/Commission chair must be maintained;
- belief that a protocol and criteria for determining which of the ADA Council members would also serve as Commissioners must be developed if the Commission is to be protected from potential political controversy;
- belief that any revised structure must be reviewed by the United States Department of Education and the Council on Postsecondary Accreditation to assess any impact—intended or unintended—on the Commission's recognition status; and
- belief that the current procedures related to nomination and election of the individuals who serve as public members of the Commission would have to be modified so that these individuals would be nominated and elected by the Commission rather than the Council.

The Commission was informed by those members of the 111H Ad Hoc Committee who were present that the proposed change in structure of the Council was intended to have no impact on the Commission. In concluding its general discussion summarized above, members of the Commission listed those areas in which there was agreement that the proposed change would impact the Commission. The Commission directed that its concerns about these areas be forwarded to the Ad Hoc Committee with a request for the committee to address them in the final report. Those areas include:

—retention of current language related to the nomination/appointment of the chairman;
—nomination/election of the public members of the Commission by the Commission rather than the Council;
—identification of a separate staff secretary (director) for each body; and
—deletion of all references to the 12 Council members who serve as Commissioners and insertion of language that indicates four Commissioners from AADE, 4 from AADS, 4 from ADA, as well as the 8 members from the other organizations listed.

On Friday, during the Council's election of the new public member of the Commission, it became clear that the responsibility for nomination and election of public Commission members would need to be shifted from the Council to the Commission; if the Council is restructured and is intended to serve the political interests of the ADA, this body cannot retain the right of selecting public Commissioners. Those Commissioners present on Friday directed that this item be added to the matters previously identified for forwarding to the 111H Ad Hoc Committee.

The Commission directed the chairman to communicate these comments to the 111H Ad Hoc Committee with a request that they be addressed in the Ad Hoc Committee's final report.

Council on Dental Education

Dental Education

Request from the American Association of Dental Examiners (AADE) to Participate in a Study of the Results of Licensure Examinations: The Council received a request from the AADE to participate in a study of the results of licensing examinations. The results of such a study would be useful as one of the outcomes measures in the Commission on Dental Accreditation's evaluation of educational programs. Additional information on this issue is included in the Commission's report (see page 59). The Council, for these reasons, concurred that it would participate with the AADE in collecting information of licensure examination results.

Advanced Dental Education

Procedures for Development and Revision of a Specialty Definition: The Council reviewed its current procedures used to approve definitions of dental specialties. When a parent specialty organization is developing or revising its definition of its specialty, the organization submits the proposed revision for Council consideration and approval. The Council, in turn, follows its long-standing practice which may include approval of the proposed definition as submitted, or referral back to the parent specialty organization providing Council rationale regarding areas of concern in the proposed revised definition, and requesting that the parent specialty organization provide new or revised language in the proposed definition.

As a result of its comprehensive study of the specialty recognition process, and following the Council's recent experience in considering revisions of specialty definitions, the Council determined that there was a need for input and comment from the appropriate communities of interest when a new or revised definition is considered. Specifically, the Council believed that a specialty's definition should be very broadly and generically stated and should not include a serial listing of all functions or procedures included within the scope of the specialty. Because accreditation standards for each specialty clearly delineate the educational and practice scope of the specialty, a definition should be limited to a few succinct sentences broadly describing the specialty.

For these reasons, the Council adopted new procedures that will be used to consider future revisions in a specialty definition. In adopting these procedures, the Council determined that they should be implemented immediately for any new or revised definitions proposed for initial consideration following the Council's May 1992 meeting. The new procedures do not apply to any revised definitions currently under review by the Council; rather, they will apply to those definitions presented for initial consideration following the May 1992 Council meeting.

The procedures that will be used in the process include: initial consideration by the Council, circulation to the communities of interest, Council review of comments from the communities of interest prior to approval, notification to communities of interest after approval and notification to the ADA House of Delegates in its *Annual Report*. The procedures for consideration of developing or revising a specialty definition have been sent to all parent specialty organizations and are available to the communities of interest upon request.

Issues Related to Recognized Dental Specialty Certifying Boards

Annual Meeting of Specialty Certifying Boards: In August 1991, the Council convened a meeting of the recognized dental specialty certifying boards, during which representatives of each of the eight specialty certifying boards participated. A major focus of the meeting centered around a discussion of due process procedures. In addition, the feasibility of developing a definition of the term "board eligible" that would be common to all recognized specialties and of establishing common language for revoking or suspending a diplomate's specialty certificate for cause, such as in nonpayment of dues or as a result of license suspension/revocation, was discussed. These two topics will be included on the agenda during the next meeting of this group scheduled for August 1992.

Proposed Change in Term of a Director of a Recognized Certifying Board: In response to an American Board of Orthodontics' (ABO) request, the Council reviewed House-adopted requirements (*Trans.*1983:527) related to the maximum term that a director of a recognized certifying board may serve.

The House-adopted Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists currently stipulate that a board director may not serve more than seven years. The ABO requested that the Council consider expanding the length of term from seven to eight years to accommodate a rotational system established by its parent organization. Because the Requirements allow for a maximum of nine voting directors, the Council concluded, in view of the ABO's request, that the maximum length of service of specialty board directors should be changed from seven to nine years. The change allows specialty certifying boards greater flexibility. Therefore, the Council recommends the adoption of the following resolution:

20. Resolved, that the Requirements for National Certifying Boards for Dental Specialists (*Trans.*1983:527), Organization of Boards (1), be amended by deleting the word "seven" in the second sentence and substituting the word "nine," so that the revised section will read:

> **Organization of Boards:** (1) Each board shall have no less than five or more than nine voting directors designated on a rotation basis in accordance with a method approved by the Council on Dental Education. Although the Council does not prescribe a single method for selecting directors of boards, members may not serve more than a total of nine years. Membership on the board shall be in accordance with a prescribed method endorsed by the sponsoring organizations. All board directors shall be diplomates of that board and only the parent organizations of boards may establish additional qualifications if they so desire.

Revision of "Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry": The *Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry* is a three-part document that delineates the scope of education and clinical experiences in pain and anxiety control in dentistry. Specifically, the document identifies the standards for teaching the subject at the predoctoral, advanced (graduate and postgraduate) education and continuing education levels. Parts One and Two of the *Guidelines* address the teaching of pain and anxiety control at predoctoral and advanced education levels respectively and are Council-approved documents. Because Part Three deals with continuing education courses in pain and anxiety control and affects practicing dentists, the House approves and adopts this section of the *Guidelines*. The "Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in a Continuing Education Course" was initially approved by the 1971 House (*Trans.*1971:533) and was subsequently revised by the 1978 House (*Trans.*1978:517) and by the 1985 House (*Trans.*1985:575).

Preliminary activities related to the need to revise the *Guidelines* was reported to the 1991 House (*Reports* 1991:116). The Council's review was prompted in part by recommendations emanating from its 1989 dental anesthesiology workshop. As a result, the Council directed that a comprehensive review of the three-part document be undertaken. Changes proposed by the Council's Anesthesiology Steering Committee were approved by the Council for circulation to the communities of interest for review and comment. The draft document was transmitted to the following: constituent dental societies; state dental boards; specialty organizations and certifying boards; the American Association of Dental Examiners; the American Association of

Dental Schools (AADS); the American Dental Society of Anesthesiology; the American Society of Dentist Anesthetists; dental deans; administrators of advanced education programs in non-dental school settings; and dental chiefs of the federal services. In addition, an open hearing was conducted during the 1992 AADS annual session.

At its March 1992 meeting, the Steering Committee considered all comments received and incorporated further changes into all three parts of the document. The changes proposed by the Steering Committee for Part One (predoctoral) of the document were essentially editorial. Subsequently, the Steering Committee determined that there was a need for further substantive revisions in this Part. Specifically, it was determined that a more comprehensive description of the level, depth and scope of instruction required for teaching local anesthesia and nitrous oxide inhalation sedation was needed. However, Part One currently does not detail the specific didactic and clinical instruction necessary to achieve competence in these pain control modalities. For this reason, it was concluded that Part One of the *Guidelines* requires further revision in order to include these content areas. For this reason, the Council determined that final action on Part One of the *Guidelines* should be delayed until the additional suggested content areas are developed, incorporated and circulated to the communities of interest for review and comment prior to final action. The Council will review these additional content areas at its December 1992 meeting.

The proposed changes in Part Two of the document included revised language for the definition of deep sedation. The proposed language change in the definition was intended to be consistent with the outpatient anesthesia requirements contained in the Commission on Dental Accreditation's *Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery*. The definition proposed by the Steering Committee differs, however, from the definition proposed by the American Association of Oral and Maxillofacial Surgeons (AAOMS). Because the Council's *Guidelines* and the Commission's *Standards* must retain the identical language for a definition of deep sedation, the Council concluded that the language in the definition of deep sedation must be resolved between the Steering Committee and the AAOMS. For this reason, the Council concluded that adoption of Part Two of the *Guidelines* should be deferred until the Steering Committee can meet with representatives of the AAOMS to resolve the deep sedation definition issue. The Council will take final action on this matter at its December 1992 meeting.

The Council also considered all comments received regarding Part Three of the *Guidelines*. The proposed changes include both editorial and substantive revisions in the instruction of nitrous oxide sedation and parenteral conscious sedation. Course objectives were added relative to abuse, occupational hazards and hallucinatory effects of use of nitrous oxide-oxygen and principles of advanced cardiac life support. With regard to instruction in nitrous oxide sedation instruction, instructional hours were reduced from a minimum of 24 to a minimum of 14. This change was made in conjunction with the elimination of a practice requirement for a specified number (5) of patients to read "including a clinical component during which competency is demonstrated." The Council believed that the reduced number of instructional hours is adequate for didactic instruction in this modality in light of the fact that the revision now requires clinical experience to the competency level. This change significantly strengthens this guideline. Regarding parenteral conscious sedation instruction, an increase from 10 to 20 patients to be managed per participant "to achieve competency in parenteral conscious sedation techniques." is being recommended. Additionally, clinical experience in airway management has been incorporated as a requirement for satisfactory completion of training in this technique. Part Three of the *Guidelines* document is included in Appendix 1 (see page 69). Accordingly, the Council recommends adoption of the following resolution.

21. Resolved, that "Part Three: Teaching the Comprehensive Control of Pain and Anxiety in a Continuing Education Program" of the *Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry* be approved, and be it further **Resolved,** that Resolution 1H-1985 (*Trans.*1985:576), approving the previous "Guidelines," be rescinded.

Issues Related to the Availability of Programs to Train Dentist Anesthesiologists: The Council considered a report dealing with concerns related to dental resident rotations to hospital anesthesia services that also sponsor medical anesthesiology programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). The concerns resulted from a June 1991 memorandum circulated by the ACGME. The memorandum advised "... that non-physicians are ineligible to train in ACGME-accredited residency programs" and further, "... that, the enrollment of non-eligible residents may be cause for withdrawal of accreditation."

Based on subsequent correspondence received from the ACGME, the Council concluded that residents enrolled in Commission-accredited advanced education training programs, as well as residents enrolled in dental anesthesiology training programs would be able to continue to rotate on medical anesthesiology services. However, the Council directed that this matter be monitored continually.

After receiving the ACGME communication, there has continued to be a growing level of concern expressed by the communities of interest regarding this issue. Residents enrolled in Commission-accredited programs (e.g., oral and maxillofacial surgery and general practice residency) do not appear to have been affected by the ACGME action. Nonetheless, since the ACGME sent its memorandum, there have been continuing difficulties related to dental anesthesiology resident stipend support. Subsequently, the Council has been apprised of the fact that four dental anesthesia residency programs apparently have closed to dentists since August 1991 as a direct result of the ACGME's memorandum.

At its March 1992 meeting, the Council's Anesthesiology Steering Committee reviewed correspondence received from several sources since the Council discussed this matter in December 1991. The Steering Committee also met with two individuals who had previously directed a university-based dental anesthesiology training program. In addition, data about dental residents enrolled in dental and medical anesthesiology residency programs provided by the American Society of Dental Anesthesiology was reviewed. This data reflects a dramatic decline in the number of training programs available

to dentists between 1990 and 1992. Based on all information considered, the Steering Committee forwarded several recommended actions to the Council for its consideration. The Council, at its May 1992 meeting, agreed with the Steering Committee's conclusions and directed that actions be taken to address the decline in the total number of positions available to train dental anesthesiologists. Specifically, the Council directed the following: (1) that a formal meeting be held with representatives of the ACGME to discuss problems resulting from the June 1991 ACGME memorandum; (2) that following a meeting with the ACGME, it should host a meeting to include representatives from the American Society of Anesthesiology, the American Dental Society of Anesthesiology, the American Society of Dentists Anesthesiologists and the American Association of Oral and Maxillofacial Surgeons to discuss matters of mutual interest related to dental anesthesiology training; (3) that additional data was needed regarding dental anesthesiology training at the predoctoral, advanced and dental anesthesiology training levels and therefore, determined that all dental schools should be surveyed to collect information on how instruction in this subject area is provided at the predoctoral and advanced education levels; and (4) that additional actions should be identified and undertaken to ensure that adequate opportunities continue to exist for dentists to train in anesthesiology. A report on the Steering Committee's activities will be considered by the Council at its December 1992 meeting.

Allied Dental Education

Trends in Allied Dental Education and Manpower: The Council has continued to follow trends in allied dental education through the annual surveys of educational programs. Survey data for 1991-92 indicated that first-year enrollment in both dental assisting and dental hygiene programs continued to rise for the third consecutive year, while dental laboratory technology enrollment also increased for the second year. The increases in program enrollment are also beginning to be reflected in program graduate figures. For the first time since 1978-79, the number of program graduates increased in all three allied disciplines. This is a continuing trend for dental hygiene especially; in 1991, for the first time since 1978, the number of dental hygiene graduates was greater than dental school graduates.

There are currently 209 dental hygiene programs, the highest number since the mid-1970s. At its December 1991 and May 1992 meetings, the Commission granted accreditation to six new programs. All of these programs are based in community colleges and confer the associate degree. The Commission has provided, on request, consultation to educational institutions explaining the various options by which programs can meet accreditation standards. Despite the growth in number of programs and increasing reported first-year class capacity due to many programs' expansion, dental hygiene programs remain nearly fully enrolled.

Many of the newly accredited dental hygiene programs are taking innovative approaches such as institutional co-sponsorship, evening class schedules or leasing an extended campus clinical facility. In addition, the Commission has approved changes in several existing programs that have redesigned their curricula or modes of presentation to accommodate needs of nontraditional students.

Unfortunately, the number of dental assisting and dental laboratory technology programs continues to decline. Following the Commission's May meeting, there were 235 dental assisting programs, in contrast to a high of 290 in 1985. From a peak of 58 programs in 1985, the number of dental laboratory technology programs has declined to 47. The Council has worked with the SELECT Oversight Committee to implement an early warning system to identify and assist programs that are significantly under-enrolled. Annual survey data for 1991-92 identified 31 assisting and eight dental laboratory technology programs that reported at least a 25% decline in enrollment. These programs were offered the resources of the SELECT Program to assist with their student recruitment efforts.

Correspondence Programs for Dental Assistants: As previously reported (*Reports* 1991:117) the Council has an on-going interest in the development and/or encouragement of dental assisting correspondence programs. The Council believes that correspondence programs would provide an effective method to meet the profession's need for educated dental assistants, especially if the independent study program met the Commission's accreditation standards. Several such programs are currently available in Canada.

The University of Kentucky College of Dentistry is developing an Independent Dental Education for Assistants (UK-IDEA) program, with initial grant funding from the American Fund for Dental Health (AFDH). The Association's Board of Trustees reviewed the IDEA proposal in April 1992 and supported the need for such a program. Both the Council on Dental Education and the Council on Dental Practice (CDP) have supported the concept of the program by providing staff consultation. The Council was informed at its May 1992 meeting that the AFDH has determined that fund raising for this project will not fit its current priorities. Therefore, the CDP is seeking alternative sources of financial support. Further progress on this program will be reported to the profession.

Council Support for State Dental Society Manpower Activities: As reported to the 1991 House (*Trans.*1991:117), the Council has for several years provided consultation and support to assist constituent dental societies in developing strategies to enhance student recruitment and initiate new allied dental education programs. In May 1991, the Council determined that more specific input was needed from state dental societies regarding the resources and assistance that would be beneficial to them. In August 1991, a survey was sent to ADA constituent dental societies to elicit information on the states' perceptions of the allied personnel shortages and the resources they believed would be helpful. Responses were received from 38 states (70% response rate). The results were reported to the Council at its December 1991 meeting and to the Board of Trustees in January 1992.

Almost all respondents (94%) believed there is a shortage of dental hygienists, while approximately two-thirds (65%) indicated a shortage of dental assistants and only 15% perceived a shortage of laboratory technicians. Fewer than half of the states had used any of the resources, services and publications currently available from various agencies of the

Association. In response to a list of potential additional resources that might be provided, the most frequently selected options included information on developing new traditional or nontraditional education programs, integrating nontraditional curriculum options into existing accredited programs and student recruitment materials. The Council's response to Resolution 117H-1991 (*Trans.*1991:603) is consistent with these survey results.

Task Force on Mandatory Education and Credentialing for Dental Assistants: In spring 1991, leadership of the American Dental Assistants Association (ADAA) approached the Association and other organizations interested in dental assisting issues for the purpose of exploring the feasibility of mandatory education and/or credentialing for dental assistants. To study this issue, the ADAA determined that a "task force" representative of the dental assisting communities should be convened. Together with all of the key organizations, the ADA agreed to participate by appointing representatives to the task force. Dr. James Clark, Tenth District trustee; Dr. Arthur Babineau, Council on Dental Education member; and Dr. Thomas Harrison, Council on Dental Practice member, were appointed to represent the Association.

The first meeting of the ADAA Task Force was held in January 1992 in Chicago. The primary purpose of the first meeting was to discuss all of the issues and to identify preliminary goals and objectives for the task force. Several additional task force meetings are anticipated, and the House will be informed of further progress.

Specialty Recognition

Study of the Specialty Recognition Process: As reported to the 1990 House (*Reports* 1990:107) and to the 1991 House (*Reports* 1991:118), the Council has undertaken a comprehensive review of the specialty recognition process. The report outlines the history of specialty recognition; it details events which have taken place since 1983 when the House called for review of all currently recognized dental specialties (*Trans.*1983:527); it outlines the conduct of the Council study; it summarizes survey results regarding the specialty recognition process; it includes information regarding procedures followed for approval of medical specialties; it reviews and reports changes made in the current procedures for recognition of a new specialty; it responds to Resolution 74H adopted by the 1988 House (*Trans.*1988:491) regarding procedures for resubmission of an application once an organization has been denied specialty recognition; it addresses issues related to a process for periodic review of currently recognized dental specialties; and it responds to Resolution 97H adopted by the 1991 House (*Trans.*1991:601) regarding specialty re-recognition (Appendix 2, see page 75).

Licensure

ADA to Host American Association of Dental Examiners (AADE)/American Association of Dental Schools (AADS) Forum in 1992: During 1990, the Council convened a forum of educators and examiners to address matters of mutual interest related to dental education and dental licensure (*Reports* 1990:107). This forum was an outgrowth of the study of a number of issues related to mobility and freedom of movement in the dental profession addressed in 1989 in Resolution 18H-1988 (*Trans.*1988:495). Because of the success of this forum, the Council was requested and agreed to convene an AADE/AADS forum at two-year intervals. Several items have been identified for discussion during the forum that will be convened during the Council's December 1992 meeting. Forum participants will discuss matters related to the performance of graduates of accredited dental schools on regional and state licensing examinations.

The Council continues to believe that formal agreements between dental schools and boards of dentistry would be beneficial to dentists identified as having clinical competency problems requiring remediation because the remediation procedures to be followed would be clearly identified. For this reason, the Council has placed this topic on the forum agenda. Additional items will be added to the agenda by AADE and AADS.

Continuing Dental Education

Council Support for the Proposed Provider Recognition Program (PRP): The Council was informed about the action taken by the 1991 House (*Trans.*1991:600) relative to its proposal to implement a PRP. The Council noted that one of its members, Dr. Henry M. Cherrick, was appointed to serve on the seven-member Presidential-appointed special committee to develop the details of a PRP in response to the 1991 House resolution. Activities of the special committee are included in the special committee's report (see page 141). The Council reiterated its firm support for the development and initiation of a PRP that meets the broad-based needs of the membership.

Collection of Data Related to Continuing Education (CE) Interests of Member Dentists: The Council, in concert with the Bureau of Economic and Behavioral Research (BEBR), developed several questions related to continuing education for inclusion in the 1992 "rainbow" special survey of dental practice. The primary focus of the questions is on where respondents obtain their CE (inside or outside of organized dentistry), what type of CE format is prevalent (lecture, participation courses, etc.) and what content areas are important to participants.

The Council has developed a data base of member dentists with a specific interest in continuing education as part of its distribution of the Continuing Education Course Listing. The June 1992 listing will be distributed to about 5,000 member dentists who have requested this publication. The listing contains, on the average, information on 900 to 1,000 CE opportunities submitted by some 100 sponsors. Following distribution of the June 1992 listing, the Council has directed that staff work with the BEBR to analyze the profile of those ADA members who have requested the CE Course Listing. This information and the information obtained through the 1992 BEBR survey questions will be used to develop additional CE programs and activities in accordance with the Council's *Bylaws* responsibilities in this area.

Issues Related to Continuing Education Credits for General Dentists: The Council is exploring, from several perspectives, the issue of CE credits for general dentists. In December 1991, the Council directed that a study be conducted to determine whether any CE content areas are frequently mandated for relicensure. Staff in the Council on Governmental Affairs and Federal Dental Services is conducting this study with assistance from Council staff. If such mandated content areas exist, constituent and component dental societies will be urged to provide courses in the identified content areas as a membership service. It is also anticipated that the results of the survey will be shared with the Council on ADA Sessions and International Relations (CASIR) and other appropriate agencies of the Association.

The Council requested the CASIR to explore the feasibility of offering cardiopulmonary resuscitation recertification as a membership service during the ADA annual session. This matter was scheduled for discussion during that Council's May 14-15, 1992 meeting.

The Council is also exploring ways in which the Association can assist members desiring to earn CE credit. The Council is working cooperatively with the Association's Department of Salable Materials and legal counsel and has discussed several alternatives related to the issue of CE in relation to specific products such as audio and video tapes or *The Journal of the American Dental Association* subscription services. Other avenues of issuing credit as a service to members will be explored further.

"Program Planning for the '90s" Workshops for 1992-93: During 1992, "Program Planning for the 90s" workshops, co-sponsored by the Council and the Academy of General Dentistry (AGD) Council on Continuing Dental Education since 1987, will be held in conjunction with the annual meetings of the AGD and the ADA (*Reports* 1991:120). Plans have also been made to offer co-sponsored workshops during 1993 in conjunction with the Chicago Mid-Winter meeting and the ADA annual meeting. The workshops are, in general, self-supporting and continue to be well-received by those CE program planners who attend them. Both councils believe that they are making a significant contribution to improvement in the quality of dental CE activities by continuing to co-sponsor these workshops.

Agreements for Remedial Education Related to Clinical Competency: The Council has explored the topic of the development of mutual formal agreements between state boards and dental schools designed to address identified clinical competency problems of dentists (*Reports* 1990:111). The few existing formal agreements between state boards and dental schools that were previously obtained by the Council will be provided to AADE/AADS forum participants to develop guidelines on such agreements during the 1992 forum (see page 66). The Council will share the guidelines developed during the forum discussion with state boards and dental schools for use as they develop their respective formal agreements.

Dental Admission Testing Program (DAT) Trends: Since 1975, the number of examinees participating in the DAT had been decreasing at a steady rate of approximately 10% annually. Beginning with the fall 1989 test administration, the number of examinees began to increase.

The total number of examinees participating in the testing program includes both the fall and the spring administrations of the test. The number of examinees participating in the testing program during the 1989-90 academic year (5,223) increased by 6.7% from the previous year. Similarly, the number of examinees participating during the 1990-91 and 1991-92 academic years also increased by approximately 8.9% and 11.9%, respectively.

Dental Admission Testing Program (DAT) Research Activities: Programmatic research on the DAT is being conducted in three areas. The first area is related to the validity of the DAT in predicting performance in dental school didactic and technique courses. The results of this research suggest that the academic portion of the DAT continues to be the best single predictor of first- and second-year dental school didactic grades and that the perceptual ability portion (PAT) is the best single, nationally available, predictor of technique performance. This area of research also has investigated the usefulness of incorporating a new item type into the PAT. Based on the research findings, the PAT is being reconfigured so that previously unused paper-folding items will become an integral part of the test. Research results suggest that inclusion of such items will allow the PAT to be a more valid predictor of dental school technique performance.

The second area of on-going research is related to test validity issues. The emphasis of this research, however, is the development of guidelines for the construction of PAT and reading comprehension test items. Research on the PAT is focusing attention on those characteristics of PAT items that tend to enhance the validity of the PAT in the prediction of performance. Research devoted to the identification of design features is valuable for the development of items that exhibit psychometric characteristics appropriate for admission tests. The research relevant to reading comprehension is examining the relationship of item difficulties to reading passages in light of cognitive processing models. Findings of this research should allow for development of such passages appropriate to the DAT.

The final area of research activity is related to the test items that exhibit performance differences that may be related to the examinee characteristics of gender and ethnicity. Research in this area is designed to identify problematic items, i.e. items that evaluate content that is differentially familiar to subgroups of examinees. These items are then reviewed and revised by test construction committees.

Department of Career Guidance/SELECT

The Department of Career Guidance/SELECT supports the activities of the Council on Dental Education through its efforts to encourage highly qualified individuals to consider careers in the dental profession. Since the report to the 1991 House (*Reports* 1991:120), SELECT distributed more than 500,000 pieces of career guidance information to state and local dental societies, dental and allied dental education programs, and to individuals requesting information from the ADA or the American Association of Dental Schools. Materials distributed

included brochures, fact sheets, posters, videos, radio and TV spots, and related publications.

In addition, SELECT continued to provide consultation services to support the development of dental society career guidance programs for traditional and nontraditional students to consider careers in dentistry, dental assisting, dental hygiene and dental laboratory technology. SELECT's orientation seminars and manuals assisted dental society efforts to involve a substantial number of members of the profession in career guidance activities.

In 1990, the SELECT Program conducted a national "train-the-trainers" workshop at the ADA Headquarters. The goal of the workshop was to train participants in the planning and activation of SELECT Program activities at state and local levels. These trainers conducted regional workshops in 1991 and are continuing to implement a series of seminars in 1992. Working cooperatively with the Council on Dental Education, SELECT has responded to Resolution 73H-1989 (*Trans.*1989:536) through this activity and other related projects.

In 1991, SELECT targeted the current shortage of qualified dental assistants with the development and national distribution of a new brochure, fact sheet and poster. Preliminary reports from state dental society SELECT coordinators and dental assisting education program directors indicate that these materials are being utilized in many constituent and component dental society career guidance programs.

Response to Assignments from the 1991 House of Delegates

Dentist's Pledge: In response to Resolution 32H-1991 (*Trans.*1991:599), the Council transmitted the revised Dentist's Pledge to the deans of all U.S. dental schools. In addition, the Dentist's Pledge was transmitted to the Department of Salable Materials. That department reported that it would have a prototype plaque made and would determine if the appearance and the cost of the plaque would be acceptable. It would then be marketed to the membership.

Vaccination of Students, Faculty and Staff: In response to Resolution 33H-1991 (*Trans.*1991:599), the Council transmitted the immunization policy for dental health education institutions to all accredited dental, advanced dental and allied dental education programs in the United States. The information was also transmitted to all accredited programs through the Commission's *Communications Update*.

ADA's Policy Statement on Federal Intervention in Licensure: Resolution 34H-1991 (*Trans.*1991:625) rescinded Resolution 6-1968-H (*Trans.*1968:248) for housekeeping purposes because it was duplicative of the Association's more comprehensive 1975 House-adopted policy (*Trans.*1975: 187;718).

Continuing Dental Education Provider Recognition Program (PRP): Resolution 35H-1991 (*Trans.*1991:599) calling for development of the details of a continuing dental education PRP was assigned to a Presidential-appointed special committee. The Council's recommendation on the initiation of a broad-based PRP as an important membership service is included in its annual report (see page 141).

Implementation of Plan to Publicize Newly Developed Licensure Examination Document: As noted in a separate report on steps to implement the plan addressed in Resolution 36H-1991 (*Trans.*1991:600) (see page 82), the new document *Guidelines for Valid and Reliable Dental Licensure Clinical Examinations* has been created, will be distributed to the identified internal and external communities in June 1992 and will be presented to identified representatives of the 22 testing agencies in a national invitational conference scheduled for July 1992. Limited consulting with testing agencies unable to attend this conference will be conducted as time and funding permit.

ADA Specialty Re-Recognition Process: As reported in another section of this report (see page 66), the Council on Dental Education considered Resolution 97H-1991 (*Trans.*1991:601) in the context of its comprehensive study of the specialty recognition process. The resolution requested that the Council submit its recommendations on the recognition and re-recognition process for consideration by the 1992 House and requests that the Council take no action relative to implementation of a re-recognition process without the endorsement of the 1992 House. The Council considered this resolution at its December 1991 and May 1992 meetings. The Council's recommendations regarding specialty recognition and re-recognition are included in its report of the comprehensive study of the specialty recognition process (see page 75).

Additional Funding for SELECT's Dental Assisting Recruitment Activities: Resolution 103H-1991 (*Trans.*1991: 602) provided the SELECT Program with $5,000 to support additional recruiting efforts for dental assistants in 1992. In response to this resolution, the SELECT Oversight Committee directed that a portion of these funds be utilized to conduct a "train-the-trainers" workshop for American Dental Assistants Association (ADAA) coordinators at the 1992 ADAA annual session. The Committee further recommended that any remaining funds provided by this resolution be utilized to support the ADAA for expenses incurred while performing consultative services in the early warning system for under-enrolled education programs. Additionally, the Committee suggested that remaining funds may also be used to pay fees for broadcasting SELECT's dental assisting radio spots for education programs that express a desire to recruit more "nontraditional" students.

Flexible Training Programs for Dental Hygiene and Dental Assisting: As noted in other sections of this report (see pages 61, 65 and 66), the Council on Dental Education and the Council on Dental Practice have cooperated in addressing Resolution 117H-1991 (*Trans.*1991:603). The councils' recommended strategies to encourage development of innovative, flexible career advancement programs for dental assistants and dental hygienists are detailed in a joint report to the 1992 House (see page 84). In addition, several immediate action plans were approved by the councils for implementation prior to the 1992 annual session. These activities were designed to provide information on innovative program options to state

dental society leadership through a special panel presentation during the 1992 annual session and publication of model curriculum material, which was reviewed by the Commission on Dental Accreditation.

Response to Assignments from the 1988 House of Delegates

Study of Establishment of a Policy and Procedure for Reapplication When an Organization has been Denied Specialty Recognition: Resolution 74H-1988 (*Trans.*1988:491) called for the Council to study the establishment of a policy and procedure for reapplication for specialty recognition once a sponsoring organization's application has been denied. In response to this resolution in 1989 (*Reports* 1989:101), the Council advised the House that this matter would be addressed as part of the Council's comprehensive study of the specialty recognition process. As noted in the report of that study presented in another section of this report (see page 75), the Council concurred with the intent of the House that a policy and procedure for resubmission of an application for recognition of a new specialty should be established. The procedures are summarized in the report and have been incorporated into the Council's "Application for Recognition of a Dental Specialty."

Summary of Resolutions

Amendment/Rescission of Current Policies:

20. Resolved, that the Requirements for National Certifying Boards for Dental Specialists (*Trans.*1983:527), Organization of Boards (1), be amended by deleting the word "seven" in the second sentence and substituting the word "nine," so that the revised section will read:

> **Organization of Boards:** (1) Each board shall have no less than five or more than nine voting directors designated on a rotation basis in accordance with a method approved by the Council on Dental Education. Although the Council does not prescribe a single method for selecting directors of boards, members may not serve more than a total of nine years. Membership on the board shall be in accordance with a prescribed method endorsed by the sponsoring organizations. All board directors shall be diplomates of that board and only the parent organizations of boards may establish additional qualifications if they so desire.

21. Resolved, that "Part Three: Teaching the Comprehensive Control of Pain and Anxiety in a Continuing Education Program" of the *Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry* be approved, and be it further **Resolved,** that Resolution 1H-1985 (*Trans.*1985:576), approving the previous "Guidelines," be rescinded.

Appendix 1

GUIDELINES FOR TEACHING THE COMPREHENSIVE CONTROL OF PAIN AND ANXIETY IN DENTISTRY

PART THREE*

TEACHING THE COMPREHENSIVE CONTROL OF PAIN AND ANXIETY IN A CONTINUING EDUCATION PROGRAM

The goal of continuing education programs in pain and anxiety control is to provide the educational opportunity for dentists to receive training in the various techniques and skills required to manage pain and anxiety in the conscious dental patient, and to permit dentists who have previously received such training to maintain and/or upgrade their knowledge and skills. The conscious patient is defined as "one with intact protective reflexes, including the ability to maintain an airway, and who is capable of rational response to question or command."

These Guidelines present a basic overview of the requirements for properly teaching continuing education courses in pain and anxiety control for the conscious patient. These include courses in local anesthesia~~ology~~, ~~psychological and~~ pharmacological and non-pharmacological methods of controlling pain and anxiety and the management of related complications. Because of their complexity, the teaching of inhalation and intravenous conscious sedation techniques is discussed in detail.

Shading indicates additions
~~Strikeouts~~ indicate deletions

*As approved by the Council on Dental Education for submission to the 1992 ADA House of Delegates

The scope of training and time required to prepare the practitioner to manage patients with deep sedation or general anesthesia restrict this aspect of teaching to an advanced education program (graduate or postgraduate). ~~level,~~

Definitions:

Methods of Pain and Anxiety Control: A variety of terms are used to describe the different methods of controlling pain and anxiety. The following are definitions of the terms as used in this document:

Local Anesthesia--is the elimination of sensations, especially pain, in one part of the body by the topical application or regional injection of a drug.

Conscious Sedation--is a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command and that is produced by a pharmacologic or non-pharmacologic method or a combination thereof.

In accord with this definition, the conscious patient is defined as "one who has intact protective reflexes, including the ability to maintain an airway, and who is capable of rational response to question or command." The drugs and techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely.

Deep Sedation--is a controlled state of depressed consciousness accompanied by partial loss of protective reflexes, including the occasional inability to independently maintain an adequate airway and/or respond purposefully to verbal command, and is produced by a pharmacologic or non-pharmacologic method or combination thereof.

General Anesthesia--is a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, and is produced by a pharmacologic or non-pharmacologic method or a combination thereof.

Routes of Administration: The following are definitions of terms used in this document to describe routes of administration:

Parenteral--is any technique of drug administration in which the drug bypasses the gastrointestinal (GI) tract. Examples: intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC)~~, epidural~~.

Inhalation--is a technique of drug administration in which a gaseous or volatile agent is introduced into the pulmonary tree and whose primary effect is due to absorption through the pulmonary bed. Example: nitrous oxide-oxygen inhalation sedation.

Verbs: The verbs used in this document (i.e., must, should, and may) were selected carefully and indicate the relative weight attached to each statement. The definitions of these words are as follows:

Must: Indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

Should: Indicates the recommended manner to obtain the standard; highly desirable.

May: Indicates freedom or liberty to follow a suggested alternative.

Levels of Skill: The following definitions of levels of skill are used in this document.

Proficient--the level of skill attained when a particular activity is accomplished with repeated quality and a more efficient utilization of time (highest level of skill).

Conscious Sedation:

A. Course level: Continuing education courses in conscious sedation techniques may be offered at three different levels (intensive, supplemental and incidental). A description of these different levels follows:

1. Intensive Courses in conscious sedation are programs designed to meet the needs of dentists who wish to become knowledgeable and proficient in the safe and effective use of nitrous oxide-oxygen inhalation and/or parenteral conscious sedation techniques. They consist of lectures, demonstrations and sufficient clinical participation to assure the faculty that the dentist understands the procedures taught and can safely and effectively apply them. Faculty must be prepared to assess the individual's competency upon successful completion of such training.

2. Supplemental (or Refresher) Courses are designed for persons with previous training in conscious sedation techniques. They are intended to provide a review of the subject and an introduction to recent advances in the field. They should be designed didactically and clinically to meet the specific needs of the participants. Participants must be able to document previous training (equivalent, at a minimum, to the intensive continuing education course described in this document) and current experience in conscious sedation to be eligible for enrollment in a supplemental or refresher course. This does not preclude allied dental personnel ~~auxiliaries~~ from attending such courses with the dentist to enhance ~~their~~ skills needed for ~~in~~ assisting the dentist in the administration of conscious sedation.

3. Incidental Courses are overview or survey programs, which are designed to provide general information about subjects related to pain and anxiety control. Such courses should be didactic and not clinical in nature, since they are not intended to develop clinical competency. Practitioners seeking to develop clinical competency in any given conscious sedation techniques are expected to complete successfully ~~complete~~ an intensive continuing education course ~~including that~~ teaching that technique. ~~in the specific conscious sedation modality(ies).~~

(Information in the remainder of this document pertaining to objectives, curricular content, sequence and length of instruction, evaluation, documentation, faculty and facilities relates to intensive continuing education courses in conscious sedation techniques.)

B. Objectives: Upon completion of an intensive continuing education course in conscious sedation techniques, the dentist should be able to:

1. Describe the anatomy and physiology of the respiratory, cardiovascular and central nervous systems, as they relate to the techniques ~~effects~~ of ~~drugs used for~~ conscious sedation.

2. Describe the pharmacologic effects of drugs used for conscious sedation.

3. Describe the methods of obtaining a medical history and ~~do~~ conduct an appropriate physical examination of a dental patient.

4. Apply these methods clinically in order to obtain an accurate evaluation of the dental patient.

5. Use this information clinically for risk assessment.

6. Choose the most appropriate technique of conscious sedation for the individual dental patient.

7. Discuss physiologic monitoring and the equipment used in such monitoring.

8. ~~Additionally,~~ Upon completion of a course in nitrous oxide-oxygen inhalation sedation techniques, the dentist should be able to:

   a. Describe the basic components of inhalation sedation equipment.

   b. Discuss the function of each of these components.

   c. List and discuss the advantages and disadvantages of inhalation sedation with nitrous oxide-oxygen.

   d. List and discuss the indications and contraindications for the use of nitrous oxide-oxygen inhalation sedation.

   e. List the complications associated with nitrous oxide-oxygen inhalation sedation.

   f. Discuss the prevention, recognition and management of these complications.

   g. Administer nitrous oxide-oxygen inhalation sedation to patients in a clinical setting in a safe and effective manner.

   h. Discuss concerns related to use of nitrous oxide-oxygen

      (1) Abuse potential
      (2) Potential occupational hazards
      (3) Hallucinatory effects

9. ~~Additionally,~~ Upon completion of a course in parenteral techniques of conscious sedation, the dentist should be able to:

   a. Describe and demonstrate the technique of venipuncture or any other parenteral technique chosen for the patient.

   b. Discuss the pharmacology of the drug(s) selected for administration.

   c. Discuss the precautions, contraindications and adverse reactions associated with the drug(s) selected.

   d. Administer the selected drug(s) parenterally to dental patients in a clinical setting in a safe and effective manner.

   e. List the complications associated with parenteral techniques of sedation.

   f. Discuss the prevention, recognition and management of these complications.

   g. Describe a protocol for management of emergencies in the dental office.

   h. List the emergency drugs and equipment required for management of life-threatening situations.

   i. Discuss the use of these emergency drugs and equipment in specific life-threatening situations.

   j. Discuss principles of advanced cardiac life support (ACLS). Certification in ACLS should be encouraged.

   ~~j~~k. Demonstrate the ability to manage life-threatening emergency situations, including cardiopulmonary resuscitation.

C. Course Content: The following course content is generally applicable to both inhalation and parenteral sedation programs:

1. Historical, philosophical and psychological aspects of pain and anxiety control.

2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological profiling.

3. Definitions and descriptions of physiological and psychological aspects of pain and anxiety.

4. Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and the unconscious state.

5. Review of respiratory and circulatory physiology and related anatomy.

6. Pharmacology of agents used in the conscious sedation techniques being taught, including drug interactions and incompatibility~~y~~ies.

7. Indications and contraindications for use of the conscious sedation modality under consideration.

8. Review of dental procedures possible under conscious sedation.

9. Patient monitoring using observation and mechanical aids, with particular attention to vital signs and reflexes related to consciousness.

10. Importance of maintaining proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs administered and patient response.

11. Prevention, recognition and management of complications and life-threatening situations that may occur during use of conscious sedation techniques, including the principles of advanced life support.

12. Importance of using local anesthesia in conjunction with conscious sedation techniques.

13. ~~Additionally,~~ Course content for programs in inhalation sedation techniques with nitrous oxide-oxygen should include:

    ~~a~~1. Description and use of inhalation sedation equipment.

    ~~b~~2. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting occupational exposure.~~elimination of these potential health hazards~~

    ~~c~~3. Discussion of abuse potential.

    ~~d~~4. Discussion of hallucinatory effects.

14. Additional course content for parenteral conscious sedation programs should include:

    ~~a~~1. Venipuncture: anatomy, armamentarium and technique.

    ~~b~~2. Sterile techniques in intravenous therapy

    ~~c~~3. Prevention, recognition and management of local complications of venipuncture.

    ~~d~~4. Description and rationale for the technique to be employed.

    ~~e~~5. Prevention, recognition and management of systemic complications of intravenous sedation, with particular attention to airway maintenance and support of the respiratory and cardiovascular systems.

~~f~~6. Abuse potential of parenteral agents.

D. Sequence and Length of Instruction: The following portions of the intensive pain and anxiety control course may be taken separately, but the first two should be considered prerequisite~~s~~ for the others:

1. Patient evaluation and risk assessment.

2. Management of medical emergencies, including the principles of advanced life support.

3. Nitrous oxide-oxygen inhalation conscious sedation techniques.

4. Parenteral conscious sedation techniques, ~~i.e.~~ e.g., intravenous conscious sedation.

Nitrous Oxide Sedation Instruction: While length of a course is only one of the many factors to be considered in determining the quality of an educational program, the course should include ~~accumulated experience indicates that~~ a minimum of ~~24~~ 14 ~~instructional~~ hours~~,~~ ~~plus supervised clinical experience in managing a minimum of five patients per participant are required to achieve competency in nitrous oxide inhalation sedation techniques.~~ including a clinical component during which competency in nitrous oxide-oxygen inhalation sedation techniques is demonstrated.

Parenteral Conscious Sedation Instruction: A minimum of ~~sixty~~ 60 hours of instruction, plus management of at least ~~ten~~ 20 patients per participant, is required to achieve competency in parenteral conscious sedation techniques. Clinical experience in managing a compromised airway is critical to the prevention of life-threatening emergencies. Participants should be provided supervised opportunities for clinical experience to demonstrate competence in management of the airway. Typically, ~~such~~ clinical experience will be provided in managing healthy adult patients. Additional supervised clinical experience is necessary to prepare participants to manage children and medically compromised adults. The faculty should ~~not hesitate to request~~ schedule participants to return for additional clinical experience ~~direct participation in patient management when they have not demonstrated sufficient~~ if competency has not been achieved in the time allotted.

E. Participant Evaluation and Documentation of Instruction: Intensive courses in conscious sedation techniques must afford participants with sufficient clinical experience to enable them to achieve competency. This experience must be provided under the supervision of qualified faculty and must be evaluated. The course director ~~faculty~~ must ~~be prepared to~~ certify the competency of participants upon satisfactory completion of training in each conscious sedation technique, including instruction, clinical experience and airway management.

Records of the didactic instruction and clinical experience (including the number of patients managed by each participant in each pain and anxiety control modality) must be maintained and available for review by appropriate credentialing agencies. Such documentation must not be, or resemble, a certificate or diploma.

F. Faculty: For all facets of training, the course should be directed by a dentist or physician qualified by training. This individual ~~with a minimum of one year of advanced education in comprehensive pain and apprehension anxiety control or its equivalent~~ should have had at least three years of experience, including the individual's formal training in general anesthesia. Dental faculty with broad clinical experience in the particular aspect of the subject under consideration should participate. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, cardiologists and psychologists, should be encouraged.

A participant-teacher ratio of not more than ten-to-one when inhalation sedation is being used and five-to-one when parenteral sedation is being used allows for adequate supervision during the clinical phase of instruction; a one-to-one ratio is recommended during the early stage of participation.

The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who will be presenting the course material.

G. Facilities: Intensive courses should be presented only in a dental or medical school, hospital, dental society-sponsored educational institution or other institution where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

Appendix 2

STUDY OF THE SPECIALTY RECOGNITION PROCESS

Background: Specialty recognition in dentistry began in 1947 with completion of the Council on Dental Education's (CDE) first comprehensive study of dental specialties. Based on this study, the 1947 ADA House of Delegates approved Requirements for Approval of Examining Boards in Dental Specialties (Reports 1947:254). As a result, the areas of oral surgery, orthodontics, pedodontics, periodontics and prosthodontics were recognized as special areas of dental practice. The number of approved specialties was increased to seven with the recognition of oral pathology in 1949 and dental public health in 1950. None of these dental specialties underwent a specialty recognition process; all were recognized by direct action of the House.

In 1959, upon recommendation from the Council, the ADA House approved a revised version of the Requirements and retitled the document Requirements for National Certifying Boards for Special Areas of Dental Practice (Trans.1959:204). This document specified, for the first time, seven criteria by which specialty areas would be recognized.

Using the 1959 criteria, the Council recommended and the House, in 1963 (Trans.1963:244), endodontics as the eighth recognized dental specialty. Thus, endodontics was the only specialty recognized using a specialty recognition process and based on specific House-approved criteria.

In 1978, the American Association of Dental Schools (AADS) was awarded a grant from the W. K. Kellogg Foundation to undertake a study of advanced dental education in the United States. The AADS, in close cooperation with the CDE, convened a task force "to review issues and problems, explore solutions to them and suggest improvements in the advanced education of dentists." In 1980, the CDE considered the report of that task force titled Advanced Dental Education: Recommendations for the '80s. Based on this review, the Council placed high priority on responding to the following recommendation:

> The task force recommends that the American Dental Association through its Council on Dental Education, undertake a major study of dental specialization to review the purpose of specialty recognition and to accomplish the most effective structuring of those areas deserving specialty recognition.

As an initial step, the Council directed that the criteria for specialty recognition contained in the Requirements adopted in 1959, be studied and, if necessary, revised. Also, on the Council's recommendation, the 1981 House adopted a resolution (Trans.1981:587) imposing a moratorium on the recognition of additional specialties until final action could be taken on new criteria. In 1981, the Council endorsed in principle a preliminary draft revision of the criteria. Subsequently, the Council requested input from all interested parties on the proposed document, with the intent that it be submitted to the 1983 House for final action.

The Council determined that revision of the 1959 criteria was necessary because, in its judgment, the criteria were confusing, repetitive and of disparate importance. In revising the criteria, the Council determined that a revision should focus more clearly and directly on specific factors considered essential for recognition. Further, it was determined that there was a need to delineate more explicitly the purpose of specialty recognition and the process for achieving and retaining such recognition. Accordingly, in 1983 (Trans.1983:527) the ADA House approved a revised document, titled Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists. These criteria have not been revised since that time.

Periodic Review of Recognized Specialties: As part of its study of specialty recognition that led to approval of revised criteria in 1983, the Council noted that only one of the eight recognized dental specialties, endodontics, was evaluated using any criteria. It was also noted that none of the recognized specialties had undergone in-depth review by the Council or House since their initial recognition. In adopting the criteria and Requirements in 1983, the House approved the concept that "each recognized specialty be reviewed within ten years of the adoption of this revised document," to determine whether the specialties continue to meet the established requirements for recognition. Further, the 1983 House Requirements stipulated that, after initial review, recognized specialties be reviewed periodically, "at intervals to be determined by the Council."

The 1983 resolution adopting the revised recognition criteria directed the Council to develop and implement a plan for the review of the recognized specialties, including a description of the process. The review process, described in the "Introduction" section of the revised criteria, states: "the sponsoring organization must submit to the Council on Dental Education a formal application which demonstrates compliance with all criteria for specialty recognition. The Council will submit its recommendation for approval or denial of the proposed specialty

to the Association's House of Delegates." It is the ADA House of Delegates that makes the final determination as to whether a discipline will be recognized by the profession as a specialty.

The timetable for review of recognized specialties was forwarded to the 1984 House (Reports 1984:48). The order in which the specialties were to be reviewed was determined by random selection during the Council's May 1984 meeting. The review of the recognized specialties was conducted as follows:

Specialty	Council Meeting
dental public health	May 1986
prosthodontics	December 1986
oral pathology	May, 1987
periodontics	December 1987
oral and maxillofacial surgery	May 1988
orthodontics	December 1988
endodontics	May 1989
pediatric dentistry	December 1989

Plans for Comprehensive Review of the Specialty Recognition Process: In view of the fact that it would complete its review of all currently recognized specialties in December 1989, at its May 1989 meeting, the Council directed that a comprehensive study of the specialty recognition process be undertaken beginning in 1990. In preparing for that review, the Council at its December 1989 meeting, discussed preliminary plans for the review. These plans included conducting surveys of general practitioners, dental specialty organizations and related dental organizations. Additionally, it was determined that the current criteria for recognition should be reviewed to determine the need for additional criteria or revision of the existing criteria. Also, the Council agreed that the current application for specialty recognition should be revised. The Council concluded that it would notify the broad communities of interest of its intent to conduct such a study. It also determined that it would impose a moratorium on the receipt of applications for recognition of new specialties to extend from January to December 1991 while the application and its procedures were undergoing revision. The communities of interest were notified of these Council actions in the February 19, 1990 issue of the ADA News. At its December 1991 meeting, the Council rescinded this moratorium, effective January 1992.

In December 1990, the Council reviewed preliminary data regarding its survey of general practitioners along with the survey data from the specialty organizations. Although the Council explored the feasibility of expanding one of its surveys to include a larger sample of general practitioners and practicing specialists, based on cost estimates for such a survey conducted by the Bureau of Economic and Behavioral Research, the Council determined that such expansion would be prohibitive and thus would not be done.

Survey Results: In October 1990, 160 general practitioners were surveyed regarding the specialty recognition process. Each of the ADA's 16 district trustees was asked to identify ten general practitioners within their district to complete the survey.

These individuals comprised the sample used for the purpose of the survey. A second follow-up mailing was sent to all non-respondents in November. By January 1991, 151 (94.4%) of the surveys were returned for analysis. Respondents reported that they strongly believe that the ADA should periodically review recognized specialties based on public need and demand for services provided by the specialty through a formal application process. Likewise, respondents indicated their belief that it is in the public interest to require recognized specialties to undergo periodic review. Sixty-three percent (95) of the respondents indicated their belief that significant changes could occur in education or in the practice environment to eliminate or vastly alter the need for all of the eight currently recognized dental specialties.

In September 1990, the eight dental specialty organizations were surveyed regarding their specific experiences with the specialty re-recognition process, as well as regarding their opinions about the value of this process. All recognized dental specialties responded to the survey. Information provided by these organizations showed a significant variation in the total cost estimates in preparing their application; all but one specialty reported that the process was not helpful to the specialty nor did any believe they benefitted significantly from the process. The Council recognized that, because seven of the eight recognized dental specialties never underwent any review, it was necessary for the Council to require information so that it could develop a database. It is understandable that the specialties could construe providing such information as a negative feature of the process. Likewise, all but one specialty reported that the process did not facilitate their strategic planning. When asked about the interval at which a specialty should seek re-recognition, all but one specialty responded by indicating that they did not support re-recognition of existing dental specialties at any interval or at all. Dental public health suggested that specialties should be reviewed "no earlier than 12-15 years."

Following receipt of the completed survey from the American Association of Orthodontists (AAO) in April 1991, additional information was provided in correspondence dated September 23, 1991, to the Council chairman. This information included a document titled, "Position of the AAO Board of Trustees on Continued Recognition of the Specialties." While the initial information received from the AAO did not support a re-recognition process for existing dental specialties, the latter document did support a recognition process and "recommends that the review for continued recognition be streamlined, whenever possible, to reduce both the time and costs."

Similarly, the initial survey information received from the American Academy of Oral Pathology (AAOP) indicated that they did not support re-recognition of existing dental specialties. In subsequent correspondence sent to the Council chairman in October 1991, the AAOP president stated, "We do not object to the concept of oversight and review, however, the process by which such is to be evaluated must be streamlined and with a specific clear-cut objective in mind."

In addition to surveying the specialty organizations, the Council also solicited comments on the specialty recognition process from the American Association of Dental Schools (AADS), the American Association of Dental Examiners (AADE) and the American Association of Hospital Dentists (AAHD). The AADS response stated that its "Executive Committee wholeheartedly supports the ADA in the comprehensive review of specialty recognition/re-recognition..." Further, the AADS comments go on to say that they also support "...the establishment of processes to evaluate defined current non-specialty areas." In their comments, the AAHD suggested that the existing criteria for recognition be revised into two sets of standards, one for initial recognition and one for re-recognition, and suggests that "the initial recognition process may necessitate several steps over 5-10 years for which the varying levels of criteria compliance are publicly acknowledged." In addition, the AAHD suggested that initial recognition "should accommodate emerging areas that cut across multiple specialty areas and alternately, the scope of certain specialties should be evaluated for inclusion of emerging areas." The AAHD recommended that the re-recognition process occur every ten years.

Summary of Information Regarding Procedures for Approval of Medical Specialties: The Council's study of the specialty recognition process included a review of the procedures used to recognize medical specialties. This process falls under the purview of the American Board of Medical Specialties (ABMS). The process for recognition of medical specialties differs

significantly from that used in dentistry. In medicine, a specialty board is established and ultimately may seek recognition from the ABMS. Once ABMS approval is granted to a new board, a new special area or sub-specialty of practice is designated. As of 1991, the ABMS had designated 23 primary specialty boards and a total of 67 specialty designation categories (this includes sub-specialties). The ABMS process does not include procedures for the re-recognition of currently recognized medical specialties. Further, the medical model does not include a process of recognition by the American Medical Association or its House of Delegates.

Proposed Revision of the Requirements for Recognition of a Dental Specialty: The five requirements for recognition of a dental specialty were reviewed to determine if there was a need for revision of the existing requirements or if additional criteria were required. The Council noted that some requirements have periodically raised questions and were subject to broad interpretation by outside agencies. Specifically, problems have been associated with the terms "readily subsumed" as contained in one of the requirements. In its discussion of this matter, the Council also noted that consideration was given to changing these terms in earlier versions of the Requirements but consensus could never be reached on an appropriate alternate phrase. Accordingly, the Council concluded that there should be no changes in the existing House-approved Requirements.

Review of the Process and Procedures for Special Appearances Regarding Specialty Recognition: At the time the existing specialties were undergoing the re-recognition process, it became necessary for the Council to establish procedures for special appearances. Two sets of procedures were subsequently established and adopted by the Council; one addresses the procedures for a special appearance by a third party and the other addresses procedures for a special appearance by the organization seeking recognition. Both procedures have been followed when these types of special appearances have been requested. These procedures were reviewed as part of its comprehensive review of the specialty recognition process. Believing that the procedures established work effectively, the Council concluded that these documents do not require change.

Revision of Specialty Recognition Application: A need for revision of the application form became apparent while the Council was in the process of reviewing each of the recognized specialties. However, at that time the Council concluded that it would not be fair to the remaining specialties to evaluate their compliance with each of the criteria using a different document.

Thus, it was determined that revision of the application should be one of the last activities conducted as part of the study, since revision of the document would depend heavily on the input received from the recognized specialties and would need to reflect any changes proposed for the recognition criteria.

In recognition of the need to develop a document that would be introspective and would lend itself to true self-analysis, while allowing the applicant to demonstrate that each of the criteria for recognition had been met, the Council made editorial revisions to the application. It is intended that the revised document will be used by organizations requesting initial recognition of a dental specialty.

Consideration of Establishing Procedures for Reapplication When an Organization Has Been Denied Recognition as a Dental Specialty: In 1988 the ADA House adopted Resolution 74H-1988 (Trans.1988:491) calling for the Council to study establishing policy related to procedures for reapplication for specialty recognition once a sponsoring organization has been denied recognition by the House. In its 1989 annual report to the House (Reports 1989:101), the Council advised the House that this issue would be studied as part of the review of the specialty recognition process.

It was noted that the American Board of Medical Specialties has established reapplication procedures; its policy states that reapplication can occur 12 months following notification of the final disposition of the application. The Council supports this concept and believes that a similar policy should be adopted as part of the ADA's specialty recognition process. If this procedure is adopted, a sponsor of a proposed specialty could not reapply until 12 months following House action or until 12 months following voluntary withdrawal of the application. (There is precedent for a sponsoring organization withdrawing an application prior to House consideration).

In another action, the Council determined that its policy on reapplication procedures should clearly state that resubmission of an application requires submission of the application in its entirety, not just those portions of the application that were found to be in non-compliance with the recognition criteria. The Council also determined that consideration of a revised application can only be considered as an entire application dealing with all criteria, not just those sections previously found to be in non-compliance. Resubmitted applications must highlight new and or clarifying information since the time of the previous submission or in response to deficiencies noted at the time of denial/withdrawal. Accordingly, the Council has established procedures for reapplication when a proposed specialty has been denied specialty recognition. The procedures have been incorporated into the Application for Recognition of a Dental Specialty as part of the section on "Instructions for Completing the Application."

Consideration of the Continued Recognition of Recognized Dental Specialties: In May 1990, the Council stated its belief that a process should remain in place for the review of currently recognized dental specialties. The Council pointed out that it would determine a specific time interval for that review, based on the findings of its study of the specialty recognition process. After reviewing a progress report on the study of the specialty recognition process, the Council reviewed suggested time intervals for re-recognition of existing specialties. In considering possible intervals, the Council reviewed the survey data provided by general practitioners, specialty organizations, the AADS and the AAHD. The Council concluded that it would establish a review cycle specifying when existing specialties will next be required to undergo review for re-recognition as a dental specialty.

1991 House of Delegates Resolution Regarding the Specialty Re-recognition Process: In October 1991 the ADA House considered a resolution calling for discontinuation of a re-recognition process for existing dental specialties (Trans.1991:601). In its review of this resolution, the Board of Trustees offered a substitute resolution that was subsequently supported by the education Reference Committee and adopted by the House. This resolution states:

97H. Resolved, that the Council on Dental Education submit its recommendations on the recognition and re-recognition process for consideration by the 1992 House of Delegates, and be it further

Resolved, that the Council on Dental Education take no action relative to the implementation of a continued re-recognition process without the endorsement of the 1992 House of Delegates.

During the 1991 ADA House's deliberation of this resolution, a delegate questioned whether the elimination of the re-recognition process would present a problem with the Federal Trade Commission. Upon advice of legal counsel, the Speaker of the House convened an Executive Session of the House of Delegates and legal implications associated with specialty re-recognition were discussed.

As noted previously, in May 1990 the Council first stated its support for a process for review of currently recognized dental specialties. The Council discussed this issue again in May 1991 and December 1991. On each occasion, the Council affirmed its earlier decision that some type of process should be in place to allow the Association to review periodically recognized dental specialties. At its December 1991 meeting, the Council concluded that re-recognition, at a fixed ten-year interval, should be required, given the rapid changes in technology, science, changing disease patterns, and changes in the scope of dental and specialty practice.

In view of concerns expressed by some of the specialty organizations about the Council's decision that called for the dental specialties to undergo the re-recognition process every ten years, the eight recognized specialty organizations were invited to comment on this issue. At its May 1992 meeting, the Council reviewed the correspondence that was received from each organization. Six specialty organizations indicated they did not support the concept of re-recognition; two organizations support the need to provide periodic evaluation of the specialties, but encouraged the Council to develop a streamlined process. As a result, the Council reconsidered its previous decision calling for re-recognition at ten-year intervals. During its deliberations, the Council continued to support the thesis that it was appropriate and important for the Association to have a mechanism in place whereby a recognized specialty could be called for review if it was believed that the specialty may no longer meet the Requirements for specialty recognition. However, the Council concluded that such a process could exist without necessitating review of all specialties at a fixed interval. For this reason, the Council considered alternative mechanisms for periodic review of recognized specialties.

Following careful consideration of the advantages and disadvantages of each proposed mechanism, the Council concluded that it should periodically conduct a comprehensive review of specialty education and practice. The Council further determined that such a study should be conducted at ten-year intervals. These studies would include, but not be limited to, factors such as changes in technology, changes in the knowledge of all specialties, specialty education enrollment patterns, changing patterns in dental disease, changing demographics, epidemiologic studies, shifts in the scope of practice of all specialties and changes in the general and specialty practice environments. Based on the recommendations and conclusions drawn from such a comprehensive study, the Council would determine if any of the currently recognized specialties should be reviewed for re-recognition. Further, the Council determined that it would begin its first comprehensive study of advanced education in 2001.

Procedures for Re-Recognition of a Dental Specialty: If the Council should determine that a recognized specialty must undergo review for re-recognition as a result of a comprehensive study of advanced education, the Council concluded that a revised re-recognition process should be established. In the Council's judgment the process for re-recognition of a currently recognized specialty should be different and more focused than the process used for initial recognition of a dental specialty. The Council determined that a streamlined introspective self-study application should be developed. Further, the Council determined that the application process should include a timetable for the procedures to be followed once the Council has called for a review of a recognized specialty. Therefore, the Council has directed that its standing Committee on Specialty Recognition draft proposed procedures and a streamlined application for re-recognition of a dental specialty.

Summary: This report summarizes activities regarding the Council's specialty recognition process since it first began in 1947. Further, the report has described the events that have occurred since the current process was adopted by the House of Delegates in 1983. The report presents findings from a comprehensive study of this process that began in December 1989 and concluded in May 1992.

Special Report of the Council on Dental Education

A Response to Resolution 36H-1991—Implementation of Plan to Publicize Newly Developed Licensure Examination Document

Background: The 1991 ADA House of Delegates adopted Resolution 36H-1991 (*Trans.*1991:600) which states:

> **Resolved,** that appropriate agencies of the Association implement the comprehensive plan presented by the Council on Dental Education that includes development of a new comprehensive document that merges the identified common core requirements with the Guidelines for Developing Dental Licensure Clinical Examinations, developed in response to Resolution 32-1989 (*Trans.*1989:524) and the 1985 AADE Guidelines for Clinical Examinations and that encourages the testing agencies and licensing jurisdictions to ensure that their examinations meet these minimum requirements.

The comprehensive plan referenced in the resolution included the following four steps, identified in the body of the report to the House (*Reports* 1991:124):

1. creation of the new document that merges the items identified in the resolution;
2. distribution of the document to previously identified internal and external audiences (*Reports* 1991:124);
3. presentation of the document at appropriate national level meetings; and
4. presentation of the document at a national invitational conference.

Step One—Guidelines Document Developed: Step one of the Resolution 36H-1991 promotional plan called for the development of a new comprehensive document that merged the identified minimum common core requirements with the Guidelines for Developing Dental Licensure Clinical Examinations, developed in response to Resolution 32-1989, and the 1991 AADE Guidelines for Clinical Examinations. This new document will be used in carrying out the other three steps of the plan.

In December 1991, the Council reviewed a preliminary draft of the new comprehensive document that was developed as step one of the plan to implement this resolution. At that time, the Council directed that the preliminary draft document be distributed to members of the ADA/AADE Licensure Committee for review and comment along with specific comments received from members of the Council. The ADA/AADE Licensure Committee was first constituted to assist the Council in addressing Resolution 14H-1988 (*Trans.*1988:494) and has met as needed to address additional assignments since that time. The licensure committee is composed of the following members: Dr. Ben D. Barker, chair and Drs. Wayne Barnes, Edward Carlson, Richard Chichetti, W.V. Kittleman, Michael Koufos, David Low, Henry Pollard and William van Dyk. Dr. Jack Kavanagh, professor, research methodology, Loyola University, again served as consultant to the committee.

The licensure committee met in February 1992 to make its final decisions on the new merged document, Guidelines for Valid and Reliable Dental Licensure Clinical Examinations. The licensure committee reviewed the document and forwarded it to the Council for approval in May 1992. The Council was pleased that the new document is formatted as a practical working document that will be easy for testing agencies to use.

Step Two—Distribution of the Guidelines: The second step of the plan approved in conjunction with this resolution relates to distribution of the new document to previously identified internal and external audiences. The licensure committee and subsequently the Council reviewed the previously developed lists for appropriateness and completeness. The revised distribution lists include the following:

External agencies:

- state boards of dentistry
- dental testing agencies
- constituent dental societies
- U. S. schools of dentistry
- specialty parent organizations and boards
- American Association of Dental Examiners
- American Association of Dental Schools
- American Student Dental Association
- National Dental Association

Internal agencies:

- ADA Officers and Board of Trustees
- the Commission on the Young Professional
- the Council on Governmental Affairs and Federal Dental Services
- the Council on Dental Practice
- the ADA membership through articles in the *ADA News* and *The Journal of the American Dental Association.*

The Council will urge the internal and external audiences to work cooperatively to ensure that the testing agencies within their spheres of influence follow the Guidelines for a valid and reliable examination and make use of the identified common core requirements in their clinical licensure examinations. It is anticipated that the Guidelines document will be distributed to these audiences in June 1992.

Steps Three and Four—Encourage Use of the Guidelines: Steps three and four call for the Council to present the new Guidelines document at a variety of national-level professional meetings and to host a national invitational conference to address the applicability of the material in the new document to the specific needs of various testing agencies. The Council supported the licensure committee's recommendation that the

order of these steps should be reversed, with the national invitational conference being convened first. This conference will be held in Chicago on Saturday, July 18, 1992.

Recognizing that a great deal of confusion and misunderstanding surrounds the licensure examination process, the goal of the 36H National Invitational Conference is to educate and assist the primary user group of the new document. The primary audience at this conference will be the Examination Committee chair of each of the 22 testing agencies, although some other representatives of licensing and testing agencies may elect to attend the conference at their own expense.

Following the conference, limited individual consultation will be provided. As determined by the licensure committee chair and as funding permits, the committee will accept invitations for two committee members to present the new document at certain other meetings of testing or licensing agencies. As invitations for individual consultation are received and considered, priority will be given to those agencies unable to send representatives to attend the National Invitational Conference because of established travel restrictions. Because funding for this project will not carry over into 1993, such consultation will occur as quickly as possible following the July conference.

Agenda of the 36H National Invitational Conference: The goal of the 36H National Invitational Conference is to educate and assist the primary user group of the new document. The conference will include the following: present an overview of the purpose and goals of the new ADA/AADE document, Guidelines for Valid and Reliable Dental Licensure Clinical Examinations; provide a brief overview of the background and process used in the studies that led to development of the document; and discuss the legal implications of the Guidelines document. The main focus of the conference will be on small break-out sessions that will allow the individual agencies to discuss how the Guidelines principles might be implemented by each agency. The results of these smaller sessions will be reported to the entire conference for general discussion prior to adjournment.

Because the remaining steps center on the ADA/AADE document developed in step one and approved by the Council, results of the other steps of the comprehensive plan approved by the 1991 House will be reported following their completion as part of the Council's 1993 report. A copy of the Guidelines document can be obtained by contacting the Council's offices.

Resolutions: This report is informational in nature and no resolutions are presented.

Joint Report of the Council on Dental Education and the Council on Dental Practice

A Response to Resolution 117H-1991—Flexible Education Programs for Dental Assistants and Dental Hygienists

Background: Concerns related to a shortage of dental assistants and dental hygienists in some regions of the country began to surface in 1986, partly as a result of an increase in the demand for dental care services combined with a variety of demographic trends. The Council on Dental Education (CDE) and the Council on Dental Practice (CDP) responded to the shortage concerns by sponsoring conferences and focus groups, publishing articles and booklets, providing direct consultation to state dental societies, and undertaking other activities to encourage and support state and local efforts.

The 1988 House of Delegates reviewed a joint CDE/CDP report (*Reports* 1988:117) that outlined contributing factors to the personnel shortage situation. A portion of the report explained the councils' conclusions that educational institutions should be encouraged to develop more flexible curriculums designed to increase accessibility for nontraditional students. From 1988 to the present, the House of Delegates has adopted several resolutions relative to manpower concerns (*Trans.*1989:533; 1989:536; 1990:551; 1990:555). CDE's responses to these resolutions were previously reported to the House (*Reports* 1990:109; 1991:113,117).

Nontraditional Programs: The Council on Dental Education and the Council on Dental Practice recognized that each geographic area has unique circumstances that must be addressed to effectively solve its manpower problems. One strategy adopted by the councils was to encourage development of allied dental education programs targeted to nontraditional students, such as returning homemakers or already employed workers. The councils believed that if these programs were sufficiently flexible to meet the needs of nontraditional students, a potential increased enrollment would be realized which in turn should help alleviate shortage problems. During the past 20 years, a small but growing number of innovative and flexible programs have been accredited by the Commission on Dental Accreditation and most of these programs are still operating successfully.

Nonetheless, some dentists continue to advocate further changes in the current educational system, especially for dental hygienists. They believe that the profession must support alternative methods of educating dental hygienists or create a different type of allied dental personnel in order to meet the need for dental hygiene services at an affordable cost. Other dental practitioners strongly support the existing curriculum and indeed may even support an expanded scope of practice for dental hygienists. Within this diversity of opinions, the 1991 House considered Resolution 117H.

Resolution 117H-1991: The 1991 House adopted Resolution 117H-1991 (*Trans.*1991:603), which states:

Resolved, that the American Dental Association Council on Dental Education be directed to develop specific accreditation guidelines for flexible educational programs for dental assistants and dental hygienists, which include the concept of career laddering or step-by-step advancement from Certified Dental Assistant to a Registered Dental Hygienist. The Council will submit these guidelines to the Commission on Dental Accreditation, and be it further

Resolved, that a specific, flexible training and educational program for dental assisting and dental hygiene be developed by the Council on Dental Education and the Council on Dental Practice for presentation to the House in 1992, and be it further

Resolved, that the Council on Dental Education be directed to develop specific language for the currently proposed *Accreditation Standards for Dental Assisting Education Programs*, and *Accreditation Standards for Dental Hygiene Education Programs* that facilitates providing a flexible as well as career advancement curriculum structure to enable an individual to move forward in their course of study without repeating basic courses common to both dental assisting and dental hygiene education. The Commission on Dental Accreditation should be urged to implement these programs, and be it further

Resolved, that the Council on Dental Education be directed to provide assistance to any constituent in developing flexible educational programs for dental assistants and dental hygienists.

Council on Dental Education/Council on Dental Practice Working Group: The CDE and CDP concurred that a working committee should be formed to guide development of the councils' response to the resolution. The following council members were appointed by the chairmen of both councils:

Dr. John Hasler, CDE (chairman)	Dr. Ronald Occhionero, CDP
Dr. Ronald Chaput, CDP	Dr. William van Dyk, CDP
Dr. Kenneth Horwitz, CDE	Dr. Robert Warren, CDE

During the working group's February 1992 meeting, the committee met with the directors of two nontraditional dental hygiene education programs who discussed their flexible approaches to training. Dr. Dana Rafferty Parker, coordinator of dental programs at Santa Fe Community College, provided information on advanced standing, articulation and college credit for core course arrangements. Other options include part-time enrollment, an evening course schedule and an extended campus site. Janet Olson, RDH, department head, Dental Assisting Hygiene Program at Community College of Philadelphia, discussed a "career ladder" program where the

first year provides dental assisting education and the second (slightly more than a calendar year) includes dental hygiene education. Students who complete the entire dental assisting-hygiene two-year sequence are eligible for licensure as dental hygienists. The working group was impressed that these and other innovative programs are consistent with the existing accreditation standards.

Based on the available information, the working committee determined that the House is requesting strategies to expand the allied dental education system within the framework of the currently existing accreditation standards. Several long-range strategies and immediate action plans were identified to accomplish that objective and address the manpower concerns of the House.

Long-Range Strategies Proposed for Consideration by the 1992 House: During consideration of this resolution, both CDE and CDP continued to support the Association's long-held position that dental assisting and dental hygiene education programs should be offered within the framework of the current accreditation system. Further, the councils believed that the recently revised dental assisting and dental hygiene accreditation standards are sufficiently flexible to support the development of innovative allied dental education programs. Therefore, the councils recommended that the Association's efforts should focus on strategies designed to encourage greater innovations such as work/study or career ladder curriculums that would enhance access to education and increase educational opportunities for both traditional and nontraditional students.

The councils believed this objective would be accomplished by, among other things, offering flexibility in program scheduling. Providing maximum accessibility might also require modification of such program features as location, facilities, educational delivery modes, admission policies and curriculum designs. Such flexible programming could offer a tremendous opportunity to attract nontraditional students such as returning homemakers and workers interested in making a career change, while maintaining necessary accreditation standards.

The councils acknowledged that the supply of qualified traditional and nontraditional candidates applying to dental hygiene programs is more than adequate. Because of this, selective admission policies allow the most qualified candidates to be chosen. With limited enrollment positions available, qualified candidates are sometimes turned away. Further, traditional program scheduling prevents many nontraditional students from entering or remaining in a program. The councils concluded that the problem is not an unqualified and/or inadequate number of applicants, but limited access to training for a broad range of students. By expanding both the number and type of programs in the current system, more students could be accepted and the attractive pool of nontraditional students would have a better chance of entering the allied dental field.

The councils emphasized that the current accreditation standards are essential to producing qualified dental personnel. They concurred that the revised accreditation standards incorporate appropriate language to support flexible programs. This belief was substantiated by the comprehensive review and acceptance by the communities of interest of the recently revised accreditation standards.

The councils agreed that the flexibility of the current accreditation standards needs to be better communicated to the Association's leaders and members. The most effective way to disseminate this information would be at the state level, particularly because allied personnel manpower problems tend to be area-specific rather than national in scope. The councils believed that the Association can best assist state dental societies to (a) influence existing programs to be more flexible and (b) increase educational opportunities for all those seeking dental hygiene education, through the following strategies. These strategies are presented for consideration and possible funding by the 1992 House of Delegates.

A. Public Relations/Professional Information Campaign. To inform the dental profession of available flexible program options, a professional communication campaign should be launched that includes:

1. **Contact Dentist Network:** The Association should develop a network of state contact dentists who would provide liaison between state/local groups and the ADA. Individuals identified to serve in this capacity should be proactive and well versed in the issues, concerns and options available to meet their state's special needs. The contact dentist would bring the message to various interest groups, such as a constituent society executive board or community college administrators, and at the same time provide feedback to the Association in order to monitor state activities.

   As a rule, community colleges respond to the demonstrated employment needs of the surrounding areas they serve. In those areas experiencing manpower shortages, the contact dentist should assist the dental community in documenting and communicating these needs to educational institutions. Further, with the support of the contact dentist, key leadership of the state dental society could effectively demonstrate to academic leadership that the current accreditation standards do not represent an obstacle to designing flexible programs.

   Even in areas where allied dental manpower shortages are not a high priority, the state contact dentist should be able to demonstrate how the state could benefit from changes and/or expansions of the current educational system. The contact dentist might demonstrate how to expand existing programs to produce more graduates, with the school and dental community realizing the benefits that this growth would bring.

   Manpower concerns aside, the responsibility of providing the community with adequate dental personnel resources should be shared by the community college and the dental society. Therefore, part of a state contact dentist's mission would be to raise the awareness of the dental community and to increase both dentists' and educators' knowledge regarding innovative curriculum options available within the accreditation standards.

   It should be noted that the proposed network of state contact dentists would have a different purpose and mission than the existing network of state SELECT representatives. SELECT is designed to focus exclusively on recruitment of students for dental and allied dental education programs. Efforts to expand the current

educational system, defend existing programs that face possible closure or encourage program innovations, are beyond the SELECT network's purview. Further, the two programs would be supported by separate budget and staff resources.

The state education contacts would be encouraged to ensure ongoing two-way communication with the SELECT coordinators, to keep each other apprised of education and manpower matters within the state. By coordinating available information, both parties would have a more complete awareness of allied dental education trends, enabling them to be responsive to the state's specific needs.

Cost implications for identifying and appointing the state contact dentist network would be minimal, initially. The costs to the Association of training these individuals and providing appropriate national-level staff support for their efforts are addressed in the following paragraphs. It is assumed that travel and other expenses for these individuals' activities would be minimal, as travel would occur primarily in-state. Any expenses incurred would be paid by the state dental society.

2. **Training for State Contact Persons:** To successfully implement the proposed network, a comprehensive training program for the state education contacts would be necessary. Contact dentists would be invited to a national training conference to ensure that they were well informed regarding their mission and objectives. Both CDE and CDP have already developed and published a considerable amount of information in the form of booklets, reports and news articles that could be used for this purpose. Information would be provided on the options for innovative allied dental education programs that are available within the accreditation standards and how dental leaders can most effectively interface with educators in their states. Training for the contact dentists would be a joint CDE/CDP venture.

   Cost implications for training the contact dentist network via a national conference would be approximately $66,500. This figure includes travel and per diem for 54 state contact dentists plus ADA officers and program speakers.

3. **Development of a Cadre of Consultants:** If a state society or educational institution decides to expand current educational programs or develop new programs in the state, the next logical step might require a consultant to facilitate the process. The councils agreed that it would be useful to identify a cadre of consultants who have specific expertise in educational program design and who would be available to respond appropriately to these requests. Although the state contact dentists would be able to communicate with state leaders and motivate changes, they would not be likely to have the specific expertise needed when a new program enters the implementation phase and requires the services of an educational consultant.

   Selection of consultants who are already knowledgeable and experienced would minimize the amount of special training needed. Therefore, the training for these consultants would concentrate on such topics as an in-depth understanding of the accreditation standards, the most effective manner of interfacing with educators, strategies for presenting information to a program director, how to impact a failing program and options to expand an existing traditional program. Also, the consultant would need to be aware of the sensitivities pertaining to academic program restructuring and the multi-faceted process that would be necessary to change an existing traditional program to a flexible program.

   All consultants would be trained at a national conference to ensure uniformity of information. Cost implications for training of 20 consultants would be approximately $25,100. It is assumed that travel expenses and consulting fees for these individuals' services would be paid by the requesting organization or institution.

B. Information Manual on Communicating with Programs. The councils determined that an informational manual on communicating effectively with educational institutions should be developed to support the state contact dentist network and expert consultants. The manual could also provide information for local volunteer dentists on how to interact effectively with educators. The councils approved a detailed outline for the proposed manual, which would serve as a workbook to support the training of the contact dentists and cadre of consultants and as a "planning guide" for constituent societies. If there is sufficient demand, the manual could be made available, at a modest price, to support efforts at the state or local level. Cost implications for the manual would be approximately $1,200 for 200 workbooks produced in-house.

C. Encouragement of Dental Society Support For Existing Educational Programs. The councils believed that local dental societies need to expand their efforts to support existing allied dental education programs—especially dental assisting programs. When a dental society is knowledgeable of programs in the community and is actively involved, these programs have a better chance of remaining viable. In such a situation, dental society members are keenly aware of the recruitment status of the program and the eventual availability of program graduates for the dental workplace. This knowledge in itself could provide a basis for dental society and community college interaction where a manpower shortage exists.

The councils noted that when early warnings of program problems are identified and proper support is rendered, these programs are more apt to survive and continue serving the community. The most effective strategy to keep a program open is to keep it fully enrolled and demonstrate that it has the support of the professional community. Further, this strategy offers an extremely cost-effective way to maintain and expand the capacity of the educational system. It was suggested that this support could be accomplished via three methods:

1. Utilize the state contact dentist system in the same manner as previously discussed.
2. Access the media by developing articles profiling dentists who have helped dental assisting and dental hygiene programs and may serve as role models for others in the dental community.
3. Encourage state contact dentists and component dental societies to identify and work with the members of allied dental education program advisory committees. Nearly all

programs have advisory committees that include practicing dentist-employers in the local community. Improved communication with these advisory committee representatives would enhance the information sharing for both parties and would serve to reinforce the dental society's efforts to work cooperatively with the community college leadership.

The cost implications of this strategy, beyond those of developing the state contact dentist network, would be minimal.

D. Correspondence Study Programs for Dental Assistants. During the previous year, both councils have reviewed and supported a proposal from the University of Kentucky for an Independent Dental Education for Assistants (UK-IDEA) program (see the CDE and CDP reports, pages 65 and 45). UK-IDEA is a dental assisting correspondence course that is intended to provide formal education to employed on-the-job trained dental assistants. The program is designed to lead to certification by the Dental Assisting National Board and its intent is to seek accreditation.

Because there are situations where traditional training is not accessible or feasible, UK-IDEA may serve as a valuable method to reach potential dental team members who otherwise would be unable to pursue a career in dental assisting. For example, rural areas often experience difficulty in attracting and retaining dental team members. A stipulation of the program requires that the course candidate be currently employed in a dental office. With the UK-IDEA program, interested individuals would be able to continue to earn an income, obtain a valuable education and have the potential to improve their career status.

The councils believed that this program, or other correspondence programs that might be developed, would offer a potentially effective answer to the need for flexible training of dental assistants. Completion of this type of accredited program would provide an affordable and accessible means for dental assistants to obtain formal training. Therefore, the councils wished to stress that this type of program offers a long-term solution for some of the concerns that prompted Resolution 117H and merits the Association's support. This strategy has no financial implications for the Association.

Immediate Action Plans: The Council also identified several action steps that could be implemented prior to the 1992 annual session, in direct response to Resolution 117H. A supplemental appropriation request to support these activities has been forwarded to the Board of Trustees.

1. A two-hour special panel presentation by individuals who have been closely involved with innovative dental assisting/dental hygiene programs will be hosted by CDP and CDE during the 1992 annual session. All delegates and other interested state society representatives will be invited to attend.
2. An information package will be distributed to delegates and dental society leaders to publicize the special panel presentation and heighten their awareness of the information that has been published on these topics.
3. "Model curriculum" information on innovative programs will be compiled to include sample curriculum content sequences, examples of contact hour allocations and descriptions of the content modules that might be included in an accredited program. Several possible nontraditional program designs will be highlighted in a publication on developing nontraditional programs.
4. CDE and CDP members will be encouraged to seek opportunities to include allied dental education and manpower issues on the agendas for regional leadership conferences and meetings whenever possible.
5. *ADA News* articles and a series of press releases will be developed to heighten interest in innovative programs. Some of this information will also be suggested for inclusion in the Dental Editors' Kit, to widen its distribution to the membership.

Need for Clarification from 1992 House: As noted above, the councils recognized that there are members of the dental community who do not believe that development of more accredited programs, traditional or nontraditional, will be adequate to solve the profession's ongoing manpower concerns, especially as they relate to dental hygienists. These individuals would like to see a more drastic overhaul of the education and care delivery systems, including development of shorter dental assisting and hygiene programs and/or programs offered in non-educational settings.

The councils did not agree that the educational system needs a major overhaul. They recognized that the current two-year requirement for the length of dental hygiene programs has been policy of the Association since 1947 (*Trans.*1947:254), and that policy was reaffirmed by the ADA House of Delegates in 1988 (*Trans.*1988:464). Therefore, the councils were unable to reconcile this policy with an interpretation of Resolution 117H that would support the development of shorter educational programs.

For these reasons, the councils acknowledged that further clarification and direction on this issue may be needed. The House may support the development of a new type of allied dental personnel who would be trained through some alternative arrangement that does not involve accreditation by the Commission. Or, the 1992 House may support development of accreditation standards for a different type of education program for allied dental personnel—either dental assistants or dental hygienists, or some new type of support personnel. In any case, a decision to develop a new type of accredited educational program should be based on the House's informed understanding of the challenges to be addressed and resources required to complete this task and the potential implications for the dental profession. Some of the factors that must be considered include:

Process to Develop New Standards. As an accrediting agency recognized by the U.S. Department of Education (USDOE) and the Council on Postsecondary Accreditation (COPA), the Commission must follow an established process for development of accreditation standards. This process must provide for input by all potentially affected communities of interest through written comments and open hearings. The need to provide adequate opportunities for input at each step of the standards development process dictates that the overall process generally requires a minimum of 12 months to complete. The task of developing standards for an entirely new type of education program which does not currently exist may be expected to

create considerable controversy. Therefore, two to three years might be needed to complete the process from development of some initial consensus regarding the responsibilities of the proposed new allied personnel to completion of the new standards.

The councils noted that previous surveys, conferences and discussions within the dental community have not clearly established the anticipated scope of responsibilities of some new type of allied personnel who might be needed to support current dental practices. Without a clear concept of the nature and scope of these individuals' duties, the definition of the training needed to prepare them for practice—including length, setting, content and clinical/laboratory experiences—would be difficult. In order to proceed with the design of appropriate educational experiences and development of accreditation standards, the Commission must first have input and direction from the potential employers.

Either the House of Delegates should provide detailed direction and rationale, or the standards-setting process would need to start with steps to gain this information. These steps could include surveys of the key communities of interest. Potential employers should be surveyed regarding the anticipated demand for such personnel, while the educational institutions would need to be surveyed on their interest in sponsoring the programs and potential support for the Commission's accreditation of them. These surveys and the data analysis should be well-designed by an outside agency in order to ensure that the results are accepted as valid by COPA and USDOE, as well as the higher education community. In addition, a national conference could provide an opportunity for the profession to exchange and refine ideas in an effort to achieve an initial consensus. The following cost estimates assume the addition of these necessary consensus-building steps.

Cost of Standards Development. The cost of developing new accreditation standards would include:

Surveys of the communities of interest (cost estimates provided by the Bureau of Economic and Behavioral Research)	$32,000
National consensus conference for dental leadership and educational institutions	9,000
Ad hoc committee to draft standards	15,000
Printing and mailing expenses to distribute draft standards	5,000
Travel expenses for Commissioners and staff to attend open hearings	4,500
TOTAL ESTIMATED COST OF DEVELOPING STANDARDS:	$65,500

Although these cost estimates do not include additional staff, it is questionable whether existing staff would be sufficient to manage a project of this size. A decision on this matter would need to be based on the circumstances at the time action is taken.

Advantages of Developing a Different Type of Allied Dental Personnel. Some dentist-employers believe that dental hygienists are presently being educated beyond the level of understanding and skill they need in most dental practices. This group contends that shorter programs (one year is often cited) including minimal basic science and general education content would be adequate to prepare qualified personnel who could provide basic oral hygiene services. Such programs would emphasize acquisition of a limited range of clinical skills, perhaps using extramural clinical practice sites. Given that such one-year programs generally culminate in a certificate of completion, rather than an associate degree, they would most likely be offered in vocational-technical schools and community colleges. Most universities and some community colleges are unable to sponsor such non-degree occupational preparation programs.

The advantages of shorter, non-degree programs might include:

- Assuming a positive response by appropriate educational institutions, an additional source of dental personnel training within the vocational-technical system;
- Increased access to education for students who are not academically prepared for college-level degree programs;
- An opportunity for on-the-job trained dental assistants to complete a one-year program and achieve employment in the new auxiliary role more quickly than through the traditional two-year dental hygiene programs;
- Provision of an auxiliary whose skill level and compensation expectations are consistent with the perceived needs of many dentist-employers;
- Long-term, an increase in the availability of dental auxiliaries capable of providing clinical oral hygiene services under direct supervision by a dentist.

Potential Challenges. During its deliberations on the feasibility of creating a new type of support personnel, the House will also need to be aware of some of the challenges such an undertaking may present.

1. **Licensure and Regulation Issues:** Development of a new type of personnel raises a number of licensure issues. If this new worker is to be licensed or credentialed at the state level, development and implementation of an appropriate credentialing system would require legislative and/or rules changes in all 54 licensing jurisdictions. It would also increase the costs and regulatory responsibilities of the state dental boards. If these individuals are not credentialed, other steps must be taken to protect the oral health of the public. It seems highly likely that significant legislative and legal challenges to any new education/credentialing programs may be expected from the allied dental communities.

   The development of a new auxiliary would result in two levels of personnel providing oral hygiene services in dental practices. A clear separation of job titles and descriptions may assist in avoiding confusion of their roles by the general public. However, the potential for

overlapping and blurring of the lines between the two levels raises regulatory and enforcement issues for state dental boards. Efforts to ensure that the new personnel perform only those patient care services for which they have been trained, under specified supervision provisions, may strain many state boards' resources.

2. **Institutional Prerogatives:** Convincing educational institutions to sponsor the educational programs for these new auxiliaries would present a different type of challenge. Although institutions usually attempt to be responsive to employment needs in the communities they serve, it is each institution's prerogative to determine the programs it will offer. Institutions are unlikely to be interested or able to mount any new program—especially one with significant start-up costs—without assurances of an ongoing employment demand for the program graduates. The profession would need data to demonstrate this demand on a local community level and strategies to communicate effectively with the higher education authorities within each state.

3. **Political Challenges:** The dental hygiene community, as well as some segments of the dental profession, can be expected to oppose development of these programs. An interesting parallel was presented in the medical field in 1988, when the American Medical Association responded to a serious shortage of nursing personnel by proposing development of a new type of hospital care workers called "Registered Care Technicians." This proposal never came to fruition because no educational institution or teaching hospital could be found to provide the training program. Several institutions that expressed initial interest were forced to back away due to strong political pressure from the nursing community.

   The Association can probably expect that questions will be raised not only about the employment potential for graduates of the new programs, but also about the long-term retention of these auxiliaries in dentistry. Although retention of traditional dental hygienists in dental practices has improved during the past decade, a significant proportion still leaves dentistry for other career choices. Boredom with limited job responsibilities and lack of variety are sometimes cited as reasons. The ability of the profession to retain employees with an even more limited scope of practice and less invested in their education and licensure may also be questioned.

4. **Expanded Scope of Recognition:** Finally, if the new programs are to be accredited by the Commission on Dental Accreditation, and thus allow the profession to guide their development, then the Commission's scope of recognition would have to be expanded. Currently, the Commission is recognized by USDOE and COPA to accredit entry-level programs in dental assisting, hygiene and laboratory technology. Both recognizing bodies would have to be petitioned for a change in scope prior to implementing any accrediting activities related to the new auxiliary programs.

   The Commission's change of scope petition would need to include information demonstrating that accreditation is necessary to protect the interests of students, to benefit the public and to improve the quality of education. Development of the petition and completion of the recognition process would likely require a minimum of one year. If challenged by the dental hygiene community, the process could conceivably take even longer and might enhance the likelihood of another organization gaining recognition by COPA and USDOE as an accrediting agency for dental hygiene.

   The 1992 House will need to weigh all of the potential advantages and challenges presented by the possible creation of a new type of allied dental personnel and, if appropriate, provide additional direction to the councils.

Summary of Council Recommendations: As outlined in this report, the councils have already undertaken several immediate action steps to encourage flexible training programs for dental assistants and dental hygienists. The House will need to review the proposed long-range strategies and determine whether these activities will provide an appropriate means of continuing the councils' efforts to address the concerns that prompted Resolution 117H. The recommended strategies are summarized below to assist the House in its deliberations.

As noted previously, the councils were firm in their support for efforts to expand the capacity and accessibility of the current allied dental education system through innovations that are consistent with the existing accreditation standards. If the House disagrees with the councils' position that the current system can be responsive to the intent of Resolution 117H, then the House should provide further clarification and direction.

Long-range strategies recommended to accomplish the objectives of Resolution 117H include:

A. Develop a public relations/professional information campaign, including three steps:

   1. Identify and appoint a state contact dentist network;
   2. Train state contact dentists via a national conference;
   3. Develop and train a cadre of expert consultants;

   Cost implications: $92,800.

B. Publish an informational manual on communicating with educational institutions about potential innovations, which would serve as the workbook to support the training of state contact dentists and consultants, as well as provide information to state/local planning committees.

   Cost implications were included in the costs of training state contact dentists identified above.

C. Encourage state dental societies to support existing educational programs through the network of state contact dentists and Association media.

   Cost implications: none.

D. Encourage development of correspondence study programs for dental assistants.

Cost implications: none.

The following resolution to implement these strategies is presented for adoption by the 1992 House.

Resolutions

New Policy/Directive:

22. Resolved, that the long-range strategies to encourage development of flexible training programs for dental hygienists and dental assistants, as outlined in the Joint Report of the Council on Dental Education and the Council on Dental Practice on Resolution 117H-1991 (*Trans.*1991:603) be approved, and be it further

Resolved, that funds to implement these strategies be included in the appropriate agencies' 1993 budget.

Joint Commission on National Dental Examinations

Minatra, Randolph D., Texas, 1992, chairman, American Association of Dental Examiners
Elzay, Richard P., Minnesota, 1992, vice-chairman, American Association of Dental Schools
Carlson, Edward C., Arizona, 1993, American Association of Dental Examiners
Chichetti, Richard J., Florida, 1994, American Association of Dental Examiners
Deck, Sally Ann, Michigan, 1994, American Dental Hygienists' Association
English, Leon J., Wisconsin, 1992, American Association of Dental Examiners
Fitzpatrick, Kevin, Michigan, 1992, American Student Dental Association
Fujimoto, Lynn, Hawaii, 1995, American Dental Association
Miller, Reuben E.V., 1995, American Association of Dental Examiners
Palmer, John E., Oregon, 1993, American Dental Association
Reed, Michael J., Missouri, 1993, American Association of Dental Schools
Revere, James H., Virginia, 1995, American Association of Dental Schools
Rupp, Roger P., Kansas, 1993, American Association of Dental Examiners
Sarro, Francis C., Delaware, 1994, American Dental Association
Williamson, James A., Maryland, 1994, public member
DeMarais, David R., director, department of testing services

Meetings: The Joint Commission on National Dental Examinations met in the Headquarters Building, Chicago, on April 2, 1992. Most of the topics considered by the Joint Commission were initially reviewed by one of three committees. The Committees on Administration, Dental Hygiene and Examination Development met on April 1.

The annual National Dental Examiners' Advisory Forum, sponsored by the Joint Commission, met in Chicago on March 31. Approximately 85 dental and dental hygiene examiners and educators from over 40 states attended the Forum. The program was devoted to an overview of trends in dental education and National Board performances.

Nineteen test construction committees met during the year to develop new editions of National Board Dental and Dental Hygiene Examinations including the new comprehensive Part II Examination.

Acknowledgments: The Joint Commission acknowledges with appreciation the contribution made by Drs. Richard Elzay, Leon English, Randolph Minatra and Mr. Kevin Fitzpatrick, who complete their service on the Joint Commission this year.

Trends in Test Candidates and Failure Rates: The number of candidates for the National Board Dental Hygiene Examinations has increased consistently since 1987: from 4,317 in 1987 to 4,872 in 1991. Candidates for Part I of the Dental Examinations decreased slightly from 6,173 in 1989 to 6,089 in 1991. Part II candidates have remained stable since 1988 (5,483 in 1991).

The failure rates of the total group of candidates, both foreign-trained and U.S.-trained, taking National Board Dental Examinations increased between 1987 and 1990. During 1990 and 1991, approximately 27% of the candidates failed one or more Part I Examinations and approximately 20% failed one or more Part II Examinations. The failure rate for U.S.-trained candidates on Part I Examinations remained stable at 15.5% between 1990 and 1991. Their failure rate on Part II Examinations also remained stable at 15.2% between 1990 and 1991. The failure rate for candidates taking the National Board Dental Hygiene Examination peaked at 14.2% in 1990 but dropped to 13.3% in 1991.

Selection of Test Constructors for National Board Examinations: During its recent meeting, the Joint Commission selected 16 new members for its dental and dental hygiene test construction committees. Each year the Joint Commission contacts constituent dental societies, dental schools and state boards of dentistry requesting applications for new test constructors to fill vacancies on a rotating basis. Fifteen to 20 applications are usually received for each vacancy.

During the selection of test constructors, the Joint Commission gave attention to any states or schools that appeared to have been under-represented in the National Board test construction process. Expertise in specific disciplines, however, was the primary criterion considered.

Assistance to Other Agencies: One of the duties of the Joint Commission is to serve as a resource for the dental profession in the area of written examinations. During the past year, staff continued to provide this support to the American Board of Periodontology, the American Association of Hospital Dentists and the Academy of General Dentistry. Assistance is provided in the development of new examinations, revising used test items, reviewing examination procedures, scoring examinations or examination analysis. This service is offered only if staff time is available and only for a fee to cover costs.

Special assistance is also provided to state boards of dentistry upon request. The Joint Commission is pleased to provide secure examinations to state boards for their internal use. A $50 service fee per candidate is charged for this special assistance.

Dental Interactive Simulations Corporation (DISC): The American Dental Association is a corporate member of DISC. The Joint Commission on National Dental Examinations is the Association agency that carries out the liaison activities with

DISC and appoints a member of the DISC Board of Directors to represent the Association.

DISC is a non-profit corporation of eight dental organizations responsible for education and evaluation in the field of dentistry. The primary goal of DISC is to improve the quality of the dental student and practitioner through the development and use of interactive computer-based patient simulations. Using a mix of educators, examiners and practitioners, DISC aims to effect major innovative changes in the education, licensure and continued competence in dentistry. DISC is seeking major funding to accomplish this goal.

The other members of DISC follow: the American Association of Dental Examiners, the American Association of Dental Schools, the Central Regional Dental Testing Service, the Northeast Regional Board, the Southern Regional Testing Agency, the Western Regional Examining Board and the Texas State Board of Dental Examiners.

Each member of DISC provided $6,000 in the process of forming this corporation. DISC also received a grant of $32,800 from the American Fund for Dental Health as assistance in seeking the major funding needed for the research and development of simulations for dentistry. A grant writing team, under the leadership of Dr. James Kennedy, is currently in the process of preparing the proposal for major funding. The Joint Commission is pleased to report that this proposal is approaching completion and will be ready to present to major funding sources in the very near future.

Informational Services Pertaining to Licensure: The staff assigned to work with the Joint Commission continues to respond to numerous requests for information pertaining to licensure. As the National Board Dental and Dental Hygiene Examinations are part of the licensure qualification process, the staff becomes a frequent liaison between dentists and dental hygienists seeking licensure or re-licensure and state boards of dentistry.

Resolutions: This report is informational in nature and no resolutions are presented.

Division of Finance and Business Affairs

Council on Insurance

ADA Holding Company, Inc.

Notes

Council on Insurance

Allen, Zoel G., Texas, 1993, chairman
Breza, John A., Michigan, 1994, vice-chairman
Bitler, Glenn F., North Carolina, 1993
Coratola, Joseph J., Connecticut, 1993
Gerstenmaier, John H., Ohio, 1994
Katz, Eugene E., Pennsylvania, 1992
Kent, Robert F., Arkansas, 1995
Magruder, H. E., Missouri, 1995
McKrill, Edward M., Alaska, 1992
Owens, Jack, California, 1995
Sather, Alfred H., Minnesota, 1994
Scott, Michael A., Florida, 1994
Seldin, Leslie W., New York, 1992
Sokoloff, Jack P., Delaware, 1992
Utzinger, David H., Arizona, 1993
Williams, John R., Illinois, 1995
Dwyer, David R., director

Meetings: The Council met at the Headquarters Building on August 23-24, 1991 and March 13-14, 1992.

Vice-Chairman: Dr. John A. Breza was elected vice-chairman of the Council at the March 1992 meeting.

Group Life Insurance Program: The Group Life Insurance Program consists of the Term Life Insurance Plan, the Noncontributory Life Insurance Plan for Dental Students and the Term Plus Insurance Plan. It is underwritten and administered by the Great-West Life & Annuity Insurance Company.

As of December 31, 1991, a total of 67,749 member dentists were participating in the Term Life Insurance Plan. Additionally, 19,393 members were insuring their spouse and 10,784 were covering their eligible dependent children under the Plan. During 1991, the volume of insurance in force rose by more than $1 billion, to a total of more than $15.5 billion. The average amount of coverage carried per member increased by 11.3% to $209,075. The Council attributes the high levels of participation and coverage amounts to the Term Life Plan's competitive costs and benefit provisions.

At year-end, 6,503 predoctoral students and dental school graduates were participating in the Noncontributory Life Insurance Plan for Dental Students. The Plan was introduced in 1981 in response to Resolution 100H-1980 (*Trans.*1980:580). It offers $25,000 of term life insurance without payment of premium until July 1 of the year following the year of graduation from dental school. The expense of the plan is borne by the ADA Group Life Insurance Program.

In 1991, approximately 50.9% of participants in the Noncontributory Plan who graduated in 1990 elected to continue coverage on a premium paying basis. This influx of younger members into the Term Life Plan should continue to have a positive impact on claims experience and thus benefit all insureds. It also provides another reason to maintain Association membership.

The Term Plus Insurance Plan was introduced as a new benefit of membership in September 1987. It combines life insurance protection with tax-advantaged fixed-income investment accounts.

Premium contributions that exceed the cost of the life insurance protection and administrative fees earn interest on a tax-deferred basis and form a "cash-value." These monies can be left to accumulate in the policy, be withdrawn or borrowed by the insured or used to pay future insurance costs. Under current law, federal income taxation on the interest earnings is deferred until such time as this money is withdrawn from the policy. If paid to the beneficiary as part of the death benefit, the interest earnings escape federal income taxation entirely.

At year-end 1991, there were 1,482 participants in the Term Plus Life Insurance Plan. During 1991, the volume of insurance in force rose by approximately $287.6 million and the average amount of coverage carried per participant increased to $194,000. Participants deposited a total of $4,392,579 to their cash accumulation accounts. These funds were allocated, in accordance with the participants' instructions, to one-, three- or five-year fixed-income accounts, which offer a guarantee of principal and yields that are competitive with those prevailing in the financial markets for investments of like maturities.

The favorable financial experience of the Life Insurance Program continued in 1991, with a 50.8% ratio of claims to premium. Based upon actuarial projections, the Council previously determined that approximately $16 million in surplus funds were available for distribution in 1992. This produced a credit for each participant equivalent to 45% of the premium for coverage in force during 1991.

Income Protection Plan: The Income Protection Plan is underwritten by the Life Insurance Company of North America, part of the CIGNA Corporation. It offers monthly benefits as high as $6,000 when an injury or illness prevents insured dentists from working in their special area of dental practice. Participants may tailor protection to meet their particular needs through a variety of coverage choices. They include short- or long-term benefit payment periods, four elimination periods as well as optional coverages, which protect against future uninsurability, inflation's impact on the purchasing power of benefit payments and gradually developing partial disability.

As of November 1, 1991, a total of 26,922 members were

participating in the Income Protection Plan. The number of participants insured under the Long-Term Plan continued its uninterrupted growth, with nearly two-thirds electing this coverage. The optional coverages also attracted additional insureds during the year.

During the period from November 1, 1990 to October 31, 1991, a total of $15,948,503 in benefits was paid under the Income Protection Plan to disabled participants.

Termination of the "Over 70" Disability Insurance Program: Coverage under the Income Protection Plan automatically terminates on the premium renewal date following the insured's attainment of age 70. At that time, dentists who practice at least 20 hours each week have been offered coverage under the "Over 70" Disability Insurance Plan. It provided for the payment of a $150 monthly benefit, for a maximum of 12 months, after the satisfaction of a 45-day waiting period. While most dentists eligible for enrollment in the Plan reject the coverage, there are currently 310 participants.

Historically, the "Over 70" Plan has produced financial deficits, which have been subsidized by the Income Protection Plan. It has not been possible to offer this coverage on a financially sound basis because of the very high incidence of disability among individuals 70 to 75 years of age. As a consequence, the insuring company was no longer willing to underwrite this program. For this reason, as well as the fact that most disability insurers terminate their policies when the insured attains age 65, the Council concluded that it was improbable that a replacement insurer could be designated. Consequently, the Council concluded that it had no alternative but to accept a proposal to cease enrollment in the "Over 70" Plan effective May 1, 1992. However, it was able to assure that current participants will be allowed to retain their coverage until they attain age 75.

Hospital Indemnity Insurance Plan: The Hospital Indemnity Insurance Plan is underwritten and administered by the Life Insurance Company of North America. It offers coverage which is intended to supplement major medical insurance policies and provides insured members with a benefit of up to $300 for each day they or one of their insured dependents is confined in a hospital. This protection is seen as a way of offsetting the considerable out-of-pocket expenses that can result from deductibles and other co-insurance features of most medical insurance policies. Issuance of coverage to members and their dependents under age 60 is guaranteed. However, benefits for certain "pre-existing conditions" may not be available during the first two years coverage is in force.

As of March 15, 1992, there were 9,784 members insured under the Hospital Indemnity Insurance Plan. In addition, 6,864 members were insuring their spouse and 2,363 were covering their eligible, dependent children. During the year, the number of participants insured at the maximum daily amount increased from 14.8% to 19.7%. In 1991, a total of $1,946,426 in benefits were paid to participants.

As a result of the favorable financial experience of the Hospital Indemnity Insurance Plan, the Council previously approved a 40% credit to reduce the renewal premiums due on March 15, 1992 and September 15, 1992 for participants under 65 years of age.

Office Overhead Expense Insurance Plan: The Office Overhead Expense Insurance Plan is underwritten and administered by the Life Insurance Company of North America. It provides the disabled insured member with reimbursement of specific expenses incurred in maintaining the dental office until a return to work is possible. This complements disability insurance, which is intended to replace net income.

The Plan incorporates many of the most attractive features of overhead expense policies introduced by the insurance industry. Monthly benefits of up to $15,000 are offered with either a 15- or 30-day elimination period. Payments commence retroactively with the first day of disability, once the waiting period has been satisfied and can continue until 24 times the maximum monthly benefit has been paid. The Plan's standard features include Waiver of Premium, a Survivor's Benefit and a Future Increase Option at no additional cost.

As of February 1, 1992, there were 8,284 members in the Plan. It continues to be most attractive to those members who are between 30 and 50 years of age, as this group represents over 83% of total participation. During the year, the number of participants insured at the previous $10,000 maximum monthly benefit rose from 4% to 6.2%. As of February 1, 1992, the benefit maximum was increased to $15,000.

During the 1991 policy year, a total of $2,143,842 in benefits were paid to disabled participants. The favorable financial experience of the Plan permitted the Council to continue the 15% credit to reduce the renewal premiums due on February 1, 1992 and August 1, 1992.

Appointment of the Great-West Life & Annuity Insurance Company to Underwrite and Administer the Income Protection, Hospital Indemnity and Office Overhead Expense Insurance Plans: At its April 7, 1992 meeting, the Board of Trustees adopted a resolution submitted by the Council on Insurance, which called for the Great-West Life & Annuity Insurance Company to replace the Life Insurance Company of North America (LINA) as administrator and underwriter of the American Dental Association Income Protection, Hospital Indemnity and Office Overhead Expense Insurance Plans.

The Council's recommendation was based upon an extensive analysis of the costs of operating the three programs in future years. These costs have, to a significant degree, been offset by investment earnings on reserves and funds held for the benefit of participating members. However, for the foreseeable future, it is expected that conditions in the financial markets will result in lower investment yields than those which prevailed in the 1970s and 1980s.

Among the Association's sponsored programs, the Income Protection Plan is most affected by conditions in the financial markets as it holds very large amounts of reserves to fund benefit payments to disabled participants. When investment yields on these reserves decline, larger amounts of premium income must be set aside to assure that the Plan's benefit obligations are adequately funded. As the current premium structure does not allow for such margins, a rate increase or reduction of claim costs is unavoidable.

The Income Protection Plan's rates were first established at its inception in 1952. They have not been increased despite the

many coverage liberalizations which have been introduced over the past 40 years. Moreover, for certain age groups, premiums have been reduced on several occasions.

At its August 1991 meeting, the Council was advised that LINA would require a rate increase if the liberal coverage provisions of the Income Protection Plan were to be preserved. However, the Council was not convinced that the magnitude of the adjustment proposed by LINA was warranted. For this reason, it sought the advice of the independent actuarial consulting firm of Towers, Perrin. The consultant advised the Council that an increase in premium was justified but that LINA's proposed adjustment was unreasonable. As a result, extensive discussions were held with the Company in an effort to reach a mutually acceptable solution. At the same time, the Council sought to protect the interests of the participants in the event that agreement with LINA would ultimately prove unattainable. It entered into negotiations with the Great-West Life & Annuity Insurance Company, which was selected on the basis of its expertise, financial strength and its favorable reputation among the membership. Most importantly, because of Great-West's already large book of business with the Association, the Council judged that it would be able to negotiate a lower profit charge from the Company than from any other insurer. Additionally, there could be economies of administration and marketing through a consolidation of insurers. These savings could be used to partially offset the anticipated reductions in future investment income.

Both insurers were instructed to submit proposals to administer and underwrite the three group plans. These proposals were considered by the Council at its March 13-14, 1992 meeting. Based upon its analysis of both proposals, the Council concluded that the participants would be better served by terminating the Association's relationship with LINA and transferring its responsibilities to Great-West Life.

Great-West's proposal was subsequently submitted to and accepted by the Board of Trustees. It preserves all of the important features of the Income Protection Plan and provides for the lowest possible rate adjustment consistent with the preservation of the Program's financial integrity. In addition, Great-West's proposal will result in no changes to the terms or costs of coverage under the Office Overhead Expense and Hospital Indemnity Insurance Plans. It further provides that no participants will be required to submit evidence of insurability to transfer their coverage to the new policies to be issued by Great-West. With the exception of the modest revisions to the Income Protection Plan described below, no participants will experience any changes to the terms and conditions of their coverage regardless of past medical history or current health.

Two changes will be made to the Income Protection Plan's coverage. The Accidental Death & Dismemberment Benefit will be eliminated and, under the seven-day waiting period option, the first-day coverage for accidents and hospitalizations will be discontinued. The Council observed that accidental death and dismemberment benefit coverage is not a critical feature and, indeed, was inappropriate to the Income Protection Plan. This benefit was introduced at the Plan's inception in 1952 at a time when it was common industry practice to offer such benefits as a marketing technique. The Council noted that accidental death benefits are included in the Association-sponsored Term Life Insurance Plan. It further observed that it was illogical to provide a "bonus" benefit for dismemberments. Instead, it was agreed that the payment of benefits for disabilities resulting from dismemberments should be the same as for other injuries and illnesses. Along with the discontinuance of the Accidental Death & Dismemberment coverage, its $3.95 premium will also be eliminated.

The Council also agreed that it made sense to eliminate coverage for disabilities within the first seven days of the onset of an illness or the date of an accident. The costs of processing and paying claims for such disablements are significant and the discontinuance of this coverage would make it possible to significantly reduce the magnitude of the needed premium increase. Therefore, the Council agreed that, for dentists electing the seven-day waiting period option, all benefits will be paid from the eighth day of disability regardless of hospitalization or accident.

The contract with Great-West provides that the insurer will receive a significantly lower profit margin than was required by LINA. The resulting savings, plus the economies expected as a result of the consolidation of the group plans' administration with Great-West, will compensate to a considerable degree for the expected reductions in future investment income.

However, despite the reduction in operating costs and the modification of the seven-day waiting period option, there was still a need for additional premium to support the Income Protection Plan's liberal benefit provisions. In particular, the Plan is experiencing a rising cost of claims for disabilities of less than 90 days duration, and even more so, for those of less than 30 days duration. This is likely the result of recent policy liberalizations which allow for the payment of benefits for certain partial disabilities. The Council was advised by its independent actuarial consultant that it would be necessary to increase the Plan's premium income if these benefits were to be preserved.

Based on an analysis of the Plan's claims experience, it was determined that rate adjustment should apply only to the Basic Plan component of each participant's total premium. The Basic Plan covers the first two years of a disability caused by sickness or the first five years of a disability caused by accident. No premium increases were indicated for premiums applicable to the Plan's long-term benefit payment options (i.e. the Extended Plans) or to the Future Increase Option, Enhanced Residual Benefit or Cost-of-Living Adjustment Benefit.

The actuaries further recommended that the adjustment to the Basic Plan premium should vary depending upon the waiting period selected by the insured. Accordingly, the Council agreed that Basic Plan premiums will increase by 36.5% for participants having the seven-day waiting period or by 12.5% for those having the 30-day waiting period. Participants can avoid these adjustments by electing longer waiting period options, the issuance of which is guaranteed. Rates for participants having the 30- and 90-day waiting period will be reduced by 13% for those under age 30, by 8% for those 30 to 39 years of age and by 3% for those between age 40 and age 50. Dentists ages 50 and older having the 90- or 180-day waiting period will experience no change in Basic Plan rates.

Approximately 70% of the participants in the Income Protection Plan carry both the Basic Plan plus its long-term coverage options. As the premium for their long-term coverage will not be increased, the magnitude of the aforementioned

adjustments when viewed in terms of their total premium payment will be modest. For example, participants in this group having the 30-day waiting period will experience an overall adjustment in billed premium from 5.7% to 7.9%, depending upon age.

While the Council would have preferred to avoid any upward adjustment in premiums, it was convinced that this is no longer possible in today's economic environment. Nevertheless, the Council is convinced that even with these rate adjustments, the costs of coverage under the Income Protection Plan will remain competitive with those policies offering similar benefits.

The transfer of administrative and underwriting responsibilities from LINA to Great-West will take place upon the expiration of each plan's present master policy. These dates are November 1, 1992 for the Income Protection Plan, February 1, 1993 for the Office Overhead Expense Insurance Plan and March 15, 1993 for the Hospital Indemnity Insurance Plan. In advance of these dates, participants will be sent their scheduled semiannual premium billings by Great-West Life.

LINA will remain responsible for the payment of all claims having their date of incurral prior to the termination of the master policies. Therefore, LINA will remain responsible for the payment of Income Protection Plan claims having their inceptions prior to November 1, 1992. The Company will be liable for these claims until the insureds return to work, die or receive the maximum benefits provided by their coverage, whichever is the first to occur. These liabilities are likely to continue for decades as many insureds will be permanently disabled and entitled to receive benefits until age 65 or, in some cases, for life.

LINA will remain responsible for all Hospital Indemnity Plan claims where the hospital confinement begins prior to March 15, 1993. For the Overhead Expense Plan, CIGNA will be liable for the reimbursement of all overhead expenses incurred by insureds who become disabled prior to February 1, 1993 until they return to work, die or receive the maximum benefits provided by their coverage, whichever is the first to occur.

In no case may CIGNA alter its claim liabilities by changing the terms and conditions of coverage provided by the master policies which are currently in effect.

In summary, the Council believes that the arrangement which has been structured with Great-West preserves the excellent values offered by the Income Protection, Hospital Indemnity and Office Overhead Expense Insurance Plans. It is confident that these programs will continue to offer coverage of the highest quality at highly advantageous rates. Moreover, it believes that through a consolidation of the administration of the Association's life, disability and hospitalization insurance plans, services for participating members cannot only be improved but delivered at more economical costs.

ADA Members Retirement Program: The Association sponsors a tax-qualified retirement program as a benefit of membership. It offers competitively priced recordkeeping, investment management, brokerage and consulting services as well as master plan documents that are pre-approved by the Internal Revenue Service. Participants may elect the convenience of a package approach that consolidates these services with a single administrator or they may use the Association sponsored Program only for investment purposes.

The ADA Members Retirement Program is administered and marketed by the Equitable Life Assurance Society of the United States, which also provides recordkeeping services and management of the master plan documents. Investment management services are provided by the Equitable Capital Management Corporation and the Equitable Real Estate Corporation. Depending upon the date of deposit, three- and five-year fixed-income funds are invested with the Equitable Life, Metropolitan Life or John Hancock Insurance Companies. An ADA Foreign Fund invests in shares of an international equities fund operated by Templeton International. Optional actuarial and recordkeeping services are offered through Trust Consultants, Inc. Optional discount brokerage services are offered through Pershing, Inc. Distribution options in the form of annuities are underwritten by the Metropolitan Life, Prudential and Nationwide Life Insurance Companies.

Dentists can structure their plans under defined contribution or defined benefit arrangements. The defined contribution master plan allows the dentist a choice of a profit sharing or a pension arrangement, or a combination of both. This offers considerable flexibility in determining the annual contribution, which is computed as a percentage of each participant's annual compensation.

Alternatively, a defined benefit master plan can be elected. It allows the dentist to target the percentage of the participants' compensation that will be paid upon retirement rather than the annual amounts to be contributed on their behalf. This approach mandates annual contributions with minimal discretion in adjusting the level of funding.

One of the major advantages of the ADA Members Retirement Program is that government approval of changes in the Master Plans is obtained by Equitable on behalf of the participants and for no additional charge. By contrast, dentists having individually designed plans typically incur substantial legal and accounting fees to make certain that their plans remain in compliance with the changing tax laws.

Other services provided by the Program are the processing and reporting of financial transactions. Participating members can also take advantage of consulting services on all aspects of the program as well as information on investment performance and counseling in selecting retirement benefit options. The Program offers telephone transfer capabilities which enable participants to reallocate their funds among the investment options. The dentist employer is provided with partially completed forms and any needed assistance in finalizing filings with the Internal Revenue Service, such as Form 5500. Finally, under the full service arrangement, Equitable prepares all tax reports and handles the required withholding when amounts are distributed to retired participants.

As an alternative to the full-service arrangement, the dentist can elect to maintain an individually designed, IRS-approved plan while using the Members Retirement Program for investment purposes only. The prime advantage of the investment-only arrangement is the flexibility it offers. There are dentists whose needs extend beyond those of a structured retirement package and who prefer to work with a particular attorney or pension consultant for plan design and administration. Under the investment-only arrangement, the employer can continue such relationships while participating in any of the investment options available under the sponsored Program.

Upon retirement, participants are offered an array of choices for taking distributions from their retirement plans. In addition to lump sum payments and installment payments, a variety of annuities can be purchased. Beginning in 1992, annuities offered through the Program are underwritten by the Prudential, Metropolitan and Nationwide Life Insurance Companies.

At the end of 1991, there were 7,109 plans in effect, covering 17,909 dentists and their employees. At year-end, the Program had total assets of approximately $867.7 million, as compared to $787.7 million at the end of 1990.

Participants allocated 64.3% of their funds among the fixed-income accounts, which provide a guarantee of both principal and interest. These include a Money Market Guarantee Account as well as three- and five-year Guaranteed Rate Accounts, which are similar to bank certificates of deposit.

The Money Market Guarantee Account (MMGA) offers short-term interest rates comparable to those of money market funds. At year-end 1991, approximately 37.5% of the participants' funds, or $325.9 million, were held in the MMGA. The interest rate credited on monies in the MMGA changes monthly. Participants are able to make contributions at any time, and there is never a market value adjustment upon withdrawal of funds.

The rate of interest credited on funds invested in the three- and five-year Guaranteed Rate Accounts (GRAs) remains unchanged until maturity. They are intended to be competitive with investments of like duration available in the financial marketplace and new rates are set weekly. These fixed-income products are designed to hold funds for the entire guarantee period and premature withdrawals may be subject to certain restrictions or interest penalties.

GRAs opened prior to February 6, 1991 are invested with the Equitable. At year-end 1991, these GRAs were valued at approximately 20.9% of the Program's total assets, or $181.1 million.

GRAs opened between February 6, 1991 and February 5, 1992 are invested with the Metropolitan Life Insurance Company and were valued at approximately 5.9% of the Program's total assets, or $51.6 million, as of December 31, 1991. GRAs issued between February 5, 1992 and February 2, 1993 are being invested with the John Hancock Life Insurance Company.

The participants deposited the remaining 35.7% of their assets in the Program's equity and real estate investment funds. The returns offered by these funds are intended to reflect the performance of the markets in which they invest and there are no guarantees of principal.

The Growth Equity Fund, which holds 24.4% of the participants' assets, or approximately $211.8 million, is invested in a portfolio primarily holding blue chip common stocks. The Fund's unit value increased during calendar year 1991 by 52.8%. This compared to a 30.5% increase in the Standard & Poor's 500 Stock Index (S&P 500). Over the ten-year period ending December 31, 1991, the Fund's unit value increased by an average of 18.9% annually as compared to an average annual increase of 17.6% in the S&P 500 Stock Index.

The Balanced Fund holds 5.7% of the participants' assets, or $49.3 million. It is invested among stocks, bonds, cash and convertibles, with the percentage of the portfolio allocated among these markets being determined by the Equitable Capital Management Corporation. The Fund's unit value increased by 43.5% during calendar year 1991, which compared to a 23.3% increase in a 50%/50% composite of the Standard & Poor's 500 Stock Index and the Shearson Lehman Government/Corporate Bond Index. Over the ten-year period ending December 31, 1991, the Fund's unit value increased by an average of 17.7% as compared to an average annual increase of 15.8% in the 50%/50% composite index.

The Aggressive Equity Fund holds 4.9% of the participants' assets, or $42.2 million. It is invested in a portfolio of common stocks of primarily small- and intermediate-sized companies possessing outstanding growth potential. The objective of the Fund is to achieve higher returns than those of more conservative stock portfolios. However, coupled with the opportunity for greater returns is the higher risk inherent in stocks comprising the portfolio. As a result, increases or decreases in unit values are expected to be greater than those of the market as a whole. The Aggressive Equity Fund's unit value increased by 88.1% during calendar year 1991, which compared to a 36% rise in the Lipper Small Company Growth Funds Average Index and a 46% rise in the Russell 2000 Stock Index. Over the ten-year period ending December 31, 1991, the Fund's unit value increased by an average of 19.2% annually, as compared to an average annual increase of 13.6% in the Lipper index and of 12.3% in the Russell index.

Approximately 0.7%, or $5.7 million of the participants' assets are held in the Real Estate Fund. It allows for participation in a high quality, commercial real estate portfolio, which has been structured to overcome previous obstacles to such investments through a diversification of commercial properties, greater liquidity of funds and a lower minimum contribution requirement. During 1991, the Fund's unit value decreased by 7.2%. Although the income generated by the real estate and cash holdings would have produced a 7.1% rate of return, this was offset by a 14.3% decrease in the value of the properties. Over the five-year period ending December 31, 1991, the Fund's unit value increased by an average of 3.9% annually, which compares with an average annual increase of 2.9% in the National Council of Real Estate Investment Funds Index.

The reported changes in the unit values for the aforementioned funds assume that deposits were invested for the entire period and are not an indication of future performance.

Introduction of the ADA Foreign Fund. On March 2, 1992, the options available for investment of contributions to the ADA Members Retirement Program were expanded by the addition of the ADA Foreign Fund. At least 95% of the money deposited in the ADA Foreign Fund is invested in shares of the Foreign Fund managed by Templeton International. The remaining deposits are held in a money market account to provide the liquidity needed to facilitate transactions between the Templeton Fund and participants. Deposits and withdrawals from the ADA Foreign Fund may be made at any time.

The Templeton Foreign Fund is invested in a portfolio of stocks of foreign companies located outside of the United States. Lipper Analytical Services has rated the Templeton Foreign Fund the number one performing international equities fund, out of a universe of 31 funds, for the five years ending December 31, 1991. During 1991, the value of a share of the Templeton Foreign Fund increased by 18.2%. This compares to a 12.5% rise in the Morgan Stanley Capital

International World Index of returns for 20 countries (EAFE Index).

The Council selected the Templeton Foreign Fund as an investment vehicle based upon an extensive review of international fund managers. This study indicated that the Templeton Foreign Fund had outperformed both the EAFE Index as well as a peer group of international equity fund managers developed by the Association's consultant, William M. Mercer Asset Planning, Inc. The study further confirmed that the fees for Templeton's Fund were very competitive. Additionally, Templeton agreed to waive its normal front-end load, which can be as high as 8.5%, for shares purchased through the ADA Foreign Fund.

Annual expense charges for the ADA Foreign Fund, including those paid to Templeton International, are deducted from the participants' balances and total 1.43%. They are payable in addition to the ADA Members Retirement Program's base expense charges.

The Council believes that the ADA Foreign Fund offers dentists and their employees an attractive way of investing in international equities markets. It is available to participants in the ADA Members Retirement Program as well as other dentists who wish to invest their tax-qualified retirement savings through the Program's "Investment Only" option.

Introduction of Self-Directed Investment Option. A Self-directed option was introduced in January 1992 as a new investment alternative for participants in the ADA Members Retirement Program. The option is designed to appeal to those dentists who have large account balances and who wish to actively trade individual stocks or invest in publicly offered mutual funds.

Dentists who wish to take advantage of the Self-directed option must deposit at least $25,000 of their retirement plan's assets in one or more of the ADA Members Retirement Program's investment funds and/or accounts. The balance of their plan's assets may be invested through the brokerage firm of their choice in any listed securities or mutual funds.

Under this arrangement, the dentist will be provided with a plan document as well as full recordkeeping services for those assets invested through the ADA Program's investment funds or accounts. However, to consolidate the ADA Program's records with those pertaining to assets invested through the dentist's brokerage account, a third-party administrator must be retained. Dentists who do not have an established relationship with an accountant or third-party administrator, are offered the services of the Trust Consultants, Inc. (TCI), which provides recordkeeping, plan design and other related services at a competitive fee schedule. Similarly, dentists who do not have a preferred stock broker to assist in trading securities may elect to use Pershing, Inc., a discount broker offering competitive commissions. Moreover, if Pershing is selected as the broker, TCI will be able to offer its services to the dentist for a reduced fee.

While the Council believes that the standard investment arrangements of the ADA Members Retirement Program will meet the needs of the vast majority of dentists, it believes that the Self-directed Account will prove attractive to those members who wish to take a very active role in the investment of their retirement savings.

Demutualization of the Equitable Life Assurance Society. The Equitable Life Assurance Society is seeking the approval of its policyholders to transform itself from a mutual to a stockholder-owned company (i.e. to "demutualize"). This process has received approval from insurance regulators and the Company's Board of Directors. All policyholders of the Company were given one vote to approve or reject the demutualization. The ADA Members Retirement Program is considered a policyholder for this purpose.

In its capacity as the Program's Trustees, the Council cast its vote in favor of the demutualization. It was the Council's judgment that the demutualization will enhance Equitable's financial strength and, therefore, provide additional security for its policyholders.

Individual Retirement Account (IRA): The Association endorses an IRA program as a benefit of membership. It is available to members, their spouse and employees.

The Association-endorsed IRA is administered by the Integrity Life Insurance Company. The participants' contributions may be allocated to one- or three-year guaranteed rate accounts, which are invested with the Equitable Life Assurance Society or to the Hudson River Trust, a mutual fund with various investment portfolios managed by the Equitable Capital Management Corporation. The investment portfolios held in the Hudson River Trust include Money Market, Stock, Aggressive Stock, Balanced, Bond, Global and High Yield Funds. The Association's Program functions as a unit investment trust, Separate Account #301, which invests in shares of the Hudson River Trust, depending upon how participants elect to allocate their investments.

At the close of 1991, there were a total of 2,659 participants in the Association-endorsed IRA. The total value of the participants' deposits was $51.9 million.

As of December 31, 1991, the participants' contributions were allocated among the investment options as follows: Money Market Fund, 23.8%; Stock Fund, 28.5%; Bond Fund, 2.4%; Guaranteed Rate Accounts, 20.6%; Balanced Fund, 20.6%; Aggressive Stock Fund, 3.5%; High Yield Fund, 0.2%; and Global Fund, 0.4%.

The percentage change in unit values for the following funds for calendar year 1991 were as follows: Money Market Fund, 5.6%; Stock Fund, 43.7%; Bond Fund, 13.7%; Balanced Fund, 40.7%; Aggressive Stock Fund, 75.6%; High Yield Fund, 24.6%; and Global Fund, 26.4%. These reported changes in unit values assume that monies were invested for the entire period and are not an indication of future performance.

Practice Security Program: The Association-sponsored Practice Security Program was introduced as a benefit of membership in 1989. It offers the dentist professional liability insurance as well as an optional package of property loss, business liability and practice interruption coverages designed to meet the needs of dental offices. The Program is offered under the auspices of the ADA Risk Purchasing Group, Inc., which enables the Association to restrict participation to member dentists.

The Program's professional liability coverage has now received regulatory approval in all states and territories except California, Colorado, Massachusetts and Puerto Rico. The optional property/casualty insurance package has received regulatory approval in 35 states.

The Practice Security Program is fully insured by the Reliance National Insurance Company, which has assets of approximately $2.8 billion and a surplus of $841 million. It is

rated A- (excellent) by A. M. Best. Through its various insurance subsidiaries, Reliance is an "admitted carrier" in all states where the Program is offered. Thus, the Company is subject to regulatory oversight of its financial condition and participates in state-operated solvency guaranty funds, where available.

Responsibility for administering and marketing the Practice Security Program was transferred from Johnson & Higgins of Illinois to Kirke-Van Orsdel Specialty, Inc. (KVI), during February and March 1991. Subsequently, KVI worked closely with the Council and Reliance National to develop the Program's optional dental office property/casualty insurance package policy as well as a new marketing program. The new promotional effort was initiated in January 1992 with a direct-mail solicitation to 56,302 members in 36 states and the District of Columbia. Mailings to an additional eight states were made in May. The purpose of these promotions is to encourage the dentist to request a quotation and proposal for coverage. Such proposals will be mailed approximately 90 days in advance of the renewal date of the dentists' current policy. The initial response to this mailing has been excellent with over 7,000 members requesting quotations by March 1992. As the current policies of these individuals approach renewal, they will be contacted by KVI and asked to consider making application for the Association-sponsored program.

Professional liability insurance offered by the Practice Security Program is written on a claims-made form and is offered to general practitioners and specialists. Unlike some competing policies, the Association's Program provides protection against malpractice allegations arising from all treatments and procedures permitted by state dental practice acts.

Separate premium classifications have been developed for general practitioners and each of the specialty groups. Rates are further differentiated based on the use of conscious sedation or general anesthesia, as well as geographic location.

Additional factors that will determine an individual dentist's premium include past claim history. A surcharge mechanism provides for the imposition of a financial penalty on those participants who have incurred claims but still remain insurable. This is intended to discourage adverse selection and, in part, address concerns that claim-free dentists subsidize the losses of others.

A dentist's rate may be further modified by a schedule of debits and credits, so that the premium could vary above or below the base rate by as much as 20%. The criteria for determining how the scheduled debits/credits will be applied to individual dentists is based on the measures they have taken to reduce the risk of a malpractice incident. These include participation in loss prevention programs within the past two years, successful completion of a home study program introduced by the Council in 1990, attendance at approved continuing education programs within the past two years and certification in basic and/or advanced cardiac life support. Additional criteria may be added in the future.

The Program offers an extended reporting endorsement at no cost to members who retire at age 59 or older and have been insured with Reliance National for the prior five consecutive years. The free endorsement is also provided in the event of the insured's death or permanent disability from the practice of dentistry.

The optional Dental Office Package policy includes coverages that are as broad, and in some cases, more advantageous than those offered by other insurers. Its features include a Blanket Business Personal Property endorsement. This addresses the problems that can result from more conventional policy forms, which require the dentist to select a separate limit of coverage for each category of property to be insured. Failure to adequately value property can result in a substantial loss at the time of claim. With the ADA Office Package, the insured will select a blanket amount of protection for all covered assets. As a result, even if the value of an individual category of property is underestimated, the difference can be covered by the blanket.

Another special feature of the package is its Business Interruption coverage, which is offered on a "Valued Daily Limit" basis. If the dentist suffers an income loss as the result of a covered exposure, the benefit elected at time of application is automatically paid without the need to substantiate the amount of the claim. However, if the dentist believes that the loss of earnings will exceed the selected daily limit, compensation can be claimed under an Actual Loss Sustained category of the Business Interruption coverage. In that event, documentation of the claim would be required and benefits would be available for up to 12 months.

As of December 31, 1991, enrollment in the Program totaled 602. This modest level of participation was expected given that the Program was not actively marketed in 1991, while its dental office insurance package was under development. The Council is hopeful that 1992's marketing campaign will make a greater number of members aware of the Program's advantages and encourage them to participate.

Professional Liability Risk Management: The Council continues to believe that one of the most effective means of controlling the rising cost of dental professional liability insurance is increasing the membership's awareness of the causes of malpractice allegations and the use of proven techniques for reducing the likelihood of such incidents. Towards this end, speakers appointed by the Council have conducted loss prevention programs at numerous dental meetings. These seminars are offered on a half- or full-day format and are available to constituent and component dental societies, study clubs and other recognized dental groups. Although the subject matter can be changed to accommodate the needs of the sponsoring group, some topics are always covered. These include a discussion of recordkeeping, informed consent, doctor/patient relationships and various legal considerations.

The cost of the seminar includes a fee of $2,000 for each one-day presentation and travel expenses for speakers including transportation, meals and lodging. The sponsoring organization is also responsible for all on-site costs and is required to provide a legal perspective on the issues to be discussed.

Requests for the program should be directed to the Association's Department of Marketing and Seminar Services.

Excess Major Medical Insurance Program: The Excess Major Medical Plan, underwritten by the Great-West Life Assurance Company, was implemented in January 1975 and was intended to offer protection against catastrophic medical care expenses.

Enrollment in the Plan proved unsatisfactory. This was attributed to the fact that, after the Plan's inception, comprehensive medical insurance products were developed which offered coverage for catastrophic as well as routine medical expenses.

A cycle of declining participation, benefit restrictions and rate increases began in 1980. Despite all corrective measures, the financial integrity of the Plan deteriorated and the Council on Insurance concluded that there was no practical alternative to its termination. Acting upon the Council's recommendation, the Board of Trustees adopted a resolution (*Trans.*1983:467) calling for the termination of the Excess Major Medical Plan effective July 1, 1985.

Subsequent to the Plan's termination on June 30, 1985, and with the passage of time, it became apparent that the Plan would not terminate in a deficit position and that surplus funds would be available. As of December 31, 1991, only 21 individuals continue to be eligible for benefits under the Plan. However, outstanding reserves and other funds held by the Plan exceed the amounts required to discharge these remaining claim obligations.

At its March 13-14, 1992 meeting, the Council accepted a proposal submitted by the Great-West Life Assurance Company calling for the distribution of the remaining assets of the Excess Major Medical Insurance Plan. It calls for the surplus funds to be made available to eligible former participants through a claim procedure, with unclaimed amounts to be distributed to the Association.

Notices will be published in two consecutive issues of the *ADA News* to alert members who participated in the Plan that they will be eligible to claim a share of the surplus for each year for which they were insured, regardless of age, policy year of participation, deductible or dependents covered. Each share will have a value of $16.23. They will have a 90-day period in which to make a request for a share of the excess funds.

It is expected that some individuals may not claim a share of the surplus. The Council agreed with Great-West that any unclaimed money should be distributed to the Association to be used for the benefit of the entire membership, as determined by the Board of Trustees.

Response to Assignments from the 1991 House of Delegates:

Disability coverage for HIV-infected Health Care Workers. At its March 1992 meeting, the Council reviewed Resolution 107H-1991 (*Trans.*1991:622), which calls for the Association to urge insurers to provide disability insurance benefits for HIV-positive health care practitioners in accordance with Association policies on practice restrictions for such individuals. The Council noted that the Centers for Disease Control (CDC) was in the process of reconsidering its guidelines on this issue and that insurance companies are likely to be influenced by the CDC's positions.

So as to base its response on the most current information, the Council postponed consideration of Resolution 107H-1991 until its August 1992 meeting, by which time it is hoped that revised CDC guidelines on HIV-positive health care practitioners will be issued.

Acknowledgments: The Council wishes to express its appreciation for the contributions of Drs. John Knox, John Lehman, Douglas McCall and Donald Toso, who have completed their service as members of the Council on Insurance. The success of the Association-sponsored insurance and retirement programs is due in no small part to the sound judgment and decisions of these member dentists.

Support for the American Fund For Dental Health: The Council wishes to acknowledge with gratitude the continuing support given the American Fund for Dental Health's Teacher Training Fellowships by the Great-West Life Assurance Company.

Support for the American Dental Association SUCCESS 91-92: The Council wishes to express its appreciation to the Great-West Life Assurance Company, the Equitable Life Assurance Society of the United States and the Life Insurance Company of North America for their support of the Association's SUCCESS Program, conducted for the benefit of junior and senior dental students.

Resolutions: This report is informational in nature and no resolutions are presented.

ADA Holding Company, Inc.

For-Profit Subsidiaries' Annual Report and Financial Affairs

Introduction: The American Dental Association is the sole shareholder of the Association's for-profit subsidiary, ADA Holding Company, Inc. (ADAHC). ADAHC in turn is the sole shareholder of its two subsidiaries, ADA Publishers, Inc. (ADAPI) and ADA Business Systems, Inc. (ADABS). The annual report outlines the financial affairs of these subsidiaries for the year-end 1991 and the first four months of 1992.

ADA Holding Company, Inc. (ADAHC): Incorporated in late 1989, ADAHC began operations on January 1, 1990 as the parent corporation for ADAPI and ADABS. The ADAHC Board provides guidance and leadership to its two for-profit subsidiaries. The Board consists of 11 directors, including the ADA President-elect, 2 ADA Trustees, 4 ADA member dentists, 2 outside directors, the ADA Executive Director and ADA Assistant Executive Director-Finance and Business Affairs. In 1991, ADAHC received $225,000 in dividend income from ADAPI and reported a net income of $193,297. In May 1992, ADAHC received a dividend of $125,000 from ADAPI, which was then paid to the American Dental Association as final payment of the long-standing inter-company balance between ADABS and the American Dental Association.

ADA Publishers, Inc. (ADAPI): In the second year as a for-profit subsidiary corporation, ADAPI reported an after-tax net profit of $713,452 for 1991, 62% over the budgeted net profit of $440,100. During 1991 and the first quarter of 1992, ADAPI repaid in full the long-term debt owed to the American Dental Association, several years ahead of schedule. As of April 30, 1992, ADAPI reported a net profit of $325,596. At the May 1992 Board meeting, the ADAHC Board of Directors declared a dividend of $125,000 be paid by ADAPI to ADAHC. This dividend was ultimately used as payment to the American Dental Association on behalf of ADABS.

The financial success of the publishing group can be attributed to increased advertiser interest and cost containment measures implemented in 1991. Studies conducted in 1991 by two independent research companies confirmed the readership and advertiser acceptance of the new *The Journal of the American Dental Association* and the continued growth and popularity of the *ADA News*. In response to the readership surveys, focus group studies and other feedback from ADA members, *The Journal* will continue to stress practical, clinical editorial content of interest and utility to the practicing dentist. Major research reports will continue to appear in *The Journal* as appropriate, but *The Journal* will continue to focus mainly on material of interest to clinicians.

ADA Business Systems, Inc. (ADABS): ADABS, formerly American Dental Office Systems, Inc. (ADOSI), was incorporated in 1984, and in 1985 it began selling practice management computer systems to dentists through a nationwide dealer network. In 1986 ADOSI entered into a joint marketing agreement with Triad Systems, a California-based computer company offering hardware, software and service to practicing dentists. The joint marketing agreement with Triad Systems was mutually terminated on August 14, 1991. ADABS reported an after-tax net profit of $5,936 in 1991.

Resolutions: This report is informational in nature and no resolutions are presented.

For-Profit 1991 Summary

	Actual	Budget
ADA Publishers, Inc.		
Revenues	$8,270,753	$7,423,800
Expenses	$7,557,301	$6,983,700
Net Revenue/(Expense) After Taxes	$713,452	$440,100
ADA Business Systems, Inc.		
Revenues	$185,520	$337,500
Expenses	$179,584	$226,600
Net Revenue/(Expense) After Taxes	$5,936	$110,900
ADA Holding Company, Inc.		
Revenues	$225,000	$0
Expenses	$31,703	$39,400
Net Revenue/(Expense) After Taxes	$193,297	($39,400)

For-Profit 1992 Summary YTD as of 4/30/92

ADA Publishers, Inc.	Actual	Budget
Revenues	$2,972,543	$2,817,762
Expenses	$2,646,947	$2,615,409
Net Revenue/(Expense) After Taxes	$325,596	$202,353
ADA Business Systems, Inc.		
Revenues	$275	$0
Expenses	$19,097	$0
Net Revenue/(Expense) After Taxes	($18,822)	$0
ADA Holding Company, Inc.		
Revenues	$1,502	$16,668
Expenses	$4,497	$15,212
Net Revenue/(Expense) After Taxes	($2,995)	$1,456

Notes

Divisions of Legal Affairs and Legislative Affairs

Council on Ethics, Bylaws and Judicial Affairs

Council on Governmental Affairs and Federal Dental Services

Notes

Council on Ethics, Bylaws and Judicial Affairs

Sewright, James R., South Dakota, 1992, chairman
Fanno, James T., Ohio, 1993, vice-chairman
Burch, Robert H., Arkansas, 1992
Cadle, Donald I., Jr., Florida, 1994
Cartwright, O. V., Texas, 1992
Clark, Terrence A., Oregon, 1995
Cooley, David F., Michigan, 1992
Giuliani, Richard L., Maryland, 1993
Hamrick, Fitzhugh N., South Carolina, 1994
Hess, Richard D., Illinois, 1995
Landis, Charles F., Jr., Tennessee, 1995
Lavalla, Gaetan J., Pennsylvania, 1995
Matis, John A., Utah, 1993
Sessa, Frank A., Connecticut, 1994
Warner, Lawrence J., California, 1994
Wentworth, Edward T., Jr., New York, 1993
Boerschinger, Thomas H., director

Meetings: The Council met on January 12-13 and April 26-27, 1992 in the Headquarters Building.

Dr. James N. Clark, trustee, Tenth District, served as liaison to the Council for the Board of Trustees for 1992. Dr. Clark monitored the proceedings of the Council during this year and attended both of its meetings.

Vice-Chairman: Dr. James N. Fanno was elected vice-chairman at the January meeting.

Appreciation: The 1992 annual session will mark the retirement of Dr. James R. Sewright, who served as the Council's chairman in 1992. Also retiring are Drs. Robert H. Burch, O. V. Cartwright and David F. Cooley. Drs. Burch and Cooley each served four years on the Council. Drs. Cartwright and Sewright each served eight years on the Council. The Council expresses its gratitude to these individuals for their leadership, contributions and dedication during their tenure.

Judicial Procedures

Appeal of Dr. Gregg: Dr. Robert H. Gregg, a member of the California Dental Association, appealed to the Council from a decision of the Judicial Council of the California Dental Association. The Council heard the appeal at its April meeting. The Council's decision on this appeal is being written at the time of the preparation of this report. This decision will be set forth in a supplemental report to the House of Delegates.

Response to Assignments from 1990 and 1991 House of Delegates

Issuance of New Advisory Opinion to "Code" Section 5-A, Advertising: In Resolution 106H-1990 (*Trans.*1990:575), the House of Delegates requested the Council to continually monitor scientific developments concerning the human immunodeficiency virus (HIV) for the purpose of insuring that the Council's ethical pronouncements and advisory opinions did not become incompatible with scientific knowledge in this area.

One of the issues which came to the Council's attention was a sudden rise in the media's attention, in the wake of the Florida case, to advertisements by dental offices of negative HIV test results. To address this issue, the Council issued an advisory opinion on this subject. This advisory opinion was issued on September 26, 1991, shortly before the 1991 annual session.

The Council was concerned that such advertisements could mislead the public by omitting material facts needed to place in proper context the relevance of a negative result on an HIV test. The Council finds no fault with a desire to promote the dental office as a safe place for dental patients. However, present methods of HIV testing are severely limited in detection of HIV seropositivity in its early stages. As a result, overemphasis of a negative result could mislead a patient. The advisory opinion, with background statement, provides:

Advisory Opinion 6 to Section 5-A, Advertising, of the "ADA Principles of Ethics and Code of Professional Conduct":

Background: The reports of the Centers for Disease Control (CDC) strongly suggest that five patients became HIV infected after treatment by a Florida dentist with AIDS (Centers for Disease Control *Morbidity and Mortality Weekly Reports* [*MMWR*] 1991:40:1-9). As a result of its investigations of this and other cases of HIV-infected health care workers (HCWs), the CDC issued guidelines for preventing transmission of HIV and HBV to patients during exposure-prone invasive health care procedures (*MMWR* 1991 40:RR-8).

The issue of the HIV-seropositive HCW has also received congressional and state legislative attention. An amendment to an unrelated bill would make it a criminal offense for a seropositive HCW to perform or participate in an invasive procedure unless the patient had been informed of this fact (Senator Helms' amendment I to Treasury Department and Postal Service Appropriations Bill, H.R. 2622). Another amendment recommends that the various state boards regulating HCWs adopt the guidelines issued by the CDC (Bipartisan compromise amendment to H.R. 2622). Also, a bill has been recently introduced which would require mandatory testing of HCWs performing "high risk invasive" procedures (H.R. 2788).

The Council is concerned because the intense media coverage accompanying these events has influenced some dentists to take out advertisements announcing the negative results of HIV tests. This, in turn, has centered additional media coverage on questions involving the legality and ethics of such advertisements (See e.g., AIDS ads draw heat for dentists. *ADA News* 1991; 22 (16) and The ethics of aids. *Asbury Park Press* 1991; Aug. 14: A-1).

The Council agrees that the issues presented by such advertisements are important, both from the public's and the profession's perspective. The Council further believes that the importance of the issues involved is heightened by the intense media attention that these issues continue to receive. Therefore, the Council has written an advisory opinion on such advertisements under the *ADA Principles of Ethics and Code of Professional Conduct.*

Discussion: The relevant provision of the ADA's *Code of Professional Conduct* provides:

> 5-A. ADVERTISING.
> Although any dentist may advertise, no dentist shall advertise or solicit patients in any form of communication in a manner that is false or misleading in any material respect.

Generally, science does not consider a negative result from currently available HIV tests to be reliable until this result is obtained from a test performed at least six months after the last exposure to the virus. Thus, even if a dentist entered into a periodic six-month testing program for HIV, it would be possible for the dentist to be HIV seropositive for a period of up to almost one year before present testing methods would yield a positive result. The Council believes that, when examined in this context, advertising a negative test result misleads the patient who relies on this fact to form a belief that the treating dentist is HIV negative at the time of dental treatment.

Does this propensity for misinformation render such an advertisement unethical? For the reasons in the following discussion, the Council believes that it does.

It is assumed that the advertisement representing a negative HIV test result is an accurate statement. However, it is possible to be technically accurate and still mislead. In a prior advisory opinion, the Council observed that a statement would be unethical if it "omit(ted) a fact necessary to make the statement considered as a whole not materially misleading ... ." (Advisory Opinion 2 to Section 5-A. Advertising).

Given the truly tragic occurrence in Florida, patient concern regarding exposure to the "AIDS" virus in a dental setting cannot be dismissed as totally irrational. A recent survey indicates that 92% of Americans know something about the possibility that a dental patient may have contacted the AIDS virus from a dentist.

While one such occurrence is one too many, it is significant that all five reports of HIV infection in the dental setting relate to one dental practice and that the manner of transmission in this practice remains uncertain. It is known that there were serious lapses in this dentist's infection control procedures. However, because the dentist in question died before he could be interviewed by the CDC epidemiologists, and because there are large gaps in the dental records of this office, it appears that the route of infection will never be known. What can be discerned from a review of the CDC reports is that the effectiveness of the barrier techniques recommended by the CDC and the ADA is not in question. This is clear because: (1) there were serious breaches in the infection control practices of the Florida dental practice; (2) with the sole exception of this practice, more than 40 look-back studies on thousands of patients treated by HIV-infected HCWs have revealed no transmission of the virus; (3) the CDC guidelines for patient protection continue to emphasize barrier techniques, not the testing of HCWs.

The CDC's confidence in proper infection control techniques is demonstrated by its concentration on "exposure-prone" procedures when it formulated guidelines for the HIV-infected HCW (*MMWR* 1991; 40:RR-8).

It is clear to the Council that the CDC has placed primary emphasis on sound infection control techniques in order to protect the public from exposure to HIV in the health care setting. It is equally clear that the CDC finds that the testing of HCWs for HIV is of secondary importance, and then only when the HCW is involved in an exposure-prone invasive procedure (*MMWR* 1991; 40:5-6).

The report of the ADA's Task Force on Invasive Procedures, adopted by the Board of Trustees, finds that exposure-prone procedures are "chiefly oral *surgery*, endodontic *surgery* and periodontic *surgery* ... ." (Board Report 6, 1991, Resolution 82—emphasis added). The vast majority of preventive and restorative dental care does not constitute an exposure-prone procedure.

Relating this information to advertisements of negative HIV test results, it is clear that, unless properly interpreted and qualified, such advertisements convey information which serves to mislead rather than inform a prospective patient. These advertisements have the additional undesirable result of unjustifiably adding to the current phobia concerning AIDS and the dental office. Patients who see such advertisements will attach undue significance to them and may well believe that something is amiss in the dental office that has not promoted that it is HIV free. This will very conceivably result in a significant portion of the public forgoing important dental care because of the misinformation generated. Delaying preventive and restorative care can result in additional oral and general health risks and additional expense to the patient and society. Dentists have an ethical obligation to refrain from advertisements which produce such a result.

The Council recognizes that a doctor has the right to inform the public on all facets of the care which the doctor stands ready to provide. However, the doctor electing to provide such information has the burden of doing so in a manner that does not mislead the public on important health issues. Moreover, a doctor must refrain from a business exploitation of an unfounded public fear when doing so will add to the public's misconception.

A serious ethical question is raised when this is done in the context of purporting to convey information to the public on the subject of preventing infection from the human immunodeficiency virus in the dental operatory, because of the degree of public attention which has been focused on this

subject. Inaccurate or incomplete information on this subject will cause the public to believe testing must be of major importance. Unnecessarily raising public concern by catering to unfounded fears about the safety of the dental office will discourage the public from seeking the dental care it requires. The Council believes that the best method of discussing this very important subject with patients of record is by direct contact between patient and doctor, either in person or by mail. The Council further believes that this form of communication should be supported by written material that has been peer reviewed for accuracy and completeness.

As a result of the foregoing considerations, the Council on Ethics, Bylaws and Judicial Affairs adopted the following advisory opinion by mail ballot. This advisory opinion was reviewed by the Council at its January meeting.

Advisory Opinion 6 to "Code" Section 5-A, Advertising

6. An advertisement which omits a material fact or facts necessary to put the information conveyed in the advertisement in a proper context can be misleading in a material respect. An advertisement to the public of HIV negative test results, without conveying additional information that will clarify the scientific significance of this fact, is an example of a misleading omission. A dental practice should not seek to attract patients on the basis of partial truths which create a false impression.

ADA "Constitution and Bylaws" Revised: The current edition of the ADA *Constitution and Bylaws*, revised as of January 1, 1992, reflects the amendments approved by the 1991 House of Delegates.

Reconsideration of Advisory Opinion 1 to Section 1-C of the "ADA Principles of Ethics and Code of Professional Conduct" Issued May 7, 1990: Resolution 92-1991 (*Trans.*1991:674) sought to rescind Advisory Opinion 1 to Section 1-C of the *ADA Principles of Ethics and Code of Professional Conduct*. This resolution was referred to the Council for a report to the 1992 House.

The advisory opinion which is the subject of Resolution 92-1991 provides:

A dentist who becomes ill from any disease or impaired in any way shall, with consultation and advice from a qualified physician or other authority, limit the activities of practice to those areas that do not endanger the patients or members of the dental staff.

This advisory opinion was issued by the Council on May 7, 1990. The contemporaneously released background statement made it clear that the Council's primary concern was patient welfare. The background statement provides, in part:

Addiction, mental illness, debilitating diseases, and if appropriate precautions are not taken, communicable diseases are examples of impairment. A decision on whether a dentist or dental auxiliary should continue to treat patients is one which must be made on the facts and circumstances of each case. A dentist who is impaired or has an impaired staff member has an ethical obligation to consult recognized medical and dental authorities with respect to the treatment of patients by the impaired individual and to abide by the recommendations received (assuming a clear consensus as to the appropriate standard of care is available). Where appropriate, the professionals consulted should review the practice and infection control procedures utilized therein.

At the time this advisory opinion was drafted and promulgated by the Council, the Council had no knowledge of the case of the Florida dentist who is now generally reported as having somehow infected several of his patients with HIV. However, the Council anticipated the problems raised by HIV-positive health care workers and the importance of strict overall infection control in such cases and determined to issue this advisory opinion to proactively address these issues.

The 1991 House of Delegates recognized that the issuance of this advisory opinion by the Council was timely, and that this advisory opinion stood the profession in good stead in the media frenzy which followed the report of the Florida situation. Resolution 84H-1991 (*Trans.*1991:642), confirming prior ADA policy, stated, in part:

The dental profession has long adhered to a moral commitment of service to the public and an ethical obligation to protect the health of the patient. An advisory opinion to the American Dental Association's *Code of Professional Conduct* urges dentists who become ill or impaired to limit the activities of practice to those areas that do not endanger either patients or dental staff.

The Board recommendation on Resolution 92-1991 recognized the service rendered to the profession by the Council's timely action. However, the Board recommended that Resolution 92-1991 be referred back to the Council for the Council to consider whether its use of the phrase "impaired in any way" might be misinterpreted to cover minor impairments, such as flu or a cold.

The Council believes that, in the context used, impairment is a term of art which connotes a serious matter. In a 1972 report by a council of the American Medical Association (*JAMA* 1973; 223: 684-87) impairment was defined as "the inability to practice medicine with reasonable skill and safety to patients by reason of physical or mental illness, including deterioration through the aging process, loss of motor skills, or the excessive use or abuse of drugs, including alcohol." The Council has received no reports of overly literal interpretations of this advisory opinion to encompass minor maladies. However, should this occur, the Council stands ready to address this issue by an appropriate amendment.

As part of its obligation to monitor the AIDS pandemic and its ramifications to the profession's ethical code, the Council has this advisory opinion under constant review. However, the Council does not believe that it would be either efficient or advantageous to make minor changes at this time. The Centers for Disease Control (CDC) has indicated that it will be issuing revised guidelines on HIV-infected health care workers in the near future. Because the present advisory opinion is compatible with the CDC's current guidelines on this subject, the Council believes it would be wise to await the new CDC guidelines before deciding upon the need for any revision. When and if revised guidelines are issued by the CDC, they will be reviewed by the Council and any necessary revisions to the advisory opinion will be made.

Issuance of New Advisory Opinion to Section 5-B, Name of Practice, of the "ADA Principles of Ethics and Code of Professional Conduct": Resolution 130-1991 (*Trans.*1991:628) sought to amend Section 5-B of the *ADA Principles of Ethics and Code of Professional Conduct.* This resolution was referred to the Council for a report to the 1992 House.

The background statement of Resolution 130-1991 suggested that the one-year limitation on the use of the name of a dentist no longer actively associated with a practice imposed by Section 5-B of the *ADA Principles of Ethics and Code of Professional Conduct* (*Code*) no longer served the profession or the public. Section 5-B of the *Code* presently reads:

> 5-B. NAME OF PRACTICE.
> Since the name under which a dentist conducts his or her practice may be a factor in the selection process of the patient, the use of a trade name or an assumed name that is false or misleading in any material respect is unethical.
>
> Use of the name of a dentist no longer actively associated with the practice may be continued for a period not to exceed one year.

Resolution 130-1991 proposed to amend the foregoing provision by striking the last sentence.

When there is a sale of a dental practice, it is common for the purchaser of the practice to desire to use the name of the practice for a period of time, in order to assure the transfer of the goodwill of the practice from the seller to the purchaser. The present *Code* provision allows this to be done for a period of one year.

The contention of the proponents of this resolution that the one-year period constitutes a disservice to the public appears to be principally concerned with the difficulty that patients might have in locating their dental records or making contact with the successor practice because of the name change after one year.

As a preface to this discussion, it must be emphasized that *Code* Section 5-B is permissive. It permits the use of the name of the dentist for one year without further qualification. Nothing prohibits listing the name of the departing dentist after this period, assuming it is done with permission, if notice is given to all that the departing dentist has retired from the practice and is no longer associated with it. Of course, this must be accomplished in a manner that will clearly inform the public of the situation at the earliest time that is practical.

The majority of the Council members believed that the one-year limitation has served dentistry well. It provides a definite, easy-to-follow rule on the use of the selling dentist's name. However, the ambiguity with respect to use of the departing dentist's name after the one-year permissive period provided for in the *Code* requires clarification. Therefore, the Council determined to issue an advisory opinion on this point.

The Council also took this opportunity to point out that a dentist permitting continued use of his or her name for any period should do so only after receiving competent legal advice. Upon examining this question, the Council was concerned that a dentist might authorize continued use of his or her name without checking with legal counsel because of the permissive language of this *Code* provision. In fact, any dentist permitting continued name usage for any period of time should be covered by malpractice and premises liability insurance during the period his or her name is used.

The following advisory opinion was issued on April 27, 1992:

Advisory Opinion 1 to "Code" Section 5-B, Name of Practice

1. Dentists leaving a practice who authorize continued use of their names should receive competent advice on the legal implications of this action. With permission of a departing dentist, his or her name may be used for more than one year, if, after the one-year grace period has expired, prominent notice is provided to the public through such mediums as a sign at the office and a short statement on stationery and business cards that the departing dentist has retired from the practice.

Council Activities

Referral from Council on Dental Education: Review of Special Committee Report Regarding Overlap in Scope of Practice of Orthodontic/Pediatric Dentistry: The report of the Special Committee was referred to the Council on Ethics, Bylaws and Judicial Affairs by the Council on Dental Education for comment on the ethical ramifications of the report. The Council reviewed in detail the Special Committee's report. The Council concluded that where two specialty areas had approximately the same accredited educational background with respect to the treatment areas or procedures which constituted the overlap area, no ethical issue was presented. However, the Council did perceive that ethical issues were present where two specialties overlapped in area of treatment or procedures and one specialty had significantly more accredited education in its specialty program in the area of the overlap.

The Council concluded that the ethical problem diminished when the prospective patient was informed of the overlap and the relative extent to which each of the overlapping specialties included the overlap procedures in their respective accredited educational programs. There was strong sentiment on the Council to issue an advisory opinion on this subject. However, the issue is a complicated one, and the Council was concerned that any advisory opinion might be either misinterpreted or be given application beyond its intended subject matter. It was also noted that the areas other than pediatric dentistry and orthodontics had not been given an opportunity to comment on this issue. Therefore, the Council determined that it would forward a report to the CDE with respect to its general conclusions. This report would contain a proposed advisory opinion. Contemporaneously, the Council will circulate its report with the proposed advisory opinion to the community of interest for additional comment. Copies of the Council's report on this subject can be obtained by contacting the office of the Council on the ADA toll-free number.

Ethics Seminars: This is the fourth year of the Council's ethics seminar programs. The Council continues to make available to regional meetings, constituent and large component societies an ethics workshop program designed to raise members' awareness of the general subject of ethics and specific ethical issues facing the profession.

This year the Director of the Council appeared before the New England Dental Leadership Conference and addressed advertising issues. A more comprehensive workshop is

scheduled for members of constituent society ethics committees in the New England area on November 4, 1992.

The Council is also scheduled to present a workshop for the Wisconsin Dental Association in conjunction with its annual meeting on September 19, 1992.

In the Council's view, the workshops constitute a proactive approach to the ethical problems confronting the profession. By raising the profile of dental ethics and members' awareness of this subject, it is believed that self-examination and peer pressure eliminate or resolve ethical problems in an expeditious manner. It is believed that this is more effective and more cost efficient than resorting to formal disciplinary proceedings.

Societies interested in a presentation of such a workshop by the Council should contact the Council office on the Association's WATS line.

Strategic Planning: At its April 26 meeting, the Council members participated in a strategic planning session for the Council. This planning session was facilitated by Ms. Patricia Newton, director, Dental Society Services of the Division of Membership and Marketing Services.

This planning session focused on the goals of the Council in relation to the agencies the Council serves, both in the dental profession and the public sector.

Members of the Council unanimously believed that this planning session was beneficial to them and enabled them to list priorities among the various Council activities. The Council intends to continue this type of planning session at future meetings as time permits.

Council Subcommittee on Dental Advertisements: This Council subcommittee continues to provide advisory opinions to component and constituent societies on dental advertisements and their compliance with the *ADA Principles of Ethics and Code of Professional Conduct*. Constituent and component societies who receive complaints about a particular advertisement may forward that advertisement to the Council and its subcommittee will provide the forwarding society with a confidential opinion and analysis of the advertisement. This opinion is advisory in the truest sense, as it is not binding on either the Council or upon the society which receives the opinion. Its intention is merely to provide the society which must deal with the complaint with a comfort level as to whether the advertisement is cause for concern under the ADA *Code*. Should the matter on which the opinion is given eventually proceed to a disciplinary hearing which results in an appeal to the Council, the members of the subcommittee will not participate in that appeal. The reports back to the Council indicate that this service is appreciated by those societies that have had occasion to use it. Societies with such issues are encouraged to contact the Council and use this service. Inquiries should be directed to the Council Director.

Proposed Amendment to "ADA Principles of Ethics and Code of Professional Conduct"

Addition of New Section Concerning the Chemically Impaired Dentist and the Obligation of Colleagues with Knowledge of this Situation: The ADA *Bylaws* provide that one of the duties of the Council is to consider proposals for amending the *ADA Principles of Ethics and Code of Professional Conduct* (Chapter X. I.).

In reviewing the *Code*, it became apparent to the Council that the *Code* does not address treatment of patients while a dentist is impaired by chemical substances, including alcohol. Also, the *Code* provides no direction with respect to the obligations of colleagues who have knowledge that a dentist may be treating patients while so impaired.

At the outset, it should be clearly understood that the Council recognizes that chemical impairment is a disease and, in and of itself, does not constitute unethical conduct. This issue has been considered in the past by the Council, and its conclusion was that dentists so impaired should be assisted by the profession, through the various assistance committees which exist at every constituent society, and the problems that impaired dentists have should not be increased by the assertion of an ethics charge. However, the treatment of patients while a dentist is so impaired is another matter. Most ethical codes of health care professions specifically address this latter situation as well as the situation where a colleague has knowledge of the treatment of patients by a fellow professional. The proposed amendment to the ADA *Code* would add a new section 1-M. Chemical Dependency. The language of the proposed section is intended to caution the dependent dentist against the treatment of patients while impaired. Also, it is intended to provide guidance to dentists who have knowledge that a colleague is treating patients while impaired. In this regard, the Council strongly believes that the problems of impaired dentists are best dealt with by persons who have knowledge and experience with such problems. Therefore, the Council drafted language which specifically designates constituent society assistance committees as appropriate bodies to receive reports from colleagues on impairment. The Council believes this will allow such complaints to be dealt with in a manner that would maintain the confidentiality of all persons involved, and yet it will provide the level of protection to which the public is entitled.

To accomplish this amendment, the Council proposes the resolution set forth at the conclusion of this report.

Resolutions

New Policy/Directive:

23. Resolved, that the *ADA Principles of Ethics and Code of Professional Conduct* be amended by the addition of a new section, Section 1-M, Chemical Dependency, to read as follows:

1-M. CHEMICAL DEPENDENCY.
It is unethical for a dentist to practice under the influence of a controlled substance, alcohol, or other chemical agents which impair the ability to practice. All dentists have an obligation to urge impaired colleagues to seek treatment. Dentists with first-hand knowledge that a colleague is practicing dentistry when so impaired have a responsibility to report such evidence to an appropriate government body or dental society committee. Reporting the situation to an assistance committee of a constituent society satisfies this obligation.

Council on Governmental Affairs and Federal Dental Services

Cross, Chauncey, Illinois, 1992, chairman
Sampe, David A., Wisconsin, 1992, vice-chairman
Bowling, Everett, West Virginia, 1994
Curtis, Howard F., Oregon, 1994
Feldstein, Stanley, New York, 1995
Kincheloe, Earl B., Wyoming, 1993
Lainson, Phillip A., Iowa, 1993
Langbert, Carl G., New Jersey, 1994
Malbon, Bennett A., Virginia, 1995
Mehlman, Edwin S., Rhode Island, 1992
Radman, W. Paul, Texas, 1995
Roebuck, Tommy, Arkansas, 1994
Rummel, David G., Ohio, 1993
Studstill, Zack, Alabama, 1992, *ad interim*
Thompson, Kay, Pennsylvania, 1993
Yuen, Stephen S., California, 1995
O'Donnell, John F., director
Hall, Maria A., manager

Meetings: On January 18-19, 1992, the Council Chairman and Drs. Mehlman, Rummel and Sampe met with the President-elect, Board of Trustees Liaison and staff to plan the Council's 1992 agenda. The Council met on March 14-16 in Washington, D.C., during which time it also met with the national dental organizations. Following the meeting, the Council participated in the Public Affairs Conference, held March 17-18.

The Council is scheduled to meet again in Washington, D.C., on July 21-23.

At the March meeting, the Dental Chiefs of the Navy, Air Force, Public Health Service and Department of Veterans Affairs, the Senior Dental Corps Staff Officer of the Army and the Special Assistant for Dental Affairs, Department of Defense, briefed the Council on issues of concern to the profession. The briefing included recruitment and retention of dental corps personnel; effects of defense downsizing on the number of dental personnel; increased representation for the federal services in the ADA House of Delegates; appointment of the new Deputy Director at the National Institute of Dental Research, Dr. Dushanka Kleinman; the expected appointment of a director for the new Division of Oral Health within the Centers for Disease Control; and status of the military dependents' dental benefit program.

Vice-Chairman: At the March meeting, Dr. David A. Sampe was elected vice-chairman of the Council.

Personnel: In February, Dr. J. Cliff Gwynn, Florida, retired from the Council. The 1992 annual session will mark the completion of the terms of service of three other members: Dr. Chauncey Cross, Dr. David A. Sampe and Dr. Edwin S. Mehlman. The Council expresses its gratitude to these four members for the exemplary manner in which they performed their duties in furthering the interests of the profession.

Policy Direction: At the March meeting, the Council approved ten issues as legislative priorities for 1992: OSHA-Bloodborne Pathogen Standard, OSHA-Hazard Communication, National Practitioner Data Bank, Campaign Finance Reform, ERISA Treatment of Self-funded Health Benefit Programs, Tort Reform/Professional Liability Insurance Reform, Medical Waste Legislation, Licensure, Tax Policy and Federal AIDS Legislation. Progress on these issues, as of mid-May, are reported in Response to Assignments from the 1991 House of Delegates.

The Council observed that two other issues, currently under development in task forces, will in time become legislative priorities of the Council: dental hygiene and health care reform.

Response to Assignments from the 1991 House of Delegates

Pre-Existing Condition Exclusion and Age of "Child": Resolutions 7H (*Trans.*1991:634) and 9H (*Trans.*1991:635), address, respectively, provisions of dental benefit programs that involve the exclusion of otherwise covered services on the basis of the condition being treated having been in existence prior to the patient's enrollment in the program, and the means of determining the "child" or "adult" status of program subscribers.

The Council has considered these resolutions with regard to the Dependents Dental Plan of the Uniformed Services, for which expansion authority has recently been granted to the Secretary of Defense by the Congress.

At present, the program provides limited benefits and does not exclude pre-existing conditions, nor does it exclude covered services related to treatment in progress at the time of a patient's enrollment. As the program expands, the Council and the Washington office will work with the Council on Dental Care Programs in order to ensure that such exclusions are not introduced.

For purposes of differentiating between "adult" and "child" in dental procedures for which coverage is provided, the Dependents Dental Plan currently does not make such determinations based on the clinical development of the patient's dentition. Rather, it defines a child as a person through age 13.

The Council is assisting the Council on Dental Care Programs in persuading the Office of Civilian Health and Medical Program of the Uniformed Services, the Department of Defense agency administering the program, to adopt a clinical development standard or define a child as a person through age 11.

Approval of Guidelines on Coordination of Benefits: Resolution 10H (*Trans.*1991:635), in part, encourages constituent societies to seek enactment of legislation that would require all policies and contracts that provide benefits for dental care to use the Association's rules to determine coordination of benefits.

The Department of State Government Affairs has notified the constituent dental societies of this provision in Resolution 10H and has offered to assist them in preparing legislation for this purpose.

Regulation of Utilization Management Organizations: Resolution 12H (*Trans.*1991:636) encourages constituent societies to seek legislation: (1) establishing standards for regulation of organizations providing dental utilization management, managed care review or prior review of dental treatment services; (2) requiring certification of these organizations; and (3) requiring that persons involved through the utilization management process in decisions affecting patient care be licensed dentists and appropriately qualified. The resolution further calls for a study of the feasibility of seeking federal legislation to regulate dental utilization review and management organizations, the results to be reported to the 1992 House of Delegates.

As of May, 15 states have enacted laws regulating private review agents. A utilization review bill awaits signature by the governor of Minnesota. Bills are pending in eight states: Alaska, Delaware, Illinois, Kansas, Michigan, Rhode Island, South Carolina and Vermont; one failed in Washington state. The Department of State Government Affairs notified constituent societies of the content of Resolution 12H and that the Department will assist constituent societies that wish to pursue legislation. The Department also reviews pending legislation at the request of constituent societies.

Regarding federal legislation to regulate dental utilization review and management organizations, the Council notes the bipartisan support in Congress and the emphasis in the Bush Administration on managed care plans and utilization review programs as methods of containing health care costs.

This support takes several forms, but one prominent approach is to introduce a federal certification process for utilization review programs. This process, however, is tied to a federal override of state regulation of such programs, an override, that is, of the regulation that Resolution 12H encourages.

The Association has objected to such federal overrides, commenting that, traditionally, the plans of health insurers and service benefit companies have been regulated by the several states and that programs, such as utilization review efforts, which support these plans should be comparably regulated. In the Council's view, this is a sound principle. Initiatives to effect regulation at the state level should be pursued vigorously, without resorting to federal regulation.

Approval of Statement on Determination of Usual Customary and Reasonable Fees: Resolution 13H (*Trans.*1991:631) calls upon the Association to encourage the adoption of the content of the Statement on Determination of UCR Fees at the state and federal levels.

The activities of the Council, Washington office and Department of State Government Affairs to accomplish the purposes of Resolution 13H are reported in the response to Resolution 68H (see page 114).

Safeguards for Medicare's HMOs: Resolution 20H (*Trans.*1991:638) amended a 1985 policy by deleting reference to the financial interests of the federal government. The policy now urges the Health Care Financing Administration to assure adequate administrative safeguards, including appropriate funding under the Medicare HMO authority, to protect the health of patients.

The amended policy will appear in *Current Policies 1954-1991* to be published this summer, and will form the basis of the Association's position, should governmental oversight of the Medicare HMO authority be determined to be ineffective, as was charged in 1984-85.

Timely Payment of Dental Claims: Resolution 21H (*Trans.*1991:639) calls for legislation to require all public and private third-party payers to reimburse dental claims within 15 business days from receipt of claim by the third-party payer or be penalized for failure to do so.

At least 17 states have enacted prompt payment provisions in their insurance laws. The Department of State Government Affairs advised constituent societies of the content of Resolution 21H. The Department maintains copies of these laws and is available to assist constituent societies interested in preparing legislation.

Bills are pending in 1992 in seven states, including Alabama and California, which already have prompt payment laws. The Alabama bill would reduce the required period of payment from 45 to 30 days; the California bill would extend the prompt payment requirement to dental insurance.

Dental Care for Military Dependents: Resolution 38H (*Trans.*1991:630) combined the applicable content of eight policies on dental care for military dependents, adopted between 1954 and 1984 into a single policy. Resolution 38H calls for a dental benefit program that conforms, where appropriate and practical, to Standards for Dental Benefit Plans (*Trans.*1988:478; 1989:547) that provides freedom of choice for dependents between a dental benefits program and space-available military facility care and that is comprehensive in coverage of dental services. Additionally, Resolution 38H supports space-available care only to the extent that its provision does not impair the dental needs of active duty forces or require additional resources.

The Military Dependents Dental Benefit Program, enacted in 1985, meets the provisions of Resolution 38H with the

exception that the program is not comprehensive. As originally authorized, the program covered "diagnostic oral examinations and preventive services and palliative emergency care ... amalgam and composite restorations and stainless steel crowns for primary teeth and dental appliance repairs." Limits were set on the service member's contribution to premiums, the overall premium and the annual cost of the program.

The National Defense Authorization Act for Fiscal Years 1992 and 1993 (P L 102-190) provides authority to the Secretary of Defense to expand the program to provide such additional dental benefits as the Secretary deems appropriate. This authority was supported by the Association. P L 102-190 also raises the service member's premium contribution limit in certain circumstances. It does not raise the annual expenditure limit.

In addition, P L 102-190 stipulates that additional covered services are to be included in a "supplemental dental benefit plan," with the coverage in the basic plan remaining as described above.

The Washington Office has expressed concern to the Subcommittee on Manpower and Personnel, Senate Armed Services Committee, and the Subcommittee on Military Personnel and Compensation, House Armed Services Committee, that this "two-tier" approach will increase the potential for adverse selection in the program.

This concern and recommendations to liberalize the program's fiscal constraints were formally submitted to the Congress in May.

The Council on Dental Care Programs will seek to expand the covered services in the program through liaison with the Office of Civilian Health and Medical Program of the Uniformed Services.

Eligibility of Veterans for Dental Services: Resolution 39H (*Trans.* 1991:624) was adopted to replace an obsolete policy on the same subject (*Trans.* 1953:232; 1975:724; 1976:877) and to express the Association's support for the present position of the Department of Veterans Affairs in providing dental care. This new policy will be included in *Current Policies 1954-1991*, to be published this summer.

Rescissions of Outdated Policies: Resolutions 40H through 47H (*Trans.* 1991:624), rescinded obsolete policies addressing Notice of Federal Administrative Changes, Relation of Dependents' Dental Care Program to Primary Mission of Uniformed Dental Services, Dental Care for Military Dependents, Remote Status of Military Installations, Criteria for Remote Area Designations, Overemphasis on the Dentist/Population Ratio, Dental Scholarships and Freedom of Choice of Dentists. These rescinded policies are being deleted from *Current Policies 1954-1991*, to be published this summer.

Dental Services for Reserves: Resolution 48H (*Trans.* 1991: 625) calls for a change in regulations or legislation to allow dental disease control treatment of reserve component personnel during individual duty training (IDT), active duty training (AT) or temporary duty (TDY) of less than 30 days. In providing this care, Resolution 48H continues, priority should be given to personnel in the lower pay grades and the dental needs of reserve component military forces should not be impaired for rapid mobilization in times of national emergency.

Under current law, only emergency dental care is authorized for reserve personnel on IDT, AT or TDY of less than 30 days. Dental disease control treatment is defined as treatment of dental conditions, which, if left untreated, are likely to result in a dental emergency within 12 months.

This resolution was transmitted to the House of Delegates by the Council in response to concerns expressed by the Dental Chiefs of the military services regarding the dental readiness of reservists mobilized during Operation Desert Shield/Storm.

As reported in the Council's *Supplemental Report 1* (*Supplement 2*, 1991:432), the military services established a tri-service committee to review how to meet the dental needs of reserve personnel. The Council was advised that the preliminary opinion of this committee was that prioritizing eligibility based on pay grade was inadvisable, since reserve rank may bear no relationship to civilian income.

At its March meeting, the Council discussed Resolution 48H with the military dental chiefs. The military dental chiefs and the Office of the Assistant Secretary of Defense for Health Affairs reported that the tri-service committee considered a number of options, including having reservists treated while on IDT, AT or TDY of less than 30 days, and allowing full-time active duty dentists to treat reservists even when the reservists are not on duty. Neither of these options was adopted. The approach of Resolution 48H was rejected, the Council was advised, mainly because of line officer insistence that reserve personnel be in training the entire time they are on training duty, without reducing this already limited time by permitting needed dental treatment to be performed.

To address this dental readiness problem, the Department of Defense has decided to require the reserve components to abide by their current oral health care standards. These standards provide that a reservist who is in a Class III condition may not be mobilized. Each reservist must sign a certification annually that he or she meets all of the physical requirements to be mobilized, including oral health. The Department of Defense is asking the reserve components to enforce this rule with whatever disciplinary action is appropriate. Thus, the burden will continue to be on the individual reservist to correct whatever dental problems exist in the Class III category.

Continuation of Doctor/Patient Relationship: Resolution 68H (*Trans.* 1991:627) calls for appropriate legislative action to oppose governmental and third-party intrusion in the doctor/patient relationship.

In the 102nd Congress, the Association is supporting S 1332, the Medicare Physician Regulatory Relief Amendments, legislation intended to simplify the processes through which physicians (including dentists) comply with Medicare regulation. In a letter to the bill's sponsor, Senator Max Baucus (D-MT), the Washington Office Director noted that practicing dentists, by and large, are not greatly affected by Medicare rules, inasmuch as most dental procedures are excluded from the program. "It is nevertheless important," the letter continues "... that the legitimate interests of practitioners of all disciplines be protected and that health benefit programs be administered to the mutual interest of subscriber-patients and health care professionals."

Among the issues that are most disruptive to the dentist-patient relationship is the inadequately worded explanation of benefits statement, in cases in which benefits in reasonable and

customary benefit programs are reduced. As one of the Association's legislative priorities, the Council and Washington Office are pursuing regulatory relief through the Secretary of Labor and legislative relief through an amendment to the Employee Retirement Income Security Act (ERISA). This amendment, presented to both the Labor Subcommittee, Senate Labor and Human Resources Committee, and the Labor-Management Relations Subcommittee, House Education and Labor Committee, is intended to be attached to S 794 and HR 2782, the ERISA Pre-emption Amendments of 1991, currently before these subcommittees. The Association-developed amendment would specify that the requirement in ERISA that claims denials (including reductions in benefits) be explained in writing in a manner calculated to be understood by the participant be expanded to include a description of the methodology used in calculating benefits in reasonable and customary benefit plans. ERISA regulates self-funded benefit programs.

With respect to insured plans, the Department of State Government Affairs is offering assistance to constituent dental societies in amending state insurance laws to require carriers to disclose the methods and data used in calculating benefits in reasonable and customary dental plans. Upon request, information and materials, including an Illinois statute for this purpose, are furnished by the Department. The Illinois law was supported by the constituent dental society.

Association efforts are also continuing to amend ERISA to subject self-funded benefit plans to state laws to assure the following: freedom of choice of practitioner; freedom of practitioners to participate in benefit programs and solvency of benefit programs; and to prohibit discrimination in benefits coverage based on the degree of the practitioner.

Another intrusion in the dentist-patient relationship, namely, the improper administration of least-expensive professionally adequate provisions in dental benefit programs, is being addressed by the Council on Dental Care Programs.

The Council notes that failure to process dental benefit claims promptly also contributes to disruption of the dentist-patient relationship. Timely payment of claims is addressed in the Council's response to Resolution 21H (See page 113).

Model for Composition of Expert Review Panel and Protocol for Evaluating HIV- or HBV-Infected Dentists: Resolution 85H (*Trans.* 1991:595) directs appropriate agencies of the ADA to develop a model for the composition of an expert review panel and a protocol that could be followed for evaluating dentists infected with the human immunodeficiency virus (HIV) and the hepatitis B virus (HBV) who wish to continue to practice. Resolution 86H (*Trans.* 1991:595) states that the ADA is opposed to any laws or regulations that require mandatory HIV testing of dentists and other health care workers.

The Department of State Government Affairs, in cooperation with the AIDS task force and several ADA agencies, developed model AIDS legislation. The model was developed to provide guidance to ensure that any state legislation or regulation that may be adopted to comply with the Centers for Disease Control (CDC) guidelines, as required by federal law, would have appropriate input from the dental community. The ADA model defines the roles of the dental boards and expert review panels in making decisions regarding practice restrictions on HIV- and HBV-infected dentists. The information was provided to all constituent society presidents-elect in January 1992 and to state dental board administrators, and its availability was announced to constituent societies.

The model, in keeping with ADA policy, does not recommend mandatory testing. To date, 18 constituent societies have requested copies of the model legislation.

Enforcement of Centers for Disease Control (CDC) Guidelines by State Boards of Dentistry: Resolution 91H (*Trans.* 1991:587) encourages constituent societies to urge state public health authorities who are given the legislative responsibility for the enforcement of CDC guidelines to assign the enforcement to state boards of dentistry.

Model legislation developed in response to Resolution 85H addresses this issue. Section 1 of the model provides for the transfer of responsibility for enforcement of compliance from the state public health officials to the health professions' licensing boards. The Department of State Government Affairs has offered assistance and advice to 18 constituent societies seeking guidance on this issue.

OSHA and Environmental Protection Agency (EPA) Penalties and Inspections and Hazard Communication Compliance: Resolution 95H (*Trans.* 1991:630) calls for amendment of the federal laws or regulations governing OSHA and the EPA to provide that first violations of hazard communication, infection control and waste disposal rules result in warnings rather than fines. Further, Resolution 95H calls for amendment of the same federal laws and regulations to provide that health care offices of private practitioners be given adequate notice prior to inspection in order to avoid interruption of patient care.

Resolution 102H (*Trans.* 1991:586) directs the appropriate agencies of the Association to seek an exemption for dentistry from the OSHA Hazard Communication Standard.

The Council observes that the Medical Waste Tracking Demonstration Program, conducted from 1989 to 1991, has been completed. Consequently, at present, no federal medical waste control program, involving inspections of health care practitioners' offices, is in operation.

With regard to regulations of the Occupational Safety and Health Administration, the Council determined at its March meeting that Association initiatives to (1) secure legislative relief from the objectionable provisions of the Bloodborne Pathogen Standard and (2) obtain an exemption from the Hazard Communication Standard were legislative priorities for 1992.

An action plan approved by the Council, and since initiated by the Association, includes a grass roots lobbying campaign by the membership and the retention of a political consultant firm, the Wexler Group, to spearhead a broad-based legislative and executive branch effort to ameliorate the adverse consequences on the practice of dentistry resulting from the OSHA regulations.

Inspections of Health Care Providers' Offices by Governmental Agencies: Resolution 110H (*Trans.* 1991:628) directs Association agencies to persuade federal and state OSHA to improve its education of federal and state inspectors and the consistency of the inspection process regarding the inspection of dental offices.

To accomplish the purpose of Resolution 110H, the Division of Legal Affairs and the Department of Federal Agency Relations are jointly arranging meetings with the federal regional administrators from each of the ten OSHA regions. These meetings are conducted with an Association officer or trustee from the district or districts involved in attendance, and their agendas include information provided by the constituent dental societies in the region. As of May, meetings have been held in Region I (Boston), Region IV (Atlanta), Region VI (Dallas), Region VII (Kansas City, MO) and Region V (Chicago). A meeting with Region III is scheduled for June 25. Topics on the agenda include: a review of examples of inconsistency in inspections of dental offices; a request that dentists be allowed to participate in training sessions of OSHA inspectors; a request that certain issues be addressed during training of inspectors; a request for development of an OSHA checklist for dental offices; problems with inspections experienced by dentists in the region; lack of sensitivity to privacy of patients and the dentist/patient relationship; the problem of the "industrial" and "safety"-type standards; a request to accommodate a busy dentist who asks the inspector to return a few hours later or the next day; and the difficulty of interpreting the vague provisions in the regulations.

In addition, the Association requested and obtained data on the number of dental inspections in each of the regions visited. These data show very few inspections of dental offices by OSHA. In Region I, 15 dental inspections were conducted between January 1, 1988, and December 12, 1991, in a region which conducts approximately 4,000 to 4,500 total inspections annually. Twelve of the 15 were in response to complaints. Region IV also conducted 15 dental inspections between January 1, 1988, and January 7, 1992, in a region that conducts 7,000 to 7,300 inspections per year. Eleven of the 15 were in response to complaints. Region VII reported six inspections of dental offices in 1991 out of a total of 2,200 inspections. All six were in response to complaints. In Region VI, 42 inspections of dental offices were conducted from January 1988 through December 1991, out of 10,000 inspections done annually. Eighteen of the 42 were in response to complaints, and 21 were program planned or "random." Region V conducted 22 inspections of dental offices from October 1990 through March 1992, in a region that conducts 7,400 to 7,900 inspections per year. All were based on complaints; there were no random inspections.

Nationally, OSHA inspected 229 dental offices in Fiscal Year 1991, in both federal and state-plan states, out of approximately 43,500 inspections conducted that year.

Only two regions reported penalty data for dental offices. Region VI had an average penalty of $1,500 per dental office, and Region IV had an average penalty of $360 per dental office. Average penalty amounts are expected to rise, however, as more inspections are performed under the new higher fine structure, authorized by Congress in 1990 and implemented by OSHA in 1991.

The five Regional Administrators exhibited an attitude of cooperation, and they agreed to establish a joint OSHA/dental task force in their regions, and to permit dentists to be guest speakers at training sessions for OSHA inspectors. The dentists for the task forces are being selected by the trustee or trustees for each OSHA region. Meetings with the remaining five regional offices will be scheduled later this year and, if necessary, in early 1993.

The Department of State Government Affairs has encouraged constituent societies in state-plan states to establish similar cooperative relationships with State OSHA officials in joint endeavors to increase mutual awareness of problems unique to dental practice inspections. Several constituent societies have reported success in inviting OSHA inspectors to speak at state meetings and other membership functions. The Oregon, South Carolina and Tennessee Dental Associations have engaged in cooperative endeavors with OSHA officials. Oregon, jointly with state OSHA officials, developed a manual for use by dentists dealing exclusively with the subject of OSHA inspections. Tennessee and South Carolina have worked with state OSHA officials to develop bloodborne pathogen compliance checklists for dental offices.

The Department of State Government Affairs has advised constituent societies of the content of Resolution 110H and has reported on these cooperative developments to other constituent societies. Information and materials are shared with constituent societies upon request.

Employee Retirement Income Security Act (ERISA) Regulations: Resolution 132-1991 (*Trans.* 1991:629) calls for Association efforts to provide beneficiaries of ERISA-regulated benefit plans with the same protection against unfair claims-settlement practices as are commonly enjoyed by beneficiaries of state-regulated plans.

These efforts are ongoing, and, for 1992, are one of the Council's legislative priorities.

Resolution 132-1991 was referred to the Council for study because of its ambitious underlying purpose, that of persuading the Department of Labor to enforce the beneficiary protection provisions of ERISA vigorously. As the Reference Committee noted, this would be an expensive undertaking, estimated between $150,000 and $250,000.

The Council concurs that reordering the priorities of a governmental agency is a daunting task.

In April, the Council Chairman and Washington Office and Department of State Governmental Affairs staff met with the Secretary of Labor and senior Department of Labor staff to discuss explanations of claims denials in dental benefit programs. The Council has been pursuing this issue with the Department since April 1991 (*Supplement 2*, 1991:433). The Council has contended that the common explanation of why dental benefits were reduced, i.e., that the charge in question "exceeds reasonable and customary," is not sufficient to comply with section 1133 of ERISA. This section requires that the reason for a claim denial be provided to the plan participant, written in a manner calculated to be understood by the participant.

In the April meeting with the Secretary, Labor Department staff noted that section 1133 provides to plan participants the opportunity for a full and fair review by the appropriate fiduciary of the decision denying the claim.

The Association has contended in the past that this review process is not a suitable mechanism for resolving disputes over dental claims, usually involving relatively small sums of money. But inasmuch as this was the Department's position, the Council is now testing a data collection process, in which patients/plan subscribers, whose benefits are reduced on the basis that the actual charge made exceeds reasonable and customary charges, are asked to request additional data

regarding the method of and basis for calculating their benefits. Should this approach prove successful, it will be incorporated into a recommended program to assist patients in obtaining full explanations of benefit calculations. If unsuccessful, the experience will be reported to the Secretary with another request for assistance.

Concurrently, efforts continue in the Congress to amend ERISA to more specifically require explanations of benefit calculations and to subject self-funded benefit plans to state laws assuring freedom of choice of practitioner, freedom of practitioners to participate in benefit programs, solvency of benefit programs and prohibiting discrimination in benefits coverage based on the degree of the practitioner.

The Council further believes that a grass roots campaign should be undertaken to involve benefits consumers and consumer advocates in efforts to strengthen ERISA enforcement activities as being in the public interest. It notes that involvement by the Association in coalitions with state attorneys general and other public advocates is already being explored, as are similar efforts through constituent dental societies and the Department of State Government Affairs.

The Council concludes that these efforts should be continued and should be performed within annual budget constraints. Accordingly, as a result of its study of Resolution 132-1991, the Council transmits the following resolution with a recommendation that it be adopted.

24. Resolved, that the American Dental Association continue its efforts in concert with appropriate public and private entities to achieve vigorous enforcement of the provisions of the Employee Retirement Income Security Act in order to provide plan subscribers in ERISA-regulated dental benefit programs with the same protections as are commonly enjoyed by subscribers of state-regulated programs.

Compensation for HIV-Infected Health Care Workers: Resolution 134-1991 (*Trans.* 1991:629) calls upon the Council to investigate and pursue national legislative possibilities to guarantee reasonable financial compensation to health care workers who may be discriminated against upon disclosure of being tested HIV positive. These Council actions would be initiated, according to Resolution 134-1991, if the government mandates testing and disclosure for health care workers. This resolution was referred to the Council for study and report to the 1992 House of Delegates, after the Reference Committee on Legal and Legislative Matters recommended that the resolution be defeated, noting that it is inconsistent to oppose certain legislation while requesting funding associated with the passage of such legislation.

The Council, at its March meeting, adopted federal AIDS legislation as a legislative priority for 1992.

To date, federal legislation that would mandate HIV testing and disclosure for health care workers has been successfully contained in the Congress. The Association has been monitoring other legislation and proposed regulations that would remove barriers that prevent HIV-infected individuals from qualifying for Social Security disability income and would expedite the disability certification process. The Council considers Resolution 134-1991 a pragmatic position for the Association in that it would establish Association support for health care workers' qualifying for disability income, as well as strengthening the Association's opposition to discrimination against HIV-infected individuals. Accordingly, the Council transmits Resolution 134-1991 with the recommendation that it be adopted.

134-1991. Resolved, that, if the government mandates HIV testing and disclosure for health care workers, the ADA Council on Governmental Affairs and Federal Dental Services investigate and pursue national legislative possibilities, that would guarantee reasonable financial compensation to health care workers who may be discriminated against upon disclosure of being tested HIV positive.

Other Legislative Priorities

In addition to the issues addressed in response to assignments from the 1991 House of Delegates, the Council, as noted above, has identified five other legislative priority issues.

Campaign Finance Reform: The Association, independently and in coalition with professional and business organizations, has steadfastly opposed legislation that would provide public financing of Congressional campaigns, further restrict political action committee (PAC) involvement in Congressional campaigns or eliminate PACs entirely.

In April, the Congress passed a campaign financing bill, which was vetoed by the President on May 9. The bill would have instituted voluntary spending limits for both House and Senate candidates in return for partial public financing of their campaigns. The maximum PAC contribution to a Senate candidate would have been reduced from the current $5,000 to $2,500 with no more than 20% of a Senate candidate's spending limit to come from PACs. House candidates could have continued to receive support up to $5,000 per PAC, but total PAC contributions to a candidate would have been limited to $200,000.

In vetoing the bill, the President stated that he objected to the public financing provision and to the bill's not eliminating PAC contributions. On May 13, the Senate sustained the President's veto.

Tax Policy: Resistance in Congress to Association efforts to restore the deductibility of interest paid on education loans and provide full and permanent deductibility of self-employed persons' health benefit expenses is almost entirely cost-related. Few Members of Congress deny the inherent fairness of the Association position, which it has been advancing independently and through the Student Loan Interest Deduction Restoration Coalition and the Coalition for Health Care Equity.

Inclusion of limited education loan and self-employed health benefit expense relief in the Democratic tax bill, passed in April, was encouraging. The bill, however, was vetoed by the President for reasons unrelated to these issues.

The Association also opposes taxation of employer contributions to employee health benefit plans. This new tax was widely rumored to be a source of funding of the President's health care reform proposal; it was not included in the proposal promulgated in February, however.

Licensure: No Congressional activity has been initiated on HR 2691, a bill that would prohibit states from employing different criteria for the licensure of dental health care professionals (dentists and dental hygienists), holding licenses in other states, from the criteria the states use for relicensure. The Association opposes this legislation as federal intervention in the licensure process (*Trans.*1975:187, 718).

Tort Reform/Professional Liability Reform: The Association supports S 489 and HR 1004, Ensuring Access through Medical Liability Reform Act, introduced by Senator Orrin Hatch (R-UT) and Representative Nancy Johnson (R-CT).

To date, the Democratic leadership in Congress has been willing to address this issue only within the context of comprehensive health care reform legislation. Enactment of such comprehensive legislation in this Congress appears unlikely. Currently, the Association, independently and as a member of the National Medical Liability Reform Coalition, is seeking to persuade Democratic members of the need to address tort reform separately from health care reform.

National Practitioner Data Bank: The Association is awaiting the Department of Health and Human Services (HHS) report to the Congress on the feasibility of establishing a monetary threshold for reporting of malpractice payments. Currently, all payments in response to patients' written claims must be reported. The report is expected to be received by the Congress in late summer.

At its July meeting, the Council will consider draft legislation to amend the law to establish a threshold, if the report so recommends. The Council will also consider other legislative alternatives should the HHS report not be supportive of a malpractice payment threshold.

Summary of Resolutions

New Policies/Directives:

24. Resolved, that the American Dental Association continue its efforts in concert with appropriate public and private entities to achieve vigorous enforcement of the provisions of the Employee Retirement Income Security Act in order to provide plan subscribers in ERISA-regulated dental benefit programs with the same protections as are commonly enjoyed by subscribers of state-regulated programs.

134-1991. Resolved, that, if the government mandates HIV testing and disclosure for health care workers, the ADA Council on Governmental Affairs and Federal Dental Services investigate and pursue national legislative possibilities, that would guarantee reasonable financial compensation to health care workers who may be discriminated against upon disclosure of being tested HIV positive.

Division of Scientific Affairs

Council on Dental Materials, Instruments and Equipment

Council on Dental Research

Council on Dental Therapeutics

American Dental Association Health Foundation

Research Institute

Paffenbarger Research Center at the National Institute of Standards and Technology

Notes

Council on Dental Materials, Instruments and Equipment

Donovan, Terence E., California, 1993, chairman
Anusavice, Kenneth J., Florida, 1992, vice-chairman
Brooks, Sharon L., Michigan, 1993
Glecos, William G., Pennsylvania, 1995
Hembree, John H., Jr., Mississippi, 1994
Hicks, Morris A., Arizona, 1995
Leary, James M., Iowa, 1994
Mohl, Norman D., New York, 1992
Overberger, James E., West Virginia, 1992
Rudd, Kenneth D., Texas, 1994
Spangberg, Larz S., Connecticut, 1995
Stanford, John W., director
Fan, P.L., associate director
Schoenfeld, Charles M., assistant director
Wozniak, Wayne T., assistant director

Meetings: The Council met on November 14-15, 1991 and on May 11-12, 1992. Dr. James H. Pearce, Jr., trustee, Fourteenth District, attended the May 1992 Council meeting. An Open Session of the Council was held on May 11, 1992 with representatives of the dental industry and other interested parties present. Liaison representatives from the Centers for Disease Control, National Institute for Standards and Technology and Food and Drug Administration were present for one or both Council meetings. Dr. Terence E. Donovan was appointed chairman and Dr. Kenneth J. Anusavice was elected vice-chairman of the Council for 1992.

Liaison Activities: Members, consultants and staff of the Council participated in meetings with the following: American Association of Orthodontists, Association for the Advancement of Medical Instrumentation, American Association of Oral and Maxillofacial Surgeons, American Academy of Dental Radiology, American Dental Trade Association, American Society for Testing and Materials, American National Standards Institute, European Committee for Standardization and the International Organization for Standardization.

Grants and Contracts: The Council was awarded a five-year contract from the National Institute of Dental Research to support activities in developing standards for dental products. The award period began on June 28, 1991. The support received to date totals $484,333, with a total of $929,881 awarded for the five-year period.

Personnel: J.W. Stanford, Ph.D., received the Chairman's Award from the American Dental Trade Association on November 9, 1991 and the Astin-Polk International Standards Medal from the American National Standards Institute on March 30, 1992. P.L. Fan, Ph.D., was appointed to the Dental Research Programs Advisory Committee of the National Institute of Dental Research.

Conferences: Council members, consultants and/or staff participated in the following conferences or workshops:

—American National Standards Institute. Public conference on "Using the Standardization Tool to Reach Business Objectives." Chicago.
—Council sponsored. National Institute of Dental Research funded. Symposium on esthetic restorative materials. Chicago.
—Kerr Manufacturing Co. sponsored. Symposium on adhesives. Carlsbad, Calif.
—University of Michigan. Black Dentistry in the 21st Century. Ann Arbor, Mich.
—Creighton University School of Dentistry. International Symposium on Adhesives in Dentistry. Omaha.
—National Institutes of Health. Technology Assessment Conference. Effects and Side Effects of Dental Restorative Materials. Bethesda.
—University of Maryland. FDA and ADA Evaluation of Dental Products. Baltimore.

Response to Assignments from 1991 House of Delegates:
Use of Biodegradable Materials in Manufacture and Packaging of Dental Materials. Resolution 93H-1991 (*Trans.*1991:598) called on the Council to request that industry use, whenever possible, in both the manufacture and packaging of disposable dental products, materials that are biodegradable. Accordingly, the Council has advised all manufacturers in its evaluation programs of the intent of Resolution 93H, as did the American Dental Trade Association and the Dental Manufacturers of America.

Mercury and Dental Amalgam: The Council continues to respond to inquiries on the use of mercury in dentistry and to assist in the preparation of printed information on the safety and use of amalgam. The Council provided technical assistance to constituent societies in dealing with amalgam issues including mercury in waste water. The Council is currently evaluating traps, filters and separator systems to decrease or eliminate mercury and amalgam particulate from waste water leaving the dental operatory. The results of such evaluations should provide assistance to members in locations faced with environmental concerns of local, state and federal agencies. The Council is also developing laboratory test methods to evaluate these devices. The results will assist the development of an international specification for amalgam separators.

Waste Disposal: The Council continues to work with manufacturers of radiographic chemicals on the issue of silver in waste water. The Council provided information on disposal of waste from dental offices.

Infection Control: The Council cooperated with other Association agencies in responding to inquiries and in preparing updates for the American Dental Association Regulatory Compliance Manual. The Council also has been revising Infection Control Guidelines.

Chemicals in the Workplace: The Council cooperated with other Association agencies in preparing comments on proposed government regulations and responding to inquiries.

Standardization Activities: The Council acts as Administrative Sponsor and Secretariat of the national and international voluntary standardization programs in dentistry. The Council continues to monitor federal programs affecting standardization activities.

Accredited Standards Committee MD156. Activities of this Council-sponsored committee were conducted by 47 subcommittees working on the development or revision of 88 specifications. This committee is the only group in the United States accredited by the American National Standards Institute (ANSI) to develop standards for dentistry. Standards are submitted to ANSI for approval as American National Standards when completed and are approved by the Council as American Dental Association specifications. During this reporting period, four new standards were developed, four existing standards were revised and three standards were reaffirmed. Work programs were initiated for ethyl silicate investments, refractory die materials and soldering investments. ASC MD156 met in Boston on March 11, 1992 with over 85 persons in attendance. In addition, meetings of 18 subcommittees of ASC MD156 were held during the week of the American Association for Dental Research meeting.

Coordination between the activities of the International Standards Organization (ISO) and the ASC MD156 continues. Subcommittees review all corresponding ISO standards for possible adoption as American National Standards. The United States also submits American National Standards to the ISO for consideration as international standards. The European community has indicated that it will adopt ISO standards in the dental field, thus helping to ensure that high quality products are available worldwide.

The Council wishes to express its appreciation to the nearly 600 volunteers who participate at no expense to the Association in the activities of ASC MD156. These include participants from dental companies, schools, government agencies and the profession. The Council also gratefully acknowledges the continued support of the National Institute of Dental Research in the development of test methodology to properly evaluate dental products.

International Standards Organization/Technical Committee 106 (ISO/TC106). The Association, through the Council, sponsors participation of the United States in ISO/TC106, Dentistry. The Council also acts as Secretariat of ISO/TC106 Subcommittee 2, Prosthodontic Materials. Actions taken by ISO/TC106 resulted in casting the U.S. vote for 17 Draft International Standards, 18 Committee Drafts, 11 new work items and reaffirmation of five International Standards. The ISO published ten standards during this reporting period. Over 30 delegates from the United States attended the meeting of ISO/TC106 in Trieste, Italy from October 14-19, 1991.

Evaluation Programs: The Council has three evaluation programs: Certification, Acceptance and Recognition.

Certification Program. Since May 1991, 29 products have been added to the List of Certified Materials, Instruments and Equipment, which now includes over 900 products. Fifty products are in the process of recertification and 158 products are being re-evaluated to verify compliance with the appropriate specification.

Acceptance Program. The Council added eight product areas to its program. Of 15 products evaluated, 12 were classified as Acceptable or Provisionally Acceptable. Renewals of classification were completed for 80 products. Over 300 products are now included in the Acceptance Program.

Recognition Program. The Recognition Program will be phased out in 1992. While most of the product areas have been transferred to either the Certification or the Acceptance program, 92 products were evaluated, with 81 being recognized. Over 300 products are still listed under the Recognition program.

Applied and Basic Research Programs: Research was conducted on the irradiance of blue light, ultraviolet light and thermal emission from visible light curing units; characterization of dental adhesives bonded to hydroxylapatite; effects of chlorhexidine on staining of restorative materials; structural properties of castable glass; electrochemistry of salivary proteins; thermal behavior of phases in amalgam; development and application of plasma etching of materials; and bond strengths of composites to various substrates. Development of test methods for national and international standards continued in the Council laboratory.

Status Reports: Reports were published on disinfecting impressions, porcelain repair materials, gloves and setting of polyvinylsiloxane impression materials, dental mercury hygiene recommendations, nonsurgical handpieces and air emphysema and sterilizers and sterilization. An approved report on ceramic orthodontic brackets is awaiting publication.

Complaint Reporting Program: There was in 1991 a 53% increase in complaints. Of the 118 processed, most involved nondelivery and requests for refunds. Technically related complaints were resolved with the cooperation of manufacturers.

Other Activities: Service to members of the Association continued with responses to requests for information and recommendations concerning safe and effective products, infection control procedures and OSHA regulations. Questions on materials and techniques have primarily focused on amalgams, how to comply with OSHA regulations, implants, lasers and posterior composites.

Published and Other Reports: There were 14 publications by Council and staff. Three research reports were presented at the 1992 meeting of the American Association of Dental Research. The list of standards, status reports, information and/or original research reports follow:

1. ADA Council on Dental Materials, Instruments and Equipment. Disinfection of impressions. JADA 1991;122(9):110.
2. ADA Council on Dental Materials, Instruments and Equipment. Dental mercury hygiene summary of recommendations in 1990. JADA 1991;122(9):112.
3. ADA Council on Dental Materials, Instruments and Equipment. Retarding the setting of vinyl polysiloxane impressions. JADA 1991;122(9):114.
4. ADA Council on Dental Materials, Instruments and Equipment. Porcelain repair materials. JADA 1991;122(9):124-30.
5. ADA Council on Dental Materials, Instruments and Equipment. Air-driven handpieces and air emphysema. JADA 1992;123(1):108-9.
6. ADA Council on Dental Materials, Instruments and Equipment. Sterilization required for infection control. JADA 1991;122(13):80.
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8. ADA Council on Dental Materials, Instruments and Equipment. Clinical Products in Dentistry. Chicago: American Dental Association; 1992.
9. Matteson SR, Joseph LP, Schoenfeld CM, et al. The report of the panel to develop radiographic selection criteria for dental patients. Gen Dent 1991;39:264-70.
10. Mueller HJ. Fracture toughness and fractography of dental ceramics. Cells Mater 1991;1:265-78.
11. Mueller HJ. Polarography of protein solutions. Trans Soc Biomater 1991;XIV:84.
12. Mueller HJ. Plasma etching of polymeric materials. Microstructural Science 1992;19:135-48.
13. Mueller HJ. Chevron-notch fracture toughness comparison of methods. Trans Acad Dent Mater 1992;5(1):187-8.
14. Mueller HJ, Jose S, Bapna MS. Fracture toughness of the composite-porcelain bond. Trans Acad Dent Mater 1992;5(1):188-90.

Resolutions: This report is informational in nature and no resolutions are presented.

Council on Dental Research

Anderson, Allen W., Illinois, 1992, chairman
Stamm, John W., North Carolina, 1992, vice-chairman
Dahl, Eva C., Wisconsin, 1993
Duncanson, Manville G., Oklahoma, 1995
Genco, Robert J., New York, 1994
Leinfelder, Karl F., Alabama, 1995
Marshall, Sally J., California, 1992, American Association for Dental Research
Morgan, Warren A., Massachusetts, 1992
Page, Roy C., Washington, 1993
Phelan, Joan A., New York, 1994
Schenkein, Harvey A., Virginia, 1994
Verrusio, A. Carl, director

Meetings: The Council met at the Headquarters Building on September 5-6, 1991 and February 3-4, 1992. In addition to Council members and Association staff, the following attended portions of the meetings: Dr. Dushanka Kleinman, deputy director, National Institute of Dental Research; Dr. John A. Clarkson, executive director, American Association for Dental Research; and Mr. Todd E. Dickerson, research consultant for the American Student Dental Association. Dr. Herbert Schilder, first vice-president, attended the September 1991 meeting.

Preparation of Congressional Testimony in Support of the 1993 National Institute of Dental Research (NIDR) Budget: The Council reviewed NIDR's 1992 and 1993 budgets with Dr. Clarkson and Dr. Kleinman. The Council was informed that the NIDR budget for 1992 will be $160.5 million. This represents an increase of almost $11 million over last year's budget, but is far below what is needed to maintain current dental research activities. The Council considered the budget (approximately $251 million) being proposed for NIDR in 1993 by the National Affairs Committee of the American Association for Dental Research and decided to support it. This would permit ongoing research to be fully funded and would provide for some growth in other areas, such as training and research centers. The Council discussed the research priorities of the profession and recommended that the Association highlight in its Congressional testimony the need for additional funding to study the following items: the relationship between aging and periodontal disease; amalgam safety and the use of alternative materials; the etiology of cleft lip and palate; the risks for women dentists of exposure to nitrous oxide and mercury vapor; and health services practices in the areas of delivery of care and cost control. The Council again expressed its concern for the future of the Biomedical Research Support Grant, which is extremely important to dentistry.

Dental Students Conference on Research: The 28th Annual Dental Students Conference on Research was held April 4-7, 1992 at the University of Texas Health Science Center at San Antonio. Approximately 60 students, representing 51 dental schools in the United States, Canada and Puerto Rico, attended the conference.

Students met with scientists, clinicians, dental educators and administrators in an informal atmosphere, and they learned about the wide variety of careers available in dental research and the many areas of research under investigation by scientists at the dental school. Research projects discussed included local and systemic modulation of neutrophil function by periodontal bacteria, assessment of trigeminal nerve injuries, three-dimensional reconstructions from CT scans, microwave-driven gas plasmas for sterilizing dental instruments and control of dental aerosols.

The Council wishes to express its sincere appreciation to Dr. John D. Rugh and Mrs. Joanne Hayashi for organizing the scientific program and the faculty and students of the dental school for their enthusiastic participation in the conference. The Council also wishes to thank Dean Kenneth L. Kalkwarf for his gracious hospitality and Dr. Harold Slavkin for his provocative keynote address, "The Changing Face of Dentistry."

The Council gratefully acknowledges Dr. Michael L. Barnett and the Warner-Lambert Company for their continued support of this important student program.

Health Screening Program (HSP): Over the 27 years of its existence, the HSP has had three principal goals: (1) to provide participating members, at no cost, with an array of valuable medical screening tests that have a value of over $300; (2) to amass a unique data bank of information on the health status of the U.S. dentist; and (3) to collect such data as can be used to answer research questions relevant to current dental issues, as, for instance, the effect on dental personnel of exposure to dental amalgam, hepatitis B and C as risk factors for dentists and neurobehavioral changes associated with exposure to dental materials.

In 1991, the following tests or examinations were available to participants: blood pressure, weight, clinical blood chemistry, cholesterol testing (including high and low density lipoproteins), hepatitis B virus surface antigen and antibody markers, HIV antibody screening, urinary mercury concentration, podiatric examination, resting electrocardiogram, periodontal screening, glaucoma screening and head, neck and soft tissue examinations.

The HSP in Seattle last October was the largest in the program's history. Participating in the program were 1,925 U.S. and foreign dentists. Some noteworthy findings follow.

—The HSP provided evidence of the continuing increase in acceptance of the hepatitis B vaccine among dental professionals. Nearly 75% of the dentists had been inoculated against hepatitis B. This is a 3% increase over the number vaccinated in 1990.

—Urinary mercury concentrations were determined on site for 1,511 dentists. The American Dental Association Health Foundation Research Institute (ADAHF) and the

University of Washington Dental School, working jointly, conducted kidney function tests and neurological evaluations on 20 dentists with high urinary mercury levels.

—Electrocardiograms were recorded from 1,415 members. The results were interpreted on site, and each dentist received a laminated card showing his/her electrocardiogram.

—Head, neck and oral examinations were carried out on 653 dentists by dentists from the Department of Veterans Affairs. Abnormalities deemed to be significant were found in 63 dentists. These dentists were contacted to learn if they had sought treatment.

—For the fifth consecutive year, anonymous testing for the antibody to the human immunodeficiency virus (HIV) was conducted. Of the 1,642 dentists who participated in the screening, none tested positive for the antibody to the virus. The Centers for Disease Control provided a special grant to screen dental hygienists and assistants for HIV. None of the 219 participants screened tested positive.

—Approximately 800 dentists participated in the periodontal screening and recording program (PSR).

—Data from the HSP were published in the following research papers: "Factors Affecting Blood Mercury Concentrations in Practicing Dentists," "Human Immunodeficiency Virus Type 1 Infection Among Dentists," "Self-Reported Percutaneous Injuries in Dentists; Implications for Risk of Transmission of HBV and HIV" and "Seroprevalence of Hepatitis C Virus Antibodies in Large Cohorts of United States Dentists." Bibliographic citations are available in the report of the Department of Toxicology, ADAHF Research Institute.

Survey of Women Dentists: The Council, in conjunction with the American Association of Women Dentists and epidemiologists at the University of North Carolina, recently published the results of a survey of the general and reproductive health of women dentists. Baseline practice pattern information was collected on all U.S. women dentists to explore the feasibility of conducting future detailed studies of specific occupational exposures in relation to health outcomes.

Research Forum for the Annual Session: The Council on Dental Research organized a program of short research presentations for the 1991 annual session. A call for research abstracts on topics of interest to clinicians was issued in March. Speakers were given ten minutes for the formal presentation of research results and five minutes for discussion.

There were presentations on AIDS, hepatitis B virus immunization in a dental school, effects of tooth bleaching, restorative materials, treatment of avulsed teeth and lasers.

The program was very well received, so the Council is presenting another Research Forum at annual session this year.

Publication:

1. Keels MA, Kaste LM, Weintraub JA, Kleinman DV, Verrusio AC, Neidle EA. A national survey of women dentists. JADA 1991; 122(13):31-3, 36-7, 40-1.

Resolutions: This report is informational in nature and no resolutions are presented.

Council on Dental Therapeutics

Ferrillo, Patrick J., Jr., Illinois, 1992, chairman
Terezhalmy, Geza T., Ohio, 1992, vice-chairman
Alfano, Martin A., Pennsylvania, 1995
Bowman, Robert W., Montana, 1995
Cassingham, R. Jack, Louisiana, 1993
Elias, Augusto, Puerto Rico, 1994
Feigal, Robert J., Minnesota, 1993
Maixner, William, North Carolina, 1994
Rowe, Nathanial H., Michigan, 1994
Terkla, Robert S., Washington, 1995
Van Hassel, Henry J., Oregon, 1992
Burrell, Kenneth H., director
Langan, Dan C., assistant director
Whall, Clifford W., assistant director

Meetings: The Council met at the Headquarters Building on September 24-25, 1991 and April 23-24, 1992, with all members in attendance with the exception of Dr. Robert J. Feigal at the April meeting. Dr. William B. Trice, first vice-president, attended the April meeting.

At its September meeting, the Council renewed its discussion of the safety and effectiveness of paraformaldehyde-containing root canal filling materials. Following discussion, the Council requested that manufacturers of these materials or other interested parties should submit safety and effectiveness data to the FDA, the Council on Dental Therapeutics and the Council on Dental Materials, Instruments and Equipment. The Council also resolved to send its bibliography on these materials to its consultants for review. Finally in view of the facts that sufficient data have not been submitted to the Council to establish the safety of these materials and that the FDA has not approved any products with this formulation, it decided that it could not recommend the use of these products at this time.

At the April meeting, the Council heard presentations from representatives of the American Association of Endodontists and the American Endodontic Society. Discussion that followed led to a series of resolutions that refines further the Council's request for data to establish the safety and effectiveness of these root canal filling materials. The Council invited manufacturers to submit paraformaldehyde-containing root canal filling materials for evaluation. The submission should include the formulation, a definition of the therapeutic benefits, the proposed promotional claims and two well-designed, prospective, independent, double-blind clinical studies to support those benefits and claims. In addition, a manufacturer must satisfy the requirements of ANSI/ADA Specification 57, Document 41 and 41A, Addendum. Furthermore, a manufacturer must provide an examination of safety and morbidity including a review of all available information and retrospective and prospective studies.

The Council, at its April meeting, also passed a series of resolutions that resulted in the termination of the chemical disinfectant/sterilant evaluation program. The Council believed that, due to shortcomings in present microbiological test methodology and the Council's inability to test these products independently of manufacturer testing, its own evaluations could be compromised. To correct these deficiencies, the Council concluded that funding be made available to establish a Council-sponsored laboratory for testing chemical disinfectants and sterilants and that an expert panel be convened to study the matter of the Council's future evaluation of these agents.

Interagency Activities: The Council and other Association agencies produced two semiannual updates to The American Dental Association Regulatory Compliance Manual. The March 1992 update was extensive due to the many changes required for implementation of OSHA's new Bloodborne Pathogen Standard on March 6, 1992. The manual provides comprehensive guidance to dentists on how to bring their offices into compliance with OSHA's Bloodborne Pathogen Standard, the Hazard Communication Standard, general employer responsibilities and medical waste disposal.

Council staff, in conjunction with staff from the Division of Legal Affairs, presented nine, day-long, "OSHA and AIDS: What You Must Know" seminars for the Association's Seminar Series to state and local dental societies.

Council staff reviewed exhibits and promotional materials distributed by manufacturers at the annual session. Products in the Council's Acceptance Program, as well as those not currently accepted by the Council, were reviewed.

Council staff also serve as reviewers for manuscripts that are submitted to *The Journal of the American Dental Association.*

Acceptance Program Activities: The following staff presentations on the Council's Acceptance Program were made: (1) "How The Council on Dental Therapeutics Runs its Acceptance Program for Dental Therapeutic Products," September 16, 1991, the American Veterinary Dentistry Society Annual Meeting and (2) "FDA and ADA Evaluation of Dental Products: Implications for Dentists and Their Patients," October 25-26, 1991, two-day symposium sponsored by the University of Maryland Dental School. (Proceedings to be published in the *Journal of Public Health Dentistry*, Special Issue, 1992.)

Response to Assignments from the 1991 House of Delegates:

N2-Type Compounds. The Council has responded to the House of Delegates assignment as outlined in Resolution 106H-1991 (*Trans.*1991:587), which directs the Association to continue its efforts to persuade the Food and Drug Administration to determine the safety of paraformaldehyde-containing root canal filling material. The Council is writing to the following committees which oversee the Food and Drug

Administration: House Energy and Commerce; Senate Labor and Human Resources; House Government Operations; House and Senate Appropriations Subcommittees. Previous direct correspondence with FDA failed to achieve satisfactory results.

Publication:

1. Facts about AIDS for the dental team. 3rd ed. Chicago: American Dental Association; 1991.

Resolutions: This report is informational in nature and no resolutions are presented.

American Dental Association Health Foundation

Morrow, Geraldine, president
Harris, Jack H., president-elect and treasurer
Trice, William B., first vice-president
Gause, Curtis E., second vice-president
Rainwater, Gary, speaker, House of Delegates
Ginley, Thomas J., secretary
Neidle, Enid A., director
Schaid, Rodney J., director of administration, emeritus

Meetings: The Board of Directors of the American Dental Association Health Foundation (ADAHF) met in August 1991. The meeting of the Board of Directors was held in conjunction with the session of the Board of Trustees of the American Dental Association.

Sponsored Programs and Activities: During the reporting period the Foundation was awarded three-quarters of a million dollars more than reported in the previous 12-month period. Awards totaled $2,631,476 or $758,154 (+40.5%) more than the 1991 reported total of $1,873,313.

The overall funding received from the federal government increased by well over one-half million dollars for a total of $1,871,514 or $528,656 (+39.4%) more than the 1991 amount of $1,342,858. These federal funds included award of overhead or indirect costs of $631,626 or $157,714 (+33.3%) in excess of $473,912 in the previous report.

The increases in both overall federal grant/contract and overhead amounts can be traced to the awards of a renewal grant and a new contract. The Heart, Lung and Blood Institute awarded (see Table 2 on the next page) Dr. Walter E. Brown, director emeritus of the Paffenbarger Research Center, a three-year renewal grant after a 12-month hiatus. The National Institute of Dental Research awarded (see Table 1 on the next page) a five-year research contract to Dr. John Stanford, director, Council on Dental Materials, Instruments and Equipment, American Dental Association, to develop improved dental instruments and materials. These two awards provided an increase in overall fundings of $422,374 or 79.9% of the aforementioned increase of $528,656. Likewise, the increase in overhead due to these two awards amounted to $142,027 or 90.0% of the $157,714 stated above.

The corporate funding of Foundation programs also increased during the reporting period. Total receipts of $759,953 or $229,598 (+43.3%) more than the 1991 figure of $530,355 were received from corporate sponsors of Foundation activities.

The primary award of added corporate fundings came from within the Association/Foundation. While some Foundation corporate fundings decreased, two major transfers of funds from Association agencies to the Foundation's corporate grants account were made. These two totaled $253,678 thus accounting for the major increase in corporate funding.

Resolutions: This report is informational in nature and no resolutions are presented.

Table 1: Extramural Programs

AWARD DATE	PRINCIPAL INVESTIGATOR	TITLE	GRANT/CONTRACT NO.	CENTER NO.	SPONSOR	TOTAL DIRECT COSTS	TOTAL INDIRECT COSTS	TOTAL ALLOWABLE COSTS
VARIOUS	WOZNIAK	CREEP COMPLIANCE TESTING DEVICE	--	7-15-15-06	INDUSTRY	$ 1,750	0	$ 1,750
04/16/92	STANFORD	SPECTROPHOTOMETER ACCESSORIES	--	7-15-15-07	PROCTER & GAMBLE	4,500	0	4,500
07/31/91	NEIDLE	FACTS ABOUT AIDS	--	7-15-25-05	WARNER-LAMBERT	20,000	0	20,000
12/31/91	NEIDLE	INFECTION CONTROL INFORMATION	--	7-15-25-06	WARNER-LAMBERT	5,000	0	5,000
VARIOUS	SCHAID	SPECIAL PROJECTS IN DRUGS & THERAPEUTICS	--	7-15-30-01	INDUSTRY	4,507	0	4,507
11/11/91 & 01/23/92	NEIDLE	GOLD MEDAL AWARD	--	7-15-35-01	CHESEBROUGH-PONDS, 1991 ADA MATCHING FUNDS, 1992	5,000 5,000	0 0	5,000 5,000
VARIOUS	GREENBERG	SPEAKERS BUREAU	--	7-15-35-05	PROCTER & GAMBLE	81,761	0	81,761
VARIOUS	NEIDLE	THE NORTON M. ROSS AWARD FOR EXCELLENCE IN CLINICAL RESEARCH	--	7-15-35-07	WARNER-LAMBERT	17,000	0	17,000
VARIOUS	GREENBERG	TASK FORCE/PERIO & GINGIVITIS	--	7-15-35-08	TASK FORCE/DES. & ANAL.	46,834	0	46,834
08/26/91	GREENBERG	PERIODONTAL THERAPY CONFERENCE	--	7-15-35-09	CONFERENCE ATTENDEES	17,694	0	17,694
02/29/92	DWYER	RETIREMENT PROGRAM	--	7-15-40-02	VARIOUS	155,194	0	155,194
02/05/92 & VARIOUS	GREENBERG	HEALTH SCREENING PROGRAM 1991	--	7-15-55-02	AFDH INDUSTRY	16,000 47,000	0 0	16,000 47,000
VARIOUS	GREENBERG	HEALTH SCREENING PROGRAM 1992	--	7-15-55-02	INDUSTRY	38,529	0	38,529
02/29/92	HANSEN	CORPORATE FILM SUPPORT	--	7-15-60-02	VARIOUS	98,484	0	98,484
09/10/91 & 04/28/92	SHUCK	CONFERENCE ON THE YOUNG DENTIST	--	7-15-75-01	CHESEBROUGH POND'S CHESEBROUGH-POND'S	50,000 35,000	0 0	50,000 35,000
06/30/91 & 02/29/92	WISE	STUDENT APPOINTMENT BOOK	--	7-15-75-02	WARNER-LAMBERT	29,000	0	29,000
03/31/91	BRAMSON	SMOKING CESSATION SYMPOSIUM	--	7-15-80-02	MARION MERRELL DOW	4,200	0	4,200
06/28/91	STANFORD	IMPROVED DENT. INSTR. & MAT'LS THROUGH STANDARDS DEVELOPMENT	N01-DE-12584	5-15-15-08	NIDR	164,635	77,599	242,234
					TOTALS	$ 847,088	$ 77,599	$ 924,687

Table 2: Paffenbarger Research Center at the National Institute of Standards and Technology

05/14/91	TUNG	CHARACTERIZATION OF HYDROXYAPATITE IMPLANT MATERIALS	P.O.# 3712500091 RA	5-20-20-23	FDA	$ 15,796	$ 9,004	$ 24,800
06/15/91	TUNG	THREE APPROACHES TO RAPID REMINERALIZATION OF THE TOOTH	5 R01 DE 08916-03	5-20-20-21	NIDR	35,307	19,253	54,560
07/08/91	BROWN	CALCIFICATION IN THE CARDIOVASCULAR SYSTEM	2 R01 HL 30035-07A1	5-20-20-24	NHL&BI	115,712	64,428	180,140
07/30/91	BOWEN	IMPROVEMENT OF PREVENTIVE & RESTORATIVE MATERIALS	5 R37 DE 05129-14	5-20-25-10	NIDR	108,878	62,060	170,938
08/09/91	EICHMILLER	SMALL INSTRUMENTATION GRANT	1 S15 DE 10082-01	5-20-05-01	NIDR	12,644	0	12,644
08/31/91	CHOW	PREVENTION OF DENTAL CARIES	5 R01 DE 05354-14	5-20-20-22	NIDR	154,736	86,746	241,482
09/25/91	BOWEN	CENTER OF EXCELLENCE FOR MATERIALS SCIENCE RESEARCH	5 P50 DE 09322-03	5-30-00-03	NIDR	336,913	192,040	528,953
11/30/91	MATHEW	CRYSTAL CHEMISTRY OF CALCIUM PHOSPHATES	5 R01 DE 05030-14	5-20-10-07	NIDR	104,118	56,925	161,043
12/18/91	JOHNSTON	ORGANOMETALLIC COMPLEXES OF URONIC ACIDS	N00014-91-J-1313	5-20-25-09	ONR	13,500	0	13,500
03/28/92	VOGEL	MECHANISM OF DENTAL CARIES	5 R01 DE 04385-16	5-20-20-25	NIDR	112,849	63,571	176,420
03/16/92	TUNG	CHARACTERIZE HYDORXYAPATITE STANDARD REFERENCE MATERIAL	P.O.# 0519700092 RA	5-20-20-29	FDA	24,800	0	24,800
					TOTALS	$ 1,035,253	$ 554,027	$ 1,589,280

Table 3: Research Institute

02/29/92	NALEWAY	FREE FLUORIDE VS. MFP	--	7-10-00-20	UNILEVER	$ 34,000	0	$ 34,000
09/17/91	NALEWAY	CHEMISTRY PROGRAM RESEARCH	--	7-10-00-21	INDUSTRY	40,500	0	40,500
02/29/92	NALEWAY	INTRAORAL MODELS SCIENTIFIC SYMPOSIUM	--	7-15-30-08	RESEARCH TESTING LABS	3,000	0	3,000
09/25/91	SIEW	RISK OF PERCUTANEOUS INJURIES	P.O.# 0009186340	5-10-00-05	CDC	25,000	0	25,000
03/04/92	SIEW	MINORITY HIGH SCHOOL STUDENT RESEARCH APPRENTICE PROGRAM	--	5-10-00-06	NCRR/NIH	15,000	0	15,000
					TOTALS	$ 117,500	0	$ 117,500
					GRAND TOTALS	$ 1,999,841	$ 631,626	$ 2,631,467

Research Institute

Neidle, Enid A., director
Naleway, Conrad A., director, chemistry department
Siew, Chakwan, director, toxicology department

The Research Institute continues to make a very important contribution to the scientific councils of the Division of Scientific Affairs and to dental research in a much larger sense. As in past years, the scientists of the Research Institute provided support services to two councils, Council on Dental Therapeutics and Council on Dental Materials, Instruments and Equipment, with seal programs. It has worked with the Council on Dental Research to identify new avenues of research, and it carried out projects on emerging issues in dentistry. In doing this, scientists from the Research Institute entered into collaborative efforts with scientists at the Paffenbarger Research Center at the National Institute of Standards and Technology, with university, government and industry-based scientists (mentioned specifically later in this report) and with international research groups. In addition, the Research Institute made a significant contribution to the Health Screening Program at the Association's annual session.

It should be emphasized that scientists from the Research Institute have developed the largest data base currently available on the health of the dentist, the prevalence of serum markers for hepatitis B and hepatitis C in the dental profession, the prevalence of antibody to human immunodeficiency virus (HIV) and therefore the rate of occupational transmission of HIV infection among dentists.

It is widely held that the work of the toxicology department has had a major impact on the acceptance of the hepatitis B vaccine by the dentist and has also created an awareness of the advisability of vaccination at the earliest possible age because of the decrease in the effectiveness of the vaccine with increasing age. This department has also played a major role in demonstrating that hepatitis C and AIDS are not occupational risks in dentistry when appropriate infection control techniques are used.

The departments of chemistry and toxicology have cooperated with other agencies of the Association in responding to emergent scientific issues, e.g., the safety of amalgam, community water fluoridation and the transmission of HIV infection from dentist to patient.

The Research Institute has sponsored the Norton M. Ross Memorial Lecture Series, which has been funded by Block Drug and the Warner-Lambert Company. The seminars are open to all Association staff members as well as to Chicago-based dental schools. These are designed to bring to the staff's attention some of the more important problems in dentistry or dental research. Speakers for 1991-92 included Dr. Eliezer Huberman, Argonne National Laboratory; Dr. John Fitchen, Epitope Corporation; and Dr. Andrew S. Rowland, National Institute of Environmental Health Sciences.

Concentration of Urinary Mercury (Hg) in Practicing Dentists: Hg assays (N = 1,511) were done on site for dentists participating in the 1991 Health Screening Program in Seattle. Participants were notified of the result before completion of the screening program and were encouraged to discuss the implications of the assay. Dentists with high Hg concentrations were offered the opportunity to consult with staff members concerning their mercury hygiene practices. The mean concentration for participating dentists was 4.9 μg Hg/L as contrasted with a mean of approximately 3 μg/L for the general public. Thirty (2%) dentists had Hg concentrations above 20 μg/L; six dentists had levels above 50 μg/L. All urine samples are being analyzed for concentrations of porphyrins, which has been found to be a sensitive marker of early kidney dysfunction. Twenty-two dentists with elevated mercury levels and 18 dentists from a control group (no detectable urinary mercury) were screened for changes in neurobehavioral performance. Early analyses suggest that there is a statistically significant association between certain neurobehavioral measures and urinary mercury concentrations. This study will be extended at the 1992 Health Screening Program.

Activities in Support of the Council Programs: The chemistry program has played an active role in the assessment and testing of products submitted to the Council on Dental Therapeutics, with special attention given to the review of fluoride dentifrices. The program has assisted in the periodic review and updating of the guidelines for fluoride dentifrices. Additionally, the program has participated in the development of international Federation Dentaire Internationale/ International Standards Organization specifications for toothpastes. These reflect the Council on Dental Therapeutic's guidelines for review of dental products. As a result of two international conferences in 1990 on the use of intraoral models for the testing of the efficacy of new anticaries systems, new statistical guidelines were developed. These guidelines are currently being tested in several clinical studies.

Role of Fluoride in the Mechanism of Caries Formation: The chemistry program, in a collaborative project with Dr. Lawrence Chow of the Paffenbarger Research Center, is investigating a means of delivering fluoride to the enamel-mineral structure. This system is being evaluated with a microbiological model that simulates oral conditions.

A second study, supported by Unilever Research, Port Sunlight Laboratory, examines the mechanism of action of the monoflurophosphate ion, in contrast to the free fluoride ion, as an effective cariostatic agent. A bacterial model is being utilized to simulate the cariogenic challenge associated with dental plaque. Contrary to many previous investigations, the data suggest that monofluorophosphate may deliver fluoride to the enamel surface more efficiently than free fluoride. Although free fluoride treatment results in more calcium fluoride deposition, monofluorophosphate treatment appears to result in the formation of a more highly fluoridated apatite.

This collaborative study has also quantified the total ionic composition of human plaque fluid. The findings are consistent with previous reports with respect to calcium, phosphate and organic acid composition. However, results strongly support the presence of a substantial quantity of readily ionizable fluoride in dental plaque; this pool of fluoride may be of great importance during cyclic cariogenic challenges.

Chemical Dynamics of Plaque: A sophisticated kinetic model that includes the effects of multiple organic acids on the decalcification of enamel has been used in a collaborative study with Dr. Jeffrey Fox at the University of Utah. This physical model has been used to interpret the chemistry of dental plaque. These studies make it possible to examine the complex inorganic system associated with the decalcification of enamel by the organic acids produced by plaque bacteria. This model is presently being refined to incorporate recent experimental data on the dissolution of human enamel.

Examination of Subgingival Plaque Acids: In continued collaboration with Dr. Peter Robinson at Northwestern University Dental School and Dr. Joseph Kein at Loyola University Dental School, the potential association between the presence of short-chain fatty acids (SCFA) in subgingival dental plaque and the severity of periodontitis was further examined. Although bacteria are causative agents in periodontitis, the relative clinical importance of the various mechanisms by which bacteria may cause periodontal destruction has not been resolved. Specifically, little is known concerning the clinical relationship between levels of toxic plaque acids and the severity of periodontal disease. Two prospective studies to examine the potential of short-chain fatty acids as markers of periodontal activity are under way.

The Department of Chemistry cooperated with the Council on Dental Therapeutics staff in reviewing other agency publications for scientific accuracy and technical correctness: these included advertising, promotional materials for ADA publications and brochures and videos produced by the Division of Communications. Staff also participated in spokesperson training sessions offered by the Division of Communications.

Additionally, exhibits and promotional materials distributed by manufacturers at annual session are reviewed for products in CDT's Acceptance program, as well as those which are not currently accepted by the Council. Chemistry department staff also serve as reviewers for manuscripts that appear in *The Journal of the American Dental Association*.

Percutaneous Injuries in Dentists: In an attempt to quantify the risk of transmission of diseases from dentist to patient, a retrospective study to determine the prevalence of percutaneous injuries among dentists was initiated. Data collected from three cohorts over the last five years (1986-1991) were analyzed. Location of injury, instrument involved and procedures during which the injury occurred were some of the factors assessed. Preliminary analysis of data indicates that there is a significant decline in the percutaneous injury rate over the five years in this study and that behavioral changes in dental practice are occurring in the face of the AIDS epidemic. Continuing declines in the injury rate can be anticipated as techniques are changed and new technologies are introduced. To the extent that the rate of percutaneous injuries is clearly related to the risk of transmission of bloodborne pathogens from dentist to patient, it is possible to conclude that the probability of transmission has been dropping with the injury rate and will continue to do so.

Safety of Home-Use Tooth Whiteners: Concern about the safety and efficacy of home-use tooth whiteners has been largely ignored. Many manufacturers of whiteners received warning letters in September, 1991 from the Food and Drug Administration (FDA) advising them that the FDA considers the product to be a "new drug" and as such it may not be introduced legally into interstate commerce. The active bleaching agent in whiteners is hydrogen peroxide (oxygenating agent), and it works through the liberation of oxygen or perhydroxyl radicals. Scientific studies of oxygenating agents show that their chronic and unsupervised use may damage temporarily the soft tissues of the mouth and may delay the healing of already damaged tissue. Damage to enamel, dentin and dental restorative materials may also occur, particularly if the product includes acid-cleaning solutions or if the products are acidic or produce acid. Additionally, the perhydroxyl radical has been implicated in carcinogenesis in the presence of a known carcinogen. The half-life of the perhydroxyl radical is extremely short, and its concentration is very low under physiological conditions. Chronic use of whiteners, however, may increase the perhydroxyl radical concentration to measurable level using a newly developed salicylate hydroxylation method. Data obtained from such measurements will provide a scientific basis for risk/benefit assessment of these popular whiteners.

Infectious Disease and its Control Among Dentists: The toxicology department is continuing its surveillance of hepatitis B virus (HBV) and hepatitis C virus (HCV) and the human immunodeficiency virus (HIV) among practicing dentists through the Association's Health Screening Program (HSP) at the annual session. In 1991, 1,570 dentists were screened for serum markers to HBV infection. About 75% had been vaccinated against HBV infection. This is over a 50% improvement compared to the 49% vaccination level of five years ago. About 25% of dentists tested remain at risk for HBV infection and about 9% showed serum evidence of prior HBV infection. These numbers show continued progress towards vaccination of all eligible dentists. Calculations from these data also indicate that the risk of death from HBV infection through dental practice is about six times greater than the risk of death from HIV infection.

For the fifth consecutive year dentists were anonymously screened for antibody against HIV at the HSP. None of 1,642 samples tested in 1991 was seropositive for HIV. Over the last five years a total of 6,948 dentists have been tested, and only one dentist has been found positive for HIV antibody. This represents a risk far below the generally accepted risk of about 0.4% for the general population. These data, plus those from other smaller studies, suggest that HIV infection is not a significant occupational risk for the dental profession.

The financial support of the Centers for Disease Control made it possible for dental hygienists and assistants to participate in HBV and HIV screenings at the HSP. Of 155 hygienists and 67 assistants, 17% and 37% respectively, remained at risk for HBV infection. Over 83% of hygienists received hepatitis B vaccines, which is higher than the 66% found among assistants. Dental assistants demonstrated an HBV natural infection incidence of 7.5%, which is close to the level seen for dentists. Hygienists had an extraordinarily low HBV infection level (2.6%), which may reflect their increased willingness to be vaccinated. A total of 224 hygienists and assistants were anonymously tested for HIV infection and none was found seropositive for HIV antibodies. These data support the ADA contention that dental professionals are at very low occupational risk for HIV infection.

HCV is thought to be transmitted similarly to HBV and HIV and is the major cause of transfusion related hepatitis. Over 2,800 serum samples from dentists at the 1989 and 1990 HSP were sent to Chiron Corporation for extensive analysis of serum markers to HCV infection. Only two dentists (0.08%) were found seropositive for HCV antibodies. Approximately 0.75% of volunteer blood donors are seropositive for HCV antibodies. Thus there appears to be no increased occupational risk of HCV infection for dentists.

Efficacy and Duration of Hepatitis B Vaccination: The hepatitis B vaccine was first introduced in July 1982. No vaccine can guarantee lifetime immunity. Sooner or later, a booster inoculation will probably be required. The Centers for Disease Control (CDC) currently is analyzing epidemiologic data to decide when a booster should be recommended. The reluctance of the CDC to come up with an official recommendation is probably because there have been no increased reports of hepatitis B infection among vaccinees. The CDC believes at this time that an anamnestic response among vaccinees is not only possible but probable.

The onset of this anamnestic response has not been adequately studied. The duration of vaccine protection remains to be determined even with optimal response. The Department of Toxicology has received the necessary funding and is now studying HSP data from 1986 to the present on serum titers of surface antibody to HBV from dentists. Individual surface antibody decay curves can then be constructed to determine the length of time serum titers will remain above the threshold level where protection against hepatitis B is ensured.

Presentations: Two papers were presented by the toxicology department at the April 1991 meeting of the International Association for Dental Research. The staff of the toxicology department accepted an invitation to present a ten-week series of toxicology lectures at Northwestern University Dental School, Department of Biomaterials.

Publications:

1. Wozniak WT, Naleway CA, Gonzalez E, Schemehorn BR, Stookey GK. Use of an in vitro model to assess the effects of APF gel treatment on the staining potential of dental porcelain. Dent Mater 1991;7:263-7.
2. Naleway CA, Curtiss LA, Miller JR. Superexchange-pathway model for long-distance electronic couplings. J Physical Chem 1991;95:8434-7.
3. Gruninger SE, Siew C, Chang S-B, et al. Human immunodeficiency virus type I infection among dentists. JADA 1992;123(3):57-64.
4. Siew C, Gruninger SE, Chow LC, Brown WE. Procedure for study of enamel mineral formation. Calcified Tissue International 1992;50:144-8.
5. Chang S-B, Siew C, Gruninger SE. Factors affecting blood mercury concentrations in practicing dentists. J Dent Res 1992;71:66-74.
6. Siew C, Gruninger SE, Burrell KH. Antibiotic interference with oral contraceptive steroid efficacy. J Louisiana Dent Assoc 1991;50:6-8.
7. Tomazic BB, Siew C, Brown WE. A comparative study of bovine pericardium mineralization: a basic and practical approach. Cells and Materials 1991;3:231-41.

Resolutions: This report is informational in nature and no resolutions are presented.

The Paffenbarger Research Center at the National Institute of Standards and Technology

Bowen, Rafael L., director
Brown, Walter E., director emeritus
Eichmiller, Frederick C., associate director and chief research scientist, Clinical Research
Rupp, Nelson W., associate director emeritus
Chow, Laurence C., assistant director and chief research scientist, Dental Chemistry
Johnston, Allen D., chief research scientist, Polymer Chemistry
Mathew, Mathai, chief research scientist, Dental Crystallography
Waterstrat, Richard M., chief research scientist, Dental Metallurgy
Marjenhoff, William A., administrative manager

The Paffenbarger Research Center (PRC), an agency of the American Dental Association Health Foundation (ADAHF), and the National Institute for Dental Research (NIDR)-funded Center of Excellence for Materials Science Research, both conduct research in the facilities for the Dental and Medical Materials Group at the National Institute of Standards and Technology in Gaithersburg, Maryland. Government scientists, as well as ADAHF research associates, contribute to the research generated in this facility. Specific accomplishments of PRC research programs during the past year are described below.

Dental Chemistry

The objectives of this program are to develop effective therapeutic and preventive treatments for dental hard tissue diseases and to develop calcium phosphate biomaterials for dental and medical applications.

Two-Solution Fluoride (F) Rinse: This PRC-developed rinse, prepared by combining a solution containing Na_2SiF_6 with one containing calcium and acetate just before use, deposits substantially more loosely bound F on enamel or dentin surfaces than does a NaF rinse of the same F concentration. In a recent intraoral study, the F deposition by several two-solution rinses having different pH and calcium concentrations were measured.

Results show (1) the optimum calcium (Ca) concentration, (2) that F deposition decreases with increasing acetate concentration and (3) that the highest F deposition obtained from the two-solution rinses was about 15 times that of the F deposited by a NaF rinse of the same F concentration. A patent application on this two-solution system was recently allowed.

Two-Component Fluoride Dentifrices: The same chemical principle for the two-solution fluoride (F) rinse is also applicable to dentifrice applications. Fluoride deposition by a two-component F dentifrice was compared with NaF- and sodium monofluorophosphate-containing dentifrices of the same total F content. Results suggest that the two-component dentifrice may be more effective than other dentifrices having the same F content.

Remineralizing Chewing Gums: The feasibility of using chewing gum as a way of enhancing salivation and increasing salivary Ca and phosphate (P) levels was evaluated. Based on their solubility properties, monocalcium phosphate monohydrate (MCPM) and an equimolar mixture of dicalcium phosphate anhydrous (DCPA) and tetracalcium phosphate (TTCP) were added to chewing gum. Each of six subjects chewed for 16 minutes a commercial sugarless bubble gum or the same gum to which MCPM (5 wt%) or a DCPA + TTCP (5 wt%) had been added. The subjects were asked to expectorate into preweighed test tubes that were replaced every two minutes. The saliva samples collected were analyzed for weight, pH and total Ca and P concentrations. Results suggest that the experimental gums may be useful for inducing salivation and promoting remineralization in xerostomic and other caries-prone patients.

Dental Caries Mechanism: In vitro experiments and theoretical models have suggested that the surface charge of teeth may be an important determinant of caries progression. A microanalytical procedure developed at the PRC under a NIDR grant was used to examine the influence of membrane properties on tooth enamel and lesion progression. The results suggest that modifying the surface charge of the tooth from negative toward positive with surface-active agents may be a viable cariostatic treatment.

Calcium Phosphate Cements (CPC): Previous studies have shown that a PRC-developed CPC, consisting of tetracalcium phosphate and dicalcium phosphate anhydrous, sets by conversion to hydroxyapatite (OHAp) when mixed with aqueous solutions. A recent study evaluated the effects on diametral tensile strength (DTS) and conversion to OHAp of additives to the liquid component of CPC. The additives included: (1) potassium chloride for ionic strength effects; (2) calcium chloride ($CaCl_2$) or potassium phosphate (K_2HPO_4) for controlling, respectively, the Ca or PO_4 concentration of the liquid phase; and (3) sodium silicate (Na_2SiO_3) for its known effects on the setting of portland cements. Conversion to OHAp was found to increase with increasing ionic strength. Both K_2HPO_4 and potassium chloride produced a significant increase in DTS over 24 hours, whereas $CaCl_2$ decreased the initial DTS over three hours. These results show that the chemical environment of CPC can significantly improve the setting and strength of CPC.

Synthetic Dentin: Recently it was shown that fast-setting, strong cements could be prepared from CPC powders (mixtures of tetracalcium phosphate and dicalcium phosphate) and poly (alkenoic acids), e.g., poly (acrylic acid). Additives were required to control the fast rate of setting of this new cement. In a more recent study, the aqueous-based reactions of CPC powders with a less reactive polyacid, were investigated, and several new types of polymeric calcium phosphate cements (PCPC) were derived. Cements prepared from the CPC powder and 30% w/v aqueous solutions of PMVE-Ma were tough and had high diametral tensile strengths. The setting times, which were longer than those of poly (acrylic acid) based PCPC, were dependent on the concentration of the aqueous polymer, the composition of the powder and the powder/liquid ratio.

Rapid Remineralization with a Carbon Dioxide Aerosol: A novel method of rapid remineralization was developed to prevent and repair incipient dental caries, to desensitize dentin and for application to etched dentin during dentin bonding procedures. Solutions containing high concentrations of calcium phosphate were obtained at a low pH, which was produced by the presence of carbonic acid formed from dissolved CO_2 in water under pressurized CO_2 atmosphere. When an aerosol was used to apply the experimental solution to teeth, ions diffused into the teeth, and the pH of the applied solution increased due to the evaporation of the CO_2. The solution precipitated amorphous calcium phosphate (ACP) that then converted to tooth mineral. The precipitation was followed by the pH change in the solution, and the solids were analyzed by various techniques. Application of the experimental solution on etched dentin during dentin bonding yielded high bond strengths. This new method of rapid remineralization overcomes the problems of present remineralization solutions, i.e., low concentrations, low diffusion rates and the low precipitation rate of apatite.

Clinical Research

The clinical program develops and evaluates materials and techniques for the future transfer of technology to private industry and dental practitioners.

Dentin and Enamel Bonding Systems: Phase two of an National Institutes of Dental Research contract evaluating permanent restorations on Class III, IV and V restorations has officially ended but recalls are continuing in an effort to extend the data to four years. Approximately 250 restorations have been placed using the original experimental protocol comparing Scotchbond Dual Cure™ to a PRC-developed ferric oxalate system. This clinical trial has been instrumental in the development of proper application techniques, packaging and delivery of improved PRC adhesive systems. Information and techniques derived from these clinical trials are extremely useful in the transfer of such technologies to private industry. Trials are also underway utilizing related techniques for the adhesive application of porcelain and metallic restorations. Current materials and techniques have demonstrated excellent results with porcelain veneers, inlays, onlays and crowns as well as cast alloy restorations. The techniques and materials developed through this work have made possible the development of two newly marketed adhesive products. Many of the problems associated with the previous products have been solved.

Radiation Shielding Materials: The development of materials for use as shielding prostheses in radiation therapy has been funded under the Center for Excellence in Dental Materials. This project has formulated elastomeric materials, similar to impression putty, that are capable of blocking significant amounts of radiation energy. Current materials have demonstrated the ability to block over 40% of ^{60}Co gamma-rays and 10 MeV X-rays and almost 100% of 7 MeV electron beams with thicknesses of 2 centimeters and less. Experiments completed in the past year have determined the effective thickness needed for several higher energies of electron beams. These data will make it possible to give reliable recommendations for use in clinical trials, arrangements for which are currently under way with several hospitals within the Department of Veterans Affairs. A dental material company is showing strong interest in producing a product from this technology. Two of the broadest claims in the patent application have been approved and the patent is expected to be issued this year. This material would have significant usefulness in shielding soft tissues and salivary glands during high-energy radiation therapy of head and neck tumors and during electron therapy for skin and mucosal carcinomas.

Electrodeposition of Glassy Alloy Prostheses: A pilot project has begun exploring the application of super-strong electrodeposited alloys for use in dental prostheses. Possible applications include resin-retained bridges, precision-attachment prostheses and implant superstructure prostheses. These applications require an extreme degree of precision as well as high material strength. While funding has run out for this project, efforts are underway to get a cooperative agreement with industry to help continue this work.

Glass Ceramic Inserts: Beta quartz glass-ceramic inserts, which were invented by PRC Director Rafael Bowen, have been successfully licensed to Lee Pharmaceutical, and products are being marketed. Many of the limitations of composite resins are due to the properties of the resin, and increasing the amount of inorganic reinforcing filler material can make such restorations more closely resemble the properties of the natural tooth crowns. The insertion of a "megafiller" that fills as much of the cavity as possible in effect reduces the amount of resin. Dentists are thereby provided with a material for forming a composite restoration that has overall less resin and more filler than would be otherwise possible. Following laboratory development by polymer chemistry and crystallography program staff, the clinical program contributed to the development of the instructions, instrumentation and protocols necessary for placement of the inserts. Clinical studies have been initiated at several U.S. and foreign universities under the guidance and review of the PRC clinical program. Technical problems associated with the manufacture of the inserts by Specialty Glass have been numerous and challenging. Cooperative efforts by PRC scientists, Lee Pharmaceuticals and Specialty Glass have been necessary to manufacture this novel product on a very short time schedule. The product has been well received and should result in a significant improvement in the properties

of directly placed composite restorations. Laboratory development of the glass-ceramic material for casting and CAD-CAM applications is continuing.

Polymer Chemistry

This program focuses on monomers and polymers (dental resins) primarily in the area of composite restorative materials and development of durable adhesive bonding of related materials to dentin as well as enamel.

Adhesive Bonding to Hard Tissues: The greater part of the effort this year has been directed to improving means of providing durable adhesive bonding of restorative materials to dentin. Currently, available materials provide significantly less durable bonding to dentin than with adjacent enamel surfaces. This year there has been steady progress in understanding the mechanisms and limitations of state-of-the-art adhesive bonding technologies. New monomers have been developed that penetrate the cleaned dentin surface and polymerize therein, and improved techniques have been developed to elucidate the resin-tooth interactions. Recently acquired instruments for optical scanning, transmission electron microscopy and nuclear magnetic resonance have accelerated the rate of progress toward more satisfactory adhesive bonding to dentin, cementum and enamel.

Protective Tooth Coatings: New adhesion and resin technologies are providing the dentist with means to apply aesthetic or transparent protective polymeric coatings to tooth surfaces. This may have special importance in the prevention of root caries. Analogous to the protective coatings on houses, automobiles and other structures against the damaging effects of environment, the application of protective coatings on the entire exposed surfaces of patients' teeth may be a new and valuable service that dentistry can provide. Results to date indicate that experimental formulations of these new PRC materials can successfully adhere to the whole tooth and withstand challenges simulating those of the oral environment.

Resin Systems with Minimal Dimensional Change: Many of the numerous limitations of dental materials containing polymerizable resins result from contraction during the conversion of the liquid monomers to the solid polymer. Attempts to create monomers that polymerize without this hardening shrinkage continue. Recent results indicate that the diametral, tensile and flexural strengths of composites containing some of these new monomers are comparable to the mechanical strengths of conventional composites.

Metal-Reinforced Dental Composites: A pilot project was initiated to investigate the feasibility of developing a polymer-bonded metallic composite resin as an alternative direct restorative material for posterior teeth. Work was temporarily suspended on this project, in view of the more promising NIST invention of a "mercury-free amalgam" material that is being pursued in collaboration with the metallurgy program of the ADA Health Foundation.

ADAHF Multinuclear Nuclear Magnetic Resonance (NMR) Facility: This NMR facility is an invaluable tool in the pursuit of the synthesis of organic compounds. Furthermore, it is generating revenue from use by investigators from other organizations so that the facility is self-supporting.

Dental Crystallography

This program studies the formation, properties and crystal chemistry of calcium phosphates, biominerals, microcrystalline glass-ceramic insert/inlay materials and other compounds associated with hard tissues and dental materials.

Biomineralization: Investigations of octacalcium phosphate (OCP) and its role in biomineralization have continued. Crystal structures of several calcium dicarboxylates have been determined. These are being used to develop a general OCP-dicarboxylate salts structural model that can provide a better understanding of the properties and mechanisms of the formation of biominerals.

Microradiography: X-ray image-magnified microradiographic (XIMM) techniques, including synchrotron radiation, were used to study various stages of partially demineralized tooth specimens. The results show that XIMM consistently produces significantly more information on the structural features of the lesion than that of contact microradiography, particularly in the early stages of demineralization.

Calcium Phosphate Cement (CPC): Support services are also provided to improve the properties of the Health Foundation's patented CPC. The studies of the effects of particle size distribution and crystallinity of CPC starting materials on the setting reaction and other properties of the cement are continuing.

Dental Metallurgy

This program investigates metal alloys that have potential value in dentistry and develops new investment materials and novel casting techniques.

Tough Biometallic Compounds: Studies continued during the past year on new alloys patented by the Health Foundation that are expected to produce fracture-resistant prosthetic devices having excellent biocompatibility. Evidence suggests that microscopic crack propagation is inhibited in alloys containing zirconium, ruthenium and palladium by the occurrence of stress-induced atomic shear transformations. Small transformed platelets are apparently formed near the ends of growing cracks, which are regions of high stress that normally lead to fracture. High stresses applied to the surface of these alloys, e.g., by cutting or machining, produce a tough, fibrous surface layer on the transformed materials that creates extraordinary wear resistance. The unique mechanical behavior of these alloys and their excellent corrosion resistance are expected to ensure their use in a variety of dental and nondental applications.

Mercury-Free Substitutes for Dental Amalgam: The formulation of direct-filling metallic pastes that can be readily manipulated and hardened at mouth temperature has traditionally required the presence of the liquid metal, mercury. Corrosion, discoloration of restored teeth and questions regarding biocompatibility of compounds containing virtually all liquid metallic elements have motivated innovative research on alternatives for dental amalgam. Exploratory studies have been undertaken on powders of relatively soft metals that can be condensed directly in the manner of gold foil, but with handling characteristics more like amalgam. Preliminary studies are focusing on an evaluation of the forces of condensation and the time required to produce satisfactory restorations.

Honors and Awards: R. L. Bowen was made an honorary member of the American Academy of Cosmetic Dentistry "in recognition of outstanding contributions made in the advancement of dentistry"; R. Bixler of the Naval Restorative Residence Program in Bethesda earned the annual research award for graduating residents for the radiation shielding project he completed under the mentorship of M. Farahani and F. C. Eichmiller.

Papers: Nineteen papers, listed below, were published by staff members.

1. Bowen RL, Marjenhoff WA. Development of an adhesive system for bonding to hard tooth tissues. J Esthet Dent 1991;3:86-90.
2. Carey CM, Vogel GL, Chow LC. Permselectivity of sound and carious human dental enamel as measured by membrane potential. J Dent Res 1991;12:1479-85.
3. Chow LC. Development of self-setting calcium phosphate cements. J Ceramic Soc Japan 1991;99:829-35.
4. Chow LC, Takagi S. Deposition of fluoride on tooth surfaces by a two-solution mouthrinse in vitro. Caries Res 1991;25:397-401.
5. Chow LC, Takagi S, Tung W, Jordan T. Digital image analysis assisted microradiography-measurement of mineral content of caries lesions in teeth. J Res Natl Inst Stand Technol 1991;96:203-14.
6. Constantino PD, Friedman CD, Jones K, Chow LC, Pelzer HJ, Sisson, GA Sr. Hydroxyapatite cement. I. Basic chemistry and histological properties. Arch Otolaryngol Head Neck Surg 1991;117:379-84.
7. Eidelman N, Brown WE, Meyer JL. Selective inhibition of crystal growth on octacalcium phosphate and nonstoichiometric hydroxyapatite by pyrophosphate at physiological concentration. J Cryst Growth 1991;113:643-52.
8. Eidelman N, Chow LC. Effects of calcium and pH on hydrolysis of fluorosilicate and fluorostanate. Caries Res 1991;25:101-7.
9. Friedman CD, Constantino PD, Jones K, Chow LC, Pelzer HJ, Sisson GA Sr. Hydroxyapatite cement. II. Obliteration and reconstruction of the cat frontal sinus. Arch Otolaryngol Head Neck Surg 1991;117:385-9.
10. Gregory TM, Chow LC, Carey CM. A mathematical model for dental caries: A coupled dissolution-diffusion process. J Res NIST 1991;96:595-604.
11. Kahn HM, Farahani M, McLaughlin WL. A radiochromic film dosimeter for gamma radiation in the absorbed-dose range 0.1-10 kGy. Radiat Phys Chem 1991;38:395-8.
12. Luper WD, Eichmiller FC, Doblecki W, Campbell D, Li SH. Effect of three sterilization techniques on finger pluggers. J Endod 1991;17:361-4.
13. McLaughlin WL, Kahn HM, Farahani M, Walker ML, Puhl JM, Seltzer M, Soares CG, Dick CE. Low-energy electron dose-distribution measurements with thin-film dosimeters. Dosimetry 1991;4:20-30.
14. Misra DN. Adsorption from solution on hydroxyapatite: Role of hydrogen bonding. Phosphorus Bulletin (Special Issue).
15. Misra DN. Adsorption of low molecular weight polyacrylic acid on hydroxyapatite: Role of molecular association and apatite dissolution. Langmuir 1991;7:2422.
16. Pashley DH, Andringa HJ, Eichmiller FC. Effects of ferric and aluminum oxalates on dentin permeability. Am J Dent 1991;4:123-6.
17. Shern RJ, Mirth DB, Bartkiewicz A, Monell-Torrens E, Li S-H, Chow LC. Effects of an acidic calcium phosphate solution and the intraoral fluoride releasing device on dental caries and fluoride uptake in rats. Caries Res 1991;25:268-76.
18. Tomazic BB, Siew C, Brown WE. Comparative study of pathologic cardiovascular biomineralization. In: JD Catravas, AD Callow, CN Gillis, US Ryan, eds. Proceedings, NATO Advanced Study Institute on Vascular Endothelium: Physiological Basis of Clinical Problems, Corfu, Greece. New York: Plenum Press; 1990: 291-2.
19. Waterstrat RM. New ternary laves phases. J Alloys and Compounds 1992;179:L33.

Presentations: Eighteen staff members of the PRC and Center of Excellence presented 20 papers at the annual meeting of the International Association of Dental Research/American Association for Dental Research in Boston, March 11-15, 1992. In addition, 40 presentations and papers on original research were given at meetings of other organizations and dental societies.

Cooperative and Educational Activities: The PRC continues to engage in a wide variety of cooperative research projects with scientists at National Institute of Standards and Technology, National Institute of Dental Research and numerous domestic and foreign academic and not-for-profit research institutions.

Grants: Approximately 80% of the staff members of the PRC and Center of Excellence are wholly or partially supported by grants from the National Institutes of Health. The current National Institute of Dental Research grant awards (direct costs) are as follows: R. L. Bowen, principal investigator, Center of Excellence for Materials Science Research, third year of five, $336,913; R. L. Bowen, principal investigator, Improvement of Preventive and Restorative Materials (MERIT award), fourth year of five, $108,878; L. C. Chow, principal investigator, Prevention of Dental Caries, third year of four, $154,736; M. Mathew, principal investigator, Crystal Chemistry of Calcium

Phosphates, third year of five, $108,045; M. Tung, principal investigator, Three Approaches to Rapid Remineralization of the Tooth, third year of four, $35,307; and G. L. Vogel, principal investigator, Mechanism of Dental Caries, fourth year of five, $112,849. The PRC has also been awarded contracts for services from the Office of Naval Research, one year, $15,000 and the Food and Drug Administration, one year, $24,800.

Resolutions: This report is informational in nature and no resolutions are presented.

Notes

Reports of Special Committees

Report of the Provider Recognition Program Special Committee

Notes

Report of the Provider Recognition Program Special Committee

Background: In its 1991 annual report to the House of Delegates (*Reports* 1991:119), the Council on Dental Education forwarded a resolution requesting the House, if it endorsed the concept, to direct the Council to initiate a continuing education Provider Recognition Program (PRP) for dentistry. The Council concluded that the House should determine whether it supported the concept of a PRP prior to spending time and resources on developing the specific details of such a program.

The following steps preceded the Council's May 1991 action to forward a resolution to the 1991 House. The process actually began several years ago as a result of concerns about the Academy of General Dentistry's (AGD) sponsor approval program expressed by various communities, but most specifically by dental educators.

- In response to these concerns, the AGD convened a special meeting in conjunction with the annual meeting of the American Association of Dental Schools (AADS) in March 1989. This meeting was chaired by Dr. Henry W. Finger, who served as president of the AGD during 1991. This meeting led to the idea for the development of a national-level sponsor recognition program modeled after the program used by medicine.
- In August 1989, the ADA Board of Trustees adopted a resolution stating:

  Resolved, that the Council on Dental Education be urged to consider the feasibility of implementing a mechanism to evaluate the institutions and organizations that offer continuing dental education and approve those that meet established standards.

- The Board resolution and ideas generated in the March 1989 meeting were discussed further in a meeting of a special task force hosted by the ADA in September 1989. Although the task force did not believe that the Accreditation Council for Continuing Medical Education (ACCME) model was directly applicable to the needs of dentistry, the ACCME model was used to stimulate discussion, which served as input from the task force to the Council's Standing Committee on Continuing Dental Education.
- The Council's Standing Committee on Continuing Dental Education met in October 1989 and developed a proposal that was reviewed and modified by the Council in December 1989. The proposal that was developed was reviewed in accordance with the Council's usual procedures which include opportunity for the communities of interest to comment on the proposal.
- This first proposal was mailed to the communities of interest in January 1990 and the comments received were reviewed by the Council in May 1990. The Council referred the proposal back to the Council's Standing Committee on Continuing Dental Education for modification.
- The standing committee met in October 1990 and reviewed all comments received from the communities of interest. The committee revised the initial proposal, making changes in the name, the parent committee structure and the review process.
- The Council reviewed the new draft proposal in December 1990, made additional changes and directed that the new proposal again be circulated to the communities of interest for review and comment.
- The second proposal was circulated to the communities of interest early in 1991. All comments received were reviewed by the Council in May 1991. Although there were varied comments and some reservations about the specific policies, procedures and eligibility criteria that would be used if such a program were implemented, the communities, in general, supported the concept of a unified, national-level program that would meet the needs of many segments of the dental profession. All groups believed that such a unified program must be operated under the aegis of the ADA, probably through the Council on Dental Education, if it were to succeed.
- The Council determined that there was adequate support for the proposed program to justify forwarding a resolution to the 1991 House of Delegates. The Council believed that the House should determine whether it wished to support the concept of such a program before additional time and resources were devoted to developing the specific details of the program.

In reviewing the Council's report, the Board of Trustees believed that it would be difficult, if not impossible, to make a sound judgment on the initiation of a PRP for dentistry without more specific information on which to base the decision. For this reason, the Board developed a substitute resolution which was subsequently adopted by the House (*Trans.*1991:600). This resolution, 35H-1991, stated:

Resolved, that the President of the American Dental Association appoint, with Board approval, a seven member committee comprised of five generalists and two specialists, with one member of the committee also being a member of the Council on Dental Education, to develop details and procedures for a continuing dental education Provider Recognition Program, with the Council providing staff support for the committee, and be it further

Resolved, that each specialty organization and the American Association of Dental Examiners, American Association of Dental Schools and Academy of General Dentistry be requested to select and fund an individual to serve as a consultant to the committee, and be it further

Resolved, that the committee be charged with the responsibility of developing and submitting for approval the details of the Provider Recognition Program to the 1992 House of Delegates, with related cost implications.

Members of the Special Committee: The seven-member Presidential-appointed special committee was composed of: Dr. W. Gene Brain, chair; and Dr. Larry R. Camp, Dr. Henry M. Cherrick, Dr. Henry W. Finger, Dr. Fraya I. Karsh, Dr. Willie V. Kittleman and Dr. Kenneth F. Schmitt. The special committee was directed to develop the details of a PRP, with financial implications, for transmittal to the 1992 House. The special committee met in mid-January and late March 1992.

At its first meeting, the special committee reviewed, in detail, the history of the ADA's previous sponsor approval program, the program currently conducted by the AGD and programs currently conducted by other professions such as medicine and pharmacy. In addition, the committee reviewed the Accreditation Council on Continuing Dental Education Program, forwarded in draft by the American Association of Dental Schools. The events of the past several years, leading to the adoption of Resolution 35H-1991 by the ADA House, were also reviewed in detail. These events have been reported to the House each year since 1989 (*Reports* 1989:104; 1990:112; 1991:119).

As part of its review of the background information, the special committee assessed the specific letters received during three separate opportunities to comment on the previously proposed programs. It became apparent to the special committee that it would be difficult to reconcile conflicting comments to the satisfaction of all parties. The committee believed, however, that it was essential to have a clear understanding of all concerns expressed in order to make its best recommendations in response to the House directive. Specifically addressing the concerns expressed was important, in the special committee's opinion, to achieving broad-based support for a PRP from the various segments of the dental community.

Comments on Results of the January 1992 Meeting: As a result of its deliberations in January 1992, the special committee developed preliminary recommendations and directed that these recommendations, together with the preliminary draft PRP standards, be transmitted to the consultants appointed by those organizations having a special interest in this activity (specifically the eight specialty organizations, the Academy of General Dentistry, the American Association of Dental Examiners, the American Association of Dental Schools and the newly formed Association for Continuing Dental Education). These consultants were asked to provide written or oral comments on the recommendations and standards for the special committee's review during its March 1992 meeting.

During its March 1992 meeting, the special committee heard testimony from the following consultants who had been appointed by their respective organizations: Dr. Mark P. Cohen, Academy of General Dentistry; Dr. Susan Zunt, American Academy of Oral Pathology; Dr. John Bogert, American Academy of Pediatric Dentistry; Dr. Donald F. Adams, American Academy of Periodontology; Dr. Paul Torgerson, American Association of Dental Examiners; Ms. Jamie D. Sharp, American Association of Dental Schools; Dr. Leif K. Bakland, American Association of Endodontists; Dr. Martin Stern, American Association of Oral and Maxillofacial Surgeons; Dr. Pelton Wheeler, American Association of Orthodontists; Dr. Herbert Hazelkorn, American Association of Public Health Dentistry; Dr. Dan Middaugh, Association for Continuing Dental Education; and Dr. John F. Burton, Federation of Prosthodontic Organizations.

The consultants made presentations to the special committee and commented on the preliminary recommendations and the draft PRP standards. The consultants also discussed the perceived benefit of such a program to their organizations. At the end of the formal presentations, there was a general discussion of issues relating to the ADA developing a PRP. The consultants, following this discussion, indicated their support for a PRP and its implementation.

The special committee weighed all comments and conflicting points of view as it developed its recommendations. In the special committee's view, providing the opportunity to discuss the program with these representatives was most helpful and allowed common and differing expectations and perceptions to be addressed.

Goals and Benefits of a Provider Recognition Program: The special committee deliberated at length on the issue of need for a PRP. The special committee unanimously concluded that dentistry, like other health professions such as medicine and pharmacy, would benefit from a strong, unified, broadly supported PRP. The most significant benefit of such a program, in the judgment of the special committee, will be to the member dentists. Through the program, member dentists will receive assurance of the reputability of those PRP-recognized continuing education (CE) providers or sponsors from whom they take CE courses. Although individual courses will not be reviewed, each PRP-recognized CE provider will be required to demonstrate compliance with established Standards/Criteria for Recognition and thus to show a history of presenting sound CE programs. Based on a sound history, it is reasonable to anticipate that future activities of recognized CE providers will also have educational value. In addition, the PRP will include a specific complaint mechanism for use as needed.

The special committee also anticipates that the PRP will benefit those participating organizations that have CE regulatory requirements (such as the state boards of dentistry) or membership requirements (such as the Academy of General Dentistry). Through their direct input into the PRP Standards/Criteria, policy and procedures, these organizations can have greater assurance about the uniform educational quality of the credits they accept as meeting their established requirements. As an additional service, when it is constituted, the PRP Steering Committee will be asked to address the issue of a uniform nationally accepted CE credit reporting form. Development of such a form will benefit the organizations, as well as individual member dentists.

The special committee specifically identified the following objectives of the PRP and directed that they be included in the PRP Procedures document:

1. To improve the educational quality of continuing dental education programs through self-evaluation conducted by the program provider in relation to the Standards/Criteria for Recognition and/or through counsel and recommendations to CE providers from the PRP Review Committee on Continuing Dental Education.

2. To assure participants that recognized continuing education program providers have the organizational structure and resources necessary to provide CE activities of acceptable educational quality, i.e., activities that should assist the participant in providing an enhanced level of care to patients.
3. To promote uniform standards for continuing dental education that can be accepted nationally by the dental profession.
4. To achieve national acceptance of the continuing dental education activities of recognized providers.
5. To assist regulatory agencies and/or other organizations responsible for granting credit in identifying those continuing dental education providers whose activities are acceptable for credit toward licensure or membership requirements or voluntary recognition programs.
6. To reduce duplication of regulatory/review efforts of multiple dental agencies by consolidation of these activities into one agency, the PRP, which includes input from these various agencies.

Rationale for Program Structure: The special committee deliberated at length about the need to balance the clearly stated desire for designated representation and input into the oversight of the PRP with the equally clearly stated need for a small, effective operational committee to actually conduct the reviews and perform the work required by such a program. After extensive discussion, the special committee determined that there was need for broad input at the policy-setting level. Once standards and policy have been established, however, they can be consistently implemented by a much smaller group.

The need for representation of all interested parties was a recurring theme presented to the special committee in both written and oral testimony. Because dentists who are specialists are also impacted by CE licensure requirements and may belong to organizations with CE membership requirements, the special committee determined that it was mandatory for the specialties to be represented on the PRP Steering Committee that will establish the standards and policy for the program. Because the PRP will encompass all of dentistry, broad-based support and wide involvement at the policy-setting level is essential. Thus two separate committees are being suggested.

Because the participating organizations will share in funding the committees, this change will not have a significant impact on the cost of the program to the ADA or to the CE providers applying for recognition. Because the Steering Committee will meet once rather than twice a year, the cost to the participating organizations will also be less than originally predicted.

To ensure an adequate balance on the PRP Steering Committee between general dentists and specialists, the four Steering Committee members funded by the ADA will be general practitioners and a public member/CE expert who may or may not be a dentist. In selecting its appointees to the Steering Committee, the Council on Dental Education will make every attempt to ensure that dental societies are represented on the committee.

Provider Recognition Program Steering Committee: To obtain broad-based input from those communities that have expressed a specific interest in participating in a PRP, an 18-member policy-making steering committee, to be called the PRP Steering Committee, will meet once per year and will be structured as follows:

8—Recognized Specialty Organizations (appointment of one member each)
2—American Association of Dental Examiners
2—American Association of Dental Schools
2—Academy of General Dentistry
2—American Dental Association*
1—Continuing Education Expert/Public member*
1—Council on Dental Education member* (chair)

18 members total—(*4 to be funded by the ADA)

Because the focus of the PRP will be on CE for dentists, the PRP Steering Committee will be composed of dentists; allied dental team members are not eligible for appointment to this committee. Each appointing organization will select individuals with knowledge, experience and interest in continuing education. The cost associated with these members attending PRP meetings will be borne by the appointing organizations.

Duties of the Provider Recognition Program Steering Committee: The PRP Steering Committee will:

1. Develop and approve the Standards/Criteria that will be used by the Review Committee on Continuing Dental Education in the review and recognition of CE providers.
2. Review and approve any policy affecting the structure and governance of the PRP.
3. Review broad-based CE issues and make recommendations regarding these matters to appropriate policy-making bodies. Make recommendations to the Review Committee on Continuing Dental Education on procedural or operational matters of interest/concern to the broad-based dental CE communities.
4. Work to develop uniform procedures and materials and encourage the broad-based use/acceptance by the dental CE communities. For example, a uniform recordkeeping form to report CE attendance and credits earned could be developed with the long-range goal of national acceptance of the form.
5. Serve as liaison to dental and dental-related organizations concerned with the approval program.

Review Committee on Continuing Dental Education: In order to operate a PRP in an efficient, cost-effective manner, recognition reviews will be conducted by an eight-member review committee that will meet twice per year and be structured as follows:

5—general dentists
2—specialists
1—CE expert/public member

8 members total

The eight members of the Review Committee on Continuing Dental Education will be selected from the members of the 18-member PRP Steering Committee outlined above. Decisions of the Review Committee on Continuing Dental Education will be final and will not be reviewed by the Council, the Board, the House or by any other body, except for appeal provisions related to due process.

Duties of the Provider Recognition Program Review Committee on Continuing Dental Education: The Review Committee on Continuing Dental Education will:

1. Evaluate the initial and re-recognition applications and progress reports submitted by those providers of continuing dental education wishing to participate in the PRP.
2. Award recognition to those CE providers found to be in substantial compliance with the PRP Standards/Criteria. All actions of the Review Committee are final. The due process rights of recognized CE providers and applicants are detailed in the PRP Appeal and Complaint Procedures documents (to be developed if implementation of PRP is authorized).
3. Develop and implement the operational policies and procedures of the PRP.
4. Develop and disseminate information, conduct workshops and support other activities related to the recognition process.
5. Serve as liaison to ADA's Council on Dental Education on issues of continuing dental education policy.

Appeals: The appellate body for the PRP will be the Council on Dental Education, which will hear any necessary appeals at its next regularly scheduled meeting. A formal appeals procedure document will be developed by the PRP Steering Committee.

Review of Continuing Education Policy for the ADA: To provide an avenue for transmitting CE policy issues to the Council on Dental Education, the Board of Trustees and House of Delegates, the eight-member Review Committee on Continuing Dental Education will consider assigned CE policy issues and report on them to the Council on Dental Education, as currently occurs with the Council's Standing Committee on Continuing Dental Education. This current standing committee would be replaced by the newly established Review Committee. The recognition decisions of the Review Committee will not be subject to review by the Board of Trustees, the House of Delegates or the Council on Dental Education. Appeal reviews will be conducted by the Council as specified in the appeals protocol that is to be developed.

Terms of Committee Members: Members of the PRP Steering Committee will be appointed annually by their respective organizations for a maximum of six consecutive years. Members of the Review Committee on Continuing Dental Education will be selected from the PRP Steering Committee. These members will also serve for a maximum of six consecutive years. A rotational schedule will be developed to ensure that a core of experienced members are serving on both committees at all times.

Rationale Related to Provider Recognition Program Details of Concern to the Dental Communities: The document, Procedures: Provider Recognition Program provides more complete information and specific details on the program procedures developed by the special committee (Appendix 1, page 146). The issues that were deemed to be of greatest interest or concern to the dental communities are discussed in the next section of this report. The recommended policy and procedures as reflected in this report and in the PRP documents were developed by the special committee during its January 1992 meeting and circulated for comment and review. Based on comments received, the advice of legal counsel and concerns of the committee, the preliminary recommendations were reviewed and modified during the committee's March 1992 meeting. The special committee believed that it had developed a strong preliminary operational framework for the PRP, although the committee noted that any successful program must be somewhat evolutionary to provide the flexibility the program must have if it is to respond to the ongoing needs of program participants.

Standards/Criteria to be Used in Review of Continuing Education Providers: The special committee reviewed approval or recognition criteria and standards used by other professions, including medicine and pharmacy, as well as the program sponsored by the AGD. The standards of the ADA's previous sponsor approval program were also reviewed, as were the draft standards of the continuing education section of the American Association of Dental Schools. The high degree of similarity among the standards of the various programs was evident.

The proposed PRP standards were developed, circulated for comment and revised based on comments and additional information received. The final document, in the judgment of the special committee, is greatly strengthened by the addition of a standard that addresses conflict of interest and commercial support for CE programs. The PRP's Standards/Criteria for Recognition are detailed in a separate document which is attached to this report (Appendix 2, page 155).

Eligibility to Participate in the Provider Recognition Program: The PRP is intended to be a unified, national-level program which is voluntary in nature. The PRP may be most applicable to those providers that offer CE activities nationally or regionally or that draw attendees from multiple states. In response to comments received, however, the special committee determined that component as well as constituent dental societies must be eligible to apply to the program. The PRP is designed as a voluntary program and the special committee determined, therefore, that any provider of CE meeting the standards will be eligible for recognition.

To be eligible to participate in the PRP, a CE provider must ensure that any clinical courses offered have a sound scientific basis in order to adequately protect the public. The PRP reserves the right not to process applications from providers who promote or sponsor CE courses that do not have a sound scientific basis, proven efficacy or ensure public safety. This issue is further addressed in Standard V of the Standards/Criteria for Recognition. That standard requires, among other things, CE providers to develop and follow their own Guidelines

for Conflict of Interest and Full Disclosure that must not conflict with the PRP standards. The disclosure of commercial support for CE programming was a very important issue in the testimony received by the special committee and inclusion of this standard was widely supported.

The PRP's Standards/Criteria for Recognition will be applied in an equitable manner to all applicants to the program. A provider must, however, be able to demonstrate that it is targeting its activities to a great extent to dentists by providing dental-oriented topics and course content. Although the PRP will recognize providers and will not make judgments about the content of individual courses, it is the intent of the PRP to recognize those providers that are primarily addressing the CE needs of dentists.

Although the PRP may not directly benefit some smaller groups, such as local CE study clubs, such groups are encouraged to explore possible affiliation agreements with their local or state dental societies.

Initial Entry Into the Provider Recognition Program: The special committee determined that the process for initial entry into the PRP should be "user friendly" and designed to encourage rather than limit participation. All applicant CE providers will complete the Provider Recognition Program Application developed by the special committee and pay the required fees (Appendix 3, page 169). The special committee indicated that the application should be field-tested and might be modified prior to implementation to ensure that its scope and depth are appropriate.

The merit of wide-spread initial involvement in a PRP (i.e., grandfathering or automatic inclusion of some groups of CE providers) was weighed against issues of equity that demand that all participating CE providers complete an application and go through essentially the same initial review process. The special committee reviewed much testimony on this topic and conflicting strong opinions were noted.

Although the AGD's National Sponsor Approval Program included provision to extend approval to those sponsors approved by the ADA in its previous sponsor approval program, this arrangement will not be part of the PRP. The PRP includes a new standard related to conflict of interest and commercial support for CE activities (see Standard V of the Standards/Criteria for Recognition). No currently recognized sponsor has demonstrated compliance with this standard. For this reason, the special committee determined that all CE providers wishing to participate in the PRP will be required to complete a PRP Application as they apply for initial entry into the program.

Frequency of Review: Recognition of a CE provider will be based on the provider's compliance with the Provider Recognition Program Standards/Criteria for Recognition. The special committee was swayed by the testimony about the potentially rapid nature of change in the CE community and believed that a period longer than five years would not adequately address issues of continuity and quality. The special committee, therefore, determined that the maximum amount of time between reviews will be five years and may include interim reports to be submitted as specified by the Review Committee on Continuing Dental Education. Continued recognition will be contingent upon payment of all required fees (such as application and annual fees). Special circumstances, such as receipt of complaints, might trigger an earlier review of a provider.

Although variable review cycles for different groups of CE providers was discussed, there did not appear to be sufficient rationale to justify that kind of inequity. Thus, all providers will be eligible for the same amount of time between reviews, i.e., a maximum of five years.

Method of Review: The PRP will use an application review process, with the provision that the provider may be requested to appear before the Review Committee on Continuing Dental Education based on concerns or problems specifically identified by the Review Committee or in response to complaints received by the Review Committee.

Additional specific review procedures are addressed in the document, Procedures: Provider Recognition Program, attached to this report. In the judgment of the special committee, it is important to point out that a provider of CE stipulates current and continued compliance with the PRP's Standards/Criteria for Recognition as part of seeking and obtaining recognition. This stipulation of compliance with the standards extends to any co-sponsorship agreements. Because the responsibility for the quality and integrity of all co-sponsored events rests with the recognized provider, such arrangements should contribute to the overall quality of dental continuing education.

Complaints Procedure/Mechanism: The PRP will recognize CE providers and will not review the content of individual courses. The PRP will, however, include a mechanism for timely review of standard-related complaints received or other specifically identified concerns about activities/courses of recognized providers. The special committee determined that an established and publicized complaint mechanism is necessary in order to address issues of quality.

Complaints can be forwarded to the Review Committee by course participants, course faculty or other CE providers. Upon receipt of complaints, the Review Committee will deal with the recognized CE provider in accordance with its established procedure. The procedure, to be developed by the Review Committee on Continuing Dental Education, will be modeled on the well-established procedure used by the Commission on Dental Accreditation to handle complaints related to the accreditation standards.

Provider Recognition Program Recordkeeping Requirements: Providers of CE have a responsibility to maintain records of course attendance. CE providers must consider the reporting requirements of those licensing jurisdictions that have CE requirements, any pertinent membership requirements established by groups with an interest in CE (such as the Academy of General Dentistry, and reporting requirements included in the PRP Standards.

The special committee determined that the PRP will not, at this time, include any centralized "course registry" mechanism. In spite of this, having a standardized, nationally accepted recordkeeping form would be a significant benefit. Thus the PRP Steering Committee will be asked, at an appropriate time,

to develop a uniform recordkeeping form to report CE attendance and credits earned. In developing such a form, the Steering Committee should work toward the long-range goal of national acceptance of the form.

Financial Details: Although the PRP will need some initial support as it becomes operational (approximately $30,000 a year for perhaps three years), the goal of the program is to become largely self-supporting as quickly as possible, perhaps by its third year of operation. The special committee determined that this goal can be accomplished with a modest application/re-recognition fee (roughly $200) and annual fees (roughly $300), based on a pool of 300 participating CE providers. When compared to the average per person fee charged for a typical one day CE program, the special committee concluded that these fees were very reasonable and should not prevent any interested provider from participating in the program. This level of fees, if paid by 300 CE providers, would generate about $102,000 per year. In the spring of 1992, the AGD's National Sponsor Approval Program had 321 currently approved sponsors. This led the special committee to conclude that 300 was a reasonable number on which to base its projected budget.

As indicated previously, the identified participating organizations will fund the meeting-related expenses of their members of the PRP Steering Committee for one meeting per year at a cost that is anticipated to be less than $1,000 per year per member. The ADA will be requested to fund the expenses of four members of the Steering Committee and the expenses associated with the PRP Review Committee on Continuing Dental Education, for an estimated total of about $17,000 per year after the program becomes operational. This projected annual expenditure will be off-set (i.e., reduced) by the amount currently budgeted for the separate Standing Committee on Continuing Dental Education.

Thus, the PRP's operational budget will be funded from the following three sources. The participating organizations will contribute approximately $9,000 or about 10% of the projected operational cost of the PRP (i.e., approximately $94,000 per year when operational). The ADA will contribute approximately $17,000 or just under 20% of the budget. The remaining 70% of the program expenses will be covered by fees paid by the recognized CE providers participating in the program.

The special committee also discussed "start-up" funding for a PRP and recognized that funds will be required to assist with the development and distribution of materials and program-related documents. There will also be expenses associated with an initial planning meeting that will be required for the program to become operational. The special committee determined that the ADA would be requested to provide initial funding (approximately $30,000) for the program.

Summary: At the conclusion of its efforts and study, the special committee enthusiastically supported the concept of a PRP and unanimously stated that dentistry, like other health professions, would benefit immeasurably from a strong, unified, broadly supported PRP. Although the member dentist might benefit most from such a program, a PRP should also benefit the participating organizations including regulatory agencies (such as state boards of dentistry) and organizations with CE membership requirements (such as the AGD). The committee recognized that any successful program will be an evolutionary process and will need to respond to the needs of program participants.

The special committee emphasized its appreciation for the direct input received from the consultants appointed by the participating organizations. The special committee considered each and every comment received as it weighed conflicting issues and developed its recommendations for the House. The special committee had to balance the overall cost-benefit of the suggestions received, but believed that being provided with all of the comments helped greatly to strengthen the resulting program proposal.

For the reasons provided in this report, the special committee recommends adoption of the following resolution.

Resolutions

New Policy/Directive:

25. Resolved, that the Provider Recognition Program, as developed by the special committee and detailed in the Standards/Criteria for Recognition, Procedures: Provider Recognition Program and Provider Recognition Program Application be implemented.

Appendix 1

PROCEDURES:

PROVIDER RECOGNITION PROGRAM

Reasons for Program

A provider that wishes to be recognized through the Provider Recognition Program must submit data documenting its compliance with the PRP Standards/Criteria for Recognition. The Provider Recognition Program (PRP) was created to assist members of the American Dental Association, the recognized specialty organizations, the American Association of Dental Schools, the American Association of Dental Examiners, the Academy of General Dentistry and the broad-based dental profession in identifying

and participating in quality continuing dental education. It is also a goal of the PRP to assist dental regulatory agencies to establish a sound basis for increasing their uniform acceptance of CE credits earned by dentists to meet the CE relicensure requirements currently mandated by 31 of the 53 (about 60%) licensing jurisdictions.

Like other health professions, dentistry has supported the importance of providing continuing education that leads to improvement in the quality of patient care. Much of organized dentistry has long affirmed that continuing study is the fundamental and lifelong responsibility of the professional person. Individual dentists affirm their support for the principle of lifelong learning through their active participation in CE activities even in those jurisdictions where CE is not required. Each year, thousands of continuing education courses are presented by hundreds of providers--dental schools, dental societies and companies that specialize in course presentations. Most provide dentists with valuable information that can be successfully integrated into the dental practice.

Recognized Providers Must Meet Standards: The PRP reviews CE providers and recognizes those who demonstrate that they routinely meet certain basic standards of educational quality. The PRP's clearly defined policies and procedures are the basis for evaluating the educational processes used by CE providers in designing, planning and implementing continuing education. This review and recognition helps individual dentists select courses presented by recognized CE providers and may enhance their level of satisfaction.

Recognition of a provider by the PRP Review Committee on Continuing Dental Education does not imply endorsement of course content, products or therapies presented. It is a goal of the PRP that the credits earned by individuals who participate in continuing education offered by recognized providers will be widely accepted by licensing jurisdictions, dental societies and other groups that have CE requirements.

Purposes and Goals

The Continuing Dental Education Provider Recognition Program was developed to meet several needs of the profession. These include a need to oversee the educational quality of continuing dental education activities of the recognized CE providers. This oversight mechanism is intended to assure the individual participant that the CE provider has the potential for offering activities of acceptable educational quality. Need has also been expressed for a system of nationally uniform standards that can promote acceptance of continuing dental education experiences by regulatory and other agencies. Specific objectives of the recognition program are:

1. To improve the educational quality of continuing dental education programs through self-evaluation conducted by the program provider in relation to the Standards/Criteria for Recognition, and/or through counsel and recommendations to CE providers from the PRP Review Committee on Continuing Dental Education.

2. To assure participants that recognized continuing education program providers have the organizational structure and resources necessary to provide CE activities of acceptable educational quality, i.e., activities that should assist the participant in providing an enhanced level of care to patients.

3. To promote uniform standards for continuing dental education that can be accepted nationally by the dental profession.

4. To achieve national acceptance of the continuing dental education activities of recognized providers.

(continued)

5. To assist regulatory agencies and/or other organizations responsible for granting credit in identifying those continuing dental education providers whose activities are acceptable for credit toward licensure or membership requirements or voluntary recognition programs.

6. To reduce duplication of regulatory/review efforts of multiple dental agencies by consolidation of these activities into one approval agency, the Provider Recognition Program, which includes input from these various agencies.

PRP GOVERNING STRUCTURE

The Provider Recognition Program is structured to include broad input from those dental groups with an interest in continuing dental education at the policy-setting level. The broad-based 18-member PRP Steering Committee establishes policy and standards for the PRP which are then implemented in a consistent manner by the smaller 8-member Review Committee on Continuing Dental Education. Decisions of the Review Committee are final and are not reviewed by the Council, the Board, the House or by any other body, except for appeal provisions related to due process.

Program Administration

The Provider Recognition Program (PRP) shall be governed by two committees, the PRP Steering Committee and the Review Committee on Continuing Dental Education.

PRP Steering Committee: Structured to ensure broad-based input from the dental profession, the PRP Steering Committee shall be responsible for overall administration of the PRP Program and for setting the policies that govern the program. The 18-member PRP Steering Committee will meet once each year in conjunction with a meeting of the Review Committee on Continuing Dental Education and will be structured as follows:

8 -- Recognized Specialty Organizations (appointment of one member each)
2 -- American Association of Dental Examiners (AADE)
2 -- American Association of Dental Schools (AADS)
2 -- Academy of General Dentistry (AGD)
2 -- American Dental Association* (ADA)
1 -- Continuing Education Expert/Public member*
1 -- Council on Dental Education member* (chair)

18 members total -- (* 4 to be funded by the ADA)

Because the focus of the PRP will be on continuing education for dentists, the PRP Steering Committee will be composed of dentists; allied dental team members are not eligible for appointment to this committee. Each appointing organization will select individuals with knowledge, experience and interest in continuing education.

The cost associated with these members attending PRP meetings will be borne by the appointing organizations. To ensure an adequate number of general practitioners, the ADA's Council on Dental Education will appoint general dentists to this committee.

Review Committee on Continuing Dental Education: Responsible for implementation of PRP policy, the Review Committee on Continuing Dental Education shall meet twice a year to review and act on all applications for initial and continued recognition. Any appeals related to recognition actions will be heard by the Council on Dental Education at its next regularly scheduled meeting at outlined below. This 8-member committee will be structured as follows:

5 -- general dentists
2 -- specialists
1 -- CE expert/public member

8 members total

The members of the Review Committee on Continuing Dental Education will be selected from the members of the 18-member PRP Steering Committee outlined above. Decisions of the Review Committee will be final and will not be reviewed by the Council, the Board, the House or by any other body, except for appeal provisions related to due process.

Terms of Committee Members: Members of the PRP Steering Committee and the Review Committee on Continuing Dental Education will be appointed annually by their respective organizations for a maximum of six (6) consecutive years. A rotational schedule will be developed to ensure that a core of experienced members are serving on both committees at all times.

Responsibilities: The responsibilities of the two PRP committees are as follows:

The Provider Recognition Program Steering Committee will:

1. Develop and approve the Standards/Criteria that will be used by the Review Committee on Continuing Dental Education in the review and recognition of CE providers.

2. Review and approve any policy affecting the structure and governance of the Provider Recognition Program.

3. Review broad-based continuing education issues and make recommendations regarding these matters to appropriate policy-making bodies. Make recommendations to the Review Committee on Continuing Dental Education on procedural or operational matters of interest/concern to the broad-based dental continuing education communities.

4. Work to develop uniform procedures and materials and encourage the broad-based use/acceptance by the dental CE communities. For example, a uniform record keeping form to report CE attendance and credits earned could be developed with the long-range goal of national acceptance of the form.

5. Serve as liaison to dental and dental-related organizations concerned with the approval program.

The Review Committee on Continuing Dental Education will:

1. Evaluate the initial and re-recognition applications and progress reports submitted by those providers of continuing dental education wishing to participate in the PRP.

2. Award recognition to those CE providers found to be in compliance with the PRP Standards/Criteria. All actions of the Review Committee are final. The due process rights of recognized CE providers and applicants are detailed in the PRP Appeal and Complaint Procedures documents (to be developed).

3. Develop and implement the operational policies and procedures of the PRP.

4. Develop and disseminate information, conduct workshops and support other activities related to the recognition process.

5. Serve as liaison to ADA's Council on Dental Education on issues of continuing dental education policy.

(continued)

Appeals

The Council on Dental Education will serve as the appellate body for the PRP. The Council will hear any necessary appeals at its next regularly scheduled meeting. Appeals will be conducted in accord with a formal appeals procedure to be developed by the PRP Steering Committee.

In the event that the PRP Committee takes adverse action on an application for provider recognition, the provider may appeal the decision. Adverse actions are defined as denial or withdrawal of recognition. The following conditions and policies apply:

1. Providers who are denied recognition have the opportunity to appeal the decision of the Review Committee if they believe the decision to be capricious, arbitrary, or prejudicial. Appeals may not be based on the length of the recognition period, disagreement with the PRP's Standards/Criteria for Recognition, or solely on the desire to provide additional information to the Committee.

2. The appellate body, i.e., the Council on Dental Education, must be notified by certified mail of the provider's intent to appeal the Review Committee's action to deny or withdraw recognition. Such notice must occur no later than 30 days following the provider's receipt of its notice of the adverse action.

3. Appeals will be heard by the Council on Dental Education at its next regularly scheduled meeting. The provider will be required to submit an Appeal Fee of $100.00 when the appeal is filed or a minimum of four weeks prior to the scheduled appeal. The appeal may include an appearance before the Council on Dental Education and other due process steps described in the PRP's Policy and Procedures on Appeals [to be developed]. The decision of the Council is final.

Voluntary Nature of the Provider Recognition Program

The Provider Recognition Program is voluntary. Neither the Review Committee on Continuing Dental Education nor the dental profession will coerce or exert pressure on any CE provider to participate in the program. Any decision not to participate in the program will be respected.

Neither the PRP Steering Committee nor the Review Committee on Continuing Dental Education will release in any form the name of a CE provider which has not applied for, or has applied for but not received, recognition. All inquiries as to the recognition status of a specific provider will be answered by referral to the published list of recognized CE providers. The continuing education provider is recognized in the following forms:

1. A recognition certificate is presented to the provider.

2. The recognized provider is authorized and encouraged to use a standard statement indicating its recognition status in course brochures and other materials publicizing its courses.

A current roster of recognized CE providers is published for distribution, and may appear periodically in The Journal of the American Dental Association as well as in other state and local dental publications. Additionally, the current roster will be provided to state dental boards, constituent dental societies, allied dental organizations and other dental professional organizations upon request. These groups may use the results of the PRP program and recognize the PRP-recognized providers in various manners to fulfill their CE interests/obligations.

Eligibility

The Provider Recognition Program is intended to be a unified, national-level program which is voluntary in nature. Although the PRP may be most applicable to those providers that offer CE activities nationally or regionally or that draw attendees from multiple states, because of the voluntary nature of the program, any provider of CE meeting the PRP Standards/Criteria and the following requirements will be eligible for recognition.

A CE provider submitting an application for approval must meet the following eligibility criteria:

1. The CE provider offers a planned program of continuing dental education activities consistent with the definition of continuing dental education provided in Section *** of this document (see page ***).

2. A CE provider must ensure that any clinical courses offered have a sound scientific basis in order that adequate protection of the public is ensured. The PRP reserves the right not to process applications from providers who promote or sponsor continuing education courses that do not have a sound scientific basis, proven efficacy or ensure public safety.

3. Institutions, organizations or major units or departments within an institution/organization (e.g., an oral surgery department of a medical center) are eligible to apply for recognition. Recognition extends only to the CE provider; recognition does not extend to individual courses, programs or lecturers. Nor does recognition extend to publications, audiovisual, home study or other materials developed by recognized providers for CE purposes.

4. To be eligible for recognition, a CE provider must be able to demonstrate that it is targeting its activities to a great extent to dentists by providing dental-oriented topics and course content. Although the PRP will recognize providers and will not make judgments about the content of individual courses, it is the intent of the PRP to recognize those providers that are primarily addressing the CE needs of dentists.

ADA component dental societies are eligible to apply for PRP recognition. Although the PRP may not directly benefit some smaller groups, such as local CE study clubs, such groups are encouraged to explore possible affiliation agreements with their local or state dental societies. Because there may be wide-spread interest in such an affiliation agreement, the PRP Steering Committee will address this issue.

PRP APPLICATION AND EVALUATION PROCEDURES

Applications

To apply for recognition, the provider must complete the "Application for Provider Recognition," a questionnaire which relates to each of the 14 areas addressed in the Standards/Criteria. The application, together with any other required or pertinent data, is submitted for evaluation by the PRP Review Committee on Continuing Dental Education.

Recognitions

The maximum term of recognition shall not exceed five years. Shorter terms of recognition may be awarded if deficiencies or concerns justify an earlier reevaluation date. In these cases, the reason(s) for a shorter period of recognition will be identified and transmitted to the provider. In no case will recognition be granted for a period of less than one year.

(continued)

All PRP-recognized continuing dental education providers shall be designated "recognized providers" for the length of their period of recognition.

Recognition of a provider does not imply recognition or approval of that provider's satellite organizations, cooperating agencies or divisions.

Any reference by a recognized provider to recognition by the PRP Committee in its announcements, promotional materials, publications or any other form of communication shall conform exactly to one of the following:

1. "(name of provider) is designated as a nationally recognized provider by the Provider Recognition Program conducted under the auspices of the American Dental Association (ADA). The current term of recognition extends from (date to date)." [Any comments/complaints should be forwarded to the PRP in care of the ADA.]

-- OR --

2. Recognized National Provider
Provider Recognition Program
[File any complaints with the PRP in care of the American Dental Association]

If the second alternative is used, the entire notice must appear in the same type size and color. The terms "accreditation" or "accredited" must not be used in conjunction with PRP recognition. Information related to filing comments or complaints may also be included on the provider's course evaluation form.

An official list of providers recognized by the Provider Recognition Program will be published and updated whenever there are additions, deletions or status changes, usually at six (6) month intervals. This list will be routinely distributed without charge to all organizations participating in the PRP; the list will be distributed to other interested groups and/or individuals upon request.

Confidentiality

The Provider Recognition Program will not release in any form the name of any continuing dental education provider that:

1. has initiated contact with the PRP Review Committee on Continuing Dental Education concerning application for recognition;

2. has applied for recognition but has not yet been apprised of a decision;

3. has applied for and been denied recognition.

Further, the PRP Review Committee on Continuing Dental Education will not confirm that a CE provider has not applied for recognition, or provide details regarding any weaknesses of a CE provider that has been recognized. All inquiries as to the recognition status of a specific CE provider will be answered by referral to the published, official list of PRP-recognized providers.

The Provider Recognition Program reserves the right to notify members of its participating organizations in the event that a provider's recognition is withdrawn, or if a provider's recognition status changes, or if a provider uses false or misleading statements regarding its PRP recognition.

Regulations Governing the Recognition Process

1. All providers interested in recognition by the PRP Committee must complete a PRP Application form and submit it to the PRP Review Committee on Continuing Dental Education for consideration. Application deadlines shall be regularized and published, and shall fall approximately three months prior to meetings of the Review Committee.

2. Within 14 days after receipt of the Application for Provider Recognition, its receipt will be acknowledged.

3. Within 30 days after receipt of the Application for Provider Recognition, it will be reviewed to determine 1) provider eligibility (based on the stated eligibility criteria) and 2) completeness of information submitted. If problems are identified, the provider will be notified that:

   a. it is ineligible to apply for recognition, and be advised to either withdraw the application or revise it to demonstrate eligibility.

   b. certain required information is missing from the Application and that this information must be submitted prior to consideration by the Review Committee.

4. The Application will be considered at the next regularly scheduled meeting of the Review Committee on Continuing Dental Education. If the Review Committee determines that the application does not provide adequate information on which to base a recognition action, the Committee may seek additional information from the applicant provider or from alternative sources.

   The Review Committee reserves the right to survey program participants or to collect supportive data through any means considered necessary to facilitate a recognition decision.

   The CE provider may request, at its own expense, an appearance before the Review Committee to provide additional information about its Application for Recognition and/or CE activities.

5. Applicant CE providers will be notified of the action taken by the Review Committee within 30 days after a recognition action is taken.

6. The effective date of recognition is the month in which action is taken by the Review Committee on Continuing Dental Education. In no case will recognition be granted retroactively or prior to action taken by the full Review Committee. The length of recognition will be clearly stated in the letter that transmits the Review Committee's action to the provider, but will not exceed five (5) years.

   If recognition is granted, the provider will be provided with the following information:

   a. the effective dates of the recognition;
   b. a statement that must be used to announce or publicize PRP recognition;
   c. an assigned provider code for use in reporting attendance at activities;
   d. responsibilities and procedures for reporting attendance at activities;
   e. general procedures and timeframes regarding expiration of recognition and reapplication;
   f. recommendations (required) and suggestions (optional) for improvements in the provider's CE program.

(continued)

Although recognition is granted for a specific time period, the recognition may be contingent on the submission of one or more progress reports at specified intervals. The PRP Review Committee on Continuing Dental Education reserves the right to reevaluate a provider at any time by surveying participants in the provider's CE activities, by reviewing activities in person, or by requiring additional information concerning the provider and/or its activities.

7. Recognition will be denied if there is non-compliance with the PRP Standards/Criteria for Recognition. If recognition is denied, the applicant provider will be provided with the following by return receipt mail:

   a. identification of the specific standards/criteria with which the Review Committee found noncompliance;

   b. recommendations (required) and suggestions (optional) for alterations and/or improvements in the recognized provider's continuing dental education program;

   c. rules and mechanisms governing appeal of the Review Committee on Continuing Dental Education's decision.

8. Recognition will be withdrawn by the Review Committee on Continuing Dental Education for the following reasons:

   a. when a voluntary request is received from the recognized provider.

   b. when the Review Committee finds noncompliance with the PRP Standards/Criteria for Recognition. Specific reasons for the action will be identified for the provider.

   c. when continuing dental education activities have not been offered for a period of two years or more.

   d. for non-payment of required fees.

Complaints

Formal written complaints about recognized CE providers will be reviewed by the Review Committee on Continuing Dental Education if the complaint documents noncompliance with the Standards/Criteria for Recognition. Complaints can be forwarded to the Review Committee by course participants, course faculty or other CE providers. Upon receipt of such a formal complaint, the Review Committee will initiate a formal review of the provider's recognition status. Such reviews will be conducted in accord with the PRP's policy on this matter [to be modeled after current Commission on Dental Accreditation policy]. Procedures that ensure due process will be followed.

A recognized provider may also be reevaluated at any time if information is received from the provider or other sources that indicates the provider has undergone changes in program administration or scope, or may no longer be in compliance with the Standards/Criteria for Recognition.

Continued Recognition of Previously Recognized Providers

The re-recognition process begins about 12 months prior to the designated recognition expiration date. The Review Committee notifies recognized CE providers and sends them information about the re-recognition procedures, including a specific time line. Application deadlines shall be regularized and published, and shall fall approximately three months prior to meetings of the Review Committee.

Providers must submit a new Application for Provider Recognition no less than three (3) months prior to the date that the provider's recognition will expire. In addition to the formal Application for Recognition, the provider must submit any other specifically identified materials documenting its continued compliance with the PRP Standards/Criteria for Recognition, as well as improvements in any previously-identified areas of deficiency or weakness.

If a provider will be promoting courses scheduled to be presented after the recognition expiration date, the provider is encouraged to submit a renewal application early to ensure that the recognition statement printed on such promotional materials will be accurate.

Fees

All recognized CE providers will pay an annual fee, as well as a modest Application fee for initial and continued recognition. Fees will be set by the Review Committee on Continuing Dental Education and will be based on the operating expenses of the PRP.

Fees for initial and continued recognition must be paid when the Application of Recognition is submitted. Annual fees are due each year on or before January 1. The following fees have been proposed as the initial PRP fees:

Annual fee -- $300
Application fee -- $200

Non-payment of all required fees within the thirty (30) day grace period following the established deadline(s) will be viewed as a decision by the CE provider to voluntarily withdraw from the Provider Recognition Program. The name of the previously recognized provider will be removed from the Current List of Recognized Providers when it is next published.

Any provider wishing to reinstate its recognition following discontinuation for non-payment of fees will be required to submit an Application form and follow the procedures for continued recognition. [Additional procedures related to payment of fees may be developed by the PRP Steering Committee.]

Appendix 2

STANDARDS/CRITERIA FOR RECOGNITION

Applicant continuing dental education providers must demonstrate compliance with published Standards/Criteria for Recognition in 14 different areas to obtain and then retain recognition. These published Standards/Criteria are accompanied in most areas by Recommendations. Although these Recommendations are suggestions, not requirements for recognition, they provide guidance that can improve the provider's continuing dental education program or make its administration easier.

I. Mission/Goals

Standards

1. The provider must develop, and operate in accordance with a written statement of its broad, long-range goals/mission related to the continuing education program.

2. The goals/mission must relate to the health care needs of the public and/or interests and needs of the profession.

(continued)

Criteria

A. The individual or authority responsible for administration of the continuing education program must have input into development of the overall program goals/mission.

B. There must be a clear formulation of the overall goals of both (a) the providing institution or organization, and (b) the entire continuing education program.

Recommendations

C. The goals/mission of the continuing education program should be consistent with the goals of the organization or institution.

D. The goals of the continuing education program should be relevant to the educational needs and interests of the intended audience.

E. A mechanism should be provided for periodic reappraisal and revision of the provider's continuing education goals.

II. Needs Assessment

Standards

1. Providers must use identifiable mechanisms to determine objectively the current professional needs and interests of the intended audience, and the content of the program must be based upon these needs.

Criteria

A. The program planner must be responsible for carrying out or coordinating needs assessment procedures.

B. Identified needs/interests must be developed from data sources that go beyond the provider's own perceptions of needs/interests.

C. The provider must document the process used to identify needs/interests.

D. The provider must state the needs/interests identified and indicate how the assessment is used in planning educational activities.

Recommendations

E. The provider must involve members of the intended audience in the assessment of their own educational needs/interests.

The needs assessment method used is not critical, provided it serves the purpose of consulting (or otherwise gaining insight into) the needs and interests of the potential audience. Advisory committees representing a cross section of the intended audience or constituency can be effective. Surveys may be conducted by mail, by phone, or during specific continuing education activities.

Cooperative efforts to gather and/or use needs assessment data are recommended, if appropriate. Where intended audiences are the same, use of another organization's needs assessment data may provide much better information than the provider's resources would otherwise allow.

III. Objectives

Standards

1. Explicit written educational objectives must be developed for each activity and published in advance for the intended audience.

Criteria

A. The program planner must be ultimately responsible for ensuring that appropriate objectives are developed for each activity. The educational objectives may, however, be prepared by instructor, course director or program planner.

B. Educational objectives must be developed for each activity during the earliest planning stages. These provide direction in selecting specific course content and choosing appropriate educational methodologies.

C. The written educational objectives must be published and distributed to the intended audience as a mechanism for potential attendees to select courses on a sound basis.

Recommendations

D. Educational objectives should form the basis of evaluating the effectiveness of the learning activity.

Specific educational objectives should describe the expected outcome(s) of the learning experience. They may include, but are not limited to, the following categories: (1) changes in the attitude and approach of the learner to the solution of dental problems; (2) corrections of outdated knowledge; (3) provision of new knowledge in specific areas; (4) introduction to and/or mastery of specific skills and techniques; and (5) alteration in the habits of the learner. Accurate educational objectives succinctly describe the education that will result from attending the course.

IV. Evaluation

Standards

1. The provider must develop and use activity evaluation mechanisms that:

   a. are appropriate to the objectives and educational methods;

   b. measure the extent to which course objectives have been accomplished;

   c. assess course content, instructor effectiveness, and overall administration.

Criteria

A. The provider must use an evaluation mechanism that will allow participants to assess their achievement of personal objectives. Such mechanisms must be content-oriented and must provide feedback to participants so that they can assess their mastery of the material. This is especially important if the activity is self-instructional in nature. The educational objectives for the activity should form the basis for the evaluation.

B. The provider must use an evaluation mechanism that will help the provider assess the effectiveness of the continuing education activity and the level at which stated objectives were fulfilled, with the goal being continual improvement of the provider's activities.

(continued)

C. The provider must periodically conduct an internal review to determine:

   a. the extent to which the goals are being achieved;

   b. the extent to which activity evaluation effectively and appropriately assesses:

      1. educational objectives;

      2. quality of the instructional process;

      3. participants' perception of enhanced professional effectiveness;

   c. if evaluation methods are appropriate to and consistent with the scope of the activity;

   d. how effectively activity evaluation data are used in planning future continuing education activities.

Recommendations

D. Minimally, the evaluation mechanisms should:

   a. be appropriate to the educational objectives and methods for the activity;

   b. measure the extent to which objectives have been met;

   c. determine participant assessment of course content with regard to whether it was practically useful, comprehensive, appropriate, and adequately in-depth;

   d. assess instructor effectiveness;

   e. assess adequacy of facilities;

   f. assess overall administration of the activity.

E. The provider should give feedback to the instructor concerning the information produced by evaluation of the continuing education activity.

V. Commercial or Promotional Conflict of Interest

Standards

1. Recognized CE providers are responsible for ensuring the content quality and scientific integrity of all continuing dental education activities for which credit is provided (see Standard XIV). Recognized CE providers are also responsible for taking specific steps to protect against and/or disclose any conflict of interest of the faculty/instructors presenting those courses.

2. When a continuing dental education course contains a commercial or promotional component, recognized providers must ensure that a balanced view of all therapeutic options is presented. Whenever possible, generic names must be used to contribute to this impartiality. If trade names are used, those of several companies must be used rather than only that of a single sponsoring company.

3. The ultimate decision regarding funding arrangements for continuing dental education activities must be the responsibility of the recognized CE provider. Continuing dental education activities may be supported by funds received from external sources if such funds are unrestricted. The external source may not select the faculty or approve the specific content of the sponsored educational experience.

4. Recognized providers must ensure the quality and content, and accept responsibility for the use of instructional materials or post-program documents that are prepared with outside financial support.

Criteria

A. Recognized CE providers must develop "Guidelines for Conflict of Interest or Full Disclosure." These guidelines must not conflict with the PRP's Standards/Criteria for Recognition. Each CE learning experience offered must conform to this policy.

B. Commercial support of CE programs and/or commercial research support must be acknowledged in printed announcements, brochures or other educational materials, although reference must not be made to specific products or commercial techniques.

C. The following are examples of outside or commercial support that is customary and proper:

* payment of reasonable honoraria
* reimbursement of out-of-pocket expenses for faculty
* modest meals or social events held as part of the educational activity

D. Following each subsidized continuing dental education activity, the recognized CE provider and the commercial supporter or other relevant parties, should each report to the other on the expenditure of funds each has provided. Documentation of the expenditure of funds must be provided for review as part of the provider re-recognition process.

Recommendation

E. The recognized CE provider should offer courses that address appropriate didactic topics and clinical learning experiences and refrain from topics and learning experiences which are commercial, promotional or appear to be intended for the purpose of endorsing either a specific commercial drug, product, treatment method or service (as contrasted with generic products, drugs, therapies or services).

VI. Educational Methods

Standards

1. Educational methods must be appropriate to the stated objectives for the activity.

2. Where participation is involved, enrollment must be related to available resources to ensure effective participation by enrollees.

Criteria

A. The continuing education program planner must be responsible for choosing the educational methods to be used in consultation with advisory committees, instructors, educational advisors, or potential attendees.

B. Educational methods must be appropriate to the characteristics or composition (especially skill level) of the intended audience.

C. Educational methods must be appropriate to the facilities used for the activity.

D. The continuing education program planner must have a written description of the methods to be used, which will assist in effective planning as well as evaluation of the activity.

(continued)

E. For participation activities, group size must be limited in coordination with the nature of available facilities and the number of instructors/evaluators. Very careful attention to group size is mandatory when planning an activity that requires participants to perform complex tasks requiring supervision and evaluation.

F. For self-instructional activities, provision must be made for participant feedback and interchange with individuals having expertise in the subject area. A mechanism by which the learner can assess his/her mastery of the material must be supplied.

G. Self-instructional activities that are primarily audio and audiovisual in nature must be augmented by additional written materials that serve the purpose of summarizing, further explaining, or clarifying the audio or audiovisual material, and which provide references that can be pursued for further study in the subject being addressed by the activity.

Recommendations

H. For self-instructional activities, use of audiovisual materials may offer valuable learning experiences when their usefulness as a means, rather than an end, is appreciated.

Providers who plan self-instructional activities should ensure the input of individuals having technical expertise in both media and self-directed learning techniques, and the application of these techniques to adult learning.

The size of the potential audience for any continuing education activity is important in determining appropriate methods. A potentially active method can become purely passive if the group is too large.

Methods requiring learner involvement (seminars, discussion groups, case reviews/preparations, laboratory work and patient treatment) have been shown to provide more effective learning experiences.

The appropriate use of films, slides, television, and other teaching aids can support and enhance other teaching methods if they are integrated into a planned educational program, rather than used as the sole method of instruction.

Providers are encouraged to give attendees resource materials and references to facilitate post-course practical application of course content, as well as continued learning.

VII. Instructors

Standards

1. Instructors chosen to teach courses must be qualified by education and experience to provide instruction in the relevant subject matter.

2. The number of instructors employed for a continuing education activity must be adequate to ensure effective educational results.

Criteria

A. Providers must assume responsibility for communicating specific course objectives and design to instructors early in the planning process.

B. The number of instructors assigned to any activity must be predicated upon the course objectives and the educational methods used.

C. The instructor/attendee ratio is most critical in participation courses. Great care must be taken to ensure that close supervision and adequate direct interchange between participants and instructors will take place.

Recommendations

D. Providers should be responsible for working closely with instructors during course planning to ensure that the stated objectives will be addressed by the presentation.

E. A wide variety of sources should be explored and used to select qualified instructors.

F. The teaching staff for any continuing education program should consist of dentists and other professionals in related disciplines who have demonstrated ability, training and experience in the relevant fields.

G. Instructors should also possess the demonstrated ability to communicate effectively with professional colleagues, and possess an understanding of the principles and methods of adult education.

H. Expertise and assistance in development and use of instructional materials and aids, when needed, should be available to support the teaching staff.

I. Providers should develop clearly-defined policies on honoraria and expense reimbursement for instructors.

VIII. Facilities

Standards

1. Facilities selected for each activity must be appropriate to accomplish:

   a. the intended educational method(s);

   b. the stated educational objectives.

Criteria

A. The recognized CE provider must be responsible for ensuring that facilities and equipment (including those borrowed or rented) are adequate and in good working condition, so that instruction can proceed smoothly and effectively.

B. CE providers must assume responsibility for the compliance by attendees with applicable laws and regulations. The provider must ensure that participation in its program by dentists not licensed in the jurisdiction where the program is presented does not violate the state practice act. Unless malpractice coverage for attendees participating in clinics is arranged by the CE provider, notice must be given to attendees to obtain written commitments of coverage from their carriers.

C. Adequate space and equipment must be provided to accommodate the size of the intended audience.

D. For participation courses, sufficient space and equipment (and patients, if used) must be available to allow active participation by each learner without any learner experiencing undue idle time.

E. If attendees are required to provide materials and equipment, the provider must make this requirement clear to potential enrollees, and the provider must provide enrollees with specific descriptions of all equipment and materials required.

(continued)

IX. Administration

Standards

1. Administration of the program must be consistent with:

   a. the goals of the program;

   b. the objectives of the planned activities.

2. The program must be under the continuous guidance of an administrative authority and/or individual responsible for its current and future content and its quality.

Criteria

A. The continuing education program must be under the ongoing supervision of an individual or an administrative authority so that there is continuity in the provider's continuing education efforts.

B. The administrative authority must have the responsibility for ensuring compliance with the quality contained in these standards and guidelines.

C. To maintain continuity, the provider must develop specific procedures for personnel changes. This is particularly important with regard to the program planner.

D. The program planner must commit sufficient time to planning and conducting the continuing education program relative to its planned size and scope of activity.

E. Where the size or extent of the continuing education program warrants, there must be provision for adequate support personnel to assist with program planning and implementation.

F. The administrative authority must be responsible for maintaining accurate records of participants' attendance. The administrative authority must be responsible for retaining information on the formal planned activities offered, including needs assessment, methods, objectives, course outlines, and evaluation procedures. This information must be available at the time of application or reapplication for provider recognition.

Recommendations

G. The responsibilities and scope of authority of the individual or administrative authority must be clearly defined.

H. The program planner should have background and experience appropriate to the task.

I. Continuity of administration and planning is necessary for the stability and growth of the program. It is recommended that:

   a. members of the administrative authority or advisory committee be selected for a term of longer than one year;

   b. members of the administrative authority or advisory committee serve staggered terms of office.

Determination of the adequacy of a provider's administration to its program's goals and its activities' objectives will necessarily be based on the Provider Recognition Review Committee's evaluation of each provider's individual situation. The Review Committee will evaluate administration in the following areas:

a. clarity of lines of authority and responsibility;
b. strength of planning process;
c. adequacy of the qualifications and quantity of personnel to manage the program;
d. continuity of administration.

Ongoing supervision of the continuing education program by an individual or administrative authority provides continuity for a provider's efforts, and experience has shown that better educational experiences are the result.

Administrative responsibility for development, distribution, and/or presentation of continuing education activities rests with the PRP-recognized provider whenever the provider acts in consort with providers that are not recognized by the PRP.

When two or more PRP-recognized providers act in consort to develop, distribute and/or present an activity, each will be equally and fully responsible for ensuring compliance with these standards.

X. Fiscal Responsibility

Standard

1. Resources must be sufficient to meet:

   a. the goals of the program;
   b. the objectives of the planned activities.

Criteria

A. Adequate resources must be available to fund the administrative and support services necessary to manage the continuing education program.

B. In instances where continuing education is only one element of a provider's activities, resources for continuing education must be a clearly identifiable component of the provider's total budget and resources.

C. The provider must provide a budget for the overall continuing education program, to include all costs and income, both direct (e.g., honoraria, publicity costs, tuition fees, refunds, or foundation grants) and indirect (e.g., use of classroom facilities or equipment, unpaid instructor time, etc.)

D. Financial aid must be acknowledged in printed announcements and brochures.

E. Printed announcements and brochures must not make reference to specific products.

Recommendations

F. Resources must be adequate for the continual improvement of the program.

G. Separate budgets for each activity should be prepared as guidelines, but institutional or organizational policies requiring that each individual activity to be prepared be self-supporting tend to restrict the quality of the continuing education program unduly, and are discouraged.

XI. Publicity

Standards

1. Publicity must be informative and not misleading. It must include:

(continued)

a. course title;
b. a description of course content;
c. the educational objectives;
d. a description of teaching methods to be used;
e. costs;
f. the name of the provider and contact person;
g. course instructor(s) and their qualifications;
h. refund and cancellation policies;
i. location;
j. date/time;
k. specifics as to the provider's recognition status and number of credits available.

2. For effective presentation and assimilation of course content, the prior level of skill, knowledge, or experience required (or suggested) of participants must be clearly specified in publicity materials.

Criteria

A. Any publicity on continuing education activities must provide complete and accurate information to the potential audience.

B. Care must be taken to avoid misleading statements regarding the nature of the activity or the benefits to be derived from participation.

C. Accurate statements concerning credits for the activity and the provider's recognition status must be included. Great care must be taken to ensure that such statements follow the wording prescribed by the agency granting the credits or recognition so that participants do not misinterpret them.

D. The name of the provider, as well as any organization or agencies providing financial support, must be clearly stated.

Recommendations

E. The attendees' expectations concerning course content and anticipated learning are based on course publicity. Complete and detailed publicity materials will help ensure that those who want and need the course will attend, and that they will be motivated to learn. Materials containing less than complete and accurate information will almost always result in disappointment and dissatisfaction on the part of all or some attendees.

XII. Admissions

Standards

1. In general, continuing education activities must be available to all dentists.

2. If activities require previous training or preparation, the necessary level of knowledge, skill or experience must be specified in course announcements.

Criteria

A. As an activity is designed, the program planner, in cooperation with the course director or instructor, may determine that previous training or preparation is necessary for learners to participate effectively in the activity. In all such cases, the provider must (1) provide a precise definition of knowledge, skill or experience required for admission; (2) demonstrate the necessity for any admission restriction, based on course content and educational objectives; and (3) specify in advance, and make available a method whereby applicants for admission may demonstrate that they have met the requirement. Such methods must be objective, specific and clearly related to the course content and stated requirements.

Recommendations

B. Where activities are offered at an advanced level, providers are encouraged to provide sequentially planned instruction at basic and intermediate levels, to allow participants to prepare for the advanced activity.

Though providers are not obligated to provide continuing education activities for all dental occupational groups, admission policies that discriminate arbitrarily among individuals within an occupational group, without sound educational rationale, are not acceptable.

XIII. Patient Protection

Standards

1. Participants must be cautioned about the potential risks of using limited knowledge when integrating new techniques into their practices.

2. Where patient treatment is involved, either by course participants or instructors, patient protection must be ensured as follows:

   a. the provider must seek assurance prior to the course, that participants possess the basic skill, knowledge, and expertise necessary to assimilate instruction and perform the treatment techniques being taught in the course.

   b. informed consent from the patient must be obtained in writing prior to treatment.

   c. appropriate equipment and instruments must be available and in good working order.

   d. adequate and appropriate arrangements and/or facilities for emergency and postoperative care must exist.

Criteria

A. Participants should be cautioned about the potential risks of incorporating techniques and procedures into their practices if the course has not provided them with adequate, supervised clinical experience in the technique or procedure to allow them to perform it competently.

B. The provider must assume responsibility for ensuring that participants treating patients (especially those from outside the state/province where the course is held) are not doing so in violation of state dental licensure laws.

C. The provider must obtain the informed consent of all patients.

D. Patients must be informed in non-technical language of:

   a. the training situation;
   b. the nature and extent of the treatment to be rendered;
   c. any benefits or potential harm that may result from the procedure;
   d. available alternative procedures;
   e. their right to discontinue treatment.

E. The provider must assume responsibility for completion of treatment by a qualified clinician, should any question of the course participant's competence arise.

F. There can be no compromise in adequate and appropriate provisions for care of patients treated during continuing education activities. Aseptic conditions, equipment and instruments, as well as emergency care facilities, must be provided.

(continued)

G. Sufficient clinical supervision must be provided during patient treatment to ensure that the procedures are performed competently.

H. The provider must assume responsibility for providing any necessary post course treatment, either through the practitioner who treated the patient during the course, or through some alternative arrangement.

Recommendations

I. In order to meet course objectives, patients should be screened prior to the course to ensure the presence of an adequate number of individuals with conditions requiring the type of treatment relevant to the course content.

J. Providers, instructors and participants must have liability protection.

K. Providers are advised to consult legal counsel regarding informed consent requirements in their locale and appropriate procedures for obtaining patient consent.

XIV. Record Keeping

Standards

1. Providers must issue accurate records of individual attendance to attendees. Each attendee is responsible for maintaining his/her own records and for reporting his/her CE activities to all appropriate bodies in accord with any jurisdictional and/or membership requirements.

2. Any record granted in connection with the continuing education activity must not be, nor resemble, a certificate or diploma.

3. Credit awarded to participants of a recognized provider's educational activity must be calculated as follows:

    a. For formal structured lectures, credit will be awarded based on the actual number of contact hours (excluding breaks, meals and registration periods). No credit will be awarded if the course is less than one hour in duration.

    b. For courses in which a significant portion of course content involves the participant in the active manipulation of dental materials or devices, the treatment of patients or other opportunities to practice skills or techniques under the direct supervision of a qualified instructor, participation credit will be awarded based on the actual number of contact hours (excluding breaks, meals and registration periods).

    c. Individuals who complete audio or audiovisual self-instructional programs should receive credit equal to twice the length of the instructional time on the program's cassette, film, or videotape, for a minimum of two hours of credit.

    d. Individuals who complete written self-instructional programs should receive a minimum of two hours of credit for each program and a maximum of eight credit hours per program segment.

Recommendations

A. Providers should be aware of the professional and legal requirements for continuing dental education that may affect their participants.

B. Providers should cooperate with course participants and with regulatory or other requiring agencies in providing documentation of course attendance, as necessary.

C. Such records and documentation should clearly indicate at least:

   a. the name of the CE provider;
   b. the date(s) of the activity;
   c. the title of the activity and/or specific subjects;
   d. educational methods used (e.g., lecture, videotape, clinical participation);
   e. number of credit hours awarded (excluding breaks and meals).

D. The documentation must not resemble a diploma or certificate that attests, or might appear to attest, to specific skill, or specialty or advanced educational status. Great care must be taken in designing such documentation to avoid misinterpretation by the public or professional colleagues.

LEXICON OF TERMS

Many discussions of continuing dental education result in misinterpretation or confusion because frequently-used terms may be defined differently in the context of continuing education (CE). To clarify the intent of this document, the following terms are defined as they will be used in relation to continuing dental education. CE providers should familiarize themselves with these definitions to ensure complete understanding of information provided in this document.

ACTIVITY: An individual educational experience such as a lecture, clinic or home-study package. (See COURSE)

CONTINUING DENTAL EDUCATION: Educational activities designed to review existing concepts and techniques, to convey information beyond basic dental education and to update knowledge on advances in dental and medical sciences. The objective is to improve the knowledge, skills and ability of the individual to deliver the highest quality of service to the public and profession. The basic sciences and behavioral and social sciences should be considered inseparable from technical knowledge in their influence on the professional person, and for this reason, educational experiences in these areas are an equally valid part of continuing dental education.

Continuing education programs are usually of short duration and are not structured or sequenced to provide academic credit toward a certificate or degree. Such courses are not applicable to advanced standing in specialty education programs. Continuing education courses are conducted in a wide variety of forms using many methods and techniques and are sponsored by a diverse group of institutions, schools and organizations. Continuing education should favorably enrich past educational experience. These programs should make it possible for dentists and allied team members to attune dental practice to modern knowledge as it continuously becomes available. All continuing education should strengthen the habits of critical inquiry and balanced judgement that denote the truly professional and scientific person.

COURSE: A type of continuing education activity; usually implies a planned and formally conducted learning experience. (See ACTIVITY)

EDUCATIONAL METHODS, METHODOLOGIES: The systematic plan or procedure by which information or educational material is made available to the learner. Some examples include lecture, discussion, practice under supervision, audiovisual self-instructional units, case presentations, and so on.

(continued)

GOAL: A statement of long-range expectations of a continuing dental education program. (See OBJECTIVE)

NEEDS ASSESSMENT: The process of identifying the specific information or skills needed by program participants and/or interests of the program participants, based on input from participants themselves or from other relevant data sources. The specific needs thus identified provide the rationale and focus for the educational program.

OBJECTIVE: Anticipated outcome of a specific continuing dental education learning experience or instructional unit, stated in behavioral or action-oriented terms. (See GOAL)

PROGRAM: The total efforts of a sponsoring organization as they relate to continuing dental educational activities offered to professional audiences.

PROGRAM PLANNING: The total process of designing and developing continuing education activities. This process includes assessing learning needs, selecting topics, defining educational objectives, selecting faculty, facilities and other educational resources, and developing evaluation mechanisms. All steps in the program planning process should be aimed at promotion of a favorable climate for adult learning.

PROVIDER: An agency (institution, organization or individual) that is responsible for organizing, administering, publicizing, presenting, and keeping records for the continuing dental education program. The CE provider assumes both the professional and fiscal liability for the conduct and quality of the program. If the CE provider contracts or agrees with another organization or institution to provide facilities, faculty or other support for the continuing education activity, the recognized provider must ensure that the facilities, faculty or support provided meet the Standards/Criteria for Recognition. The CE provider remains responsible for the overall educational quality of the continuing education activity.

RECOGNITION: Recognition is conferred upon CE providers or sponsoring organizations which are judged to be conducting a continuing dental education program in compliance with the Standards/Criteria for Recognition. (The term "accreditation" is not used in the context of continuing dental education, as "accreditation" has a precise educational meaning that implies that an on-site review based on curricular or patient service standards has been conducted by an accrediting agency recognized by the U.S. Department of Education or the Council on Postsecondary Accreditation. The review process used by the Provider Recognition Program does not meet these specific criteria.)

RECOMMENDATIONS: Detailed suggestions and/or assistance in interpreting and implementing the Standards/Criteria for Recognition. (See STANDARDS/CRITERIA FOR RECOGNITION)

STANDARDS/CRITERIA FOR RECOGNITION: The criteria which applicant continuing dental education providers will be expected to meet in order to attain and then retain recognition status. (See RECOMMENDATIONS) The verbs used in the Standards/Criteria for Recognition (i.e., must, should, could, may) were selected carefully and indicate the relative weight attached to each statement. Definitions of the words which were utilized in preparing the standards are:

1. Must expresses an imperative need, duty or requirement; an essential or indispensable item; mandatory.

2. Should expresses the recommended manner to meet the standard; highly recommended, but not mandatory.

3. May or could expresses freedom or liberty to follow an idea or suggestion.

Appendix 3

PROVIDER RECOGNITION PROGRAM
APPLICATION

GENERAL INFORMATION

Official Name of Applicant Sponsor: _____

Address: _____
Street

_____
City State Zip Code

Telephone: (_____) _____

Individual to Whom Future Correspondence Regarding this Application Should be Addressed:

Name:_____

Title:_____

Address: _____
Street

_____
City State Zip Code

Telephone: (_____) _____

Indicate the length of time CE activities have been offered:
_____number of years.

Reviewed and approved by: (signature/title of person responsible for accuracy and completion)

_____

_____
(date)

SECTION I

Please complete the information as requested in each column of the List of CE Activities that follows (page 3). Include any cancelled activities as well as self-instructional programs. For a specially programmed activity, such as a dental organization's annual meeting, you may attach a meeting program. However, if you do so, you must:

1) indicate those courses that were cancelled by either listing cancelled sessions or by writing the word "cancelled" across the description in the program;

2) include attendance at participation courses. Participation can be written on a separate sheet or in the margin of the program;

3) note any courses where prerequisites were required.

The committee will use this information to determine the scope of your program, the audience which it attracts, and your performance as related to criteria concerning faculty/student ratio.

(continued)

LIST OF CE ACTIVITIES IN THE LAST TWELVE MONTHS

Applicant Name: _____

Title of Activity	Date(s) Offered	Location/ Setting	* Intended Audience	Number of Partici-pants	Number of Course Instructors on Site	** Method of Delivery	Co-sponsors	Credit Hours

(Please make additional copies of this sheet as needed)

*** Intended Audience - abbreviations:**
G-General Dentists; **S**-Dental Specialists; **DH**-Dental Hygienists; **DA**-Dental Assistants; **DL**-Dental Laboratory Technicians; **OP**-Other Professionals

**** Method of Delivery - abbreviations:**
L-Lecture, formal CE of at least one hour in duration. **P**-Participation, at least 30% of course time involves practice of skill. **SI**-Self-Instructional, audio, audio-visual and written correspondence courses meeting guidelines which require ancillary materials and a post-test mechanism.

SECTION II

In this section, the Provider Recognition Committee is looking for general information on the CE program of the sponsor. The information requested is relevant to each of the Recognition Standards/Criteria in 14 different areas. For clarification, please refer to the Standards as you complete each section. Applicant CE providers will be evaluated according to the Standards/Criteria to determine appropriate recognition actions.

I. MISSION/GOALS

A. State the overall mission of the sponsoring institution or organization:

_____
_____
_____
_____

B. State the broad long-range goals of the continuing dental education program:

_____
_____
_____
_____

1) How does the individual or authority responsible for administration of the CE program have input into development of the overall program goals?

_____
_____
_____

2) How frequently are goals reviewed? By whom?

_____
_____
_____

II. NEEDS ASSESSMENT

A. Which of the following methods are used to assess needs and interests? Indicate how often each method checked is used.

Methods used:	How often?
[] survey/questionnaire*	_____
[] course evaluation form*	_____
[] verbal feedback during course	_____
[] advisory committee input	_____
[] advice from professional	_____
[] public health statistics or other pertinent patient care data	_____
[] other:_____	_____ (specify)

* If you checked one of these items, a sample copy is required.

B. How are the results of needs/interest assessment efforts used in future program planning? (Use additional sheets to explain, if necessary.)

_____
_____
_____
_____
_____
_____

III. OBJECTIVES

A. Are specific objectives (learner outcomes) developed for each CE program?

[] Yes [] No

If no, please explain: _____
_____

B. Who is responsible for the development of objectives?

_____
_____

C. Please attach four (4) sample copies of your objectives for any <u>one</u> of your continuing education programs.

D. Objectives are made available to potential participants in the following way (check all that apply):

[] course brochures or announcement
[] course hand-out materials
[] presented verbally by course presenter at outset of course
[] other:_____
_____
(please describe)

(continued)

IV. EVALUATION

A. Which of the following were course participants asked to evaluate in the last 12 months? (Append sample copies of forms used for this purpose.)

[] course content
[] instructor
[] course handout materials
[] facilities
[] administrative arrangements
[] how well course met participants' expectations
[] use of educational aids (slides, transparencies, films)

B. Which of the following methods are used by the sponsor to measure participant achievement of course objectives? (Check all that apply and append samples of any forms used for this purpose.)

[] pretest and post-test
[] observations by course instructor during participation course
[] debriefing following course
[] follow-up survey
[] other: _____
(specify)

C. What feedback is provided to instructors following the program evaluation by course participants?

_____
_____
_____

D. How are the results of the evaluation utilized in improving future CE activities?

_____
_____
_____
_____

E. What methods are used to determine learners' mastery of the material?

_____
_____
_____
_____

V. COMMERCIALISM OR PROMOTIONAL CONFLICT OF INTEREST

A. Does your organization offer courses for which you receive commercial support?

[ ] No
[ ] Yes (indicate approximate number of courses per year: _____)

B. Has your organization developed "Guidelines for Conflict of Interest or Full Disclosure" that address issues related to disclosure of commercial support and faculty/instructor conflict of interest?

[ ] No
[ ] Yes (A copy of the current "Guidelines" must be attached.)

C. If your organization offers CE courses with a commercial or promotional component or conducts funded CE-related research, attach samples of printed announcements, brochures or other educational materials and highlight/mark the text that acknowledges such support.

D. Describe how you screen potential instructors (as defined in Section VII of this application) for commercial links that would need to be disclosed or any other potential conflicts of interest. Attach a copy of any information form used in this screening process.

_____
_____
_____
_____

E. If your standard instructor contract addresses issues related to disclosure or conflict of interest, provide a copy of the contract and highlight/mark the relevant text.

VI. EDUCATIONAL METHODS

A. How are educational methods (lecture, group discussion, participation or media usage) related to the course objectives?

_____
_____
_____

B. Who selects the educational methods?

_____
_____
_____

C. Describe the way in which your continuing education programs are designed to allow and encourage participants to become actively involved in the learning process.

_____
_____
_____
_____

D. Does your organization offer credit for self-instructional programs?

[] Yes [] No

E. For self-instructional activities, what provisions are made for participant feedback and interchange with individuals having expertise in the subject area?

_____
_____
_____
_____

F. If your organization offers audio, audio-visual, or written self-instructional activities, a sample of the following must be submitted for review:

a. written materials that clarify, summarize, and further explain the taped programs;

b. self-evaluated exercises referenced directly to the text or tape that serve to clarify, summarize and further explain the textual or taped materials;

(continued)

c. references that can be pursued for further study in the subject matter being addressed by the program;

d. the post-test mechanism that determines retention of the material presented.

VII. INSTRUCTORS

Definition: The terms instructor and/or teaching staff are intended to apply to all speakers, clinicians, or presenters at live presentations, as well as those who prepare educational content for self-instructional learning materials.

A. How do you determine whether the instructor is qualified to provide instruction in the relevant subject matter?

_____
_____
_____
_____

B. How is the number of instructors determined for:

1) Laboratory courses:

_____
_____
_____

2) Clinical (patient treatment) courses:

_____
_____
_____

3) Lecture courses:

_____
_____
_____

C. How are course instructors involved in advance planning for the CE activity?

_____
_____
_____

VIII. FACILITIES

A. How do you determine the suitability of the facilities and equipment needed for your CE activities?

_____
_____
_____

B. How do you determine the maximum number of enrollees?

_____
_____
_____

C. Do you limit the number of enrollees based upon the facilities?

[] Yes [] No

D. How are enrollees advised of specific materials needed?

_____
_____
_____

IX. ADMINISTRATION

A. Please list (if appropriate for your organization) the names and titles of all permanent staff of your organization who are responsible for CE. For each of them, estimate the percentage of their annual workload spent on CE activities. Attach an up-to-date job description, if available, for each individual. Mark with an asterisk the name of the individual with primary day-to-day responsibility for the CE program.

Name	Title	% of Time Spent on CE Annually
1.		
2.		
3.		
4.		
5.		

B. Please list the names of the individuals serving on your CE committee or council and indicate academic degrees, if any (DDS, DMD, RDH, MS, PhD, etc.). Mark with asterisk the name of the chairperson of your CE committee or council.

Name of Committee/Council _____

Name	Title	Years of Service on Committee/Council
1.		
2.		
3.		
4.		
5.		

C. Indicate which of the following are responsibilities of the administration or CE committee (check all that apply; if shared by administration and committee check both columns).

Program Admin.	CE Comm.	Other (attach an explanation for each "other" area checked)	
[ ]	[ ]	[ ]	Select continuing education topics
[ ]	[ ]	[ ]	Select instructors or clinicians
[ ]	[ ]	[ ]	Develop educational objectives
[ ]	[ ]	[ ]	Select facilities/sites for CE activities
[ ]	[ ]	[ ]	Budget for CE activities
[ ]	[ ]	[ ]	Advertise CE activities
[ ]	[ ]	[ ]	Maintain records (Standard XIV)
[ ]	[ ]	[ ]	Evaluate quality of program administration and/or instruction

X. FISCAL RESPONSIBILITY

A. What are the sources of funds available for CE programs sponsored by your organization?

(continued)

[] Tuition and fees
[] Budget from parent organization
[] Grants (source)_____
[] Sales of products or equipment
[] Other sources (Explain) _____
_____
_____

B. Is a clearly identified portion of your budget allocated for CE activities?

[] Yes [] No

C. In preparing for CE activities, do you develop a specific budget for the program to include sources of income and items of expense?

[] Yes [] No

XI. PUBLICITY

A. Indicate how CE activities are generally publicized (check all that apply):

[] Direct mail brochures
[] Journal/newsletter announcements
[] Announcements at dental organizational meetings
[] Word of mouth
[] Other:_____
(specify)

B. Indicate which of the following were included in course publicity materials prepared in the last 12 months:

	Always	Sometimes	Never
Course content description....	[]	[]	[]
Educational objectives.....	[]	[]	[]
Cost.....	[]	[]	[]
Instructor names.....	[]	[]	[]
Qualifications.....	[]	[]	[]
Sponsoring organization.....	[]	[]	[]
Prerequisites for admission...	[]	[]	[]
Location.....	[]	[]	[]
Dates.....	[]	[]	[]
Course titles.....	[]	[]	[]
Contact person.....	[]	[]	[]
Refund/cancellation policies..	[]	[]	[]
Course credit information.....	[]	[]	[]

C. Please attach four (4) copies of a sample brochure from one of your mailings.

XII. ADMISSIONS

From your "List of CE Activities" in Section I (page 3), mark with an asterisk those courses open only to those individuals possessing prerequisite skills or requirements. Please include a copy of the course announcement or brochure for each course you mark.

XIII. PATIENT PROTECTION

This Standard is applicable only to sponsors offering CE activities that involve the treatment of patients by either the clinician or participants. If this situation does not apply, please indicate "not applicable" and skip to the next section.

A. For each setting in which participants are treated by either the clinician or participants, provide the following information (responses should apply to all clinical sites listed):

1) List operatory equipment available:

2) List methods used to ensure sterile techniques:

B. Describe the provisions available for emergency care in the following situations. In describing the provisions, include available facilities, equipment, personnel and location in relation to course site.

1) Medical Emergencies:

2) Dental Procedure Emergencies:

C. In all activities where patients are treated by either participants or clinicians, is patient treatment accomplished in compliance with the state dental practice act?

[] Yes [] No

If no, please explain:

D. Prior to treatment in CE activities, how are patients informed of 1) the training situation, and 2) the arrangements made for follow-up care?

E. Indicate who is responsible for obtaining informed consent. Append the form used for this purpose.

F. What arrangements are made to ensure that the following are provided?

1) Pre-operative examination and preparation:

Name and title of person responsible:

(continued)

2) Post operative (follow-up) care:

_____
_____
_____
_____

Name and title of person responsible:_____
_____

G. Prior to a course, how do you assess the participant's ability to assimilate instruction and perform the treatment technique(s) being taught?

_____
_____
_____

H. Explain what arrangements are made concerning liability protection for 1) instructors, and 2) participants.

_____
_____
_____

I. 1) Are participants warned of the hazards of using limited knowledge in integrating new techniques into their practice?

[] Yes [] No

2) Who is responsible for ensuring that this is done?

_____
_____

J. Describe any follow-up contact the sponsor has with participants following courses in which new patient treatment techniques were practiced/learned?

_____
_____
_____

XIV. RECORD KEEPING

A. How does your organization maintain records of course attendance?

_____
_____
_____

B. How does the participant obtain information about his/her record of attendance at a program?

_____
_____
_____

C. If a diploma or certificate of completion or attendance is used by your organization, a sample copy must be submitted for review.

Resolutions

Notes

Resolutions

Alaska Dental Society

Handbook on Dental Therapeutics

The following resolution was submitted by the Alaska Dental Society and transmitted on April 2, 1992 by Ms. Martha A. Reinbold, executive director, Alaska Dental Society.

Whereas, the American Dental Association is the world wide leader of organized dentistry, and
Whereas, continued leadership in this health care sector depends upon many things, among those being publications of reference, and
Whereas, the American Dental Association has not printed a handbook on dental therapeutics since 1983, therefore, be it

26. Resolved, that the ADA again publish a handbook on dental therapeutics.

Louisiana Dental Association

Standardization of State Dental Licensure Examinations

The following resolution was submitted by the Louisiana Dental Association and transmitted on May 4, 1992 by Dr. R. Jack Cassingham, president, Louisiana Dental Association.

27. Resolved, that the ADA actively support and encourage standardization of state dental licensure practice examinations for dentists and hygienists throughout the United States and its possessions.

Louisiana Dental Association

Amendment of ADA Position Statement on Federal Intervention in Licensure

The following resolution was submitted by the Louisiana Dental Association and transmitted on May 6, 1992 by Dr. R. Jack Cassingham, president, Louisiana Dental Association.

28. Resolved, that the Position Statement on Federal Intervention in Licensure (*Trans.*1975:187, 718) be amended by addition of the following at the end of the second paragraph:

> However, the Association is opposed to discrimination by states in the licensing of dental health care professionals based solely on the premise that the professional was first granted the license involved by another state. In such cases of discrimination, then and only then, would federal intervention in licensure be appropriate to protect the rights of the dental health care professional.

and be it further

Resolved, that the phrase in the summary "and federal intervention in the state licensing system" be deleted, and be it further
Resolved, that the American Dental Association actively support H.R. 2691 introduced into the first session of the 102nd Congress of the United States by Congressman William Jefferson of Louisiana.

Delegate C. Richmond Corley, Jr., Louisiana

Amendment of ADA "Bylaws" Regarding Dues of Life Members Over the Age of 75

The following resolution was submitted on May 20, 1992 by Dr. C. Richmond Corley, Jr., delegate, Louisiana.

Background: In a typical situation, dentists reaching age 75 have contributed 50 years of service to the dental profession. During these years as members of the American Dental Association, they have paid their dues. Therefore, it is appropriate that our association honor them by exempting them from any further dues obligation.

29. Resolved, that Chapter I, Membership, Section 50, Dues and Reinstatement, Paragraph B. Life Members, of the *Bylaws* be amended by adding a new subparagraph c., to read as follows:

> c. Life members who reach the age of seventy-five (75) shall be exempt from the payment of all dues for the calendar year in which such age is attained and thereafter, regardless of their income status.

1991 Resolution Referred to 1992 House of Delegates for Action

Commission on Relief Fund Activities

Amendment Provisions of the ADA Relief Fund "Indenture of Trust"

31-1991. Resolved, that Article IX, Amendment, of the ADA Relief Fund *Indenture of Trust*, be amended by deleting the following words at the end of the first sentence: "provided notice of the proposed amendment or resolution to terminate this trust shall have been given to the members of the House of Delegates in advance of said session in the same way as notice is given of a proposal to amend the *Constitution* of the Association," so that the entire amended section reads as follows:

Article IX
Amendment

This *Indenture of Trust* may be amended or the trust thereby created may be terminated by due corporate action of the Association and in the absence of any other prescribed method, this trust may be amended or altered at any annual session of the House of Delegates of the Association by a two-thirds (⅔) majority vote of the members present and voting. Forthwith upon the adoption of any amendment to this *Indenture of Trust* a new Indenture of Trust shall be executed between the American Dental Association and the members of the Commission on Relief Fund Activities then in office. No amendments to this *Indenture of Trust* shall be effective to divert any portion of the Trust Property to any purpose other than a charitable purpose. Upon the termination of this trust, the Trust Property shall revert back to the Association to be used by it exclusively for charitable purposes.

ADA Audit, 1991

Notes

Association Finances: A Joint Letter from the Treasurer and the Executive Director

Introduction

The Association enjoyed a year of financial growth in 1991. Stringent cost controls and revenue enhancements coupled with income tax refunds contributed to the favorable performance. This was also the year that the Association embarked upon its building renovation program, the initial phase of which is expected to be completed in 1993 at a total cost of more than $12 million.

The expansion of Association for-profit activities in recent years has led to the creation of various subsidiary corporations. To reflect the activity of these companies individually and in total, the format of the audit reports was expanded. Even though the various corporations function independently on a daily basis, the net results of all of their individual operations impact upon the Association's financial standing, as reflected in the consolidated financial statements.

In addition, the audit reports for the American Dental Association Relief Fund and The ADA Endowment and Assistance Fund, Inc. are also included. It should be noted that the Relief Fund statements do not show comparative data for 1990 because of a change in the fiscal year from July 1 to December 31. Future reports will contain financial results for two full 12-month periods.

ADA and Subsidiary Operations

Audit Report: The international accounting firm of KPMG Peat Marwick conducted the audit of the Association and its subsidiary operations. Upon completion of their audit, KPMG Peat Marwick was of the opinion that the statements present fairly, in all material respects, the financial position of the Association and subsidiaries as of December 31, 1991 and 1990.

The format of the audit report has been expanded to include "consolidating" financial statements which provide intercompany transactions and other account information. As requested by the 1990 House of Delegates, each financial statement includes revenues and expenses by natural category. The comments which follow relate to the audit reports of the Association and its subsidiaries.

General Overview of Financial Statements: The additional financial statements which were added for 1991 include the following: a consolidating balance sheet; statement of revenues, expenses and equity; as well as a statement of cash flows for the ADA and all of its subsidiary companies.

The purpose of these additional statements is to separate the ADA General Fund into its divisional and account components so each of these may be reviewed individually. The Operating Division is displayed in total and by its Operating and Investment Account components. The Reserve Division is also separated into its Capital Formation and Restricted accounts. In addition, the American Dental Association Health Foundation, American Dental Real Estate Corporation, and the ADA Holding Company, Inc. and Subsidiaries are also included. The format of the report provides a column titled "Eliminations," which is used by the auditors to avoid the double counting which invariably develops from transactions arising between a parent company and its subsidiaries.

The notes to the financial statements refer to a "Subsequent Event," footnote No. 9, which describes the Association's plans to offer an early retirement window to approximately 60 employees who meet the eligibility requirements. This program is part of the Board's on-going efforts to streamline the activities of the Association.

Association Balance Sheet: The Association strengthened its Balance Sheet during 1991 by a $4.9 million increase in assets, while liabilities decreased by over $300,000. This had the effect of raising the Association's equity position by $5.2 million to $26.3 million. Major increases occurred in cash, income taxes receivable, marketable securities, as well as notes and loans payable.

Association Revenues and Expenses: Revenues grew by 8% over the prior year while expenses increased by 4.1%. The Association on a consolidated basis (i.e., including all subsidiary companies) had revenues in excess of expenses of $5,175,012 compared to $2,175,452 in 1990.

Investment Account Analysis: The investment accounts of the Association are segregated into three categories: Capital Formation that holds longer term investments such as the Washington Office and the for-profit subsidiaries; Operating Division Investment Account consists of U.S. government agency securities that are readily convertible to cash; and the Reserve Division Restricted Investment Account that is comprised of marketable securities primarily in common stocks.

At the year-end 1991, net income allowed for additions to the Operating Division Investment Account of $2.7 million.

Below is a recap of year-end balances for the five-year period ending December 31, 1991. These balances represent the total equity in each account including capital stock.

Recap of Year-End Balances

	Investment Accounts			
		Reserve Division		
Year-Ended	Operating Division	Capital Formation	Reserve Restricted	Total Investment
1987	$1,605,015	2,805,617	3,610,443	8,021,075
1988	1,727,112	1,509,172	4,777,891	8,014,175
1989	3,484	1,843,901	5,430,915	7,278,300
1990	503,577	1,317,870	6,476,472	8,297,919
1991	3,231,064	1,693,815	8,257,359	13,182,238

Subsidiary Operations: American Dental Real Estate Corporation ended 1991 with a deficit of $237,781 after all income tax adjustments. Although this represents a significant shortfall, the deficit should be evaluated in light of the fact that the Association does not pay rent on the space it occupies in Washington. This has an imputed value of almost $350,000, which compensates for the economic losses from American Dental Real Estate Corporation.

Until the depressed Washington area real estate market improves, there is no economic incentive to sell this building. It is also noteworthy that new construction and renovation of neighboring properties bode well for future appreciation and marketability.

ADA General Fund

Overview: Revenues for the Association's General Fund were $45,016,243 and exceeded the 1991 budget of $42,558,100 by $2,458,143 or 5.8%. Expenses of $42,330,103 exceeded the budget of $41,426,300 by $903,803 or 2.2%. After taking an income tax benefit of $620,385 due to the filing of amended tax returns for the years 1987-1989 into account, expenses exceeded the budget by $283,418 or 0.7%. This combination resulted in net revenues being favorable to the $1,131,800 budget by $2,174,723. In light of the favorable financial performance in 1991, it was determined that cash in the amount of the entire 1991 net income of $3,306,523 would be transferred from the General Fund to the Operating Division Investment Account.

Revenues: Major variances in the sources of revenues in excess of budget are accounted for in the following table.

Salable Materials Program, primarily Scientific Affairs material relating to infection control and OSHA	$1,411,660
Membership dues, after rebates to constituent societies	578,892
Finance, interest earned on investment of operating account funds	347,825
All other revenues, net favorable variance	119,766
Total	$2,458,143

Expenses: The following are favorable (unfavorable) variances by major categories of expenses.

Expected salary savings from unfilled staff positions during the year that did not materialize, increased use of part-time, temporary and overtime help during the hiring freeze.	($699,673)
Consulting fees were higher than anticipated, which is primarily attributable to the Oral Health Issues Campaign.	(400,612)
Contract fee-ADAPI, a mid-year renegotiation of the contract with the ADA resulted in additional fees to compensate for an increased distribution of *JADA* under the dues equity program.	(300,000)
Income tax benefit	620,385
All other expense variances, net favorable.	496,482
Total	($283,418)

Conclusion

Although the Association experienced a very good year in 1991, the challenges that lie ahead are many. While budgetary restraint is the watchword, there is increased demand for Association services as the government through OSHA and other regulatory measures continues to encroach upon the practice of dentistry. Principal and interest payments related to the remodeling and asbestos abatement of the Headquarters Building must also be factored into the financial equation.

Recognizing that funds necessary to support programs and services may well exceed the Association's resources, the Board will be using a form of zero base budgeting for 1993, which attempts to analyze and prioritize activities within the Association. This is an ambitious task that the Board hopes will allocate available funding to programs that will best serve the membership and public.

Treasurer

Executive Director

Independent Auditors' Report

The Board of Trustees, American Dental Association

We have audited the accompanying consolidated balance sheets of American Dental Association and subsidiaries as of December 31, 1991 and 1990, and the related consolidated statements of revenues, expenses and equity, and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of American Dental Association and subsidiaries as of December 31, 1991 and 1990, and the results of their operations and their cash flows for the years then ended in conformity with generally accepted accounting principles.

Our audits were made for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information included in Schedules 1 through 3 is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations and cash flows of the individual companies. The consolidating information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

KPMG Peat Marwick

Chicago, Illinois
March 6, 1992

American Dental Association and Subsidiaries

December 31, 1991 and 1990

Consolidated Balance Sheets

AMERICAN DENTAL ASSOCIATION AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
DECEMBER 31, 1991 AND 1990

	1991	1990
ASSETS		
Cash and cash equivalents	$ 3,758,374	3,332,871
Receivables, net of allowance for doubtful accounts of $99,500 and $135,500 in 1991 and 1990	2,160,551	2,333,745
Income taxes receivable (Note 6)	944,370	253,183
Inventories, net of reserves of $335,000 in 1991 and $405,000 in 1990	1,217,136	1,212,224
Marketable securities, at market (Note 2)	13,294,943	9,967,033
Property and equipment, net (Note 3)	12,483,375	11,993,346
Other real estate (Note 3)	12,184,424	12,423,112
Funds held for deferred compensation (Note 4)	3,009,578	3,076,364
Deferred charges and other assets	2,772,768	2,359,803
Total assets	$51,825,519	46,951,681
LIABILITIES AND EQUITY		
Accounts payable	$ 1,913,358	2,075,377
Accrued liabilities	1,896,491	1,900,118
Notes and loan payable (Note 5)	11,555,836	11,051,817
Income taxes payable, including deferred taxes (Note 6)	-	137,426
Deferred revenues	6,990,290	7,356,315
Liability for deferred compensation (Note 4)	3,009,578	3,076,364
Other liabilities	141,831	211,141
Total liabilities	25,507,384	25,808,558
Equity	26,318,135	21,143,123
Total liabilities and equity	$51,825,519	46,951,681

See accompanying notes to consolidated financial statements.

American Dental Association and Subsidiaries

Years Ended December 31, 1991 and 1990

Consolidated Statements of Revenues, Expenses and Equity

AMERICAN DENTAL ASSOCIATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF REVENUES, EXPENSES AND EQUITY
YEARS ENDED DECEMBER 31, 1991 AND 1990

	1991	1990
Revenues:		
Membership dues	$29,141,992	27,748,689
Advertising & subscriptions	7,434,048	7,009,416
Rental income	5,345,665	5,256,923
Sales of educational materials	4,554,751	3,715,909
Educational testing fees	2,134,976	1,948,811
Grants and contributions	3,201,931	3,354,734
Meeting and seminar registration fees	403,507	492,032
Investment income	2,115,055	494,136
Other income	3,125,475	3,200,132
Total revenues	57,457,400	53,220,782
Expenses:		
Staff compensation, taxes and benefits	22,011,263	20,946,812
Publication and project expenses	10,968,247	10,352,934
Meeting and travel expenses	4,867,942	5,167,898
Professional services	4,677,348	3,863,797
Facility and utility expenses	4,143,371	3,978,472
Office expenses	2,877,050	2,849,085
Depreciation and amortization	1,597,992	1,846,031
Interest expense	994,014	1,067,256
Other expenses	1,021,035	1,006,660
Total expenses	53,158,262	51,078,945
Excess of revenues over expenses before income taxes and extraordinary item	4,299,138	2,141,837
Income tax benefit (expense) (Note 6)	873,659	(49,726)
Excess of revenues over expenses before extraordinary item	5,172,797	2,092,111
Extraordinary item - reduction of income tax expense due to utilization of prior year's net operating loss carryforward (Note 6)	2,215	83,341
Excess of revenues over expenses	5,175,012	2,175,452
Equity at beginning of year	21,143,123	18,967,671
Equity at end of year	$26,318,135	21,143,123

See accompanying notes to consolidated financial statements.

American Dental Association and Subsidiaries

Years Ended December 31, 1991 and 1990

Consolidated Statements of Cash Flows

AMERICAN DENTAL ASSOCIATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED DECEMBER 31, 1991 AND 1990

	1991	1990
Cash flows from operating activities:		
Excess of revenues over expenses	$ 5,175,012	2,175,452
Adjustments to reconcile excess of revenues over expenses to net cash provided by operating activities:		
Depreciation and amortization	1,597,992	1,846,031
Unrealized (appreciation) depreciation in market value of marketable securities	(793,911)	275,419
Gain on sale of marketable securities	(290,523)	(3,607)
Loss on disposal of equipment	-	108,436
Changes in other assets and liabilities:		
Receivables	173,193	255,594
Income taxes receivable	(691,187)	(12,683)
Inventories	(4,912)	(4,638)
Deferred charges and other assets	(427,676)	(425,490)
Accounts payable and accrued liabilities	(165,925)	(522,989)
Income taxes payable, including deferred taxes	(137,426)	137,426
Deferred revenues	(366,024)	1,630,354
Other liabilities	(7,168)	5,181
Net cash provided by operating activities	4,061,445	5,464,486
Cash flows from financing activities:		
Proceeds from issuance of notes payable	600,000	633,460
Proceeds from issuance of mortgage loan payable	-	9,550,000
Repayments of notes payable	-	(1,458,315)
Repayments of mortgage loan	(85,048)	(7,956,092)
Payments on capital lease obligation	(72,803)	(56,899)
Net cash provided by financing activities	442,149	712,154
Cash flows from investing activities:		
Purchase of marketable securities	(41,267,761)	(32,187,628)
Sale and maturity of marketable securities	39,024,294	29,010,528
Acquisitions of property, equipment and leasehold improvements	(1,834,624)	(1,345,861)
Net cash used in investing activities	(4,078,091)	(4,522,961)
Net increase in cash and cash equivalents	425,503	1,653,679
Cash and cash equivalents at beginning of year	3,332,871	1,679,192
Cash and cash equivalents at end of year	$ 3,758,374	3,332,871
Cash paid during the year for:		
Interest	$ 1,091,129	992,736
Income taxes	467,382	9,883

See accompanying notes to consolidated financial statements.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1991 and 1990

AMERICAN DENTAL ASSOCIATION AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
DECEMBER 31, 1991 AND 1990

1. Significant Accounting Policies

Basis of Presentation:

The American Dental Association (Association) is organized as an association of members of the dental profession and is designed, as its corporate purpose states, "to encourage the improvement of the health of the public and to promote the art and science of dentistry."

The accompanying consolidated financial statements include the accounts of the Operating and Reserve Divisions of the Association; the American Dental Association Health Foundation (ADAHF); the Association's wholly-owned not-for-profit real estate corporation, American Dental Real Estate Corporation (ADREC); and the Association's wholly-owned for-profit subsidiary ADA Holding Company, Inc. (ADAHC), and its wholly-owned subsidiaries ADA Business Systems, Inc. (ADABSI) and ADA Publishers, Inc. (ADAPI). All significant intercompany accounts and transactions have been eliminated in consolidation.

Cash Equivalents:

Cash equivalents at December 31, 1991 and 1990 consist primarily of deposits under an overnight repurchase agreement.

Marketable Securities:

Investments in marketable securities are carried at market value.

Marketable securities held in the Operating Division are available for current use while marketable securities held in the Reserve Division are not intended for current use. In the event of emergency situations, Reserve Division assets may be used in operations upon approval of the Board of Trustees, with subsequent reporting to the Association's House of Delegates. Investment expenses of $28,999 and $20,787 in 1991 and 1990, respectively, are included in other expenses in the accompanying consolidated financial statements.

Inventories:

Inventories, consisting principally of salable educational materials and supplies, are carried at the lower of cost or market. Cost is determined using the first-in, first-out method.

Investment in Land:

The Association's investment in land (Note 3) is carried at cost.

Property and Equipment:

Property, equipment and leasehold improvements are stated at cost, less accumulated depreciation. Depreciation is computed on the straight line method over the estimated useful lives of the assets which are as follows:

Buildings	30-55 years
Building improvements	10-30 years
Furniture, equipment and libraries	3-20 years

Leasehold improvements are amortized over the shorter of their estimated useful life or the remaining term of the lease.

Deferred Compensation:

Investments held for deferred compensation are carried at market value and are not available for current use.

Revenue and Expense Recognition:

Membership dues are recognized as income during the membership year which ends on December 31. Amounts received in advance are deferred to the subsequent year. Unearned membership dues, which have been included in deferred revenues in the accompanying consolidated financial statements, amounted to approximately $4,034,000 and $4,417,000 at December 31, 1991 and 1990, respectively.

Subscriptions to periodicals are recognized as income over the terms of the subscriptions. Advertising revenue and direct publication costs are recognized in the period the related periodical is issued.

Testing fees are recognized as income when the related examinations are administered.

Grants received are recognized as income when costs of the related programs or projects are incurred. Amounts received but not yet expended are reported as deferred revenues in the accompanying consolidated financial statements. Grants to other organizations are recorded as expense when authorized by the Board of Trustees.

Pension Costs:

Pension costs are determined under the projected unit credit cost method. This method determines the present value of benefits accrued to date under the provisions of the pension plan and ignores any further benefit accruals.

Income Taxes:

Income taxes are charged to operations based upon income reported for financial statement purposes. Deferred income taxes are provided for the tax effects of timing differences between financial reporting and taxable income.

Reclassifications:

Certain 1990 amounts have been reclassified to conform to the 1991 presentation.

2. Marketable Securities

Marketable securities at December 31, 1991 and 1990 consisted of the following:

	1991		1990	
	Market	Cost	Market	Cost
Money market funds	$ 4,542,716	4,542,716	3,829,861	3,829,861
Certificates of deposit	2,248,443	2,248,443	1,830,380	1,830,380
U.S. Government obligations	12,504	12,964	12,517	12,964
Common stocks	6,491,280	4,457,576	4,294,275	3,054,493
	$13,294,943	11,261,699	9,967,033	8,727,698

The market value of marketable securities held in the Reserve Division amounted to $8,232,334 and $6,457,538 at December 31, 1991 and 1990, respectively.

(Continued)

Gross unrealized appreciation and depreciation on common stocks amounted to $2,160,191 and $126,487 as of December 31, 1991 and $1,435,181 and $195,399 as of December 31, 1990.

ADAHF deferred investment income of approximately $112,780 and $131,279 for the years ending December 31, 1991 and 1990, respectively. These amounts will be recognized as income when costs of the related grant programs or projects are incurred.

Reserve division investments totalling $445,000 are pledged as collateral to secure a loan made to an affiliated entity of the Association by a third party.

3. Property and Equipment and Other Real Estate

Property and equipment at December 31, 1991 and 1990 consisted of the following:

	1991	1990
Land	$ 712,113	712,113
Building	12,381,169	12,381,169
Building improvements	5,110,336	4,506,491
Furniture and equipment	6,927,008	5,914,967
Film and book libraries	440,190	440,190
	25,570,816	23,954,930
Less accumulated depreciation	13,087,441	11,961,584
	$12,483,375	11,993,346

Depreciation expense for the years ended December 31, 1991 and 1990 amounted to $1,043,479 and $1,072,651, respectively.

Furniture and equipment includes approximately $414,500 of costs at both December 31, 1991 and 1990 related to equipment held under capital leases. Accumulated depreciation amounted to $312,540 and $242,209 at December 31, 1991 and 1990, respectively. Amortization of assets held under capital leases is included in depreciation expense.

Other real estate located in Washington, D.C. consisted of the following at December 31, 1991 and 1990:

	1991	1990
Land	$ 3,030,000	3,030,000
Building	9,602,195	9,602,195
Building improvements	339,442	336,206
Building equipment	37,968	37,968
	13,009,605	13,006,369
Less accumulated depreciation	825,181	583,257
	$12,184,424	12,423,112

Depreciation expense on other real estate for the years ended December 31, 1991 and 1990 amounted to $241,924 and $316,078, respectively.

Leasehold improvements included in deferred charges and other assets at December 31, 1991 and 1990 consisted of the following:

	1991	1990
Tenant leasehold improvements	$2,112,150	1,996,464
Less accumulated amortization	1,344,357	1,033,558
	$ 767,793	962,906

Amortization expense for tenant leasehold improvements amounted to $312,589 and $457,302 in 1991 and 1990, respectively.

The Association leases portions of both the Headquarters building and the Washington office building to unrelated parties under operating leases with varying terms. These amounts may be adjusted upon renewal of the leases. Minimum future rentals to be earned from leases currently in effect are:

1992	$2,248,403
1993	2,019,315
1994	1,765,055
1995	1,350,448
1996	1,021,079
Thereafter	1,425,197
	$9,829,497

Building expenses include the cost of facilities occupied by the Association, as well as those costs related to other tenants.

4. Deferred Compensation

Pursuant to agreements between the Association and certain officers and employees, portions of their compensation have been set aside for investment as directed by those participants. Title to the segregated assets is retained by the Association until termination of employment or services. In addition, the Association has adopted a supplemental retirement income plan for certain employees. The benefits provided under the plan are in addition to the benefits available under the pension plan for employees of the Association. Title to the segregated assets is retained by the Association until retirement.

5. Notes and Loan Payable

In February 1989, ADREC purchased the building which resides on land in Washington, D.C. owned by the Association for $9,500,000. In connection with that purchase, ADREC assumed the existing mortgage which was refinanced in 1990.

The notes and loan payable at December 31, 1991 and 1990 consisted of the following:

	1991	1990
Long-term notes payable:		
9.125% mortgage loan; due in monthly payments of $77,753, with the remaining balance due in 1995	$ 9,441,624	9,526,672
Short-term notes payable:		
Operating and capital improvement bank line of credit at the prime lending rate, expiring on June 30, 1992	1,800,000	1,200,000
Bridge bank loan at the prime lending rate, expiring on June 30,1992	300,000	300,000
Installment note payable for equipment	14,212	25,145
	$11,555,836	11,051,817

The mortgage loan is secured by the land and building and is guaranteed by the Association. Maximum borrowings available under the bank line of credit, which is also guaranteed by the Association, are $2,000,000.

The aggregate annual principal payments required on notes and the loan payable outstanding at December 31, 1991, for each of the next four years are: $2,185,703 in 1992, $82,764 in 1993, $88,305 in 1994, and $9,199,064 in 1995.

Interest expense amounted to $994,014 and $1,067,256 in 1991 and 1990, respectively.

6. Income Taxes

The Association, ADAHF and ADREC are exempt from taxation on income related to their exempt purposes under sections 501(c)(6), 501(c)(3) and 501(c)(2) of the Internal Revenue Code (Code), respectively. As exempt organizations, the Association, ADAHF and ADREC are subject to Federal and state income taxes on income determined to be unrelated business taxable income and on the income of the Association's for-profit subsidiaries.

The Association files a consolidated Federal income tax return with ADREC. ADAHC files a consolidated Federal income tax return with ADAPI and ADABSI. ADAHF files its own tax return.

Income tax expense (benefit) for the years ended December 31, 1991 and 1990 is as follows:

	1991	1990
Current:		
Federal	$(719,654)	15,704
State	(200,521)	(6,920)
Current income tax expense (benefit)	(920,175)	8,784
Deferred:		
Federal	44,301	(35,009)
State	-	(7,390)
Deferred income tax expense (benefit)	44,301	(42,399)
Utilization of net operating loss carryforward	2,215	83,341
Income tax expense (benefit)	$(873,659)	49,726

Income tax expense differs from the amount computed by applying the statutory Federal income tax rate of 34% to income before income tax expense and extraordinary item for the years ended December 31, 1991 and 1990 primarily as the result of the effect of state income taxes and other items.

Deferred income taxes are primarily the result of timing differences between the deductibility of bad debts expense for tax and book purposes and the excess of tax depreciation over book depreciation.

During the years ended December 31, 1991 and 1990, ADABSI realized benefits of $2,215 and $83,341, respectively, resulting from the utilization of net operating loss carryforwards generated in prior years. ADABSI has remaining net operating loss carryforwards for tax return and financial reporting purposes of $1,400,000 which are available to offset only its future taxable income. These carryforwards expire as follows: $690,000 in 2001, $419,000 in 2002 and $291,000 in 2003.

ADREC's non-exempt operating results are included in the consolidated Federal income tax return of the Association. Under the terms of an inter-company tax allocation agreement between ADREC and the Association, ADREC is paid for the tax benefits used by the Association in its consolidated Federal income tax return. ADREC has recorded income tax benefits of $433,922 in 1991 and $138,330 in 1990 under the terms of the agreement. As of December 31, 1990, ADREC had incurred net operating losses for tax purposes of $695,504 which, in conjunction with net operating losses for tax purposes of $412,555 generated during 1991, were utilized by the Association to recover federal income taxes paid by the Association in 1987 and 1988. The utilization of ADREC's net operating losses, included in the income tax benefit recorded in 1991, amounted to $416,475. As of December 31, 1991, ADREC does not have any remaining net operating losses to be carried forward for tax purposes.

7. Employee Benefit Plans

The Association and its subsidiaries have a noncontributory defined benefit Employees' Retirement Trust pension plan which covers substantially all employees meeting certain eligibility requirements. Pursuant to agreements between the Association and certain employees the Association also has an Employees' Supplemental Trust retirement income plan. Generally, the funding policy is to contribute annually amounts which are deductible for Federal income tax purposes. Retirement benefit payments are based on years of credited service, average compensation of the final five years of employment, and the average Social Security limit at employment termination date.

The following table sets forth the plans funded status and amounts recognized in the Association's consolidated financial statements:

	1991			
	Employees' Retirement Trust	Employees' Supplemental Trust	Total	1990 Total
Actuarial present value of benefit obligations:				
Accumulated benefit obligation, including vested benefits of $14,708,289 and $0 in 1991 and $11,273,872 in 1990, respectively	$15,097,556	35,461	15,133,017	11,666,542
Projected benefit obligation for services rendered to date	20,723,983	506,217	21,230,200	16,445,573
Plan assets at fair value, primarily bonds, stocks and insurance guarantee contracts	19,898,848	-	19,898,848	15,342,809
Projected benefit obligation in excess of plan assets	(825,135)	(506,217)	(1,331,352)	(1,102,764)
Unrecognized net loss from past experience different from that assumed and effects of changes in assumptions	1,693,492	361,208	2,054,700	1,260,836
Prior service cost not yet recognized in net periodic pension cost	713,699	-	713,699	814,463
Unrecognized net asset at January 1, 1987 being recognized over 15 years	(187,453)	-	(187,453)	(206,199)
Prepaid (accrued) pension expense included in deferred charges and other assets	$ 1,394,603	(145,009)	1,249,594	766,336
Net periodic pension cost for 1991 and 1990 included the following components:				
Service cost-benefits earned during the period	$ 1,147,847	24,673	1,172,520	1,042,729
Interest cost on projected benefit obligation	1,414,473	33,631	1,448,104	1,177,463
Actual return on plan assets	(3,311,513)	-	(3,311,513)	(753,074)
Net amortization and deferral	1,815,235	31,131	1,846,366	(560,501)
Net periodic pension cost	$ 1,066,042	89,435	1,155,477	906,617

The weighted-average discount rate and rate of increase in future compensation levels used in determining the actuarial present value of the projected benefit obligation were 7.75% and 6% respectively for 1991. The expected long-term rate of return on assets was 10%. The discount rate used at the beginning of each year to determine the net periodic pension cost was 8.25% with all other assumptions the same as described above except that the weighted-average discount rate used to determine the actuarial present value of the projected benefit obligation for 1990 was 8.25%.

The Association has a savings and retirement plan for all eligible employees. The Association matches 25% of contributed amounts up to a maximum of $250 per participant each year. The Association contributions under this plan were approximately $64,960 in 1991 and $61,110 in 1990.

The Internal Revenue Service has informed the Savings and Employees' Retirement Trust administrators that the plans are qualified under provisions of the Code and, therefore, are exempt from Federal income taxes. The Employees' Supplemental Trust is a nonqualified plan and as such is not exempt from Federal income taxes (see Note 4).

8. Commitments and Contingencies

In 1991, the Association initiated an asbestos abatement and remodeling program for its headquarters building. At December 31, 1991, anticipated expenditures for asbestos abatement approximated $2,877,000 for 1992 and $1,080,000 for 1993. Anticipated expenditures for remodeling approximated $5,776,000 for 1992 and $1,950,000 for 1993.

In addition the Association is involved in various asserted and unasserted claims incidental to the normal conduct of its business.

In the opinion of management and the Association's legal counsel, the ultimate disposition of these matters will not have a material adverse effect on the consolidated results of operations or financial position of the Association.

9. Subsequent Event

In February 1992, the Board of Trustees for the Association approved an amendment to the Employees' Retirement Trust pension plan. The amendment provides an early retirement window for approximately 60 covered employees. The ultimate financial impact of this amendment cannot presently be determined.

American Dental Association and Subsidiaries

December 31, 1991

Consolidating Balance Sheet

Schedule 1

AMERICAN DENTAL ASSOCIATION AND SUBSIDIARIES
CONSOLIDATING BALANCE SHEET
DECEMBER 31, 1991

	GENERAL FUND											
	Operating Division			Reserve Division								
	Operating Account	Investment Account	Total	Capital Formation Account	Restricted Account	Total	Total General Fund	ADAHF	ADREC	ADAHC	Eliminations	Total
ASSETS												
Cash and cash equivalents	$ 3,168,550	-	3,168,550	-	-	-	3,168,550	3,553	216,903	369,368	-	3,758,374
Receivables, net	1,286,187	-	1,286,187	-	25,025	25,025	1,311,212	191,138	28,438	629,763	-	2,160,551
Due from (to) affiliates	619,124	-	619,124	(500,000)	-	(500,000)	119,124	(150,182)	152,429	(121,371)	-	-
Income taxes receivable	792,847	-	792,847	-	-	-	792,847	-	-	151,523	-	944,370
Inventories	1,191,115	-	1,191,115	-	-	-	1,191,115	-	-	26,021	-	1,217,136
Marketable securities, at market	46,399	3,231,064	3,277,463	-	8,232,334	8,232,334	11,509,797	1,785,146	-	-	-	13,294,943
Investment in subsidiaries	-	-	-	(836,185)	-	(836,185)	(836,185)	-	-	-	836,185	-
Property and equipment, net	12,167,002	-	12,167,002	-	-	-	12,167,002	26,028	-	290,345	-	12,483,375
Other real estate	-	-	-	3,030,000	-	3,030,000	3,030,000	-	9,154,424	-	-	12,184,424
Funds held for deferred compensation	3,009,578	-	3,009,578	-	-	-	3,009,578	-	-	-	-	3,009,578
Deferred charges and other assets	2,455,824	-	2,455,824	-	-	-	2,455,824	-	277,239	155,939	(116,234)	2,772,768
Total assets	$24,736,626	3,231,064	27,967,690	1,693,815	8,257,359	9,951,174	37,918,864	1,855,683	9,829,433	1,501,588	719,951	51,825,519
LIABILITIES AND EQUITY												
Accounts payable	$ 1,587,227	-	1,587,227	-	-	-	1,587,227	107,362	433	218,336	-	1,913,358
Accrued liabilities	1,871,199	-	1,871,199	-	-	-	1,871,199	2,227	-	23,065	-	1,896,491
Notes and loans payable	-	-	-	-	-	-	-	-	11,555,836	116,234	(116,234)	11,555,836
Deferred revenues	5,202,682	-	5,202,682	-	-	-	5,202,682	1,584,234	-	203,374	-	6,990,290
Liability for deferred compensation	3,009,578	-	3,009,578	-	-	-	3,009,578	-	-	-	-	3,009,578
Other liabilities	91,903	-	91,903	-	-	-	91,903	-	49,928	-	-	141,831
Total liabilities	11,762,589	-	11,762,589	-	-	-	11,762,589	1,693,823	11,606,197	561,009	(116,234)	25,507,384
Equity:												
Common stock	-	-	-	-	-	-	-	-	100	100	(200)	-
Paid-in capital	-	-	-	-	-	-	-	-	-	500,000	(500,000)	-
Accumulated earnings (deficit)	12,974,037	3,231,064	16,205,101	1,693,815	8,257,359	9,951,174	26,156,275	161,860	(1,776,864)	440,479	1,336,385	26,318,135
Total equity	12,974,037	3,231,064	16,205,101	1,693,815	8,257,359	9,951,174	26,156,275	161,860	(1,776,764)	940,579	836,185	26,318,135
Total liabilities and equity	$24,736,626	3,231,064	27,967,690	1,693,815	8,257,359	9,951,174	37,918,864	1,855,683	9,829,433	1,501,588	719,951	51,825,519

See accompanying independent auditors' report.

American Dental Association and Subsidiaries

Year Ended December 31, 1991

Consolidating Statement of Revenues, Expenses and Equity

Schedule 2

AMERICAN DENTAL ASSOCIATION AND SUBSIDIARIES
CONSOLIDATING STATEMENT OF REVENUES, EXPENSES AND EQUITY
FOR THE YEAR ENDED DECEMBER 31, 1991

	GENERAL FUND											
	Operating Division			Reserve Division								
	Operating Account	Investment Account	Total	Capital Formation Account	Restricted Account	Total	Total General Fund	ADAHF	ADREC	ADAHC	Eliminations	Total
Revenues:												
Membership dues	$29,141,992	-	29,141,992	-	-	-	29,141,992	-	-	-	-	29,141,992
Advertising and subscriptions	-	-	-	-	-	-	-	-	-	7,434,048	-	7,434,048
Rental income	4,205,092	-	4,205,092	-	-	-	4,205,092	-	1,356,565	-	(215,992)	5,345,665
Sales of educational material	4,554,751	-	4,554,751	-	-	-	4,554,751	-	-	-	-	4,554,751
Educational testing fees	2,134,976	-	2,134,976	-	-	-	2,134,976	-	-	-	-	2,134,976
Grants and contributions	527,164	-	527,164	-	-	-	527,164	4,217,051	-	-	(1,542,284)	3,201,931
Meeting and seminar registration fees	403,507	-	403,507	-	-	-	403,507	-	-	-	-	403,507
Investment income	651,088	27,487	678,575	448,803	1,406,118	1,854,921	2,533,496	3,073	-	27,289	(448,803)	2,115,055
Other income	3,397,671	-	3,397,671	-	-	-	3,397,671	66,271	-	994,937	(1,333,404)	3,125,475
Total revenues	45,016,241	27,487	45,043,728	448,803	1,406,118	1,854,921	46,898,649	4,286,395	1,356,565	8,456,274	(3,540,483)	57,457,400
Expenses:												
Staff compensation, taxes and benefits	18,381,794	-	18,381,794	-	-	-	18,381,794	2,262,991	12,738	1,353,740	-	22,011,263
Publication and project expenses	5,700,920	-	5,700,920	-	-	-	5,700,920	145,608	-	5,121,719	-	10,968,247
Meeting and travel expenses	4,540,803	-	4,540,803	-	-	-	4,540,803	214,093	-	113,046	-	4,867,942
Professional services	3,971,799	-	3,971,799	-	28,999	28,999	4,000,798	418,199	68,375	189,976	-	4,677,348
Facility and utility costs	3,264,126	-	3,264,126	-	-	-	3,264,126	-	663,013	216,232	-	4,143,371
Office expenses	2,294,734	-	2,294,734	-	-	-	2,294,734	471,656	5,687	119,973	(15,000)	2,877,050
Grants to health related groups	1,807,668	-	1,807,668	-	-	-	1,807,668	-	-	-	(1,807,668)	-
Depreciation and amortization	1,272,388	-	1,272,388	-	-	-	1,272,388	11,715	284,077	29,812	-	1,597,992
Interest expense	4,582	-	4,582	-	-	-	4,582	-	989,432	-	-	994,014
Other expenses	1,091,289	-	1,091,289	-	-	-	1,091,289	748,154	4,946	445,658	(1,269,012)	1,021,035
Total expenses	42,330,103	-	42,330,103	-	28,999	28,999	42,359,102	4,272,416	2,028,268	7,590,156	(3,091,680)	53,158,262
Excess (deficiency) of revenues over expenses before income tax expense and extraordinary item	2,686,138	27,487	2,713,625	448,803	1,377,119	1,825,922	4,539,547	13,979	(671,703)	866,118	(448,803)	4,299,138
Income tax benefit (expense)	620,385	-	620,385	-	-	-	620,385	-	433,922	(180,648)	-	873,659
Excess (deficiency) of revenues over expenses before extraordinary item	3,306,523	27,487	3,334,010	448,803	1,377,119	1,825,922	5,159,932	13,979	(237,781)	685,470	(448,803)	5,172,797
Extraordinary item - Reduction of income tax expense due to utilization of prior year's net operating loss carryforward	-	-	-	-	-	-	-	-	-	2,215	-	2,215
Excess (deficiency) of revenues over expenses	3,306,523	27,487	3,334,010	448,803	1,377,119	1,825,922	5,159,932	13,979	(237,781)	687,685	(448,803)	5,175,012
Equity at beginning of year	12,698,424	503,577	13,202,001	1,317,869	6,476,473	7,794,342	20,996,343	147,881	(1,539,083)	(247,206)	1,785,188	21,143,123
Equity transfers	(3,030,910)	2,700,000	(330,910)	(72,857)	403,767	330,910	-	-	-	-	-	-
Equity at end of year	$12,974,037	3,231,064	16,205,101	1,693,815	8,257,359	9,951,174	26,156,275	161,860	(1,776,864)	440,479	1,336,385	26,318,135

See accompanying independent auditors' report.

American Dental Association and Subsidiaries

Year Ended December 31, 1991

Consolidating Statement of Cash Flows

Schedule 3

AMERICAN DENTAL ASSOCIATION AND SUBSIDIARIES
CONSOLIDATING STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED DECEMBER 31, 1991

	GENERAL FUND											
	Operating Division			Reserve Division								
	Operating Account	Investment Account	Total	Capital Formation Account	Restricted Account	Total	Total General Fund	ADAHF	ADREC	ADAHC	Eliminations	Total
Cash flows from operating activities:												
Excess (deficiency) of revenues over expenses	$3,306,523	27,487	3,334,010	448,803	1,377,119	1,825,922	5,159,932	13,979	(237,781)	687,685	(448,803)	5,175,012
Adjustments to reconcile excess (deficiency) of revenues over expenses to net cash provided by operating activities:												
Depreciation and amortization	1,272,388	-	1,272,388	-	-	-	1,272,388	11,715	284,077	29,812	-	1,597,992
Unrealized (appreciation) depreciation on marketable securities and investments	-	-	-	-	(793,923)	(793,923)	(793,923)	12	-	-	-	(793,911)
Gain on sale of marketable securities	-	-	-	-	(290,523)	(290,523)	(290,523)	-	-	-	-	(290,523)
Changes in assets and liabilities -												
Accounts receivable	(20,691)	-	(20,691)	-	(6,098)	(6,098)	(26,789)	33,287	22,813	176,884	(33,002)	173,193
Due from/to affiliated organizations	517,494	-	517,494	72,857	-	72,857	590,351	107,658	(336,956)	(355,037)	(6,016)	-
Income taxes receivable	(539,664)	-	(539,664)	-	-	-	(539,664)	-	-	(151,523)	-	(691,187)
Inventories	(143,116)	-	(143,116)	-	-	-	(143,116)	-	-	138,204	-	(4,912)
Investment in subsidiaries	-	-	-	(448,803)	-	(448,803)	(448,803)	-	-	-	448,803	-
Deferred charges and other assets	(16,061)	-	(16,061)	-	-	-	(16,061)	-	38,947	4,422	(454,984)	(427,676)
Accounts payable and accrued liabilities	12,080	-	12,080	-	-	-	12,080	8,157	(123,251)	(95,913)	33,002	(165,925)
Income taxes payable	-	-	-	-	-	-	-	-	-	(137,426)	-	(137,426)
Deferred revenue	(185,685)	-	(185,685)	-	-	-	(185,685)	(174,998)	-	(5,341)	-	(366,024)
Other liabilities	-	-	-	-	-	-	-	-	(7,168)	-	-	(7,168)
Net cash provided (used) by operating activities	4,203,268	27,487	4,230,755	72,857	286,575	359,432	4,590,187	(190)	(359,319)	291,767	(461,000)	4,061,445
Cash flows from financing activities:												
Proceeds from loans payable	-	-	-	-	-	-	-	-	600,000	-	-	600,000
Payments on loans payable	-	-	-	-	-	-	-	-	-	(461,000)	461,000	-
Payments on mortgage note payable	-	-	-	-	-	-	-	-	(85,048)	-	-	(85,048)
Payments on capital lease obligations	(61,870)	-	(61,870)	-	-	-	(61,870)	-	(10,933)	-	-	(72,803)
Net cash provided (used) by financing activities	(61,870)	-	(61,870)	-	-	-	(61,870)	-	504,019	(461,000)	461,000	442,149
Cash flows from investing activities:												
Purchase of marketable securities	(29,063,660)	(2,727,487)	(31,791,147)	-	(3,931,074)	(3,931,074)	(35,722,221)	(5,545,540)	-	-	-	(41,267,761)
Sale/maturity of marketable securities	30,248,562	-	30,248,562	-	3,240,732	3,240,732	33,489,294	5,535,000	-	-	-	39,024,294
Acquisitions of equipment and leasehold improvements	(1,706,931)	-	(1,706,931)	-	-	-	(1,706,931)	-	(30,679)	(97,014)	-	(1,834,624)
Net cash used in investing activities	(522,029)	(2,727,487)	(3,249,516)	-	(690,342)	(690,342)	(3,939,858)	(10,540)	(30,679)	(97,014)	-	(4,078,091)
Net increase (decrease) in cash and equivalents	3,619,369	(2,700,000)	919,369	72,857	(403,767)	(330,910)	588,459	(10,730)	114,021	(266,247)	-	425,503
Cash and cash equivalents at beginning of year	2,580,091	-	2,580,091	-	-	-	2,580,091	14,283	102,882	635,615	-	3,332,871
Equity transfers	(3,030,910)	2,700,000	(330,910)	(72,857)	403,767	330,910	-	-	-	-	-	-
Cash and cash equivalents at end of year	$3,168,550	-	3,168,550	-	-	-	3,168,550	3,553	216,903	369,368	-	3,758,374

See accompanying independent auditors' report.

Independent Auditors' Report

The Board of Trustees, American Dental Association Health Foundation

We have audited the accompanying balance sheets of American Dental Association Health Foundation as of December 31, 1991 and 1990, and the related statements of revenues, expenses and equity, and cash flows for the years then ended. These financial statements are the responsibility of the Foundation's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of American Dental Association Health Foundation as of December 31, 1991 and 1990, and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

KPMG Peat Marwick

Chicago, Illinois
March 6, 1992

American Dental Association Health Foundation

December 31, 1991 and 1990

Balance Sheets

AMERICAN DENTAL ASSOCIATION HEALTH FOUNDATION
BALANCE SHEETS
DECEMBER 31, 1991 AND 1990

	1991	1990
ASSETS		
Cash	$ 3,553	14,283
Unbilled contract revenues and reimbursable grant expenses	191,138	224,425
Marketable securities, at market (Note 2)	1,785,146	1,774,619
Furniture and equipment, net (Note 3)	26,028	37,742
Total assets	$ 2,005,865	2,051,069
LIABILITIES AND EQUITY		
Accounts payable	$ 107,362	95,351
Accrued liabilities	2,227	6,081
Due to American Dental Association (Note 5)	150,182	42,524
Restricted grant advances and deferred revenues (Note 1)	1,584,234	1,759,232
Total liabilities	1,844,005	1,903,188
Equity	161,860	147,881
Total liabilities and equity	$ 2,005,865	2,051,069

See accompanying notes to financial statements.

American Dental Association Health Foundation

Years Ended December 31, 1991 and 1990

Statements of Revenues, Expenses and Equity

AMERICAN DENTAL ASSOCIATION HEALTH FOUNDATION
STATEMENTS OF REVENUES, EXPENSES AND EQUITY
YEARS ENDED DECEMBER 31, 1991 AND 1990

	1991	1990
Revenues:		
Government contracts and grants	$ 1,680,511	1,987,204
Corporate grants	994,256	741,799
American Dental Association grant (Note 5)	1,542,284	1,506,093
Investment income, net	3,073	4,336
Other income	66,271	19,771
Total revenues	4,286,395	4,259,203
Expenses:		
Staff compensation, taxes and benefits	2,262,991	2,234,401
Meeting and travel expenses	214,093	255,017
Laboratory and office expenses	471,656	626,602
Professional services	418,199	429,256
Direct publication and project costs	145,608	78,932
Depreciation	11,715	14,962
Other expenses, including indirect costs	748,154	630,770
Total expenses	4,272,416	4,269,940
Excess (deficiency) of revenues over expenses	13,979	(10,737)
Equity at beginning of year	147,881	158,618
Equity at end of year	$ 161,860	147,881

See accompanying notes to financial statements.

American Dental Association Health Foundation

Years Ended December 31, 1991 and 1990

Statements of Cash Flows

AMERICAN DENTAL ASSOCIATION HEALTH FOUNDATION
STATEMENTS OF CASH FLOWS
YEARS ENDED DECEMBER 31, 1991 AND 1990

	1991	1990
Cash flows from operating activities:		
Excess (deficiency) of revenues over expenses	$ 13,979	(10,737)
Adjustments to reconcile excess (deficiency) of revenues over expenses to net cash provided by operating activities:		
Depreciation	11,715	14,962
Unrealized (appreciation) depreciation in market value of marketable securities	12	(561)
Changes in assets and liabilities:		
Unbilled contract revenues and reimbursable grant expenses	33,287	(137,263)
Accounts payable and accrued liabilities	8,157	(23,809)
Due to (from) affiliated organizations	107,658	44,442
Restricted grant advances and deferred revenues	(174,998)	299,213
Net cash (used) provided by operating activities	(190)	186,247
Cash flows from investing activities:		
Purchase of marketable securities	(5,545,540)	(6,355,530)
Sale and maturity of marketable securities	5,535,000	6,150,000
Net cash used in investing activities	(10,540)	(205,530)
Net decrease in cash	(10,730)	(19,283)
Cash at beginning of year	14,283	33,566
Cash at end of year	$ 3,553	14,283

See accompanying notes to financial statements.

American Dental Association Health Foundation

Notes to Financial Statements, December 31, 1991 and 1990

AMERICAN DENTAL ASSOCIATION HEALTH FOUNDATION
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 1991 AND 1990

1. Significant Accounting Policies

Basis of Presentation:

The American Dental Association Health Foundation (Foundation), an affiliated foundation of the American Dental Association (Association), was organized to operate exclusively for charitable, scientific and educational purposes. The Foundation conducts certain research projects financed by grants awarded by the Association and others.

The members of the Board of Trustees of the Association also serve as members of the Board of Directors of the Foundation. The Foundation is an Illinois not-for-profit corporation.

Certain 1990 amounts have been reclassified to conform to the 1991 presentation.

Marketable Securities:

Marketable securities are carried at market value and are available for current use.

Revenue Recognition:

Grants received are recognized as income when costs of the related programs or projects are incurred. Amounts received but not yet expended are reported as deferred revenues.

Furniture and Equipment:

Furniture and equipment are stated at cost less accumulated depreciation. Depreciation is computed on the straight line method over the estimated useful lives of the assets, which is 10 years.

Costs of laboratory equipment purchased with Federal funds are consistently charged to expenses as title to the assets acquired may be subject to return to the granting agency.

2. Marketable Securities

Marketable securities at December 31 consisted of the following:

	1991		1990	
	Market Value	Cost	Market Value	Cost
Certificates of deposit	$ 1,772,642	1,772,642	1,762,102	1,762,102
U.S. Government obligations	12,504	12,964	12,517	12,964
	$ 1,785,146	1,785,606	1,774,619	1,775,066

The Foundation deferred investment income of $112,780 in 1991 and $131,279 in 1990. These amounts will be recognized as income when costs of the related grant programs or projects are incurred.

3. Furniture and Equipment

Furniture and equipment at December 31 consisted of the following:

	1991	1990
Furniture and equipment	$ 271,648	271,648
Less accumulated depreciation	245,620	233,906
	$ 26,028	37,742

Depreciation expense amounted to $11,715 and $14,962 in 1991 and 1990, respectively.

4. Income Taxes

The Foundation is exempt from taxation on income related to its exempt purpose under Section 501(c)(3) of the Internal Revenue Code. There was no significant unrelated business income in 1991 or 1990 and therefore a provision for income taxes was not required.

5. Transactions With Related Parties

The Foundation receives an annual grant from the Association for the Foundation's research activities sponsored by the Association. The grant amounted to $1,542,284 and $1,506,093 in 1991 and 1990, respectively. The Foundation receives financial and administrative services from the Association as may be required. In 1991 and 1990 the Foundation paid $547,374 and $616,871, respectively, for such services. Included in these allocated expenses are pension expense charges associated with the Foundation's employees participation in the Association's defined benefit pension and savings and retirement plans. These expenses, which amounted to $140,825 and $85,564 for 1991 and 1990, respectively, are based upon the actual cash contributions made by the Association to the plans for the benefit of Foundation employees.

Independent Auditors' Report

The Board of Directors and Stockholder, American Dental Real Estate Corporation

We have audited the accompanying balance sheets of American Dental Real Estate Corporation (a wholly-owned subsidiary of American Dental Association) as of December 31, 1991 and 1990, and the related statements of revenues, expenses and accumulated deficit, and cash flows for the years then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of American Dental Real Estate Corporation as of December 31, 1991 and 1990, and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

KPMG Peat Marwick

Chicago, Illinois
March 6, 1992

American Dental Real Estate Corporation

December 31, 1991 and 1990

Balance Sheets

AMERICAN DENTAL REAL ESTATE CORPORATION
(A WHOLLY-OWNED SUBSIDIARY OF AMERICAN DENTAL ASSOCIATION)
BALANCE SHEETS
DECEMBER 31, 1991 AND 1990

	1991	1990
ASSETS		
Cash and cash equivalents	$ 216,903	102,882
Receivables	28,438	51,251
Due from American Dental Association	152,429	-
Building and equipment, net (Note 2)	9,154,424	9,393,112
Deferred charges and other assets (Note 3)	277,239	330,896
Total assets	$ 9,829,433	9,878,141
LIABILITIES AND STOCKHOLDER'S DEFICIT		
Notes and loan payable (Note 5)	$11,555,836	11,051,817
Accounts payable and accrued liabilities	433	123,684
Due to American Dental Association	-	184,527
Other liabilities	49,928	57,096
Total liabilities	11,606,197	11,417,124
Stockholder's equity:		
Common stock, $1 par value. Authorized 1,000 shares; issued and outstanding 100 shares.	100	100
Accumulated deficit	(1,776,864)	(1,539,083)
Total stockholder's deficit	(1,776,764)	(1,538,983)
Total liabilities and stockholder's deficit	$ 9,829,433	9,878,141

See accompanying notes to financial statements.

American Dental Real Estate Corporation

Years Ended December 31, 1991 and 1990

Statements of Revenues, Expenses and Accumulated Deficit

AMERICAN DENTAL REAL ESTATE CORPORATION
(A WHOLLY-OWNED SUBSIDIARY OF AMERICAN DENTAL ASSOCIATION)
STATEMENTS OF REVENUES, EXPENSES AND ACCUMULATED DEFICIT
YEARS ENDED DECEMBER 31, 1991 AND 1990

	1991	1990
Revenues:		
Building income, principally rentals	$ 1,356,565	1,159,938
Expenses:		
Staff compensation, taxes and benefits	12,738	21,584
Facility costs, including utilities	663,013	734,264
Professional services	68,375	68,151
Office expenses	5,687	10,426
Depreciation and amortization	284,077	346,643
Interest expense	989,432	1,067,256
Other expenses	4,946	4,114
Total expenses	2,028,268	2,252,438
Excess of expenses over revenues before income tax benefit	(671,703)	(1,092,500)
Income tax benefit (Note 4)	433,922	138,330
Excess of expenses over revenues	(237,781)	(954,170)
Accumulated deficit at beginning of year	(1,539,083)	(584,913)
Accumulated deficit at end of year	$(1,776,864)	(1,539,083)

See accompanying notes to financial statements.

American Dental Real Estate Corporation

Years Ended December 31, 1991 and 1990

Statements of Cash Flows

AMERICAN DENTAL REAL ESTATE CORPORATION
(A WHOLLY-OWNED SUBSIDIARY OF AMERICAN DENTAL ASSOCIATION)
STATEMENTS OF CASH FLOWS
YEARS ENDED DECEMBER 31, 1991 AND 1990

	1991	1990
Cash flows from operating activities:		
Excess of expenses over revenues	$(237,781)	(954,170)
Adjustments to reconcile excess of expenses over revenues to net cash used in operating activities:		
Depreciation and amortization	284,077	346,643
Changes in assets and liabilities:		
Receivables	22,813	(33,409)
Due from/to American Dental Association	(336,956)	82,199
Deferred charges and other assets	38,947	(637)
Accounts payable	(123,251)	53,113
Other liabilities	(7,168)	4,554
Net cash used in operating activities	(359,319)	(501,707)
Cash flows from financing activities:		
Proceeds from issuance of notes payable	600,000	633,460
Repayments of notes payable	(10,933)	(1,458,315)
Proceeds from issuance of mortgage loan payable	-	9,550,000
Repayment of mortgage loan	(85,048)	(7,956,092)
Net cash provided by financing activities	504,019	769,053
Net cash used in investing activities:		
Acquisition of building, equipment and leasehold improvements	(30,679)	(415,033)
Net increase (decrease) in cash and cash equivalents	114,021	(147,687)
Cash and cash equivalents at beginning of year	102,882	250,569
Cash and cash equivalents at end of year	$ 216,903	102,882
Supplemental disclosure of cash flow information -		
Cash paid during the year for interest	$1,086,547	992,736

See accompanying notes to financial statements.

American Dental Real Estate Corporation

Notes to Financial Statements, December 31, 1991 and 1990

AMERICAN DENTAL REAL ESTATE CORPORATION
(A WHOLLY-OWNED SUBSIDIARY OF AMERICAN DENTAL ASSOCIATION)
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 1991 AND 1990

1. Significant Accounting Policies

Basis of Presentation:

American Dental Real Estate Corporation (ADREC), a wholly-owned subsidiary of the American Dental Association (Association), was organized as a not-for-profit corporation for the exclusive purpose of holding title to property, collecting rental income thereon, and remitting the net income to the Association.

Cash equivalents:

Cash equivalents at December 31, 1991 substantially consist of a deposit under an overnight repurchase agreement.

Building, Equipment and Leasehold Improvements:

Building, equipment and leasehold improvements are carried at cost, net of accumulated depreciation and amortization. Depreciation is computed on the straight line method over the estimated useful lives of the assets, which are 30 years for the building and building improvements, and seven years for equipment. Leasehold improvements are amortized over the shorter of their estimated useful lives or the remaining term of the lease.

Revenue Recognition:

Building rental income is recorded as revenue when earned.

Reclassifications:

Certain 1990 amounts have been reclassified to conform to the 1991 presentation.

2. Building and Equipment

Building and equipment at December 31, 1991 and 1990 consisted of the following:

	1991	1990
Building	$ 9,602,195	9,602,195
Building improvements	339,442	336,206
Building equipment	37,968	37,968
	9,979,605	9,976,369
Less accumulated depreciation	825,181	583,257
	$ 9,154,424	9,393,112

Depreciation expense for building and equipment amounted to $241,924 and $316,078 in 1991 and 1990, respectively.

ADREC leases portions of the building to unrelated parties under operating leases with varying terms. Minimum future rentals to be earned from non-cancelable leases currently in effect are $1,140,277 in 1992, $1,042,915 in 1993, $935,020 in 1994, $590,215 in 1995, $306,384 in 1996 and $270,815 thereafter. These amounts may be adjusted upon renewal of the leases.

3. Leasehold Improvements

Leasehold improvements included in deferred charges and other assets at December 31, 1991 and 1990 consisted of the following:

	1991	1990
Tenant leasehold improvements	$ 221,930	194,487
Less accumulated amortization	79,485	37,331
	$ 142,445	157,156

Amortization expense for leasehold improvements amounted to $42,153 and $30,565 in 1991 and 1990, respectively.

4. Income Taxes

ADREC is exempt from taxation on income related to its exempt purpose under Section 501(c)(2) of the Internal Revenue Code (Code). No Federal or state income taxes were owed on unrelated business activities in 1991 or 1990 as such operations generated losses.

ADREC's non-exempt operating results are included in the consolidated Federal income tax return of the Association. Under the terms of an informal tax allocation agreement between ADREC and the Association, ADREC is paid for the tax benefits used by the Association in its consolidated Federal income tax return. ADREC has recorded income tax benefits of $433,922 in 1991 and $138,330 in 1990 under the terms of the agreement.

As of December 31, 1990, ADREC had incurred net operating losses for tax purposes of $695,504 which, in conjunction with net operating losses for tax purposes of $412,555 generated during 1991, were utilized by the Association to recover federal income taxes paid by the Association in 1987 and 1988. The utilization of ADREC's net operating losses, included in the income tax benefit recorded in 1991, amounted to $416,475. As of December 31, 1991, ADREC does not have any remaining net operating losses to be carried forward for tax purposes.

5. Notes and Loan Payable

In February 1989, ADREC purchased for $9,500,000 the building which occupies land owned by the Association. In connection with that purchase, ADREC assumed the existing mortgage which was refinanced in 1990.

The notes and loan payable at December 31, 1991 and 1990 consisted of the following:

	1991	1990
Long-term loan payable -		
9.125% mortgage loan; due in monthly payments of $77,753, with the remaining balance due in 1995	$9,441,624	9,526,672
Short-term notes payable:		
Operating and capital improvement bank line of credit at the prime lending rate, expiring on June 30, 1992	1,800,000	1,200,000
Bridge bank loan at the prime lending rate, expiring on June 30, 1992	300,000	300,000
Installment note payable for equipment	14,212	25,145
	$11,555,836	11,051,817

The mortgage loan is secured by the land and building and is guaranteed by the Association. Maximum borrowing under the bank line of credit, which is also guaranteed by the Association, is $2,000,000.

The aggregate annual principal payments required on the loan and notes payable outstanding at December 31, 1991 for each of the next four years are: $2,185,703 in 1992, $82,764 in 1993, $88,305 in 1994, and $9,199,064 in 1995.

Interest expense amounted to $989,432 and $1,067,256 in 1991 and 1990, respectively.

6. Transactions With Related Parties

The Association occupies space in the building owned by ADREC, however the Association is not charged rent for the use of this space.

7. Liquidity

During 1991 and 1990 ADREC sustained significant operating deficits resulting in negative cash flows from operations. The ability of ADREC to continue operating the rental property is dependent upon receipt of additional advances, necessary to fund working capital requirements, from the Association. The Association intends to provide for the necessary funding so as to allow ADREC to meet its 1992 obligations.

Independent Auditors' Report

The Board of Directors and Stockholder, ADA Holding Company, Inc.

We have audited the accompanying consolidated balance sheets of ADA Holding Company, Inc. and subsidiaries (a wholly-owned subsidiary of American Dental Association) as of December 31, 1991 and 1990, and the related consolidated statements of income and retained earnings, and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of ADA Holding Company, Inc. and subsidiaries as of December 31, 1991 and 1990, and the results of their operations and their cash flows for the years then ended in conformity with generally accepted accounting principles.

Our audits were made for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information included in Schedules 1 through 3 is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations and cash flows of the individual companies. The consolidating information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

KPMG Peat Marwick

Chicago, Illinois
March 6, 1992

ADA Holding Company, Inc. and Subsidiaries

December 31, 1991 and 1990

Consolidated Balance Sheets

ADA HOLDING COMPANY, INC. AND SUBSIDIARIES
(A WHOLLY-OWNED SUBSIDIARY OF AMERICAN DENTAL ASSOCIATION)
CONSOLIDATED BALANCE SHEETS
DECEMBER 31, 1991 AND 1990

	1991	1990
ASSETS		
Cash and cash equivalents	$ 369,368	635,615
Receivables, net of allowance for doubtful accounts of $67,000 in 1991 and $91,500 in 1990	537,684	800,896
Officer and employee receivables	92,079	5,750
Income taxes receivable (Note 4)	151,523	-
Inventories	26,021	164,225
Furniture and equipment, net (Note 2)	290,345	223,143
Deferred charges and other assets	155,939	160,362
Total assets	$ 1,622,959	1,989,991
LIABILITIES AND STOCKHOLDER'S EQUITY		
Accounts payable	$ 218,336	254,860
Accrued liabilities	23,065	82,454
Income taxes payable, including deferred taxes (Note 4)	-	137,426
Payable to American Dental Association	121,371	476,408
Deferred revenues	203,374	208,715
Loan payable to American Dental Association (Note 5)	116,234	577,234
Total liabilities	682,380	1,737,097
Stockholder's equity:		
Common stock, $1 par value. Authorized 1,000 shares; issued and outstanding 100 shares.	100	100
Additional paid-in capital	500,000	500,000
Retained earnings (deficit)	440,479	(247,206)
Total stockholder's equity	940,579	252,894
Total liabilities and stockholder's equity	$ 1,622,959	1,989,991

See accompanying notes to consolidated financial statements.

ADA Holding Company, Inc. and Subsidiaries

Years Ended December 31, 1991 and 1990

Consolidated Statements of Income and Retained Earnings

ADA HOLDING COMPANY, INC. AND SUBSIDIARIES
(A WHOLLY-OWNED SUBSIDIARY OF AMERICAN DENTAL ASSOCIATION)
CONSOLIDATED STATEMENTS OF INCOME AND RETAINED EARNINGS
YEARS ENDED DECEMBER 31, 1991 AND 1990

	1991	1990
Revenues:		
Advertising, including classified ads	$ 7,109,158	6,715,359
Subscriptions	324,890	448,605
Publishing fees (Note 5)	760,000	460,000
Royalty income (Note 3)	185,520	494,461
Investment income	27,289	25,632
Other income	49,417	30,040
Total revenues	8,456,274	8,174,097
Expenses:		
Staff compensation, taxes and benefits (Note 5)	1,353,740	1,516,886
Publication, printing and project expenses	5,121,719	4,819,931
Facility and utility costs	216,232	252,511
Professional services	189,976	222,550
Office expense	119,973	114,726
Meeting and travel expenses	113,046	106,707
Loss on disposal of equipment	-	108,436
Depreciation	29,812	18,713
Other expenses, including allocated general and administrative expenses	445,658	439,391
Total expenses	7,590,156	7,599,851
Income before income tax expense and extraordinary item	866,118	574,246
Income tax expense (Note 4)	(180,648)	(230,650)
Income before extraordinary item	685,470	343,596
Extraordinary item - reduction of income tax expense due to utilization of prior years' net operating loss carryforward (Note 4)	2,215	83,341
Net income	687,685	426,937
Accumulated deficit at beginning of year	(247,206)	(674,143)
Retained earnings (deficit) at end of year	$ 440,479	(247,206)

See accompanying notes to consolidated financial statements.

ADA Holding Company, Inc. and Subsidiaries

Years Ended December 31, 1991 and 1990

Consolidated Statements of Cash Flows

ADA HOLDING COMPANY, INC. AND SUBSIDIARIES
(A WHOLLY-OWNED SUBSIDIARY OF AMERICAN DENTAL ASSOCIATION)
CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED DECEMBER 31, 1991 AND 1990

	1991	1990
Cash flows from operating activities:		
Net income	$ 687,685	426,937
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation	29,812	18,713
Loss on disposal of equipment	-	108,436
Changes in assets and liabilities -		
Receivables	263,213	441,892
Due from officers and employees	(86,329)	(5,750)
Income taxes receivable	(151,523)	-
Inventories	138,204	168,341
Deferred charges and other assets	4,422	(3,591)
Accounts payable and accrued liabilities	(95,913)	138,607
Income taxes payable, including deferred taxes	(137,426)	137,426
Payable to American Dental Association	(355,037)	(316,671)
Deferred revenues	(5,341)	(132,969)
Net cash provided by operating activities	291,767	981,371
Net cash used by financing activities -		
Repayment of loan payable	(461,000)	-
Net cash used by investing activities -		
Acquisitions of furniture and equipment	(97,014)	(347,772)
Net increase (decrease) in cash and cash equivalents	(266,247)	633,599
Cash and cash equivalents at beginning of year	635,615	2,016
Cash and cash equivalents at end of year	$ 369,368	635,615
Supplemental disclosure of cash flow information -		
Cash paid during the year for income taxes	$ 467,382	$ 9,883

See accompanying notes to consolidated financial statements.

ADA Holding Company, Inc. and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1991 and 1990

ADA HOLDING COMPANY, INC. AND SUBSIDIARIES
(A WHOLLY-OWNED SUBSIDIARY OF AMERICAN DENTAL ASSOCIATION)
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
DECEMBER 31, 1991 AND 1990

1. Significant Accounting Policies

Basis of Presentation:

ADA Holding Company, Inc. (ADAHC), a wholly-owned subsidiary of the American Dental Association (Association), was organized for the purpose of holding equity positions in, and managing, the for-profit corporations organized by the Association. ADAHC officially began operations on January 1, 1990.

The accompanying consolidated financial statements include the accounts of ADAHC and its wholly-owned subsidiaries, ADA Publishers, Inc. (ADAPI) and ADA Business Systems, Inc. (ADABSI). All significant intercompany accounts and transactions have been eliminated in consolidation.

Cash Equivalents:

Cash equivalents of $342,711 and $578,047 at December 31, 1991 and 1990, respectively, consist of deposits under overnight repurchase agreements.

Officer and Employee Receivables:

Officer and employee receivables consist of salary and travel advances to officers and employees.

Inventories:

Inventories, consisting of paper stock, are carried at the lower of cost or market. Cost is determined using the first-in, first-out method.

Furniture and Equipment:

Furniture and equipment are stated at cost less accumulated depreciation. Depreciation is computed on the straight line method over 5-10 years, the estimated useful lives of the assets.

Revenue and Expense Recognition:

Subscriptions to periodicals are recognized as revenue over the terms of the subscriptions. Advertising revenue and direct publication costs are recognized in the period the related publication is issued. Royalty income is recorded as revenue when earned.

Income Taxes:

Income taxes are charged to operations based upon income reported for financial statement purposes. Deferred income taxes are provided for the tax effects of timing differences between financial reporting and taxable income.

2. Furniture and Equipment

Furniture and equipment at December 31, 1991 and 1990 consisted of the following:

	1991	1990
Furniture and equipment	$ 343,891	246,877
Less accumulated depreciation	53,546	23,734
	$ 290,345	223,143

Depreciation expense for the years ended December 31, 1991 and 1990 amounted to $29,812 and $18,713, respectively.

3. Royalty Income

In 1986, ADABSI entered into an asset purchase and joint marketing agreement with Triad Systems Corporation. Under the terms of the agreement, ADABSI received royalty income amounting to $185,520 and $494,461 during 1991 and 1990, respectively. The agreement expired in August 1991 and was not renewed by ADABSI. ADABSI is currently negotiating a new agreement with a different company, however, the outcome of such negotiations cannot be determined at this time.

4. Income Taxes

ADAHC files a consolidated Federal income tax return with its wholly-owned subsidiaries.

Income tax expense (benefit) for the years ended December 31, 1991 and 1990 is as follows:

	1991	1990
Current:		
Federal	$ 167,422	156,418
State	(33,290)	33,290
Current income tax expense	134,132	189,708
Deferred:		
Federal	44,301	(35,009)
State	-	(7,390)
Deferred income tax expense	44,301	(42,399)
Utilization of net operating loss carryforward	2,215	83,341
Total income tax expense	$ 180,648	230,650

Income tax expense differs from the amount computed by applying the statutory Federal income tax rate of 34% to income before income tax expense and extraordinary item for the years ended December 31, 1991 and 1990 primarily as the result of the effects of state income taxes, the application of the alternative minimum tax and other items.

Deferred income taxes are primarily the result of timing differences between the deductibility of bad debts expense for tax and book purposes and the excess of tax depreciation over book depreciation.

During the years ended December 31, 1991 and 1990, ADABSI realized a benefit of $2,215 and $83,341, respectively, resulting from the utilization of net operating loss carryforwards generated in prior years. ADABSI has remaining net operating loss carryforwards for tax return and financial reporting purposes of approximately $1,400,000 which are available to offset only its future taxable income. These carryforwards expire as follows: $690,000 in 2001, $419,000 in 2002 and $291,000 in 2003. Such loss carryforwards will be recognized as an extraordinary item in the period in which they are used to reduce income taxes payable.

5. Transactions With Related Parties

The Association provides ADAHC and its subsidiaries with administrative services as may be required. The allocated cost of such services amounted to $498,395 and $440,086 during the years ended December 31, 1991 and 1990, respectively. Included in these allocated expenses are pension expense charges associated with ADAHC and its subsidiaries employees who are participants in the Association's defined benefit pension and savings and retirement plans. These expenses, which amounted to $86,439 and $40,126 in 1991 and 1990, respectively, are based upon the actual cash contributions made by the Association to the plans for the benefit of employees of ADAHC and its subsidiaries.

The Association also leases equipment and office space to ADAPI. Rent expense under these leases amounted to $215,992 and $252,881 during 1991 and 1990, respectively. Minimum future rentals to be paid under non-cancelable operating leases currently in effect are $15,000 for each year through 1996 and $45,000 thereafter.

Effective January 1, 1990, the Association and ADAPI entered into a publishing agreement. The term of the agreement is five years with an option for automatic renewal for an additional five years, unless terminated by the parties pursuant to terms of the agreement. Under the terms of the agreement, ADAPI agreed to perform all publishing and distributing functions related to the Association's three major publications as well as for any new publications which might be developed in the future. In connection with the agreement, the Association assigned all relevant production and advertising contracts, together with all non-member subscriptions and the revenue from single copy sales, to ADAPI. Under the terms of the agreement, the Association paid publishing fees to ADAPI in the amount of $760,000 and $460,000 during the years ended December 31, 1991 and 1990, respectively. Also under the terms of the agreement, ADAPI paid a royalty fee to the Association for the use of its trademarks in connection with its publishing activity. The royalty is payable at a rate of 2% of ADAPI's pre-tax income. Royalties paid amounted to $18,681 in 1991 and $7,349 in 1990.

In addition to the publishing agreement, the Association transferred all relevant publishing assets and liabilities with a net book value of $1,077,234 as of January 1, 1990 to ADAPI in exchange for a $577,234 non-interest bearing loan payable to the Association. In connection with the transfer, ADAPI recognized a capital contribution of $500,000, which has been reflected as additional paid-in capital in the accompanying consolidated financial statements. Repayment of the loan is not subject to a predetermined repayment schedule. ADAPI paid $461,000 on the loan during 1991, leaving a balance due as of December 31, 1991 of $116,234.

ADA Holding Company, Inc. and Subsidiaries

December 31, 1991

Consolidating Balance Sheet

Schedule 1

ADA HOLDING COMPANY, INC. AND SUBSIDIARIES
(A WHOLLY-OWNED SUBSIDIARY OF AMERICAN DENTAL ASSOCIATION)
CONSOLIDATING BALANCE SHEET
DECEMBER 31, 1991

	ADAHC	ADAPI	ADABSI	Eliminations	Consolidated ADAHC
ASSETS					
Cash and cash equivalents	$ 11,820	349,761	7,787	-	369,368
Receivables	(484)	528,777	9,391	-	537,684
Due from officers and employees	-	92,079	-	-	92,079
Income taxes receivable	151,523	-	-	-	151,523
Inventories	-	26,021	-	-	26,021
Investment in ADAPI	1,000	-	-	(1,000)	-
Investment in ADABSI	100	-	-	(100)	-
Furniture and equipment	-	290,345	-	-	290,345
Deferred charges and other assets	-	141,119	14,820	-	155,939
Total assets	$ 163,959	1,428,102	31,998	(1,100)	1,622,959
LIABILITIES AND STOCKHOLDER'S EQUITY					
Accounts payable	$ 910	217,426	-	-	218,336
Accrued liabilities	-	15,565	7,500	-	23,065
Payable to affiliated organizations	(3,441)	(327,467)	452,279	-	121,371
Deferred revenues	-	203,374	-	-	203,374
Loan payable to American Dental Association	-	116,234	-	-	116,234
Total liabilities	(2,531)	225,132	459,779	-	682,380
Stockholder's equity:					
Common stock	100	1,000	1,000,000	(1,001,000)	100
Additional paid-in capital	-	500,000	-	-	500,000
Retained earnings (deficit)	166,390	701,970	(1,427,781)	999,900	440,479
Total stockholder's equity	166,490	1,202,970	(427,781)	(1,100)	940,579
Total liabilities and stockholder's equity	$ 163,959	1,428,102	31,998	(1,100)	1,622,959

See accompanying independent auditors' report.

ADA Holding Company, Inc. and Subsidiaries

Year Ended December 31, 1991

Consolidating Statement of Income and Retained Earnings

Schedule 2

ADA HOLDING COMPANY, INC. AND SUBSIDIARIES
(A WHOLLY-OWNED SUBSIDIARY OF AMERICAN DENTAL ASSOCIATION)
CONSOLIDATING STATEMENT OF INCOME AND RETAINED EARNINGS
YEAR ENDED DECEMBER 31, 1991

	ADAHC	ADAPI	ADABSI	Eliminations	Consolidated ADAHC
Revenues:					
Advertising, including classified ads	$ -	7,109,158	-	-	7,109,158
Subscriptions	-	324,890	-	-	324,890
Publishing fees	-	760,000	-	-	760,000
Royalty income	-	-	185,520	-	185,520
Investment income	225,000	27,289	-	(225,000)	27,289
Other income	-	49,417	-	-	49,417
Total revenues	225,000	8,270,754	185,520	(225,000)	8,456,274
Expenses:					
Staff compensation, taxes and benefits	-	1,271,850	81,890	-	1,353,740
Publication, printing and project expenses	607	5,058,841	62,271	-	5,121,719
Facility and utility costs	-	215,632	600	-	216,232
Professional services	15,776	158,531	15,669	-	189,976
Office expense	974	113,581	5,418	-	119,973
Meeting and travel expenses	26,673	81,549	4,824	-	113,046
Depreciation	-	28,617	1,195	-	29,812
Other expenses, including allocated general and administrative expenses	3,787	434,154	7,717	-	445,658
Total expenses	47,817	7,362,755	179,584	-	7,590,156
Income before income tax expense	177,183	907,999	5,936	(225,000)	866,118
Income tax (expense) benefit	16,114	(194,547)	(2,215)	-	(180,648)
Income before extraordinary item	193,297	713,452	3,721	(225,000)	685,470
Extraordinary item: Reduction of income tax expense due to utilization of prior years' net operating loss carryforward	-	-	2,215	-	2,215
Net Income	193,297	713,452	5,936	(225,000)	687,685
Retained earnings (deficit) at beginning of year	(26,907)	213,518	(1,433,717)	999,900	(247,206)
Dividends declared and paid	-	(225,000)	-	225,000	-
Retained earnings (deficit) at end of year	$ 166,390	701,970	(1,427,781)	999,900	440,479

See accompanying independent auditors' report.

ADA Holding Company, Inc. and Subsidiaries

Year Ended December 31, 1991

Consolidating Statement of Cash Flows

Schedule 3

ADA HOLDING COMPANY, INC. AND SUBSIDIARIES
(A WHOLLY-OWNED SUBSIDIARY OF AMERICAN DENTAL ASSOCIATION)
CONSOLIDATING STATEMENT OF CASH FLOWS
YEAR ENDED DECEMBER 31, 1991

	ADAHC	ADAPI	ADABSI	Eliminations	Consolidated ADAHC
Cash flows from operating activities:					
Net income	$ 193,297	713,452	5,936	(225,000)	687,685
Adjustments to reconcile net income to net cash provided by operating activities:					
Depreciation and amortization	-	28,617	1,195	-	29,812
Changes in assets and liabilities -					
Receivables	484	151,635	111,094	-	263,213
Due from officers and employees	-	(86,329)	-	-	(86,329)
Income taxes receivable	(151,523)	-	-	-	(151,523)
Inventories	-	138,204	-	-	138,204
Deferred charges and other assets	-	11,782	(7,360)	-	4,422
Accounts payable and accrued liabilities	(14,800)	(87,533)	6,420	-	(95,913)
Income taxes payable	16,485	(153,911)	-	-	(137,426)
Payable to affiliated organizations	(33,123)	(212,416)	(109,498)	-	(355,037)
Deferred revenues	-	(5,341)	-	-	(5,341)
Net cash provided by operating activities	10,820	498,160	7,787	(225,000)	291,767
Cash flows from financing activities:					
Repayment of loan payable	-	(461,000)	-	-	(461,000)
Payment of dividends	-	(225,000)	-	225,000	-
Net cash used by financing activities	-	(686,000)	-	225,000	(461,000)
Net cash used by investing activities -					
Acquisitions of furniture & equipment	-	(97,014)	-	-	(97,014)
Net increase (decrease) in cash and cash equivalents	10,820	(284,854)	7,787	-	(266,247)
Cash and cash equivalents at beginning of year	1,000	634,615	-	-	635,615
Cash and cash equivalents at end of year	$ 11,820	349,761	7,787	-	369,368

See accompanying independent auditors' report.

Independent Auditors' Report

The Board of Directors and Stockholder, ADA Publishers, Inc.

We have audited the accompanying balance sheets of ADA Publishers, Inc. (a wholly-owned subsidiary of ADA Holding Company, Inc.) as of December 31, 1991 and 1990, and the related statements of income and retained earnings, and cash flows for the years then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of ADA Publishers, Inc. as of December 31, 1991 and 1990, and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

KPMG Peat Marwick

Chicago, Illinois
March 6, 1992

ADA Publishers, Inc.

December 31, 1991 and 1990

Balance Sheets

ADA PUBLISHERS, INC.
(A WHOLLY-OWNED SUBSIDIARY OF ADA HOLDING COMPANY, INC.)
BALANCE SHEETS
DECEMBER 31, 1991 AND 1990

	1991	1990
ASSETS		
Cash and cash equivalents	$ 349,761	634,615
Receivables, net of allowance for doubtful accounts of $67,000 in 1991 and $84,000 in 1990	528,777	680,412
Due from officers and employees (Note 1)	92,079	5,750
Due from affiliated organizations, net (Note 4)	327,467	115,051
Inventories	26,021	164,225
Furniture and equipment, net (Note 2)	290,345	221,948
Deferred charges and other assets	141,119	152,902
Total assets	$ 1,755,569	1,974,903
LIABILITIES AND STOCKHOLDER'S EQUITY		
Accounts payable	$ 217,426	253,770
Accrued liabilities	15,565	66,754
Income taxes payable, including deferred taxes (Note 3)	-	153,911
Deferred revenues	203,374	208,716
Loan payable to American Dental Association (Note 4)	116,234	577,234
Total liabilities	552,599	1,260,385
Stockholder's equity:		
Common stock, $1 par value. Authorized, issued and outstanding 1,000 shares.	1,000	1,000
Additional paid-in capital	500,000	500,000
Retained earnings	701,970	213,518
Total stockholder's equity	1,202,970	714,518
Total liabilities and stockholder's equity	$ 1,755,569	1,974,903

See accompanying notes to financial statements.

ADA Publishers, Inc.

Years Ended December 31, 1991 and 1990

Statements of Income and Retained Earnings

ADA PUBLISHERS, INC.
(A WHOLLY-OWNED SUBSIDIARY OF ADA HOLDING COMPANY, INC.)
STATEMENTS OF INCOME AND RETAINED EARNINGS
YEARS ENDED DECEMBER 31, 1991 AND 1990

	1991	1990
Revenues:		
Advertising, including classified ads	$ 7,109,158	6,715,359
Subscriptions	324,890	448,605
Publishing fees (Note 4)	760,000	460,000
Investment income	27,289	15,220
Other income	49,417	30,041
Total revenues	8,270,754	7,669,225
Expenses:		
Staff compensation, taxes and benefits (Note 4)	1,271,850	1,381,395
Publication, printing and project expenses	5,058,841	4,754,505
Facility and utility costs	215,632	240,734
Professional services	158,531	187,767
Office expense	113,581	107,408
Meeting and travel expenses	81,549	87,410
Loss on disposal of equipment	-	108,436
Depreciation	28,617	17,388
Other expenses, including allocated general and administrative expenses	434,154	416,753
Total expenses	7,362,755	7,301,796
Income before income tax expense	907,999	367,429
Income tax expense (Note 3)	(194,547)	(153,911)
Net income	713,452	213,518
Retained earnings at beginning of year	213,518	-
Dividends paid	(225,000)	-
Retained earnings at end of year	$ 701,970	213,518

See accompanying notes to financial statements.

ADA Publishers, Inc.

Years Ended December 31, 1991 and 1990

Statements of Cash Flows

ADA PUBLISHERS, INC.
(A WHOLLY-OWNED SUBSIDIARY OF ADA HOLDING COMPANY, INC.)
STATEMENTS OF CASH FLOWS
YEARS ENDED DECEMBER 31, 1991 AND 1990

	1991	1990
Cash flows from operating activities:		
Net income	$ 713,452	213,518
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation	28,617	17,388
Loss on disposal of equipment	-	108,436
Changes in assets and liabilities:		
Receivables	151,635	447,877
Due from officers and employees	(86,329)	(5,750)
Due from affiliated organizations, net	(212,416)	(115,051)
Inventories	138,204	168,341
Deferred charges and other assets	11,782	3,869
Accounts payable and accrued liabilities	(87,533)	121,817
Income taxes payable, including deferred taxes	(153,911)	153,911
Deferred revenues	(5,341)	(132,969)
Net cash provided by operating activities	498,160	981,387
Net cash used in investing activities - Acquisitions of property and equipment	(97,014)	(347,772)
Cash flows from financing activities:		
Proceeds from issuance of common stock	-	1,000
Repayment of loan payable	(461,000)	-
Payment of dividends	(225,000)	-
Net cash provided by (used in) financing activities	(686,000)	1,000
Net increase (decrease) in cash and cash equivalents	(284,854)	634,615
Cash and cash equivalents at beginning of year	634,615	-
Cash and cash equivalents at end of year	$ 349,761	634,615
Supplemental disclosure of cash flow information - Cash paid during the year for income taxes	$ 459,518	$ -

See accompanying notes to financial statements.

ADA Publishers, Inc.

Notes to Financial Statements, December 31, 1991 and 1990

ADA PUBLISHERS, INC.
(A WHOLLY-OWNED SUBSIDIARY OF ADA HOLDING COMPANY, INC.)
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 1991 AND 1990

1. Significant Accounting Policies

Basis of Presentation:

ADA Publishers, Inc. (ADAPI) is a wholly-owned subsidiary of ADA Holding Company, Inc. (ADAHC), which in turn is a wholly-owned subsidiary of the American Dental Association (Association). ADAPI is a for-profit corporation whose current business is to perform all publishing functions for the publications of the Association, including JADA, ADA News and Dental Teamwork. ADAPI began operations on January 1, 1990.

Cash Equivalents:

Cash equivalents of $342,711 and $578,047 at December 31, 1991 and 1990, respectively, consist of deposits under overnight repurchase agreements.

Due from Officers and Employees:

Due from officers and employees consists of salary and travel advances to officers and employees.

Inventories:

Inventories, consisting of paper stock, are carried at the lower of cost or market. Cost is determined using the first-in, first-out method.

Furniture and Equipment:

Furniture and equipment are stated at cost less accumulated depreciation. Depreciation is computed on the straight line method over 5-10 years, the estimated useful lives of the assets.

Revenue and Expense Recognition:

Subscriptions to periodicals are recognized as revenue over the terms of the subscriptions. Advertising revenue and direct publication costs are recognized in the period the related publication is issued.

Income Taxes:

Income taxes are charged to operations based upon income reported for financial statement purposes. Deferred income taxes are provided for the tax effects of timing differences between financial income and taxable income.

2. Furniture and Equipment

Furniture and equipment at December 31, 1991 and 1990 consists of the following:

	1991	1990
Furniture and equipment	$ 330,643	233,629
Less accumulated depreciation	40,298	11,681
	$ 290,345	221,948

Depreciation expense for the years ended December 31, 1991 and 1990 amounted to $28,617 and $17,388, respectively.

3. Income Taxes

ADAPI's operating results are included in the consolidated Federal income tax return of ADAHC. Income taxes for financial reporting purposes are calculated as if ADAPI filed its own Federal income tax return.

Income tax expense (benefit) for the years ended December 31, 1991 and 1990 is as follows:

	1991	1990
Current:		
Federal	$ 186,616	159,940
State	(36,370)	36,370
Current income tax expense	150,246	196,310
Deferred:		
Federal	44,301	(35,009)
State	-	(7,390)
Deferred income tax expense	44,301	(42,399)
Total income tax expense	$ 194,547	153,911

Income tax expense differs from the amount computed by applying the statutory Federal income tax rate of 34% to income before income tax expense for the years ended December 31, 1991 and 1990 primarily as the result of the effects of state income taxes and other items.

Deferred income taxes are primarily the result of timing differences between the deductibility of bad debts expense for tax and book purposes and the excess of tax depreciation over book depreciation.

4. Transactions With Related Parties

The Association and ADAHC provide ADAPI with administrative services as may be required. The allocated cost of such services amounted to $474,770 and $426,139 during the years ended December 31, 1991 and 1990, respectively. Included in these allocated expenses are pension expense charges associated with ADAPI's employees who are participants in the Association's defined benefit pension and savings and retirement plans. These expenses, which amounted to $73,840 and $36,105 in 1991 and 1990, respectively, are based upon the actual cash contributions made by the Association to the plans for the benefit of employees of ADAPI.

The Association also leases equipment and office space to ADAPI. Rent expense under these leases amounted to $215,992 and $252,881 during 1991 and 1990, respectively. Minimum future rentals to be paid under non-cancelable operating leases currently in effect are $15,000 for each year through 1996 and $45,000 thereafter.

At December 31, 1991 and 1990, amounts due from (to) affiliated organizations were as follows:

	1991	1990
Association	$ (2,671)	(57,731)
ADAHC, includes approximately $111,000 related to federal income taxes recoverable	190,364	75,708
ADA Business Systems, Inc., a wholly-owned subsidiary of ADAHC	139,774	97,074
	$ 327,467	115,051

(Continued)

Effective January 1, 1990, the Association and ADAPI entered into a publishing agreement. The term of the agreement is five years with an option for automatic renewal for an additional five years, unless terminated by the parties pursuant to terms of the agreement. Under the terms of the agreement, ADAPI agreed to perform all publishing and distributing functions related to the Association's three major publications as well as for any new publications which might be developed in the future. In connection with the agreement, the Association assigned all relevant production and advertising contracts, together with all non-member subscriptions and the revenue from single copy sales, to ADAPI. Under the terms of the agreement, the Association paid publishing fees to ADAPI in the amount of $760,000 and $460,000 during the years ended December 31, 1991 and 1990, respectively. Also under the terms of the agreement, ADAPI paid a royalty fee to the Association for the use of Association trademarks in connection with its publishing activity. The royalty is payable at a rate of 2% of ADAPI's pre-tax income. Royalties paid amounted to $18,681 and $7,349 for 1991 and 1990, respectively.

In addition to the publishing agreement, the Association transferred all relevant publishing assets and liabilities with a net book value of $1,077,234 as of January 1, 1990 to ADAPI in exchange for a $577,234 non-interest bearing loan payable to the Association. In connection with the transfer, ADAPI recognized a capital contribution of $500,000, which has been reflected as additional paid-in capital in the accompanying financial statements. Repayment of the loan is not subject to a predetermined repayment schedule. ADAPI paid $461,000 on the loan during 1991, leaving a balance due at December 31, 1991 of $116,234.

Independent Auditors' Report

The Board of Directors and Stockholder, ADA Business Systems, Inc.

We have audited the accompanying balances sheets of ADA Business Systems, Inc. (a wholly-owned subsidiary of ADA Holding Company, Inc.) as of December 31, 1991 and 1990, and the related statements of income and accumulated deficit, and cash flows for the years then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of ADA Business Systems, Inc. as of December 31, 1991 and 1990, and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

KPMG Peat Marwick

Chicago, Illinois
March 6, 1992

ADA Business Systems, Inc.

December 31, 1991 and 1990

Balance Sheets

ADA BUSINESS SYSTEMS, INC.
(A WHOLLY-OWNED SUBSIDIARY OF ADA HOLDING COMPANY, INC.)
BALANCE SHEETS
DECEMBER 31, 1991 AND 1990

	1991	1990
ASSETS		
Cash	$ 7,787	-
Receivables, net of allowance for doubtful accounts of $7,500 in 1990	9,391	120,485
Furniture and equipment, net (Note 3)	-	1,195
Other assets	14,820	7,460
Total assets	$ 31,998	129,140
LIABILITIES AND STOCKHOLDER'S EQUITY		
Accounts payable and accrued liabilities	$ 7,500	1,080
Due to affiliated organizations (Note 5)	452,279	561,777
Total liabilities	459,779	562,857
Stockholder's equity:		
Common stock, $10 par value. Authorized, issued and outstanding 100,000 shares.	1,000,000	1,000,000
Accumulated deficit	(1,427,781)	(1,433,717)
Total stockholder's equity	(427,781)	(433,717)
Total liabilities and stockholder's equity	$ 31,998	129,140

See accompanying notes to financial statements.

ADA Business Systems, Inc.

Years Ended December 31, 1991 and 1990

Statements of Income and Accumulated Deficit

ADA BUSINESS SYSTEMS, INC.
(A WHOLLY-OWNED SUBSIDIARY OF ADA HOLDING COMPANY, INC.)
STATEMENTS OF INCOME AND ACCUMULATED DEFICIT
YEARS ENDED DECEMBER 31, 1991 AND 1990

	1991	1990
Revenues:		
Royalty income (Note 2)	$ 185,520	494,461
Expenses:		
Staff compensation, taxes and benefits (Note 5)	81,890	135,491
Publication and project expenses	62,271	65,132
Professional services	15,669	13,530
Facility and utility costs	600	11,631
Office expense	5,418	4,464
Meeting and travel expenses	4,824	2,753
Depreciation	1,195	1,325
Other expenses	7,717	9,926
Total expenses	179,584	244,252
Income before income tax expense and extraordinary item	5,936	250,209
Income tax expense (Note 4)	(2,215)	(93,224)
Income before extraordinary item	3,721	156,985
Extraordinary item - reduction of income tax expense due to utilization of prior years' net operating loss carryforward (Note 4)	2,215	83,341
Net income	5,936	240,326
Accumulated deficit at beginning of year	(1,433,717)	(1,674,043)
Accumulated deficit at end of year	$(1,427,781)	(1,433,717)

See accompanying notes to financial statements.

ADA Business Systems, Inc.

Years Ended December 31, 1991 and 1990

Statements of Cash Flows

ADA BUSINESS SYSTEMS, INC.
(A WHOLLY-OWNED SUBSIDIARY OF ADA HOLDING COMPANY, INC.)
STATEMENTS OF CASH FLOWS
YEARS ENDED DECEMBER 31, 1991 AND 1990

	1991	1990
Cash flows from operating activities:		
Net income	$ 5,936	240,326
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation	1,195	1,325
Changes in assets and liabilities:		
Receivables	111,094	(5,985)
Other assets	(7,360)	(7,460)
Accounts payable and accrued liabilities	6,420	1,080
Due to affiliated organizations	(109,498)	(231,302)
Net cash provided by (used by) operating activities	7,787	(2,016)
Cash at beginning of year	-	2,016
Cash at end of year	$ 7,787	-
Supplemental disclosure of cash flow information -		
Cash paid during the year for income taxes	$ -	9,883

See accompanying notes to financial statements.

ADA Business Systems, Inc.

Notes to Financial Statements, December 31, 1991 and 1990

ADA BUSINESS SYSTEMS, INC.
(A WHOLLY-OWNED SUBSIDIARY OF ADA HOLDING COMPANY, INC.)
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 1991 AND 1990

1. Significant Accounting Policies

Basis of Presentation:

ADA Business Systems, Inc. (ADABSI), a for-profit corporation, is a wholly-owned subsidiary of ADA Holding Company, Inc. (ADAHC), which in turn is a wholly-owned subsidiary of the American Dental Association (Association).

Furniture and Equipment:

Furniture and equipment are stated at cost less accumulated depreciation. Depreciation is computed on the straight line method over 10 years, the estimated useful life of the assets.

Revenue Recognition:

Royalty income is recorded as revenue when earned.

Income Taxes:

Income taxes are charged to operations based upon income reported for financial statement purposes.

2. Royalty Income

In 1986, ADABSI entered into an asset purchase and joint marketing agreement with Triad Systems Corporation. Under the terms of the agreement, ADABSI received royalty income amounting to $185,520 and $494,461 during 1991 and 1990, respectively. The agreement expired in August 1991 and was not renewed by ADABSI. ADABSI is currently negotiating a new agreement with a different company, however, the outcome of such negotiations cannot be determined at this time.

3. Furniture and Equipment

Furniture and equipment at December 31, 1991 and 1990 consisted of the following:

	1991	1990
Furniture and equipment	$ 13,248	13,248
Less accumulated depreciation	13,248	12,053
	$ -	1,195

Depreciation expense for the years ended December 31, 1991 and 1990 amounted to $1,195 and $1,325, respectively.

4. Income Taxes

ADABSI's operating results are included in the consolidated Federal income tax return of ADAHC. Income taxes for financial reporting purposes are computed as if ADABSI filed its own Federal income tax return.

Income tax expense for the years ended December 31, 1991 and 1990 is as follows:

	1991	1990
Federal	$ -	9,883
State	-	-
Current income tax expense	-	9,883
Utilization of net operating loss carryforward	2,215	83,341
Total income tax expense	$ 2,215	93,224

Income tax expense differs from the amount computed by applying the statutory Federal income tax rate of 34% to income before income tax expense and extraordinary item for the year ended December 31, 1990 primarily as the result of the application of the alternative minimum tax.

During the years ended December 31, 1991 and 1990, ADABSI realized benefits of $2,215 and $83,341 resulting from the utilization of net operating loss carryforwards generated in prior years. ADABSI has remaining net operating loss carryforwards for tax return and financial reporting purposes of approximately $1,400,000 which are available to offset its future taxable income. These carryforwards expire as follows: $690,000 in 2001, $419,000 in 2002 and $291,000 in 2003. Such loss carryforwards will be recognized as an extraordinary item in the period in which they are used to reduce income taxes payable.

5. Transactions With Related Parties

The Association, ADAHC and ADAHC's wholly-owned subsidiary ADA Publishers, Inc. (ADAPI), provide ADABSI with accounting and administrative services as may be required. The allocated cost of such services amounted to $19,837 and $13,947 during the years ended December 31, 1991 and 1990, respectively. Included in these allocated expenses are pension expense charges associated with ADABSI employees who are participants in the Association's defined benefit pension and savings and retirement plans. These expenses, which amounted to $12,598 and $4,021 in 1991 and 1990, respectively, are based upon the actual cash contributions made by the Association to the plans for the benefit of employees of ADABSI.

At December 31, 1991 and 1990, the amount payable to each of the affiliated organizations is as follows:

	1991	1990
ADAHC	$ 196,236	49,324
ADAPI	139,774	97,074
Association	116,269	415,379
	$ 452,279	561,777

Independent Auditors' Report

Commission on Relief Fund Activities, American Dental Association

We have audited the accompanying balance sheet of American Dental Association Relief Fund (Relief Fund) as of December 31, 1991, and the related statements of revenues and expenses and change in fund balance and cash flows for the year then ended. These financial statements are the responsibility of the Relief Fund's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of American Dental Association Relief Fund as of December 31, 1991, and the results of its operations and its cash flows for the year then ended in conformity with generally accepted accounting principles.

KPMG Peat Marwick

Chicago, Illinois
April 9, 1992

American Dental Association Relief Fund

December 31, 1990

Balance Sheet

AMERICAN DENTAL ASSOCIATION RELIEF FUND
BALANCE SHEET
DECEMBER 31, 1991

ASSETS

Interest and dividends receivable	$ 72,686
Amounts for grants due from constituent societies	21,670
Marketable securities, at market (note 2)	6,520,605
Equipment, net	3,423
Prepaid expenses	2,500
Total assets	$6,620,884

LIABILITIES AND FUND BALANCE

Accounts payable	$ 15,285
Amounts due to affiliates	3,356
Amounts payable to constituent societies	504,608
Total liabilities	523,249
Fund balance	6,097,635
Total liabilities and fund balance	$6,620,884

See accompanying notes to financial statements.

American Dental Association Relief Fund

Year Ended December 31, 1991

Statement of Revenues and Expenses and Change in Fund Balance

AMERICAN DENTAL ASSOCIATION RELIEF FUND
STATEMENT OF REVENUES AND
EXPENSES AND CHANGE IN FUND BALANCE
YEAR ENDED DECEMBER 31, 1991

REVENUES:	
Contributions	$ 432,441
Allocation of contributions to constituent societies	(374,478)
Net contributions	57,963
Earnings (loss) on investments:	
Interest and dividends	432,776
Investment management fees and expenses	(26,362)
Net realized capital gains	386,396
Net unrealized appreciation	368,611
Total net gain on investments	1,161,421
Miscellaneous income	14,139
Total revenues	1,233,523
EXPENSES:	
Grant to The ADA Endowment and Assistance Fund, Inc.	1,210,001
Relief Grants	367,498
Fund-raising	72,339
General and administrative	153,911
Total expenses	1,803,749
Deficiency of revenues over expenses	(570,226)
Fund balance at beginning of year	6,667,861
Fund balance at end of year	$6,097,635

See accompanying notes to financial statements.

American Dental Association Relief Fund

Year Ended December 31, 1991

Statement of Cash Flows

AMERICAN DENTAL ASSOCIATION RELIEF FUND
STATEMENT OF CASH FLOWS
YEAR ENDED DECEMBER 31, 1991

Cash flows from operating activities:	
Deficiency of revenues over expenses	$(570,226)
Adjustments to reconcile to net cash provided by operating activities:	
Depreciation	180
Unrealized appreciation on investments	(368,611)
Changes in assets and liabilities:	
Decrease in interest and dividends receivable	7,767
Increase in amounts for grants due from constituent societies	(5,964)
Decrease in marketable securities	840,386
Increase in prepaid expenses	(1,637)
Decrease in accounts payable	(9,065)
Decrease in amounts due to affiliates	(2,176)
Increase in amounts payable to constituent societies	72,307
Net cash used by operating activities	(37,039)
Net cash used by investing activities - Acquisition of equipment	(3,603)
Net decrease in cash	(40,642)
Cash at beginning of year	40,642
Cash at end of year	$ -

See accompanying notes to financial statements.

American Dental Association Relief Fund

Notes to Financial Statements, December 31, 1991

AMERICAN DENTAL ASSOCIATION RELIEF FUND
NOTES TO FINANCIAL STATEMENTS
December 31, 1991

1. Significant Accounting Policies

Basis of presentation:

The American Dental Association Relief Fund (Relief Fund) was established by the American Dental Association (ADA) under the terms of an Indenture of Trust (Relief Trust) executed September 30, 1948. The Relief Fund renders financial aid to members of the dental profession and their dependents who, because of misfortune, age or other disabling conditions, are not wholly self-sustaining. The Commission on Relief Fund Activities (Commission), elected from the ADA membership, is the trustee for the Relief Fund.

The Relief Trust may be amended or terminated by action of the ADA. Upon termination, the Trust properties shall revert to the ADA to be used exclusively for charitable purposes.

Investment activities, which would otherwise be considered investing activities in the statement of cash flows, are presented as operating activities as they represent the normal operations of the Relief Fund.

Marketable Securities:

Investments in marketable securities are carried at market.

Revenue recognition:

All income from investments is recognized on the accrual basis. Contributions, which are received from the ADA membership directly and through constituent societies, are recognized when received.

Allocation of Relief Fund contributions:

The rules of the Relief Fund provide that refunds of contributions may be made to constituent societies if those societies have been established as charitable organizations having purposes consistent with those of the Relief Fund, and have been accorded tax-exempt status under the Internal Revenue Code. Prior to payment of any refund, constituent society relief funds are also required to submit annual financial statements. Such financial statements are required to be audited by a certified public accountant at least once every five years. Refunds in the amount of $357,734 at December 31, 1991 (from prior years' Relief Fund contributions) are payable to societies whose relief funds have not yet qualified for payment under the rules of the Relief Fund.

Grant expense:

Grants to relief recipients are recorded when the grant is paid. Obligations for future grant payments previously authorized by the Commission amounted to $129,897 at December 31, 1991. Grants paid are shared equally by the Relief Fund and the recipient's constituent society.

2. Marketable Securities

Marketable securities as of December 31, 1991 consisted of the following:

	Cost	Market
Commercial paper	$ 382,596	382,596
Corporate bonds	1,269,363	1,360,480
U.S. Government obligations	1,019,977	1,259,081
Common stocks	2,540,986	3,518,448
Total	$5,212,922	6,520,605

3. Related Party Transactions

The ADA provides administrative and financial support to the Relief Fund. General and administrative expenses include allocations from the ADA.

4. Income Taxes

The Relief Fund qualifies under section 501(c)(3) of the Internal Revenue Code (Code) and, therefore, is exempt from Federal income taxes under section 501(a) of the code.

Independent Auditors' Report

The Board of Directors, The ADA Endowment and Assistance Fund, Inc.

We have audited the accompanying balance sheets of The ADA Endowment and Assistance Fund, Inc. (Endowment Fund) as of December 31, 1991 and 1990, and the related statements of revenues, expenses and change in fund balance and cash flows for the years then ended. These financial statements are the responsibility of the Endowment Fund's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of The ADA Endowment and Assistance Fund, Inc. as of December 31, 1991 and 1990, and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

KPMG Peat Marwick

Chicago, Illinois
April 9, 1992

The ADA Endowment and Assistance Fund, Inc.

December 31, 1991 and 1990

Balance Sheets

THE ADA ENDOWMENT AND ASSISTANCE FUND, INC.
BALANCE SHEETS
DECEMBER 31, 1991 AND 1990

	1991	1990
ASSETS		
Cash	$ 29,522	6,991
Loans receivable, net of allowance for uncollectable loans of $0 and $8,488 in 1991 and 1990	239,038	285,019
Interest and dividends receivable	15,431	3,017
Marketable securities, at market (note 2)	1,797,843	467,990
Prepaid expenses	2,500	-
Total assets	$ 2,084,334	763,017
LIABILITIES AND FUND BALANCE		
Accrued liabilities	$ -	264
Amounts due to affiliates	4,724	483
Total liabilities	4,724	747
Fund balance	2,079,610	762,270
Total liabilities and fund balance	$ 2,084,334	763,017

See accompanying notes to financial statements.

The ADA Endowment and Assistance Fund, Inc.

Years Ended December 31, 1991 and 1990

Statement of Revenues and Expenses and Change in Fund Balance

THE ADA ENDOWMENT AND ASSISTANCE FUND, INC.
STATEMENT OF REVENUES,
EXPENSES AND CHANGE IN FUND BALANCE
YEARS ENDED DECEMBER 31, 1991 AND 1990

	1991	1990
REVENUES:		
Grant from American Dental Association Relief Fund	$ 1,210,001	-
Interest on loans	5,108	10,372
Interest income	71,772	37,458
Dividend income	3,445	-
Unrealized appreciation on investments	81,470	-
Total revenues	1,371,796	7,830
EXPENSES:		
General and administrative	54,456	44,741
Provision for uncollectable loans	-	8,488
Total expenses	54,456	53,229
Excess (deficiency) of revenues over expenses	1,317,340	(5,399)
Fund balance at beginning of year	762,270	767,669
Fund balance at end of year	$ 2,079,610	762,270

See accompanying notes to financial statements.

The ADA Endowment and Assistance Fund, Inc.

Years Ended December 31, 1991 and 1990

Statements of Cash Flows

THE ADA ENDOWMENT AND ASSISTANCE FUND, INC.
STATEMENTS OF CASH FLOWS
YEARS ENDED DECEMBER 31, 1991 AND 1990

	1991	1990
Cash flows from operating activities:		
Excess (deficiency) of revenues over expenses	$1,317,340	(5,399)
Adjustments to reconcile to net cash provided by operating activities:		
Decrease in loans receivable (net)	45,981	86,354
Increase in interest receivable	(12,414)	(3,017)
Decrease in refundable income taxes	-	7,194
(Increase) decrease in investments	(1,329,853)	207,010
Increase in prepaid expenses	(2,500)	-
Decrease in accounts payable	-	(149,329)
(Decrease) increase in accrued liabilities	(264)	264
Increase (decrease) in amounts due to affiliates	4,241	(136,086)
Total adjustments	(1,294,809)	12,390
Net cash provided by operating activities	22,531	6,991
Cash at beginning of year	6,991	-
Cash at end of year	$ 29,522	6,991

See accompanying notes to financial statements.

The ADA Endowment and Assistance Fund, Inc.

Notes to Financial Statements, December 31, 1991

THE ADA ENDOWMENT AND ASSISTANCE FUND, INC.
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 1991

1. Significant Accounting Policies

Basis of presentation:

The ADA Endowment and Assistance Fund, Inc. (Endowment Fund) was established by a transfer of properties from the Disaster Trust of the American Dental Association Disaster Victims Emergency Loan Fund (Disaster Fund) on December 31, 1989, at which time the Disaster Fund was terminated. The Members of the Commission on Relief Fund Activities, elected from the membership of the American Dental Association (ADA) serve as Directors for the Endowment Fund. The Endowment Fund was organized for charitable and educational purposes, which include providing emergency assistance in the form of interest-free loans to dentists who were victims of natural disasters and whose resources had been seriously depleted, and other loans or grants for charitable purposes.

Investment and loan activities, which would otherwise be considered investing activities in the statement of cash flows, are presented as operating activities as they represent the normal operations of the Endowment Fund.

Marketable Securities:

Investments in marketable securities are carried at market.

Revenue recognition:

Interest income from loans is recognized when received which is not materially different from recognition on the accrual basis.

2. Marketable Securities

Marketable securities at December 31, 1991 and 1990 consisted of the following:

	12/31/91		12/31/90	
	Market	Cost	Market	Cost
Commercial paper	$ 625,215	625,215	467,990	467,990
U.S. Government obligations	645,766	604,254	-	-
Corporate bonds	267,925	257,240	-	-
Common stocks	258,937	229,664	-	-
	$1,797,843	1,716,373	467,990	467,990

Unrealized appreciation on marketable securities amounted to $81,470 and $0 at December 31, 1991 and 1990, respectively.

3. Related Party Transactions

The ADA provides administrative and financial support to the Endowment Fund. General and administrative expenses include allocations from the ADA.

4. Loans Receivable

Loans receivable consist of non-interest bearing loans to disaster victims. Interest, however, is payable on any amounts outstanding after loan maturity. Annual interest rates are 6% on loans granted prior to April 1, 1980, 10% on loans granted between April 1, 1980 and March 31, 1981 and 12% on loans granted after March 31, 1981.

5. Income Taxes

The Endowment Fund qualifies under Section 501(c)(3) of the Internal Revenue Code (Code) and, therefore, is exempt from Federal income taxes under Section 501(a) of the Code.

American Dental Association

Supplemental Financial Information for the Year Ended December 31, 1991 (Unaudited)

SUMMARY

	ACTUAL	BUDGET
REVENUES		
MEMBERSHIP DUES INCOME	29,141,992	28,600,000
RENTAL INCOME	4,205,092	4,251,100
SALES OF EDUCATIONAL MT'L INCOME	4,554,751	3,029,700
EDUCATIONAL TESTING FEE INCOME	2,134,976	1,847,600
GRANTS & CONTRIBUTIONS	527,165	366,800
MEETING REGISTRATION FEE INCOME	403,507	622,000
INVESTMENT INCOME	651,088	242,700
MISCELLANEOUS INCOME	3,397,671	3,598,200
TOTAL REVENUES	45,016,242	42,558,100
EXPENSES		
STAFF COMPENSATION	18,381,794	17,721,300
PUBLICATION & PROJECT	5,700,920	5,642,300
MEETING & TRAVEL EXPENSES	4,540,803	4,359,400
PROFESSIONAL SERVICES	3,971,799	3,318,200
FACILITY & UTLTITY COSTS	3,264,126	3,445,100
OFFICE EXPENSES	2,294,734	2,417,000
GRANTS TO HEALTH RELATED GROUPS	1,807,668	1,760,500
DEPRECIATION/AMORTIZATION	1,272,388	1,778,000
INTEREST EXPENSE	4,582	125,000
OTHER EXPENSES	1,091,289	859,500
EXPENSE SUB-TOTAL	42,330,103	41,426,300
INCOME TAXES	(620,385)	
TOTAL EXPENSES	41,709,718	41,426,300
NET REVENUE/(EXPENSE)	3,306,524	1,131,800

HOUSE/BOARD/EXECUTIVE DIRECTOR

	ACTUAL	BUDGET
REVENUES		
MEMBERSHIP DUES INCOME		
RENTAL INCOME		
SALES OF EDUCATIONAL MT'L INCOME		
EDUCATIONAL TESTING FEE INCOME		
GRANTS & CONTRIBUTIONS		
MEETING REGISTRATION FEE INCOME		
INVESTMENT INCOME		
MISCELLANEOUS INCOME		
TOTAL REVENUES		
EXPENSES		
STAFF COMPENSATION	1,305,773	1,323,500
PUBLICATION & PROJECT	296,910	239,200
MEETING & TRAVEL EXPENSES	1,017,413	836,100
PROFESSIONAL SERVICES	1,008,507	835,600
FACILITY & UTLTITY COSTS		
OFFICE EXPENSES	219,167	196,500
GRANTS TO HEALTH RELATED GROUPS		
DEPRECIATION/AMORTIZATION		
INTEREST EXPENSE		
OTHER EXPENSES	297,577	262,400
EXPENSE SUB-TOTAL	4,145,347	3,693,300
INCOME TAXES		
TOTAL EXPENSES	4,145,347	3,693,300
NET REVENUE/(EXPENSE)	(4,145,347)	(3,693,300)

DIVISION OF LEGAL AFFAIRS

	ACTUAL	BUDGET
REVENUES		
MEMBERSHIP DUES INCOME		
RENTAL INCOME		
SALES OF EDUCATIONAL MT'L INCOME		
EDUCATIONAL TESTING FEE INCOME		
GRANTS & CONTRIBUTIONS		
MEETING REGISTRATION FEE INCOME		
INVESTMENT INCOME		
MISCELLANEOUS INCOME	12,425	
TOTAL REVENUES	12,425	
EXPENSES		
STAFF COMPENSATION	788,462	793,900
PUBLICATION & PROJECT	35,782	40,600
MEETING & TRAVEL EXPENSES	56,628	74,400
PROFESSIONAL SERVICES	380,215	401,000
FACILITY & UTLTITY COSTS		
OFFICE EXPENSES	24,000	25,000
GRANTS TO HEALTH RELATED GROUPS		
DEPRECIATION/AMORTIZATION		
INTEREST EXPENSE		
OTHER EXPENSES	16,909	18,200
EXPENSE SUB-TOTAL	1,301,996	1,353,100
INCOME TAXES		
TOTAL EXPENSES	1,301,996	1,353,100
NET REVENUE/(EXPENSE)	(1,289,571)	(1,353,100)

DIVISION OF LEGISLATIVE AFFAIRS

	ACTUAL	BUDGET
REVENUES		
MEMBERSHIP DUES INCOME		
RENTAL INCOME		
SALES OF EDUCATIONAL MT'L INCOME		
EDUCATIONAL TESTING FEE INCOME		
GRANTS & CONTRIBUTIONS		
MEETING REGISTRATION FEE INCOME	3,220	
INVESTMENT INCOME		
MISCELLANEOUS INCOME		
TOTAL REVENUES	3,220	
EXPENSES		
STAFF COMPENSATION	1,271,505	1,269,600
PUBLICATION & PROJECT	54,129	69,400
MEETING & TRAVEL EXPENSES	240,184	352,000
PROFESSIONAL SERVICES	9,722	41,100
FACILITY & UTLTITY COSTS	10,587	14,500
OFFICE EXPENSES	116,310	124,300
GRANTS TO HEALTH RELATED GROUPS		
DEPRECIATION/AMORTIZATION		
INTEREST EXPENSE		
OTHER EXPENSES	55,547	50,100
EXPENSE SUB-TOTAL	1,757,984	1,921,000
INCOME TAXES		
TOTAL EXPENSES	1,757,984	1,921,000
NET REVENUE/(EXPENSE)	(1,754,764)	(1,921,000)

DIVISION OF COMMUNICATIONS

	ACTUAL	BUDGET
REVENUES		
MEMBERSHIP DUES INCOME		
RENTAL INCOME		
SALES OF EDUCATIONAL MT'L INCOME		
EDUCATIONAL TESTING FEE INCOME		
GRANTS & CONTRIBUTIONS	51,962	15,000
MEETING REGISTRATION FEE INCOME	23,338	18,100
INVESTMENT INCOME		
MISCELLANEOUS INCOME	(5,536)	15,000
TOTAL REVENUES	69,764	48,100
EXPENSES		
STAFF COMPENSATION	1,091,561	1,373,300
PUBLICATION & PROJECT	1,204,127	1,187,000
MEETING & TRAVEL EXPENSES	116,664	87,300
PROFESSIONAL SERVICES	742,133	232,300
FACILITY & UTLTITY COSTS		
OFFICE EXPENSES	39,912	50,800
GRANTS TO HEALTH RELATED GROUPS		
DEPRECIATION/AMORTIZATION		
INTEREST EXPENSE		
OTHER EXPENSES	8,555	6,900
EXPENSE SUB-TOTAL	3,202,952	2,937,600
INCOME TAXES		
TOTAL EXPENSES	3,202,952	2,937,600
NET REVENUE/(EXPENSE)	(3,133,188)	(2,889,500)

DIVISION OF SALEABLE MATERIALS

	ACTUAL	BUDGET
REVENUES		
MEMBERSHIP DUES INCOME		
RENTAL INCOME		
SALES OF EDUCATIONAL MT'L INCOME	4,439,051	3,027,700
EDUCATIONAL TESTING FEE INCOME		
GRANTS & CONTRIBUTIONS		
MEETING REGISTRATION FEE INCOME		
INVESTMENT INCOME		
MISCELLANEOUS INCOME	309	
TOTAL REVENUES	4,439,360	3,027,700
EXPENSES		
STAFF COMPENSATION	640,461	595,300
PUBLICATION & PROJECT	1,963,654	1,691,400
MEETING & TRAVEL EXPENSES	45,475	41,700
PROFESSIONAL SERVICES	9,470	12,500
FACILITY & UTLTITY COSTS		
OFFICE EXPENSES	32,935	21,000
GRANTS TO HEALTH RELATED GROUPS		
DEPRECIATION/AMORTIZATION		
INTEREST EXPENSE		
OTHER EXPENSES	96,251	72,700
EXPENSE SUB-TOTAL	2,788,246	2,434,600
INCOME TAXES		
TOTAL EXPENSES	2,788,246	2,434,600
NET REVENUE/(EXPENSE)	1,651,114	593,100

DIVISION OF MEMBERSHIP & MARKETING SERV

	ACTUAL	BUDGET
REVENUES		
MEMBERSHIP DUES INCOME		
RENTAL INCOME		
SALES OF EDUCATIONAL MT'L INCOME		
EDUCATIONAL TESTING FEE INCOME		
GRANTS & CONTRIBUTIONS	57,000	50,000
MEETING REGISTRATION FEE INCOME	261,252	370,300
INVESTMENT INCOME		
MISCELLANEOUS INCOME	53,720	50,000
TOTAL REVENUES	371,972	470,300
EXPENSES		
STAFF COMPENSATION	1,750,994	1,820,200
PUBLICATION & PROJECT	529,938	622,600
MEETING & TRAVEL EXPENSES	272,115	290,900
PROFESSIONAL SERVICES	266,598	247,200
FACILITY & UTLTITY COSTS		
OFFICE EXPENSES	324,908	386,100
GRANTS TO HEALTH RELATED GROUPS		
DEPRECIATION/AMORTIZATION		
INTEREST EXPENSE	4,582	125,000
OTHER EXPENSES	11,788	9,300
EXPENSE SUB-TOTAL	3,160,923	3,501,300
INCOME TAXES		
TOTAL EXPENSES	3,160,923	3,501,300
NET REVENUE/(EXPENSE)	(2,788,951)	(3,031,000)

DIVISION OF CONFERENCES & MEETING SERV

	ACTUAL	BUDGET
REVENUES		
MEMBERSHIP DUES INCOME		
RENTAL INCOME	1,441,935	1,433,700
SALES OF EDUCATIONAL MT'L INCOME	102,703	1,000
EDUCATIONAL TESTING FEE INCOME		
GRANTS & CONTRIBUTIONS	80,292	
MEETING REGISTRATION FEE INCOME	75,669	146,500
INVESTMENT INCOME		
MISCELLANEOUS INCOME	1,685,181	1,770,100
TOTAL REVENUES	3,385,780	3,351,300
EXPENSES		
STAFF COMPENSATION	1,633,029	1,637,000
PUBLICATION & PROJECT	440,054	492,700
MEETING & TRAVEL EXPENSES	1,301,054	972,400
PROFESSIONAL SERVICES	413,994	318,400
FACILITY & UTLTITY COSTS	53,655	40,400
OFFICE EXPENSES	218,114	167,600
GRANTS TO HEALTH RELATED GROUPS		
DEPRECIATION/AMORTIZATION		
INTEREST EXPENSE		
OTHER EXPENSES	100,716	89,700
EXPENSE SUB-TOTAL	4,160,616	3,718,200
INCOME TAXES		
TOTAL EXPENSES	4,160,616	3,718,200
NET REVENUE/(EXPENSE)	(774,836)	(366,900)

DIVISION OF FINANCE

	ACTUAL	BUDGET
REVENUES		
MEMBERSHIP DUES INCOME		
RENTAL INCOME		
SALES OF EDUCATIONAL MT'L INCOME		
EDUCATIONAL TESTING FEE INCOME		
GRANTS & CONTRIBUTIONS		
MEETING REGISTRATION FEE INCOME		
INVESTMENT INCOME	590,397	242,700
MISCELLANEOUS INCOME	23,128	23,000
TOTAL REVENUES	613,525	265,700
EXPENSES		
STAFF COMPENSATION	1,165,403	1,088,600
PUBLICATION & PROJECT	37,659	83,700
MEETING & TRAVEL EXPENSES	12,000	19,500
PROFESSIONAL SERVICES	101,036	141,000
FACILITY & UTLTITY COSTS		
OFFICE EXPENSES	56,422	38,800
GRANTS TO HEALTH RELATED GROUPS		
DEPRECIATION/AMORTIZATION		
INTEREST EXPENSE		
OTHER EXPENSES	1,277	2,400
EXPENSE SUB-TOTAL	1,373,797	1,374,000
INCOME TAXES		
TOTAL EXPENSES	1,373,797	1,374,000
NET REVENUE/(EXPENSE)	(760,272)	(1,108,300)

HEADQUARTERS BUILDING

	ACTUAL	BUDGET
REVENUES		
MEMBERSHIP DUES INCOME		
RENTAL INCOME	2,746,153	2,817,400
SALES OF EDUCATIONAL MT'L INCOME		
EDUCATIONAL TESTING FEE INCOME		
GRANTS & CONTRIBUTIONS		
MEETING REGISTRATION FEE INCOME		
INVESTMENT INCOME		
MISCELLANEOUS INCOME	22,862	30,000
TOTAL REVENUES	2,769,015	2,847,400
EXPENSES		
STAFF COMPENSATION	348,605	343,400
PUBLICATION & PROJECT	1,772	2,100
MEETING & TRAVEL EXPENSES		500
PROFESSIONAL SERVICES	51,530	40,500
FACILITY & UTLTITY COSTS	3,147,138	3,390,200
OFFICE EXPENSES	147,043	157,000
GRANTS TO HEALTH RELATED GROUPS		
DEPRECIATION/AMORTIZATION		
INTEREST EXPENSE		
OTHER EXPENSES	4,531	4,500
EXPENSE SUB-TOTAL	3,700,619	3,938,200
INCOME TAXES		
TOTAL EXPENSES	3,700,619	3,938,200
NET REVENUE/(EXPENSE)	(931,604)	(1,090,800)

DIVISION OF BUSINESS AFFAIRS

	ACTUAL	BUDGET
REVENUES		
MEMBERSHIP DUES INCOME		
RENTAL INCOME		
SALES OF EDUCATIONAL MT'L INCOME	11,270	
EDUCATIONAL TESTING FEE INCOME		
GRANTS & CONTRIBUTIONS		
MEETING REGISTRATION FEE INCOME		
INVESTMENT INCOME		
MISCELLANEOUS INCOME	253,578	360,000
TOTAL REVENUES	264,848	360,000
EXPENSES		
STAFF COMPENSATION	1,869,482	1,907,100
PUBLICATION & PROJECT	27,291	35,100
MEETING & TRAVEL EXPENSES	6,416	6,500
PROFESSIONAL SERVICES	630	3,000
FACILITY & UTLTITY COSTS		
OFFICE EXPENSES	382,947	458,800
GRANTS TO HEALTH RELATED GROUPS		
DEPRECIATION/AMORTIZATION		
INTEREST EXPENSE		
OTHER EXPENSES	3,631	(6,100)
EXPENSE SUB-TOTAL	2,290,397	2,404,400
INCOME TAXES		
TOTAL EXPENSES	2,290,397	2,404,400
NET REVENUE/(EXPENSE)	(2,025,549)	(2,044,400)

DIVISION OF CENTRAL ADMINISTRATION

	ACTUAL	BUDGET
REVENUES		
MEMBERSHIP DUES INCOME	29,141,992	28,600,000
RENTAL INCOME	15,004	
SALES OF EDUCATIONAL MT'L INCOME		
EDUCATIONAL TESTING FEE INCOME		
GRANTS & CONTRIBUTIONS		
MEETING REGISTRATION FEE INCOME		
INVESTMENT INCOME	60,691	
MISCELLANEOUS INCOME	712,751	699,200
TOTAL REVENUES	29,930,438	29,299,200
EXPENSES		
STAFF COMPENSATION	541,172	(512,600)
PUBLICATION & PROJECT	7,829	5,700
MEETING & TRAVEL EXPENSES	88,571	103,300
PROFESSIONAL SERVICES	244,271	278,000
FACILITY & UTLTITY COSTS	52,746	
OFFICE EXPENSES	422,239	471,000
GRANTS TO HEALTH RELATED GROUPS	222,000	227,000
DEPRECIATION/AMORTIZATION	1,272,388	1,778,000
INTEREST EXPENSE		
OTHER EXPENSES	295,373	148,800
EXPENSE SUB-TOTAL	3,146,589	2,499,200
INCOME TAXES	(620,385)	
TOTAL EXPENSES	2,526,204	2,499,200
NET REVENUE/(EXPENSE)	27,404,234	26,800,000

DIVISION OF DENTAL PRACTICE

	ACTUAL	BUDGET
REVENUES		
MEMBERSHIP DUES INCOME		
RENTAL INCOME	2,000	
SALES OF EDUCATIONAL MT'L INCOME	1,727	1,000
EDUCATIONAL TESTING FEE INCOME		
GRANTS & CONTRIBUTIONS	184,372	179,800
MEETING REGISTRATION FEE INCOME	38,028	80,900
INVESTMENT INCOME		
MISCELLANEOUS INCOME	595,779	622,000
TOTAL REVENUES	821,906	883,700
EXPENSES		
STAFF COMPENSATION	2,047,812	2,092,600
PUBLICATION & PROJECT	551,601	638,700
MEETING & TRAVEL EXPENSES	493,745	674,000
PROFESSIONAL SERVICES	505,607	560,300
FACILITY & UTLTITY COSTS		
OFFICE EXPENSES	116,490	142,400
GRANTS TO HEALTH RELATED GROUPS		
DEPRECIATION/AMORTIZATION		
INTEREST EXPENSE		
OTHER EXPENSES	155,305	162,400
EXPENSE SUB-TOTAL	3,870,560	4,270,400
INCOME TAXES		
TOTAL EXPENSES	3,870,560	4,270,400
NET REVENUE/(EXPENSE)	(3,048,654)	(3,386,700)

DIVISION OF EDUCATION

	ACTUAL	BUDGET
REVENUES		
MEMBERSHIP DUES INCOME		
RENTAL INCOME		
SALES OF EDUCATIONAL MT'L INCOME		
EDUCATIONAL TESTING FEE INCOME	2,134,976	1,847,600
GRANTS & CONTRIBUTIONS	121,594	122,000
MEETING REGISTRATION FEE INCOME	2,000	6,200
INVESTMENT INCOME		
MISCELLANEOUS INCOME	43,399	28,900
TOTAL REVENUES	2,301,969	2,004,700
EXPENSES		
STAFF COMPENSATION	2,299,311	2,336,600
PUBLICATION & PROJECT	527,584	513,300
MEETING & TRAVEL EXPENSES	752,829	781,400
PROFESSIONAL SERVICES	237,515	206,100
FACILITY & UTLTITY COSTS		
OFFICE EXPENSES	140,300	125,700
GRANTS TO HEALTH RELATED GROUPS	38,384	32,300
DEPRECIATION/AMORTIZATION		
INTEREST EXPENSE		
OTHER EXPENSES	26,739	22,700
EXPENSE SUB-TOTAL	4,022,662	4,018,100
INCOME TAXES		
TOTAL EXPENSES	4,022,662	4,018,100
NET REVENUE/(EXPENSE)	(1,720,693)	(2,013,400)

DIVISION OF SCIENTIFIC AFFAIRS

	ACTUAL	BUDGET
REVENUES		
MEMBERSHIP DUES INCOME		
RENTAL INCOME		
SALES OF EDUCATIONAL MT'L INCOME		
EDUCATIONAL TESTING FEE INCOME		
GRANTS & CONTRIBUTIONS		
MEETING REGISTRATION FEE INCOME		
INVESTMENT INCOME		
MISCELLANEOUS INCOME	75	
TOTAL REVENUES	75	
EXPENSES		
STAFF COMPENSATION	1,628,224	1,652,800
PUBLICATION & PROJECT	22,590	20,800
MEETING & TRAVEL EXPENSES	106,168	119,400
PROFESSIONAL SERVICES	570	1,200
FACILITY & UTLTITY COSTS		
OFFICE EXPENSES	53,543	52,000
GRANTS TO HEALTH RELATED GROUPS	5,000	5,000
DEPRECIATION/AMORTIZATION		
INTEREST EXPENSE		
OTHER EXPENSES	15,390	15,500
EXPENSE SUB-TOTAL	1,831,485	1,866,700
INCOME TAXES		
TOTAL EXPENSES	1,831,485	1,866,700
NET REVENUE/(EXPENSE)	(1,831,410)	(1,866,700)

OPERATING DIVISION - HEALTH FOUNDATION

	ACTUAL	BUDGET
REVENUES		
MEMBERSHIP DUES INCOME		
RENTAL INCOME		
SALES OF EDUCATIONAL MT'L INCOME		
EDUCATIONAL TESTING FEE INCOME		
GRANTS & CONTRIBUTIONS		
MEETING REGISTRATION FEE INCOME		
INVESTMENT INCOME		
MISCELLANEOUS INCOME		
TOTAL REVENUES		
EXPENSES		
STAFF COMPENSATION		
PUBLICATION & PROJECT		
MEETING & TRAVEL EXPENSES		
PROFESSIONAL SERVICES		
FACILITY & UTLTITY COSTS		
OFFICE EXPENSES		
GRANTS TO HEALTH RELATED GROUPS	1,542,284	1,496,200
DEPRECIATION/AMORTIZATION		
INTEREST EXPENSE		
OTHER EXPENSES		
EXPENSE SUB-TOTAL	1,542,284	1,496,200
INCOME TAXES		
TOTAL EXPENSES	1,542,284	1,496,200
NET REVENUE/(EXPENSE)	(1,542,284)	(1,496,200)

RESEARCH FUND

	ACTUAL	BUDGET
REVENUES		
MEMBERSHIP DUES INCOME		
RENTAL INCOME		
SALES OF EDUCATIONAL MT'L INCOME		
EDUCATIONAL TESTING FEE INCOME		
GRANTS & CONTRIBUTIONS	31,945	
MEETING REGISTRATION FEE INCOME		
INVESTMENT INCOME		
MISCELLANEOUS INCOME		
TOTAL REVENUES	31,945	
EXPENSES		
STAFF COMPENSATION		
PUBLICATION & PROJECT		
MEETING & TRAVEL EXPENSES	31,542	
PROFESSIONAL SERVICES		
FACILITY & UTLTITY COSTS		
OFFICE EXPENSES	402	
GRANTS TO HEALTH RELATED GROUPS		
DEPRECIATION/AMORTIZATION		
INTEREST EXPENSE		
OTHER EXPENSES	1,702	
EXPENSE SUB-TOTAL	33,646	
INCOME TAXES		
TOTAL EXPENSES	33,646	
NET REVENUE/(EXPENSE)	(1,701)	

1991 Contingent Fund

Board-Approved Allocations Compared with Actual

	Board Approved Allocations	Actual Expenses (Net)
House/Board/Executive Director		
Retained technical services to test scrap dental amalgam, in order to determine its impact on the environment.	$110,000	$ 43,945
Board, council, and staff task force on Association's health policy.	$ 12,600	$ 8,585
Board of Trustee's January 1992 meeting rescheduled for Dec. 5-7, 1991.	$ 25,000	$ 32,290
Division of Legal Affairs		
Retain special outside counsel and an expert epidemiologist/toxicologist to work on a dental amalgam matter at FDA.	$100,000	$ 93,767
To match funds with the New Jersey Dental Association to help defend a member against the New Jersey Department of Environment Protection's claim of improper disposal of carpules.	$ 2,000	$ 2,000
Arizona State Dental Association grant for outside legal fees to support lobbying efforts concerning amalgam in waste matter.	$ 35,000	$ 48,520
Division of Membership and Marketing Services		
One day meeting for dental specialty organization leaders.	$ 1,500	$ 858
Division of Conference and Meeting Services		
Purchase five printers for use in producing registration badges and tickets both in advance and on-site at annual session.	$ 28,000	$ 28,000
Division of Dental Practice		
Support of dental informatics activities in 1991.	$ 76,800	$ 98,524
Division of Education		
Funding for in-house production of continuing education course listings.	$ 18,000	$ 7,117
Meeting of the Special Committee to review comments from the two specialties and report on findings.	$ 4,000	$ 3,807
Meeting of the Special Committee to study the structure and process of the Commission on Dental Accreditation.	$ 4,000	$ 3,139
Council retreat to accomplish planning and goal-setting work.	$ 12,400	$ 11,415
Total Net Expense Allocation for 1991 Contingent Fund	$429,300	$381,967

Notes

Appendix

Notes

Index to Resolutions

1991 Resolutions