1999

1999 Annual Reports and Resolutions

American Dental Association

American
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Association

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1999

Annual Reports and Resolutions

140th Annual Session

Honolulu, Hawaii

October 9-13, 1999

Table of Contents

Special Note

Copies of *1999 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.

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Notes

Reports of Councils and Commissions

Divisions of Communications, Conference and Meeting Services, and Membership and Dental Society Services

Council on ADA Sessions and International Programs

Council on Communications

Council on Membership

Notes

Council on ADA Sessions and International Programs

Kell, Kathryn A., Iowa, 1999, chairman
Baker, Gary O., Missouri, 2001
Breeland, Nona I., North Carolina, 2000
Fulton, David J., Sr., Illinois, 2001
Goodman, William, Oklahoma, 2001
Hagman, Gerrit C., Georgia, 1999
Harvey, Brien, Arizona, 2000
Hewett, Sally, Washington, 2002
Kell, H. Lindy, California, 2000
Kondis, Stephen L., Pennsylvania, 1999
Qadri, Azam M., Ohio, 1999, *ex officio**
Richter, Neal B., Indiana, 1999
Schachner, Joseph, New York, 2002
Schwartz, Stephen F., Texas, 2002
Socher, Jeffrey C., Illinois, 2000, *ex officio*
Tom, Alan, Hawaii, 1999, *ex officio*
Tonelli, J. Steven, Massachusetts, 2002
Unger, Michael, New Jersey, 2001
Vuchetich, Thomas A., Michigan, 2000
Jeske, Edward T., director
Cherrett, Helen McK., manager
Dujon, Dorsay, manager
Johnson, Patricia, manager

Meetings: The Council met February 5-6, 1999 in Honolulu at the Hilton Hawaiian Village Hotel and June 3-5, 1999 at the ADA Headquarters Building in Chicago.

Activities: The Council on ADA Sessions and International Programs continued during the past year to function as the planning body for the annual scientific session and as the agency overseeing the Association's international volunteer and educational programs for the membership. At its February meeting, the Council continued planning for the 1999 annual scientific session, initiated planning for the 2000 meeting in Chicago and reviewed the operation of its international programs. Also at its February meeting, the Council reviewed the action items it had identified to support the Association's strategic planning goals and objectives and evaluated progress it had made to meeting these. At the June meeting, the Council finalized plans for the 1999 annual session and continued planning for the 2000 meeting. It also reviewed those international matters that are under its purview and considered the nominations of members to receive the certificate of recognition for service in a foreign country. The Council also re-evaluated its action items and developed new items to further support those Plan goals and objectives related to the Council functioning.

The Strategic Plan of the American Dental Association: The Association's annual scientific session provides a full schedule of the highest quality continuing dental education courses to the membership and provides members documentation of their attendance at courses for continuing education purposes. As such, the scientific session supports Goal II. Practice Support, Objective i. Enhance the success of member dentists by providing them the means to maximize their practice and management skills and personal well-being.

At the same time, the meeting generates significant nondues revenues for the Association and therefore also provides the resources which support Goal V. The Association: Member and Support Services, Objective v. Continue to optimize ADA processes and to focus financial resources on core activities to ensure successful achievement of the Association's strategic goals.

The ADA Health Volunteers Overseas Dentistry Program, which by providing education and training, improves dental care in developing countries and areas in crises that have little or no access, supports Goal III. Image, Objective iii. Promote benefits of oral health to the public.

Through membership and participation in the activities of the Global Health Council (formerly the National Council for International Health), the Association ensures that dentistry has a role in the international health care endeavors of this organization and therefore the NCIH activities also support Goal III. Objective iii.

* Committee on the New Dentist member without the power to vote.

The Council has identified action plans to support various goals and objectives of the Plan; has established criteria for measuring success in meeting those; and has evaluated the effectiveness of its activities using those criteria. Certain activities which no longer supported the Plan were eliminated and new action items which could support the Plan were identified.

139th Annual Session, San Francisco, California, October 24-28, 1998

The site of the Association's 139th Annual Session was San Francisco. This was the ninth time the Association met there. Moscone Center was the location for the technical exhibits, table clinics, and most of the scientific program as well as other activities related to the scientific session. Meeting rooms at the Center for the Arts and the Argent Hotel (formerly the ANA Hotel) near the Convention Center were also used for scientific programs to provide an adequate number of continuing education seats for participants. Total registration was 47,162 including 13,526 dentists of whom 697 were internationals. A total of 1,544 technical exhibit booths were sold to 647 different companies making the 1998 exhibition the largest dental exhibit in the United States. A total of 18 complimentary booths in the upper and lower lobbies of Moscone Center South were provided to various dental-related organizations. The ADA Pavilion in Exhibit Hall D in Moscone Center North provided complimentary space to 15 ADA agencies and ADA-related organizations.

Scientific Program: In 1998, 195 courses on a wide selection of dental topics were offered in San Francisco during the annual session. Over 11,000 participants attended at least one course during annual session. Five courses were videotaped, and most of the other courses were audiotaped. These tapes were available for purchase at the meeting and afterwards. Three programs were offered with simultaneous interpretation; two from English into Portuguese and one from Portuguese into English.

A full schedule of registered clinics, lectures and participation workshops was offered during the annual session in San Francisco. In addition to the open attendance courses, 22 participation workshops and 15 registered clinics were offered. The registered clinics included a variety of topics, including: scientific, practice management, esthetics and endodontics. Attendance at the clinics was 4,420. Workshops had more than 990 participants. In addition to the regular schedule of courses, "The Technology Day: taking the byte out of technology," was well attended with over 515 attendees and "Team Building Conference III: creating your dream team," was held with 350 participants for this two-day program.

Post-Session Seminars: Post-session seminars were offered in Lake Tahoe, NV. Dr. Paul C. Belvedere's, "Increasing the use of direct composite resins in the anterior segment of the mouth," and Ms. Cheryl Farr's program, "The wow factor: technology and techniques for the advanced esthetic practice," were scheduled for the two-day program. Over 90 participants attended the two seminars.

Table Clinics: Ninety-one table clinics were presented on Saturday and Sunday, October 24 and 25, 1998.

1998 ADA/Dentsply Student Clinician Program: The student program, which celebrated its 40th anniversary at the 1998 annual session, is conducted annually by the Council on ADA Sessions and International Programs and is financially supported by Dentsply International, Inc., York, PA.

Outstanding student clinicians representing the 54 accredited dental schools in the United States, including Puerto Rico, presented table clinics for judging on the morning of Monday, October 26 and to the general attendance on Monday afternoon at Moscone Center. On Tuesday morning the winning students presented their clinics.

Winning students in Category I, Clinical Application and Technique, were: Sam Yong Kim, Loma Linda University School of Dentistry, first place; Eric P. Holmgren, University of Pennsylvania School of Dental Medicine, second place; and Joseph W. Park, Medical University of South Carolina College of Dental Medicine, third place.

Winning students in Category II, Basic Science and Research, were: Michael A. Feinberg, University of California, San Francisco School of Dentistry, first place; Jamson C. Wu, University of California, Los Angeles School of Dentistry, second place; and Jaleh Pourhamidi, University of Pittsburgh, School of Dental Medicine, third place.

The first place winners in each category were awarded a travel prize to present their winning table clinics at the 1999 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: Dr. John Olmsted, Greensboro, NC, chairman; Dr. Shirley Austin, Dearborn, MI; Dr. Stephen B. Corbin, Brookeville, MD; Dr. Cordell Fisher, Irvine, CA; Dr. Peter Guevara, Pittsburgh; Dr. Brenda Harman, Novato, CA; Dr. Arthur Hunger, York, PA; Dr. Keith Krell, Des Moines, IA; Dr. Dan Middaugh, Seattle; and Dr. John S. Rutkauskas, Hinsdale, IL.

Judges for Category II were: Dr. Richard Tatum, Columbia, MD, chairman; Dr. Stephen Abel, New York; Dr. Robert Augsburger, Tulsa, OK; Dr. Carmen Yolanda Bonta, Piscataway, NJ; Dr. Gordon Christensen, Provo, UT; Dr. Thomas Emmering, Wheaton, IL; Dr. Joseph V. Levy, Burlingame, CA; Dr. Theresa Madden, Portland, OR; Dr. Mirdza E. Neiders, Amherst, NY; Dr. Rahele Rezai, Washington, DC; Dr. Richard G. Shaffer, Potomac, MD; Dr. Guy S. Shampaine, Bowie, MD; Dr. Roger Stambaugh, Santa Monica, CA; Dr. Rada Sumareva, Brooklyn, NY; Dr. Thomas Van Dyke, Boston; and Dr. Joel White, Half Moon, CA.

140th Annual Session, Honolulu, Hawaii, October 9-13, 1999

Honolulu is the site of the American Dental Association's 1999 annual session. This is the second time the Association will meet in that city, the last time being in 1989. The Hawaii Convention Center is the venue for the technical exhibition, registration, the major portion of the scientific program as well as the meetings of the House of Delegates. The Ala Moana Hotel is the location of the Health Screening Program and the ADA/Dentsply Student Clinician Program and the Ilikai Nikko Hotel accommodates the Team Building Conference IV.

Scientific Program: The scientific program offers courses on a wide range of topics, including: aesthetics, prosthodontics, periodontics, anesthesia, restorative dentistry, financial investments and practice management. A special Pre-Session "Technology Day II: taking another byte out of technology," is scheduled for Friday, October 8, 8:00 a.m.-4:30 p.m., and a two-day "Team Building Conference IV: formula for success" is scheduled for Friday and Saturday, October 8-9, 8:00 a.m.-4:30 p.m. In addition to the scientific sessions, general interest programs are scheduled, including topics such as cooking, nutrition and quality of life.

Table Clinics: The table clinic program was suspended for this meeting due in part to limited space at the Hawaii Convention Center.

Post-Session Seminars: Three post-session seminars are offered on Maui, Kauai and Hawaii, "The Big Island," on Thursday and Friday, October 14 and 15. Dr. Mark Friedman is presenting a two-day seminar on, "Porcelain veneers: success and failure," at the Outrigger Wailea Resort, Maui. Ms. Jennifer de St Georges is presenting a two-day seminar on, "Doctor, you deserve to be successful," at the Kauai Marriott Resort on Kauai. Dr. James Dunn is presenting a two-day seminar "Esthetic dental treatments for the new century," at the Hilton Waikoloa Village on Hawaii, "The Big Island." These programs are scheduled for 8:30 a.m. to noon both days.

ADA/Dentsply Student Clinician Program: This year's student clinician program marks its 41st year as an important part of the annual session. The clinics are presented at the Ala Moana Hotel near the Convention Center. Each accredited dental school in the United States, including Puerto Rico, was invited to send the winner of its table clinic competition to participate in the national competition at the ADA 1999 annual session on the morning of Monday, October 11. On that afternoon these students present their clinics to the general registration along with the winners of the 1999 Dentsply competitions in Australia, Canada, the Republic of Germany, France, India, Japan, Scandinavia and the United Kingdom. All the winning U.S. and international clinicians again present their clinics on the morning of Tuesday, October 12 at the Convention Center.

Technical Exhibition: Over 650 companies are staffing over 1,000 10' x 10' booths at the Hawaii Convention Center during annual session providing members and their staff a one stop shopping opportunity for products which offer the latest in dental science and technology. While the number of booths available this year is less than usual due to the smaller size of the Hawaii Convention Center, the 1999 ADA exhibition remains one of the largest dental exhibitions in the country.

International Activities

Certificate of Recognition for Volunteer Service in a Foreign Country: At its June meeting, the Council reviewed the nominations for the Certificate of Recognition for Volunteer Service in a Foreign Country. There were 115 nominations that completely fulfilled the criteria and were awarded Certificates and six incomplete applications. The discrepancy in the number of applications presented and the number of certificates actually awarded is generally because of lack of adequate documentation. Since the program was initiated in 1975, 2,016 Certificates have been awarded to individuals in 48 states and the District of Columbia. This year an article about the program appeared in the *ADA News* and a mailing was sent to constituent and component dental societies and deans of dental schools. In addition, a mailing was sent seeking nominations to the 69 volunteer organizations listed in the publication *International Dental Volunteer Organizations: A Guide to Service and a Directory of Programs.*

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 an 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 and South America. This year the Council registered 81 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. The provision of current professional journals to dental school libraries in developing 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 in these countries.

Global Health Council: In 1998, the National Council on International Health (NCIH), an organization of more than 1,000 medical professionals and organizations, ranging from: pharmaceutical companies such as Merck and Becton Dickinson; government agencies such as the Peace Corps and the Centers for Disease Control and Prevention; international

relief organizations such as CARE and Save the Children; religious relief agencies; universities such as Harvard and John Hopkins; and health care organizations like the ADA, was completely reorganized. This reorganization followed the recommendations of Dr. C. Everett Koop's NCIH Strategic Consultative Group. The ADA, through its Council member representative, Dr. Kathryn Kell, played a prominent role in this transition.

The pivotal changes included the appointment of a new executive director, Dr. Nils Daulaire. The reduction from the previous 32-member Board of Trustees to a more manageable number of 12 handpicked influential senior-level individuals allowed for a redirection of efforts to fund-raising and governance. The mission of this organization is to advance policies and programs that improve health around the world. Thus, the first item on the new Board's agenda was an organizational name change from the National Council on International Health to Global Health Council, so as to better reflect the scope of the Council which will now focus on the need for improving global health and making health one of the cornerstones of globalization. The new Council aims to become, within five years, the pre-eminent nongovernmental source of information, practical experience, analysis and public advocacy for the most pressing global health issues. To facilitate this transition, the W.K. Kellogg Foundation, the John D. & Catherine T. MacArthur Foundation and the William H. Gates Foundation have all awarded the Global Health Council grants.

Although ADA representative Dr. Kell no longer has a seat on the Board, she attended the annual conference, which is held each year in Washington, D.C. This conference is the largest gathering of its kind in the United States. Attracting health and development professionals from around the world, it serves as an interactive forum for the international health community to share common experiences and to review and present strategies to improve health programs and policies. This year, the theme of the 26th annual conference was "Global Health, Poverty and Development." Participants explored how poverty and disease interact, not only in developing countries but also in the United States. At this conference Dr. Kell supported the efforts to develop an oral health committee as part of the Advisory Board.

Dentistry Overseas: In 1989 the Board of Trustees adopted a proposal (*Trans.*1989:471) which 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 six consultants and one member of the Council who acts as the liaison. Dr. Kathryn Kell is the Council's liaison, and Dr. Peter Berthold, Dr. Arthur I. Hazlewood, Dr. Gary S. Leff, Dr. Stephen B. Mackler, Dr. Eric Spohn and Dr. Rosalie A. Warpeha (chairperson) were appointed to serve on the committee for terms ending with the 1999 annual session.

As of April 1999, there were 193 members in the Dentistry Overseas Division of HVO. During 1998, dental volunteers in this program served as follows: 6 in Brazil; 2 in India; 1 in Jamaica; 5 in St. Lucia; 7 in Vietnam; 10 in Zimbabwe; and 2 in Bangladesh. In 1999, the committee met on February 27 and 28 in Miami Beach, FL and reappointed Dr. Warpeha as chair. At this meeting, the committee reviewed the annual reports from the current programs in Brazil, Haiti, India, Jamaica, St. Lucia, Vietnam and Zimbabwe. The committee also finalized the details for a new program in Bangladesh. This program, located in the Pioneer Dental College in Dhaka, will provide clinical and didactic instruction for dental students. Volunteers will prepare and deliver lectures on basic sciences, clinical and laboratory subjects. The committee is aware that some volunteers will be hesitant to go to this region but the story that appeared in the *ADA News* has generated interest. The committee also reviewed the possibility for programs in Ecuador and Fiji, and decided to renew the contact with Guyana as well as discussing initial plans for a volunteer training session during the ADA annual session in the year 2000.

Procter & Gamble selected the Dentistry Overseas site in Zimbabwe for the development of a 60-second television commercial which is currently being run nationwide. The primary thrust of this commercial is to show the company's and the dental profession's commitment to improving worldwide dental health. The commercial mentions HVO and the interest generated in the program by this airing of this commercial has been most positive.

In August, HVO will hold a liaison meeting in Chicago and a representative from Dentistry Overseas was invited to participate along with representatives from all the seven major health organizations who now sponsor a division.

At the 1999 annual session scientific program, an update on the ADA/HVO program will be presented as part of an educational forum entitled "Worldwide Professional Collaborations." The speakers will be Dr. Francis G. Serio, Dr. C. Neil Kay and Dr. Xuan Lan Phan (Vietnam), who was a recipient of the HVO orthodontic training program in Vietnam. Program chairpersons and volunteers will be available for questions after the formal presentation.

Acknowledgments: The Council wishes to express its sincere gratitude to Dr. Alan Tom, general chairman of the 1999 Committee on Local Arrangements, who leaves the Council after this year, for his assistance in the planning and production of the annual session and also for his useful input to all the Council's deliberations. The Council also wishes to thank those who so capably assisted Dr. Tom in the Committee's activities related to the 1999 annual session: Dr. Martin Henry Zais, vice chairman, Committee on Local Arrangements; Dr. Ernest W. Scheerer, co-chairman, Program Coordinating Committee; Dr. Richard C. Courson, co-chairman, Program Coordinating Committee; Dr. Sanford K. Kamezawa, co-chairman, Hospitality Committee; Dr. John M. Fujioka, co-chairman, Hospitality Committee; Dr. Calbert M.B. Lum, co-chairman, Registration and Special Services Committee; and Dr. Edward L. Ho, co-chairman, Registration and Special Services Committee. The Council also wishes to express its sincere appreciation to the entire membership of the Committee on Local Arrangements for their valuable contributions to the production of the annual session and to the

Hawaii County Dental Society and the Hawaii Dental Association for their support of the ADA annual session. Without the assistance and cooperation of these individuals and organizations, the 1999 annual session could not be possible.

The Council also wishes to recognize those of its members who will be completing their terms on the Council at the conclusion of the 1999 annual session: Dr. Kathryn A. Kell, who served as Council chair for 1999, Dr. Gerrit C. Hagman, Dr. Stephen Kondis and Dr. Neal B. Richter, whose initial appointment to the Council expires at the close of this annual session. The Council would also like to recognize the contributions made by Dr. Azam M. Qadri, who served on the Council during 1999 as the representative of the Standing Committee on the New Dentist. The Council will miss them and wishes them all the best in their future endeavors.

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

Council on Communications

Tonne, William J., Illinois, 1999, chairman
Hewitt, Richard F., South Carolina, 2000, vice chairman
Bartro, Robert E., Rhode Island, 2001, *ad interim*
Carpo, Christine B., Illinois, 1999, *ex officio**
Curtis, Eric K., Arizona, 2000
Eggleston, Frank K., Texas, 2000
Feinberg, Edward, New York, 1999
Harms, Kimberly A., Minnesota, 2002
Keisner, Kim D., Arkansas, 2001
Oberbreckling, Paul J., Wisconsin, 1999
O'Brien, Michael, Alabama, 2002
Perle, Charles H., New Jersey, 1999
Rice, Janet Hatcher, Tennessee, 2001
Rosen, Sherwin Z., California, 2000
Spruill, William T., Pennsylvania, 2001
Strickland, Daniel J., Ohio, 2002
Wilson, D. Richard, Oregon, 2002
Mickel, Clayton B., director
O'Donnell, Kathleen, manager

Organization: The Council on Communications continued to channel and maximize its members' skills and energies through subcommittees corresponding to the departments of the Division of Communications. Subcommittee chairmen were: Dr. Sherwin Z. Rosen, Media and Creative Services; Dr. Kim D. Keisner, Professional and Washington Communications; and Dr. William T. Spruill, Public Information and Education.

Dr. Henry Finger, Fourth District trustee, served as the Board of Trustees' liaison to the Council.

Meetings: The Council met in the Association's Headquarters Building on January 15-16, 1999, with a second meeting scheduled for June 4-5.

Personnel: The Council expresses appreciation to retiring members Dr. William J. Tonne, Dr. Edward Feinberg, Dr. Paul J. Oberbreckling and Dr. Charles H. Perle. The Council is grateful to Dr. Tonne for his commitment and leadership as chairman.

Participation in Conferences and Other Activities: Council representatives attended the House of Delegates at the 1998 annual session and the Association's Grassroots Conference in Washington, D.C., March 21-23, 1999. Representatives will attend the National Conference on the New Dentist in Nashville July 29-31, 1999. Dr. Tonne and Dr. Hewitt represented the Council on the Association's Critical Issues Task Force, which tracks emerging issues at the national, state and local levels that have a potential impact on the dental profession. Additional Council representation in Association activities is mentioned in other sections of this report.

Procedures Manual: At its January meeting, the Council reviewed a new procedures manual containing protocols for Council proceedings and activities. The manual, with revisions in format requested by the Council, will be presented to the full Council after the 1999 ADA annual session.

The Strategic Plan of the American Dental Association: At its January 1999 meeting, the Council responded to Resolution B-67-1998 (*Trans.*1998:626), which directed Association agencies to examine their activities in relation to the Association's Strategic Plan and eliminate those activities that do not support the Plan. The Council identified no activities that fail to support the Plan.

The Council also initiated the development of a response to B-79-1998 (*Trans.*1998:632), which directed agencies, working with the Office of Quality and Strategic Planning as a resource, to develop criteria for measuring the effectiveness of their activities as part of the Plan implementation process.

The Council approved criteria for evaluating programs relating to Plan Goals:

1. *Advocacy.* Dental *Advocate* newsletter, Federal Issues Kit.

2. *Practice Support.* Council participation in Salable Materials Advisory Panel.

3. *Image.* National Children's Dental Health Month (NCDHM), ADA Dental Minute radio and TV programs, National Spokespersons Program, Alternative Public Awareness Program, Media Relations Program, Spokesperson Training Program.

* Committee on the New Dentist member without the power to vote.

4. *Information.* Video news releases, public service announcements, ADA ONLINE, dental editor support.

5. *The Association: Member and Support Services.* Council participation in Critical Issues Task Force.

Examples of identified criteria are: the level of demand for campaign materials; media coverage; nondues revenue generated; and feedback from evaluation forms and focus groups. The actual evaluation will take place in year 2000.

Response to Assignments from the 1998 House of Delegates

Alternative Public Awareness Campaign and Related Activities. Resolution 100H-1998 (*Trans.*1998:689) outlined several public awareness initiatives to be conducted during 1999 and specifically charged the Council with assessing current and future public relations activities to supplement public awareness advertising activities, especially as they relate to consumer education. At its June meeting, the Council is scheduled to review a comprehensive audit of the Association's existing public relations initiatives that has been developed in response to Resolution 100H.

In other Council activities in response to resolution 100H, at its January meeting the Council viewed new public awareness materials developed by the advertising consulting firm of Jordan Associates. The Council requested that the firm continue development of new public awareness campaign advertisements, based on research as specified in the resolution and contingent upon the participation of up to five states. The Council was also presented with national public relations opportunities by Jordan Associates and requested that the firm develop more detailed proposals.

Council chairman Dr. William J. Tonne served on the Public Awareness Advisory Group appointed by ADA president Dr. S. Timothy Rose to work with the Council on implementation of Resolution 100H. The advisory group's primary responsibility was to explore opportunities for corporate participation in and funding of public awareness activities.

A detailed report, as stipulated in resolution 100H, will be transmitted to the House of Delegates separately.

***Facts for Communicators*:** At its June 1999 meeting, the Council is scheduled to review *Facts for Communicators*, a resource for dental communicators including officers and members of the Board of Trustees, the Association's national spokespersons, and designated dental society leaders. The Council also recommends that dental society executive directors provide dental editors with a copy of the document. After the Council's initial review, any republication of *Facts*, as well as any updating as events and developments dictate, will be reviewed and approved by the Council chairman or his/her designee.

As recommended by the Council, in May 1999 the most recent update of *Facts* became available online as a "living document." Timely changes can now keep the document up to date on an ongoing basis, and newly developed information can be added promptly. *Facts* is located in *ADA InSite* in the members-only content area of ADA ONLINE. The entire document, or sections of it as needed, can be downloaded and printed.

Dental Editors: Under the procedures approved by the Council at its January 1999 meeting, each year the Council chairman appoints at least one member as the Council's liaison for dental editor issues. The liaisons assist the Council in fulfilling its duty to assist dental editors and support; consult with Communications staff on dental editor matters, as appropriate; represent the Council at appropriate editor forums, such as conferences and meetings; and serve as liaisons to dental editor or dental journalism groups.

Dr. Eric K. Curtis and Dr. Edward Feinberg served as the Council's 1999 dental editor liaisons. There was Council representation at the annual meeting of the American Association of Dental Editors (AADE) in San Francisco in October 1998; at the Association's Dental Editors Conference in Chicago February 18-19, 1999; and at the meeting of the AADE board of directors in Chicago February 19, 1999.

At its January 1999 meeting, the Council requested that staff conduct a survey of dental editors to determine how editors gather and receive information, their awareness of Association resources for dental editors, additional resources they need or want, and other information as appropriate. A survey questionnaire, developed in consultation with the Association's Survey Center, was distributed to dental editors in April 1999.

National Spokespersons: At its January 1999 meeting, the Council recommended that a proposed list of 1999 national spokespersons be submitted to the ADA Board of Trustees for approval. The Board approved the proposed list at its February meeting. The Council notes that ADA national spokespersons presented consumer messages on ABC-TV's "World News Tonight" and NBC-TV's number-one rated morning program "The Today Show"; on other top programs with large nationwide audiences; and in major newspapers and leading consumer publications.

Other Media Activities: In response to action taken by the Board of Trustees at its August 1998 meeting, the Council now has input into the selection of topics for video news releases (VNRs) and broadcast scripts. Topics approved by the Council for 1999 VNRs include cosmetic dentistry and periodontal disease.

In addition, the Council chairman reviews all Association news releases and scripts.

The Council approved Consumer Advisor Dr. Maria Lopez Howell as the host for ADA DENTAL MINUTE, the Association's nationally distributed television series, which has been requested by almost 250 broadcast and cable stations in 47 states. As approved by the Council at its January meeting, ADA DENTAL MINUTE has been edited and formatted for radio, to replace DENTAL NEWSLINE and provide continuity of messages for maximum consumer impact.

Salable Materials Advisory Panel: In response to action taken by the Board of Trustees at its August 1998 meeting, Council representatives are now invited to the annual meeting of the Association's Salable Materials Advisory Panel. Dr. Michael O'Brien and Dr. William Spruill are the 1999 representatives. Prior to this year's meeting, they and other panel members will receive packets of existing materials, including patient education brochures, for review. Council representatives will also attend the full-day meeting June 25 and participate in current product review and discussion of new product ideas.

National Children's Dental Health Month (NCDHM): As its first choice for a theme for the year 2000 NCDHM campaign, the Council approved a space theme, which will have particular appeal for children. Final materials for the campaign will be submitted to the Council chairman for approval in July.

Frequently Asked Questions for ADA ONLINE: Under the procedures approved by the Council at its January 1999 meeting, either the Council chairman or his/her designee is involved in the development of Frequently Asked Questions for posting in the consumer content area of ADA ONLINE. Recommendations for new topics and questions are elicited from the Subcommittee on Public Information and Education and the full Council.

Consumer topics for Frequently Asked Questions approved by the Council at its January 1999 meeting include: replacement of restorations; the harmful effects of smoking and using smokeless tobacco; mouth guards; antibiotic prophylaxis; and oral piercing. Final materials are reviewed by the Council chairman before being posted online.

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

Council on Membership

Brodoski, Richard V., Michigan, 1999, chairman
Smith, Maria A., Connecticut, 2000, vice chairman
Adams, Anne C., Virginia, 1999
Bell, David J., Arkansas, 2002
Cartwright, Chris S., Texas, 2001
Davis, Gary S., Pennsylvania, 2000
Dohm, Otto W., North Dakota, 2000
Hoffman, Charles W., Florida, 2002, *ad interim*
Holifield, Mark, Tennessee, 1999, *ex officio**
Lopez, Alfred L., Jr., New Mexico, 2001
Matanzo, Thomas, Ohio, 2002
Morgenstern, Thomas F., New Jersey, 1999
Pendergrast, Phyllis, Alaska, 2002
Perry, Richard P., Illinois, 2001
Richardson, Marlene K., Kentucky, 2000
Schinnerer, Donald M., California, 1999
Weiss, Lois Lazarus, New York, 2001
Jarr, Paul W., director

Meetings: The Council met at the ADA Headquarters Building on February 26-28, 1999 and will meet again on June 18-20, 1999. Dr. Myron Pudwill, Tenth District trustee, served as the Board of Trustees liaison to the Council. The Chairman appointed three subcommittees of the Council to focus on major areas of activity: Tripartite Membership Issues, Target Marketing Issues and Member Benefits/Communication Issues. The subcommittees met on February 20 and are scheduled to meet on June 18, 1999.

Personnel: At its June 1998 meeting, the Council nominated Dr. Richard V. Brodoski, chairman and elected Dr. Maria A. Smith, vice chairman for 1998-1999. At the close of the 1999 annual session, the terms of four highly regarded members of the Council will end: Dr. Anne C. Adams, member 1995-1999 who also served as chairman 1997-1998; Dr. Richard V. Brodoski, member 1995-1999, who also served as chairman 1998-1999; Dr. Thomas Morgenstern, member 1995-1999; and Dr. Donald M. Schinnerer, member 1995-1999. The Council wishes to acknowledge these individuals for their thoughtful, determined leadership and for the many contributions they made during their years on the Council.

The Strategic Plan of the American Dental Association: At its August 1997 meeting, the ADA Board of Trustees took action requiring ADA agencies to begin implementation of the new *ADA Strategic Plan 1998-2001.*

In February 1999, at the request of the Board of Trustees and Strategic Planning Committee, the Council on Membership participated in a planning session to: discuss its current activities and eliminate those which were found to be unnecessary; develop criteria for measuring the effectiveness of those which were not eliminated; and to identify new programs, services and activities based on the priorities of the ADA Strategic Plan, appropriately tying all programs to the Strategic Plan. The Council submitted its preliminary implementation plan to the Strategic Planning Committee for review and submission to the Board of Trustees at its June 1999 meeting.

The following is a summary of the planned activities intended to accomplish specific objectives in support of the Strategic Plan Goal V., The Association: Membership and Support Services.

Goal V. The Association: Membership and Support Services.

The primary duties of the Council focus on planning and implementing activities that will achieve a strong membership and stable source of financial support. Council actions will seek to increase membership of all dentists in order to continue being the unified voice of dentistry. The Membership Services Outreach Program will continue to provide "hands on support" and develop new training opportunities for state and local society volunteers and staff. The collective theme of ADA recruitment and retention marketing materials will focus on communicating the "value of membership" by identifying the benefits of the tripartite structure and enhancing membership opportunities for dental students, women, minorities and otherwise underrepresented populations of dentists. Council activities, which will continue to be modified, include the Annual Conference on Membership Recruitment and Retention, the Student Marketing Plan, the Minority Recruitment Campaign and target marketing activities aimed at women dentists and recent graduates.

The Council has recommended ongoing research efforts to identify and customize services to meet various member needs and improve the products and services offered to members.

*Committee on the New Dentist member without the power to vote.

The results of the 1996 *Member Needs and Opinion Survey* and 1996 *Nonmember and Past Member Opinion Surveys* were widely distributed throughout the tripartite. Ongoing analysis of this data reduces duplication of services and allows the tripartite to continuously refine its member segments, whether defined by age, practice settings or geographic and cultural differences. The 1996 survey results have provided many ADA agencies including the Strategic Planning Committee and the Department of Salable Materials with useful data and analysis. The rapid changes in the profession make it necessary to routinely collect relevant data that can provide quantitative measures to evaluate Association programs and services. Based on the development and implementation of the 1996 survey, the Council has recommended similar research be conducted in the year 2000 to allow comparisons for established programs and benchmark data for new activities.

The Council identified opportunities to enhance relationships with related organizations and continues to explore alternative categories of membership and related services for dental auxiliaries, spousal membership, federally employed dentists and affiliate members.

Response to Assignments from the 1998 House of Delegates

Amendment of ADA *Bylaws* Regarding Dues Discount for First-Time Members: Resolution 1H-1998 (*Trans.*1998:685) amended the *Bylaws* to allow a one-time 50% reduction of active member dues to a licensed dentist who had never been an active member of the Association. The current edition of the ADA *Constitution and Bylaws*, revised to January 1, 1999, incorporates the amendment.

Tripartite Membership Application Procedures: Resolution 21H-1998 (*Trans.*1998:685) urged constituent societies to review their membership application procedures to ensure there are no barriers to membership and urged the use of the Tripartite Member Application. Resolution 21H-1998 was communicated to the Council's Membership Chair Network and will be published in the next edition of *Current Policies*.

Amendment of ADA *Bylaws* Regarding Electronic Debit Installment Programs: Resolution 22H-1998 (*Trans.*1998:692) amended the *Bylaws* to allow tripartite members to participate in installment dues payment programs sponsored by either the constituent or component dental society. The *Bylaws* amendment requires monthly installment payments that conclude with the current dues amount fully paid by June 30 to the ADA. Resolution 22H-1998 was communicated to the Council's Membership Chair Network in January and the current edition of the ADA *Constitution and Bylaws*, revised to January 1, 1999, incorporates the amendment.

Amendment of ADA *Bylaws* Regarding Direct Membership for Federal Contract Dentists: Resolution 23H-1998 (*Trans.*1998:695) amended the *Bylaws* to clarify the direct member eligibility of civilian dentists who are under a full-time third-party contract to provide dental services to the beneficiaries of a federal agency. To qualify for direct membership, the dentists must not engage in private practice and not be eligible for tripartite membership. Resolution 23H-1998 was communicated to the Council's Membership Chair Network in January and the current edition of the ADA *Constitution and Bylaws*, revised to January 1, 1999, incorporates the amendment.

During the review and discussion of Resolution 23 by the Board of Trustees, concerns were expressed regarding the possibility that a full-time federal contract dentist could also maintain a part-time private practice and therefore be eligible for tripartite membership. In response to this concern, the ADA's application procedures have been modified to strengthen the verification process and ensure that the appropriate constituent and component society is contacted and appraised of the direct member applicant. The application and employment verification procedures are as follows.

> In addition to a completed application form, the Department of Membership Information (DMI) requests verification of employment status by requiring a copy of the employment contract and documentation of current licenses. In addition, DMI verifies with constituent and component societies that the applicant is not engaged in private practice. A copy of the application is faxed to the constituent dental society, and then forwarded to the component dental society with a letter explaining that the candidate has applied for direct ADA membership and asks for written verification that the dentist is not engaged in private practice within their jurisdiction. The letter also suggests that if appropriate, the dental society contact the dentist regarding possible eligibility for tripartite membership.

It should also be noted that based on a previous House directive, Resolution 71H-1989 (*Trans.*1989:539), the constituent societies are routinely notified of all federally employed ADA direct members. The Department of Membership Information sends a roster of direct members to each constituent society annually and requests that they notify the ADA if they have a question concerning an individual's direct member eligibility.

Amendment of the ADA *Bylaws* Regarding Mechanism for a Special Assessment: Resolution 52-1998 (*Trans.*1998:684) was referred to the appropriate agencies for study and report to the 1999 House of Delegates. The resolution proposes that the Association consider amending the ADA *Bylaws* to include a provision for special assessments. Currently, the Association does not have a mechanism to fund projects through special assessments that are of a specific nature and that have a specific time frame for completion. In the past, the House of Delegates has used a temporary dues increase to generate revenue for projects with a specific purpose, such as the asbestos abatement and renovation of tenant-occupied floors in the ADA Headquarters Building funded through Resolution 35H-1992 (*Trans.*1992:583). The Council was assigned responsibility for Resolution 52-1998 and, at its February 1999

meeting, the Council received background material for its review and analysis.

The Council spent considerable time at its February meeting discussing the membership issues associated with this resolution and identified several key concerns that were developed as Council recommendations. As part of the study, the Council reviewed previous actions of the ADA House of Delegates relative to special assessments, the utilization of special assessments by constituent and component societies and discussed the possible impact the proposed resolution would have on Association operations and management. Ultimately, the Council agreed to support the concept of establishing a mechanism to fund certain projects through special assessments and focused its discussion on member reaction to a dues increase across all member categories. The Council addressed other key issues including the need to specify a time frame for completion of all projects funded by special assessments, the need to share the responsibility of funding a special assessment, and whether the grassroots members would better understand, and therefore be more willing to retain membership and fund special projects through an assessment.

Resolution 52-1998 would create a provision within the ADA *Bylaws* for a special assessment that would allow the House of Delegates the option to fund projects that are not part of the whole budget for ongoing operational activities and programs. Although there is no quantifiable data available, the Council agreed that the general membership may view favorably an assessment to fund special projects when they are essential for the continued operation of the Association, or for special projects which are deemed important to the profession. While dues are based upon implementing and administering the core services the Association provides to its members, the provision for a special assessment would provide the House of Delegates the opportunity to individually review special projects that are of a definite time frame and purpose. While the House of Delegates can debate the need for any budgeted program or activity, a special assessment proposal could be useful in focusing attention on the need and time frame of the project, and the amount and duration of the proposed assessment to fund it.

It should be noted that data reviewed by the Council indicates numerous constituent dental societies that have utilized special assessments for various projects over the last several years. Although most society assessments were approved for a one-year period, many recent assessments were for multiyear projects. According to the *1997 Survey of Constituent and Component Societies*, since 1993, a total of 21 constituent societies have reported as least one special assessment. In 1998, six component societies reported special assessments ranging from $20 to $275. Also, in 1998, six component societies reported special assessments ranging from $15 to $195. It should be noted that only 104 component dental societies returned the 1997 survey.

The last time the ADA House of Delegates faced the issue of special assessments was 1980, when the Board of Trustees sought a method to pay for an institutional advertising campaign. The Board's Resolution 50-1980 (*Trans.*1980:544) proposed a *Bylaws* amendment to permit special assessments but the resolution was not adopted. In 1980, the Board also proposed a companion Resolution 51-1980 (*Trans.*1980:545) which assumed adoption of Resolution 50-1980 and called for a special one-year assessment of active members ($37 each) to pay for an institutional advertising program in 1981. A vote was taken on Resolution 51-1980 and also failed.

In considering this proposal, the Council notes that this resolution would focus the burden of paying for programs funded by special assessment on active members. Because the dues of active life, affiliate, associate and retired members are a percentage of dues of active members and this resolution would have only active members paying a special assessment, the dues of these other categories of membership would not be affected and active members would have to shoulder the entire amount of the assessment. This approach seems inconsistent with the spirit of proportionate cost sharing among dues-paying members. If the same program were paid from general dues and nondues revenue of the Association, all members would share the cost of the program on the same basis that they do now with all programs. The Council believes that if appropriate, assessments should be levied in a manner consistent with the dues structure. The Council also discussed the proposed *Bylaws* language in terms of the types of projects which might be appropriately funded by a special assessment.

The Council carefully analyzed the proposed *Bylaws* language and discussed the types of projects which might be appropriately funded through a special assessment. The Council believes that although the *Bylaws* should allow the House of Delegates the maximum flexibility in utilizing the assessment mechanism to fund a variety of special projects, the *Bylaws* should also establish a basic set of criteria that can be useful to the House in evaluating future proposals.

As proposed, Resolution 52-1998 contains most of the essential elements the Council feels are vital to qualify a particular project for consideration for special assessment funding. In summary, the Council suggests the following criteria for special assessment consideration:

- Notice of the proposed assessment is given to the delegates and the general membership in compliance with the established provisions for changing active member dues.
- The notice must clearly state *the need* for the proposed assessment, *the amount* to be assessed to each category of membership, and the *specific timetable* for completion of the project.

In addition, the Council is very supportive of placing restrictions on the use of special assessment revenues which could be perceived positively by the membership. As written, Resolution 52-1998 proposes that the income from an assessment shall only be used for the specific purpose stated in the notice, unless otherwise directed by the House of Delegates with at least a two-thirds (2/3) affirmative note.

The primary duties of the Council focus on planning and implementing activities that will maintain a strong membership and a stable source of financial support. The Council believes

the Association will achieve its goals if the Association agencies solicit the members' opinions and take appropriate actions to meet needs.

The Council supports the intent of Resolution 52-1998, and believes that members are more receptive to funding projects of a limited duration through special assessments rather than increasing member dues. In addition, the Council believes that the fact that revenue from a special assessment could only be used for the specific purpose stated in the official notice, unless changed by the House of Delegates by a two-thirds (2/3) affirmative vote. This could be perceived positively by members and might enhance members' comfort in the way members' dollars are utilized for these specific activities. The Council did not feel, however, that only active members should pay for programs funded by special assessment in all cases, as this is inconsistent with the Association's dues structure and the assessment may disproportionately impact active members when other categories of membership may also benefit. Therefore the Council recommends the following new resolution.

1. Resolved, that Chapter XVII. FINANCES of the *Bylaws* be amended by the addition of a new Section 50. SPECIAL ASSESSMENTS to read as follows:

Section 50. SPECIAL ASSESSMENTS: In addition to the payment of dues required in Chapter I, Section 50 of these *Bylaws*, a special assessment may be levied by the House of Delegates upon active, active life, retired, affiliate and associate members of this Association as provided in Chapter I, Section 50 of these *Bylaws*, for the purpose of funding a specific project of limited duration. Such an assessment may be levied at any annual or special session of the House of Delegates by a two-thirds (2/3) majority vote of the delegates present and voting, provided notice of the proposed assessment has been presented in writing at least ninety (90) days prior to the first day of the session of the House of Delegates at which it is to be considered. Notice of such a resolution shall be sent by a certifiable method of delivery to each constituent society not less than ninety (90) days before such session to permit prompt, adequate notice by each constituent society to its delegates and alternate delegates to the House of Delegates of this Association, and shall be announced to the general membership in an official publication of this Association at least sixty (60) days in advance of the session. The specific project to be funded by the proposed assessment, the time frame of the project, and the amount and duration of the proposed assessment shall be clearly presented in giving notice to the members of this Association. Revenue from a special assessment and any earnings thereon shall be deposited in a separate fund as provided in Chapter XVII, Section 40 of these *Bylaws*. The House of Delegates may amend the main motion to levy a special assessment only if the amendment is germane and adopted by a two-thirds (2/3) majority vote of the delegates present and voting. The House of Delegates may consider only one specific project to be funded by a proposed assessment at a time. However, if properly adopted by the House of Delegates, two or more special assessments may be in force at the same time.

Any resolution to levy a special assessment that does not meet the notice requirements set forth in the previous paragraph also may be adopted by a unanimous vote of the House of Delegates, provided the resolution has been presented in writing at a previous meeting of the same session.

and be it further

Resolved, that Chapter I. MEMBERSHIP of the *Bylaws* be amended by deleting Section 50 in its entirety and substituting in its place a new Section 50. DUES, SPECIAL ASSESSMENTS AND REINSTATEMENT to read as follows:

Section 50. DUES, SPECIAL ASSESSMENTS AND REINSTATEMENT:

A. ACTIVE MEMBERS.* The dues of active members shall be three hundred eighty-two dollars ($382.00) due January 1 of each year.** In addition to their annual dues, active members shall pay any special assessments levied by the House of Delegates in accordance with Chapter XVII, Section 50 of these *Bylaws*, due January 1 of each year. Notwithstanding the foregoing, any dentist, who satisfies the eligibility requirements for active membership under Chapter I, Section 20A of these *Bylaws* and who satisfies any of the following conditions shall be entitled to pay the reduced active member dues and special assessment listed under such satisfied condition so long as that dentist maintains continuous membership, subject to the further reductions permitted under the provisions of Chapter I, Section 50H, of these *Bylaws*:

(1) On a one-time basis, the dentist, when awarded a D.D.S. or D.M.D. degree, shall be exempt from the payment of active member dues and any special assessment for the remaining period of that year, and shall pay twenty-five percent (25%) of active member dues and special assessment for the first full calendar year following the year in which the degree was awarded, fifty percent (50%) of active member dues and special assessment in the second year, seventy-five percent (75%) in the third year and one hundred percent (100%) in the fourth year and thereafter.

(2) The dentist who is engaged full-time in (a) an advanced training course of not less than one academic year's duration in an accredited school or residency program in areas neither recognized by this Association nor accredited by the Commission on Dental

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* Effective January 1, 2000 the dues of active members shall be reduced by twenty-five dollars ($25.00) from the level of active members dues in effect in 1999.

** Effective January 1, 2000 the dues of active members shall be reduced by fourteen dollars ($14.00) from the level of active members dues in effect in 1999.

Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall pay thirty dollars ($30.00) due on January 1 of each year until December 31 following completion of such program. For the dentist who enters such a course or program within one (1) year of the award of D.D.S. or D.M.D. degree and who pays dues of thirty dollars ($30.00) per annum while in such a program, the applicable foregoing condition (1) shall toll until completion of that program. Upon completing the program, the dentist shall pay dues for active members at the next period-in-time level that is applicable under condition (1). The dentist who is engaged full-time in (a) an advanced training course of not less than one academic year's duration in an accredited school or residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall be exempt from the payment of any active member special assessment then in effect through December 31 following completion of such course or program.

(3) An active member who is serving dentistry full-time for a charitable organization and is receiving neither income nor a salary for such charitable service other than a subsistence amount which approximates a cost of living allowance shall pay dues of five dollars ($5.00) due January 1 of each year, and shall be exempt from the payment of any special assessment then in effect through December 31 following completion of such service; provided that such charitable service is being performed continuously for not less than one year and provided further that such member does not supplement such subsistence income by the performance of services as a member of the faculty of a dental or dental auxiliary school, as a dental administrator or consultant, or as a practitioner of any activity for which a license to practice dentistry or dental hygiene is required.

(4) On a one-time basis, a new graduate of a non-accredited dental school who has recently been licensed to practice dentistry in a jurisdiction in which there is a constituent dental society of the American Dental Association shall be exempt from payment of active member dues and any special assessment for the remaining period of the year in which the license was issued. The newly licensed graduate of a non-accredited school shall pay twenty-five percent (25%) of active member dues and any special assessment the first full calendar year following the year in which the license was obtained, fifty percent (50%) of active member dues and any special assessment in the second year, seventy-five percent (75%) in the third year and one hundred percent (100%) in the fourth year and thereafter.

(5) On a one-time basis, a licensed dentist applying for membership, who has never been an active member of this Association and is not otherwise eligible as a new graduate under this Section of the Bylaws, shall pay fifty percent (50%) of active member dues and any special assessment in the first year, and shall pay one hundred percent (100%) of active member dues and any special assessment in the second year and each year thereafter.

B. LIFE MEMBERS.

a. Active Life Members. Regardless of a member's previous classification of membership, the dues of life members who have not fulfilled the qualifications of Chapter I, Section 20G of these Bylaws with regard to income related to dentistry shall be fifty percent (50%) of the dues of active members, due January 1 of each year. In addition to their annual dues, active life members shall pay fifty percent (50%) of any active member special assessment levied by the House of Delegates in accordance with Chapter XVII, Section 50 of these Bylaws, due January 1 of each year.

b. Retired Life Members. Life members who have fulfilled the qualifications of Chapter I, Section 20G of these Bylaws with regard to income related to dentistry shall be exempt from payment of dues and any special assessment levied by the House of Delegates in accordance with Chapter XVII, Section 50 of these Bylaws.

C. STUDENT MEMBERS. The dues of predoctoral student members shall be five dollars ($5.00) due January 1 of each year. The dues of a dentist who is engaged full-time in (a) an advanced training course of not less than one academic year's duration in an accredited school or residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall pay thirty dollars ($30.00) due January 1 of each year. Predoctoral student members and dentists who are engaged full-time in (a) an advanced training course of not less than one academic year's duration in an accredited school or residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall be exempt from payment of any special assessment levied by the House of Delegates in accordance with Chapter XVII, Section 50 of these *Bylaws*. Student membership terminates on December 31 after graduation or after completion of a residency or graduate work as provided in Chapter I, Section 20C of these *Bylaws*.

D. HONORARY MEMBERS. Honorary members shall be exempt from payment of dues and any special assessment

levied by the House of Delegates in accordance with Chapter XVII, Section 50 of these *Bylaws*.

E. AFFILIATE MEMBERS. The dues of affiliate members shall be fifty percent (50%) of the dues of active members, due January 1 of each year. In addition to their annual dues, affiliate members shall pay fifty percent (50%) of any active member special assessment levied by the House of Delegates in accordance with Chapter XVII, Section 50 of these *Bylaws*, due January 1 of each year.

F. ASSOCIATE MEMBERS. The dues of associate members shall be twenty-five percent (25%) of the dues of active members, due January 1 of each year. In addition to their annual dues, associate members shall pay twenty-five percent (25%) of any active member special assessment levied by the House of Delegates in accordance with Chapter XVII, Section 50 of these *Bylaws*, due January 1 of each year.

G. RETIRED MEMBERS. The dues of retired members shall be twenty-five percent (25%) of the dues of active members, due January 1 of each year. In addition to their annual dues, retired members shall pay twenty-five percent (25%) of any active member special assessment levied by the House of Delegates in accordance with Chapter XVII, Section 50 of these *Bylaws*, due January 1 of each year.

H. MEMBERS SELECTED AFTER JULY 1 AND OCTOBER 1. Those members selected to active membership in this Association after July 1, except for those whose membership has lapsed for failure to pay the current year's dues and/or special assessments, shall pay one half (1/2) of the current year's dues and one half (1/2) of any active member special assessment then in effect, and those selected after October 1, shall pay one-quarter (1/4) of the current year's dues and one quarter (1/4) of any active member special assessment then in effect; except that a student member, upon classification as an active member by a constituent society shall pay no further dues or special assessments for the remainder of the calendar year in which the member was entitled to the benefits of student membership.

I. LOSS OF MEMBERSHIP AND REINSTATEMENT.

a. An active, active life, student, affiliate or retired member whose dues have not been paid by March 31 of the current year shall cease to be a member of this Association. An active, active life, affiliate or retired member who has not paid his or her special assessment(s) by March 31 of the current year shall cease to be a member of this Association.

b. Reinstatement of active, life, retired, student or affiliate membership may be secured on payment of dues and/or special assessments of this Association by a former active member in accordance with Chapter I, Section 50A, by a former life member in accordance with Chapter I, Section 50Ba, by a former retired member in accordance with Chapter I, Section 50G, by a former student member in accordance with Chapter I, Section 50C, and by a former affiliate member in accordance with Chapter I, Section 50E, and on compliance by a former active, life or retired member with the pertinent bylaws and regulations of the constituent and component societies involved.

c. An associate member whose dues and/or any special assessment have not been paid by March 31 of the current year shall cease to be a member of this Association. An associate member who terminates full-time employment in dentally-related education or research at an accredited institution of higher education shall cease to be an associate member of this Association December 31 of that calendar year.

J. ACCEPTANCE OF BACK DUES AND SPECIAL ASSESSMENTS. Back dues and/or special assessments, except as otherwise provided in these *Bylaws*, shall be accepted for not more than the three years of delinquency prior to the date of application for such payment. The rate of such dues and/or special assessments, except as otherwise provided in these *Bylaws*, shall be in accordance with Chapter I, Section 50A of these *Bylaws*.

An active member, who had been such when entering upon active duty in one of the armed services or equivalent duty in the Public Health Service but who, during such military or equivalent duty, interrupted the continuity of active membership because of failure to pay dues and/or special assessments and who, within one year after separation from such military or equivalent duty, resumed active membership, may pay back dues and/or special assessments for any missing period of active membership at the rate of dues and/or special assessments current during the missing years of membership for the purpose of establishing continuity of active membership in order to qualify for life membership.

K. DUES AND SPECIAL ASSESSMENTS OF MEMBERS WHO SUFFER FINANCIAL HARDSHIP. Those members who have suffered a significant financial hardship that prohibits them from payment of their full dues and/or special assessments may be excused from the payment of fifty percent (50%), seventy-five percent (75%) or all of the current year's dues and/or special assessment(s) as determined by their constituent and component dental societies. The constituent and component society secretaries shall certify the reason for the waiver, and the constituent and component societies shall provide the same proportionate waiver of their dues as that provided by this Association.

L. PROVISIONAL MEMBER. The dues and/or special assessments of provisional members shall be the same as the dues and/or special assessments of active members.

M. PERCENTAGE DUES OR SPECIAL ASSESSMENTS. In establishing the dollar rate of dues or special assessments in this chapter expressed as a percentage of active member

dues or special assessments, computations resulting in fractions of a dollar shall be rounded up to the next whole dollar.

N. PAYMENT DATE FOR DUES AND SPECIAL ASSESSMENTS. Dues and special assessments of all members are payable January 1 of each year, except that active and active life members may participate in an installment payment plan sponsored by their respective constituent or component dental societies. A constituent- or component-sponsored plan shall require monthly installment payments that conclude with the current dues and/or special assessment amount fully paid by June 30. Fees for transactional costs may be imposed, prorated to this Association and the constituent or component dental society. The installment dues and/or special assessment plan shall provide for expeditious transfer of each member's dues and/or special assessments to this Association and his or her constituent or component dental society, if such exists, as soon as commercially feasible.

and be it further

Resolved, that Chapter II. CONSTITUENT SOCIETIES, Section 30. POWERS AND DUTIES of the *Bylaws* be amended in Subsection E by adding the phrase "and special assessments" between the words "dues" and "for" in line 524, so the amended Subsection E reads as follows:

E. It shall be its duty to collect membership dues and special assessments for this Association in conformity with Chapter I, Section 50, of these *Bylaws*.

Amendment of ADA *Bylaws* to Require Tripartite Membership Upon Completion of Dental School: Resolution 82-1998 (*Trans.*1998:695) was referred to the Council on Membership as the appropriate agency for study and report to the 1999 House of Delegates. The resolution proposed that the Association amend its *Bylaws* to require dentists pursuing postdoctoral education to maintain membership in their constituent and component society, if such exist.

The Council on Membership reinforced the importance of the inclusion of graduate students in organized dentistry and took action to encourage constituent outreach to dentists enrolled in postdoctoral programs in that constituent. However, the Council on Membership recommended that the current membership options for graduate students be maintained, and that the proposed *Bylaws* amendment not be enacted.

The three current membership options for graduate students include: to join as tripartite members; to join the ADA directly as graduate student members; or to join the ADA through the American Student Dental Association, affording dual ASDA/ADA membership.

Enactment of the proposed resolution would impact the Association in a number of ways. First, it would eliminate two membership options for graduate students: ADA direct membership and ASDA/ADA membership. Second, it would mandate the development of a new membership category for many constituents and components. Third, it would effectively eliminate the option of the direct provisional membership category for dental school graduates who have not yet begun to practice dentistry.

Eliminating Membership Options. The Council agreed that eliminating barriers to membership was an important goal for the Association. However, the Council did not find that multiple membership options served as a barrier to membership, but rather as an inducement to a lifelong commitment to organized dentistry. It was noted that the resolution background statement focused on graduate students who proceed directly from predoctoral to postdoctoral education to private practice, all within the same constituent. For dentists in this situation, tripartite membership may be the best choice and this membership option is open to them.

For dentists who are not in this situation, requiring tripartite membership may be perceived as a barrier in itself. It was noted that residents of the 20 constituents that have no dental school must receive their predoctoral education outside their home state. In addition, there are ten constituents that have no postdoctoral educational programs, and some specialties offer very few programs. Therefore, the likelihood of dentists pursuing postdoctoral education outside the constituent where they plan to practice is high. For these members especially, direct graduate student membership in the ADA or ASDA/ADA membership may be preferred.

In addition, approximately 10% of ADA graduate student members take advantage of ASDA/ADA dual membership. These dentists, many of whom are progressing directly from predoctoral to postdoctoral education programs, wish to maintain their ASDA membership and ASDA benefits.

Therefore, from both the membership market share and member service points of view, the Council felt it was in the best interests of the Association to maintain all three membership options for graduate students.

Mandating the Development of a New Membership Category. The Council reviewed the membership categories currently offered by the constituents, and noted that there are 21 constituents which do not have a graduate student membership category; 14 do not have a category for dental students at all. Requiring all constituents to offer predoctoral and postdoctoral dental student memberships, regardless of their own perceived need, was felt by the Council to be inappropriate.

Eliminating ADA Direct Provisional Membership Category. In every dental school class, there are individuals who do not begin to practice immediately, often due to problems with achieving licensure or to a decision to delay dental practice for personal reasons. Keeping these individuals as a part of organized dentistry has been a priority for the Association. Resolution 68H-1996 (*Trans.*1996:677) increased the length of time a dentist is eligible for provisional membership from 18 months to 30 months following dental school graduation. Resolution 82-1998 could have the effect of eliminating the

direct provisional membership category. A total of 37 dentists paid dues in this membership category in 1998.

In conclusion, the Council on Membership determined that the proposed *Bylaws* change would not benefit the Association or its members. The Council also noted additional information regarding the membership needs and opinions of graduate students would be available following completion of the Member Needs and Opinions Research presented in the 2000 Council on Membership budget.

Alternative Procedure for Changing Member Dues: Resolution 113H-1998 (*Trans.*1998:683) directs an appropriate agency to study alternative procedures for changing member dues and report to the 1999 House of Delegates. The Council discussed this resolution at its February 1999 meeting and requested that a comprehensive report be prepared for the June 1999 Council meeting. The Council's report and recommendations will be reported to the 1999 House of Delegates in a supplemental report.

Other Council Activities

Development of New Membership Statistic Reports: The conversion of membership records to a new Tripartite Association Management System (TAMS) database required that all membership reports be developed from the ground up for all business operations. The TAMS Membership module was installed in December 1998, six months after the initial conversion of membership records from the mainframe computer system. This module allows for recording specific membership information such as dues payments, designation of where the member maintains membership, membership classification and other related membership data. This data is required to report end-of-year membership statistics.

Because of the significant time needed to convert membership records and in light of the timing of the delivery of the Membership Module at the end of the year, a plan was needed to prioritize the development of the annual membership reports.

A national report of 1998 members by constituent society was produced and distributed to the officers and members of the ADA Board of Trustees. This report was used for determining delegate allocation for the ADA House of Delegates. In addition, over 40 new reports were developed for use by the tripartite with TAMS when it is installed for the constituent or component societies. Other priority reports include production of other membership lists, labels and datasets for recruitment and retention efforts and mailings to target market segments, for invoicing 1999 membership dues for direct members and production of membership cards. Development of the National Recruitment and Retention Report that reports market share for constituent and component societies and the Membership Statement that reports members by membership classification and rate paid are to be produced in 1999.

The following table is presented for the information of the House. Additional data will be reported upon its availability.

ADA Membership

End of Year 1998	Total Members
Affiliate	1,389
Air Force	592
Alabama Dental Association	1,560
Alaska Dental Society	294
Arizona State Dental Association	1,643
Arkansas State Dental Association	980
Army	459
Associate	66
California Dental Association	17,928
Civil Service	97
Colegio de Cirujanos Dentistas de Puerto Rico	420
Colorado Dental Association	2,492
Connecticut State Dental Association	2,602
Delaware State Dental Society	327
Dental School	10,298
Dental Society of the State of New York	13,849
District of Columbia Dental Society	531
Florida Dental Association	6,332
Georgia Dental Association	2,676
Graduate Member	3,142
Hawaii Dental Association	838
Honorary	196
Idaho State Dental Association	615
Illinois State Dental Society	6,323
Indiana Dental Association	2,603
International	249
Iowa Dental Association	1,680
Kansas Dental Association	1,150
Kentucky Dental Association	1,833
Louisiana Dental Association	1,797
Maine Dental Association	674
Maryland State Dental Association	2,498
Massachusetts Dental Society	4,571
Michigan Dental Association	5,485
Minnesota Dental Association	2,856
Mississippi Dental Association	937
Missouri Dental Association	2,166
Montana Dental Association	517
Navy	677
Nebraska Dental Association	996
Nevada Dental Association	580
New Hampshire Dental Society	693
New Jersey Dental Association	4,334
New Mexico Dental Association	602
North Carolina Dental Society	2,894
North Dakota Dental Association	319

End of Year 1998 (continued)	Total Members
Ohio Dental Association	5,448
Oklahoma Dental Association	1,400
Oregon Dental Association	1,990
Panama Canal Dental Society	1
Pennsylvania Dental Association	6,114
Provisional	37
Public Health Service	328
Rhode Island Dental Association	608
South Carolina Dental Association	1,422
South Dakota Dental Association	317
Tennessee Dental Association	2,288
Texas Dental Association	7,500
Utah Dental Association	1,223
Vermont State Dent Society	358
Veterans Affairs	504
Virgin Islands Dental Association	25
Virginia Dental Association	2,999
Washington State Dental Association	3,446
West Virginia Dental Association	786
Wisconsin Dental Association	2,801
Wyoming Dental Association	245
Total All Constituents	**155,600**

Target Marketing: The Department of Membership Marketing conducts recruitment initiatives targeted to direct members (graduate students and federally employed dentists) as well as specific tripartite membership segments (recent graduates, new dentists and minority dentists). In 1998-1999, three new recruitment brochures were developed for dentists in graduate school, the federal dental services and private practice (tripartite). The brochures incorporated appropriate membership applications.

Recruitment initiatives in 1998-1999 included multiple direct mail contacts, a special wrap cover for selected nonmembers on a bonus issue of *ADA News*, as well as a "how to join in 1999" special cover on *JADA* for ADA members of the graduating class of 1998.

ADA Membership Services Outreach Program (MSOP) (previously the Field Service Program): The MSOP continues to demonstrate its effectiveness in assisting dental societies to establish or rejuvenate membership committees to address recruitment and retention issues, including membership meetings, benefit and diversity. The following are selected activities conducted in collaboration with MSOP over the past year:

- Dental Society of Western Pennsylvania (Pittsburgh) held two successful first-ever receptions, one for women dentists and another for faculty and dental school leaders; formed a dental school mentor program and reactivated social committee.
- New Orleans Dental Association initiated a mentor program for new graduates, invited nonmembers to crawfish party, initiated outreach to diverse/ethnic dental organizations and participated in Dentist Day at the state legislature.
- Philadelphia County Dental Society held a reception for women dentists with corporate sponsorship, awarded dental schools scholarships and created a newsletter for all dentists.
- Florida Dental Association participated in ASDA weekend, initiated a dental school mentor program and began a statewide recruitment and retention program.
- Baltimore City Dental Society supported ongoing outreach to dental students and prospective members, met with nearby dental societies regarding cooperative efforts and made plans for a special event at the dental museum.
- Baltimore County Dental Association focused on new member retention and leader recognition and participated in a joint Benefits Communications workshop with Baltimore City Dental Society.
- San Mateo County Dental Society (CA) created a quarterly new member orientation and new member kit, as well as an ADA tripartite benefits brochure and participated in an ADA Goals and Roles planning workshop.
- Santa Clara County Dental Society (CA) welcomed several new members at every monthly dental meeting with introductions and new member materials and created three practice management seminars which attracted 150 attendees each.
- San Francisco Dental Society held two successful dental student receptions, conducted special outreach to women dentists and new members and conducted informal research to aid in planning events for new dentists.
- Blue Grass Dental Society (KY) created a task force and created an action agenda for 1999, scheduled speakers about organized dentistry in conjunction with the practice management seminars at the dental school and identified nonmembers for recruitment initiatives.
- Nebraska Dental Association coordinated student outreach at Creighton and University of Nebraska dental schools, identified potential new members and planned a membership display at the NDA annual meeting.
- Metropolitan District Dental Society (Boston) conducted mail and phone campaigns inviting new/young and ethnic dentists to join the Metropolitan District Dental Society, hosted new and potential members at each monthly meeting and invited transfer-nonrenews to join.
- Columbus Dental Society (OH) gained 20 new members by hosting nonmembers at general meeting and providing information highlighting benefits of membership and applications, recognized member anniversaries in the Columbus Dental Society bulletin.

To enhance the dental society membership function, the Membership Services Outreach Program also piloted two regional membership staff training days. These events trained dental society staff to approach membership recruitment and

retention as an ongoing process and to integrate it with other dental society events and activities. Membership Services Outreach Program staff provided recruitment and retention resources, while staff from the ADA Department of Membership Information educated attendees about collecting, maintaining and using membership records and reports. Participants from the constituent and component societies contributed their perspectives on the membership function and brainstormed ways to improve cooperation between the national, state and local levels.

At the Council's request, the ADA Survey Center conducted the 1997-1998 ADA Field Service Program Evaluation. The survey was mailed to the 139 members of the membership committees and boards of the 11 constituent and component dental societies that participated in the 1997-98 Field Service Program. More than 85% of respondents expressed satisfaction with the Field Service experience in their dental society. Ninety-seven percent of participants indicated that their society would continue to make member recruitment and retention a priority in the future.

As recruitment and retention continues to be a priority for constituents and components, MSOP is focusing on expanding its offerings so that it continues to stimulate thought and action at the state and local levels of membership activities. Several workshops will be developed and tested in 1999 and offered to dental societies in 2000.

ADA Annual Conference on Membership Recruitment and Retention: The ADA's sixth "ADA Annual Conference on Membership Recruitment and Retention" was held November 6-7, 1998, at ADA Headquarters. The purpose of the conference is to assist constituent and component dental society volunteer leaders and staff who are interested in sharing and learning proven techniques to enhance their membership efforts. The November conference attracted more than 100 attendees, including 42 member dentists, 58 dental society staff and representatives from the Alliance of the American Dental Association, the American Academy of Periodontology, the American Association of Women Dentists, the American Dental Society of Anesthesiology, the National Dental Association and the National Association of Filipino Dentists.

Over 54% of the 1998 attendees (ADA members and dental society staff only) attended the 1997 conference (compared to 35% of 1997 participants attending the 1996 conference.) Twenty-one of the 35 attendees who completed the Overall Conference Evaluation responded that their dental society planned on having a representative attend the conference in 1999. The remaining 14 responded "don't know" or left the question blank.

Each attendee received a conference tote bag complete with Recruitment and Retention Resource Guide and handouts for each session. The format of the conference consisted of general sessions over a period of one and one half days. Plenary sessions for the November 1998 conference included: ADA Membership Overview and Strategic Outlook; Retention and Recruitment Through Better Communication; Beyond Diversity To A 21st Century Solution; Diversity Open Forum; ADA Recruitment and Retention Tips, Open Forum; a post-conference session, New Dentist Transition Program; and Smart Start Program Training.

The overall evaluation for the conference was a 4.5 on a scale of 1 to 5, with 5 as "excellent." "Conference Organization" was rated 4.7, "Conference Speakers" was rated 4.4 and "Resources" was rated 4.6.

Recruitment and Retention Resources: Developing publications and other resources that successfully communicate the value of membership in the Association remained a priority of the Council in 1999. Some resources, such as the content of ADA ONLINE, and the *Connections* booklet, are designed to communicate the benefits of membership directly to the individual dentist. Others, such as the *Membership Benefits Briefs* newsletter, are designed for use by constituent and component dental societies to enhance their own recruitment and retention efforts.

Connections. Each year, the Association publishes *Connections*, a members-only guide to ADA programs and services. The 1999 booklet was designed to be a phone directory linking members with specific ADA staff who can answer their questions. The topical listings which cover the Association's major areas highlighted even more ADA programs and services in the body of the booklet than in the past. *Connections* is produced exclusively for members and is not distributed to the general public. In 1999, for the first time, advertising was allowed to defray some of the cost of production and mailing. Advertisers included Great-West Life (insurance programs), ADA 1 PLAN (financial programs) and The Equitable (Roth IRA and retirement program).

Dues Billing Stuffer. To raise member awareness of the many programs and services their dues supported in 1998, the Department of Membership Services sent each constituent dental society a quantity of prefolded flyers to insert in their dues notices in October 1998. The flyer featured an ADA "To Do List," which included 14 actions undertaken by the ADA on behalf of members on a daily basis throughout 1998.

1999 ADA Member Decal. This decal continues to be one of the most visible and well-received symbols of membership. A quantity of decals was sent to constituents in October 1998, with a request that they insert one with each 1999 membership card.

Benefits Ads. To encourage constituent and component dental societies to raise awareness of member benefits—a key to member retention—the Department of Membership Services developed a series of eight small ads promoting various ADA benefits. The ads were sent to constituent and component dental editors with the request that they include an ad in each issue of their newsletter or journal as an ADA "Benefit of the Month." Since many dental societies have neither the staff nor the financial means to produce such ads on their own, providing easy access to such resources is a primary retention strategy of the Council.

Benefits Brochures. In order to convey the value of membership to dentists, a brochure on the benefits of membership was developed. This piece was used by the Association, as well as by constituent and component dental societies, in 1998-99 recruitment efforts. More than 40,000 copies of this brochure were distributed.

The ADA Home Page. ADA ONLINE now includes more than 200 references to membership issues, including information on the benefits of ADA membership, career alternatives, frequently asked questions, directory of State/Local Dental Societies and membership applications. Membership Services staff worked with Communications staff to develop benefits messages to be carried on the Internet and to increase the exposure of membership information.

Membership Benefit Briefs. This newsletter is the core of the Council's communication with constituent and component membership marketing staff and volunteers. The bimonthly publication highlights and explains ADA benefits and provides a forum for dental societies to share successful recruitment and retention strategies.

ADA Tours. The Division of Membership and Dental Society Services is also responsible for providing tours of the Headquarters Building for interested visitors. It is anticipated that staff will conduct tours for more than 300 visitors in 1999. Visitors receiving tours have included: dental students; constituent president-elects; members in town for dental meetings, or on vacation; and dental spouses and international guests. The response has been very positive.

Resources for the Recruitment of Underrepresented Membership Segments. As a part of the Council on Membership's ongoing activities to support tripartite recruitment of underrepresented membership segments, the Department of Membership Marketing provided three recruitment and retention resource kits to constituent and component societies in 1998-1999. Updated resource kits regarding two target markets were distributed in June 1998: *New Dentists in Organized Dentistry* and *Women Dentists in Organized Dentistry*. The kits included facts and statistics, membership needs and opinions, suggested outreach tactics, sample membership marketing plans and more.

To support the recruitment and retention of dentists of minority racial and ethnic backgrounds, the Department of Membership Marketing developed and distributed *Diversity in Organized Dentistry: A Membership Recruitment and Retention Resource Kit for Dental Societies* in March 1999. The kit included facts about dental diversity, highlights from the *ADA 1996 Dentist Profile Survey*, tips for recruiting minority dentists, case studies from constituent and component outreach efforts and sample letters.

Student Marketing Plan: The American Dental Association has long recognized the importance of reaching out to dental students and integrating them into the family of organized dentistry while they are in dental school. Predoctoral students join the American Dental Association as student members through the American Student Dental Association (ASDA). The ultimate goal is to increase dental students' awareness of and membership in the American Dental Association and to establish a lifelong membership commitment to organized dentistry among students and recent graduates.

The ADA Council on Membership oversees the Association's student initiatives and each year adopts a comprehensive Student Marketing Plan. The activities developed, implemented and evaluated in these plans have made a significant impact on student market share, from 67% in 1995, to 72.2% in 1996, to 73.5% in 1997, and to 79.9% in 1998, based on July 1 yearly reports at the end of each academic year. In 1997, the activities outlined in the student marketing plan also contributed significantly to an increase of 10.3% in first-year-out conversion. The class of 1996 first-year-out market share was 61.4% compared with class of 1995 first-year-out market share of 51.1%. (End of Year 1998 membership figures are not available.)

The Council on Membership directs the student marketing activities through the following strategies. These strategies are interactive and interdependent; they are not prioritized.

1. Increase direct communications with all predoctoral students to increase their awareness and understanding of ADA membership benefits.
2. Coordinate membership marketing activities with ASDA.
3. Educate students to the tripartite structure and how to join organized dentistry.
4. Increase the ADA's understanding of the needs and interests of dental students at each stage of their education.
5. Implement strategies to establish a lifelong commitment to organized dentistry among students and recent graduates.
6. Strengthen and position the Office of Student Affairs as the point of entry for students into the American Dental Association.

Office of Student Affairs. Under the direction of the Council on Membership, the Office of Student Affairs (OSA) is responsible for managing the Student Marketing Plan. The overall goal of the OSA is to improve communications and strengthen relationships with dental students and to obtain a better understanding of the students' needs, concerns and interests. The OSA serves as the primary Association contact for dental students, ASDA leaders, ASDA staff, state and local leaders and staff, as well as Association leaders and staff interacting with dental students. The Council approved the following three goals for the OSA:

1. establish relationships with ASDA chapter representatives to ensure that all students are aware of the importance and value of American Dental Association;
2. membership;
3. establish a presence in the dental schools and develop a positive relationship with the dental school;

administration, particularly the Dean of Student Affairs; and

4. provide American Dental Association leadership and the constituent and component societies with comprehensive information and resources to facilitate establishment of personal relationships with students.

The Council recognizes that the fulfillment of these goals and the success of the OSA requires the support and collaborative efforts of ASDA.

Student Awareness Program. The Student Awareness Program was first implemented in 1989 to introduce students to the Association and its programs and services. As a primary component of the Student Marketing Plan, this communications activity is evaluated yearly and has undergone several revisions since its implementation. In 1998-99, the Program featured a personalized welcome letter to first-year students from President Whiston; a "welcome to the profession" card distributed to first-year students in the fall; a customized student appointment book, sponsored by Warner-Lambert, sent to second- and third-year members; *Connections*, the Association's guide to member services, mailed to senior members; and a graduation card from ADA President S. Timothy Rose mailed to all senior dental students in the spring. In addition, the *ASDA to ADA: A Progressive Partnership* poster was updated for 1999 with a "less is more" approach. The posters will be distributed to ASDA delegates for display on their schools' ASDA bulletin boards for fall recruitment. The poster encourages students to contact the ASDA delegate or the ADA Office of Student Affairs for more information.

The Student Communications Campaign. Initiated in 1994, the campaign features three mailings to dental students each year, with the goal of increasing the students' awareness and understanding of the importance of membership while collecting information regarding student needs and interests. The messages in these mailings are targeted to the needs and interests of students at each level in school and each includes a business reply postcard for student response. Due to the new information resources available to students, response rates to the mailings have increased to 15-20%, depending upon the mailing topic.

ADA Info-Paks. In order to position the Office of Student Affairs as a valuable resource for dental students and to facilitate two-way communication with dental students, thereby strengthening their ties to organized dentistry, the OSA initiated this service in 1997 to respond to students' information requests. Twelve information packets (ADA *Info-Paks*) are now available on request on the following topics: Practice Management; Managing Finances; Managed Care and Marketplace Issues; Licensure; Alternative Careers in Dentistry; OSHA; Insurance Programs; ADA ONLINE; Locating a Practice; Legislative Issues; Postdoctoral Programs; and DMSOs. These *Info-Paks* are updated on an as needed basis. Since the initiation of this service in 1997, approximately 20,000 ADA *Info-Paks* have been distributed. A record of the information sent to each dental student is kept in the OSA Database. In addition, to facilitate access to *Info-Pak* information for dental students and others interested, the *Info-Paks* were posted on ADA ONLINE in 1998.

Sharing Ideas, Sharing Success. This informative kit was developed to encourage constituent and component dental societies to establish relationships with area dental schools and dental students. It includes: facts about students; examples of programs for students; ADA Office of Student Affairs resources; sample speeches and discussion guide; constituent roadmaps; student component districts; staff contacts for constituents and components; market share conversion chart; student representation at constituent level; calendar of dental school events; and a sample student marketing plan.

Placement Program Development. With greater numbers of recent graduates seeking employment as associates, there is an increasing demand for placement program services. Recognizing that this service is one most appropriately provided at the state or local level, the Office of Student Affairs and Committee on the New Dentist developed the publication *Placement Program Development* to assist constituent and component dental societies. This manual outlines the need and offers guidelines for service development and/or enhancement. It was distributed in the spring of 1999.

Presentations to Dental Students. In response to the many requests for assistance in developing presentations for a dental student audience, the Office of Student Affairs developed *Presentations to Dental Students.* This resource assists volunteer leaders in preparing for their presentations at dental schools. It includes *ADA Resources for the Dental Student Member*, sample speeches, a discussion guide, tips on presentation do's and don'ts and facts about dental students.

PowerPoint Presentation for Dental Students. To enhance the ADA Office of Student Affairs frequent presentations to dental students, a descriptive PowerPoint presentation was developed. This visual aid highlights the resources available that can help make dental students' education and transition to practice easier and more rewarding. Included in the presentation are: ADA publications, practice management information, licensure issues, financial service, managed care and marketplace issues (including DMSOs), insurance programs, legislative activities, ADA *Info-Paks* and ADA ONLINE.

New Dentist Transition Program. Developed and implemented in 1993 by the Committee on the New Dentist (CND), the New Dentist Transition Program is a key component of the Student Marketing Plan. The Transition Program is based upon personal contact and provides information to assist dental school seniors in making the transition from student member to full active member. Presenters include representatives from the CND, Association

staff, new/young dentist members from the local component society and other Association representatives as appropriate. Seniors attending the program receive first-hand information on Association benefits and how, why, and when to join and have the opportunity to discuss transition issues and concerns with colleagues and peers. The 1999 program was presented to nine schools in fall 1998 and 11 schools from early February through late April 1999. Participating schools included:

Fall 1998
University of Medicine and Dentistry of New Jersey
University of Puerto Rico
Temple University
University of Missouri at Kansas City
University of Southern California
University of the Pacific
Ohio State University
University of Louisville
University of Texas at San Antonio

Spring 1999
University of Illinois
University of California at Los Angeles
University of Oklahoma
Southern Illinois University
Tufts University
University of Tennessee
University of Michigan
University of Iowa
University of Pittsburgh
University of Maryland
University of California at San Francisco

"Getting Off to a Smart Start" Program. The Committee on the New Dentist, recognizing the importance of reaching dental students beginning their first year in dental school, developed a transition-type seminar for freshmen which is presented in conjunction with the Transition Program. Entitled "Getting Off to a Smart Start," the program introduces organized dentistry, introduces the leaders and staff who are available to assist them through their dental education and career, informs students of the resources available to them as ADA/ASDA members and discusses the cost of dental education, the resources available and planning needed to help minimize the impact of student indebtedness.

Schools participating in the "Smart Start" program in 1998-1999 include:

Fall 1998
Boston University
University of Medicine and Dentistry of New Jersey
Temple University
University of Missouri at Kansas City
University of Southern California
University of the Pacific
Ohio State University
University of Louisville

Spring 1999
University of Illinois
University of California at Los Angeles
University of Oklahoma
Southern Illinois University
University of Tennessee
University of Michigan
University of Pittsburgh
University of Maryland
University of Puerto Rico

Summary of Resolutions

1. Resolved, that Chapter XVII. FINANCES of the *Bylaws* be amended by the addition of a new Section 50. SPECIAL ASSESSMENTS to read as follows:

Section 50. SPECIAL ASSESSMENTS: In addition to the payment of dues required in Chapter I, Section 50 of these *Bylaws*, a special assessment may be levied by the House of Delegates upon active, active life, retired, affiliate and associate members of this Association as provided in Chapter I, Section 50 of these *Bylaws*, for the purpose of funding a specific project of limited duration. Such an assessment may be levied at any annual or special session of the House of Delegates by a two-thirds (2/3) majority vote of the delegates present and voting, provided notice of the proposed assessment has been presented in writing at least ninety (90) days prior to the first day of the session of the House of Delegates at which it is to be considered. Notice of such a resolution shall be sent by a certifiable method of delivery to each constituent society not less than ninety (90) days before such session to permit prompt, adequate notice by each constituent society to its delegates and alternate delegates to the House of Delegates of this Association, and shall be announced to the general membership in an official publication of this Association at least sixty (60) days in advance of the session. The specific project to be funded by the proposed assessment, the time frame of the project, and the amount and duration of the proposed assessment shall be clearly presented in giving notice to the members of this Association. Revenue from a special assessment and any earnings thereon shall be deposited in a separate fund as provided in Chapter XVII, Section 40 of these *Bylaws*. The House of Delegates may amend the main motion to levy a special assessment only if the amendment is germane and adopted by a two-thirds (2/3) majority vote of the delegates present and voting. The House of Delegates may consider only one specific project to be funded by a proposed assessment at a time. However, if properly adopted by the House of Delegates, two or more special assessments may be in force at the same time.

Any resolution to levy a special assessment that does not meet the notice requirements set forth in the previous paragraph also may be adopted by a unanimous vote of the House of Delegates, provided the resolution has been

presented in writing at a previous meeting of the same session.

and be it further

Resolved, that Chapter I. MEMBERSHIP of the *Bylaws* be amended by deleting Section 50 in its entirety and substituting in its place a new Section 50. DUES, SPECIAL ASSESSMENTS AND REINSTATEMENT to read as follows:

Section 50. DUES, SPECIAL ASSESSMENTS AND REINSTATEMENT:

A. ACTIVE MEMBERS.* The dues of active members shall be three hundred eighty-two dollars ($382.00) due January 1 of each year.** In addition to their annual dues, active members shall pay any special assessments levied by the House of Delegates in accordance with Chapter XVII, Section 50 of these *Bylaws*, due January 1 of each year. Notwithstanding the foregoing, any dentist, who satisfies the eligibility requirements for active membership under Chapter I, Section 20A of these *Bylaws* and who satisfies any of the following conditions shall be entitled to pay the reduced active member dues and special assessment listed under such satisfied condition so long as that dentist maintains continuous membership, subject to the further reductions permitted under the provisions of Chapter I, Section 50H, of these *Bylaws*:

(1) On a one-time basis, the dentist, when awarded a D.D.S. or D.M.D. degree, shall be exempt from the payment of active member dues and any special assessment for the remaining period of that year, and shall pay twenty-five percent (25%) of active member dues and special assessment for the first full calendar year following the year in which the degree was awarded, fifty percent (50%) of active member dues and special assessment in the second year, seventy-five percent (75%) in the third year and one hundred percent (100%) in the fourth year and thereafter.

(2) The dentist who is engaged full-time in (a) an advanced training course of not less than one academic year's duration in an accredited school or residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall pay thirty dollars ($30.00) due on January 1 of each year until December 31 following completion of such program. For the dentist who enters such a course or program within one (1) year of the award of D.D.S. or D.M.D. degree and who pays dues of thirty dollars ($30.00) per annum while in such a program, the applicable foregoing condition (1) shall toll until completion of that program. Upon completing the program, the dentist shall pay dues for active members at the next period-in-time level that is applicable under condition (1). The dentist who is engaged full-time in (a) an advanced training course of not less than one academic year's duration in an accredited school or residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall be exempt from the payment of any active member special assessment then in effect through December 31 following completion of such course or program.

(3) An active member who is serving dentistry full-time for a charitable organization and is receiving neither income nor a salary for such charitable service other than a subsistence amount which approximates a cost of living allowance shall pay dues of five dollars ($5.00) due January 1 of each year, and shall be exempt from the payment of any special assessment then in effect through December 31 following completion of such service; provided that such charitable service is being performed continuously for not less than one year and provided further that such member does not supplement such subsistence income by the performance of services as a member of the faculty of a dental or dental auxiliary school, as a dental administrator or consultant, or as a practitioner of any activity for which a license to practice dentistry or dental hygiene is required.

(4) On a one-time basis, a new graduate of a non-accredited dental school who has recently been licensed to practice dentistry in a jurisdiction in which there is a constituent dental society of the American Dental Association shall be exempt from payment of active member dues and any special assessment for the remaining period of the year in which the license was issued. The newly licensed graduate of a non-accredited school shall pay twenty-five percent (25%) of active member dues and any special assessment the first full calendar year following the year in which the license was obtained, fifty percent (50%) of active member dues and any special assessment in the second year, seventy-five percent (75%) in the third year and one hundred percent (100%) in the fourth year and thereafter.

(5) On a one-time basis, a licensed dentist applying for membership, who has never been an active member of this Association and is not otherwise eligible as a new graduate under this Section of the *Bylaws*, shall pay fifty percent (50%) of active member dues and any special

* Effective January 1, 2000 the dues of active members shall be reduced by twenty-five dollars ($25.00) from the level of active members dues in effect in 1999.

** Effective January 1, 2000 the dues of active members shall be reduced by fourteen dollars ($14.00) from the level of active members dues in effect in 1999.

assessment in the first year, and shall pay one hundred percent (100%) of active member dues and any special assessment in the second year and each year thereafter.

B. LIFE MEMBERS.
a. Active Life Members. Regardless of a member's previous classification of membership, the dues of life members who have not fulfilled the qualifications of Chapter I, Section 20G of these *Bylaws* with regard to income related to dentistry shall be fifty percent (50%) of the dues of active members, due January 1 of each year. In addition to their annual dues, active life members shall pay fifty percent (50%) of any active member special assessment levied by the House of Delegates in accordance with Chapter XVII, Section 50 of these *Bylaws*, due January 1 of each year.
b. Retired Life Members. Life members who have fulfilled the qualifications of Chapter I, Section 20G of these *Bylaws* with regard to income related to dentistry shall be exempt from payment of dues and any special assessment levied by the House of Delegates in accordance with Chapter XVII, Section 50 of these *Bylaws*.

C. STUDENT MEMBERS. The dues of predoctoral student members shall be five dollars ($5.00) due January 1 of each year. The dues of a dentist who is engaged full-time in (a) an advanced training course of not less than one academic year's duration in an accredited school or residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall pay thirty dollars ($30.00) due January 1 of each year. Predoctoral student members and dentists who are engaged full-time in (a) an advanced training course of not less than one academic year's duration in an accredited school or residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall be exempt from payment of any special assessment levied by the House of Delegates in accordance with Chapter XVII, Section 50 of these *Bylaws*. Student membership terminates on December 31 after graduation or after completion of a residency or graduate work as provided in Chapter I, Section 20C of these *Bylaws*.

D. HONORARY MEMBERS. Honorary members shall be exempt from payment of dues and any special assessment levied by the House of Delegates in accordance with Chapter XVII, Section 50 of these *Bylaws*.

E. AFFILIATE MEMBERS. The dues of affiliate members shall be fifty percent (50%) of the dues of active members, due January 1 of each year. In addition to their annual dues, affiliate members shall pay fifty percent (50%) of any active member special assessment levied by the House of Delegates in accordance with Chapter XVII, Section 50 of these *Bylaws*, due January 1 of each year.

F. ASSOCIATE MEMBERS. The dues of associate members shall be twenty-five percent (25%) of the dues of active members, due January 1 of each year. In addition to their annual dues, associate members shall pay twenty-five percent (25%) of any active member special assessment levied by the House of Delegates in accordance with Chapter XVII, Section 50 of these *Bylaws*, due January 1 of each year.

G. RETIRED MEMBERS. The dues of retired members shall be twenty-five percent (25%) of the dues of active members, due January 1 of each year. In addition to their annual dues, retired members shall pay twenty-five percent (25%) of any active member special assessment levied by the House of Delegates in accordance with Chapter XVII, Section 50 of these *Bylaws*, due January 1 of each year.

H. MEMBERS SELECTED AFTER JULY 1 AND OCTOBER 1. Those members selected to active membership in this Association after July 1, except for those whose membership has lapsed for failure to pay the current year's dues and/or special assessments, shall pay one half (1/2) of the current year's dues and one half (1/2) of any active member special assessment then in effect, and those selected after October 1, shall pay one-quarter (1/4) of the current year's dues and one quarter (1/4) of any active member special assessment then in effect; except that a student member, upon classification as an active member by a constituent society shall pay no further dues or special assessments for the remainder of the calendar year in which the member was entitled to the benefits of student membership.

I. LOSS OF MEMBERSHIP AND REINSTATEMENT.
a. An active, active life, student, affiliate or retired member whose dues have not been paid by March 31 of the current year shall cease to be a member of this Association. An active, active life, affiliate or retired member who has not paid his or her special assessment(s) by March 31 of the current year shall cease to be a member of this Association.
b. Reinstatement of active, life, retired, student or affiliate membership may be secured on payment of dues and/or special assessments of this Association by a former active member in accordance with Chapter I, Section 50A, by a former life member in accordance with Chapter I, Section 50Ba, by a former retired member in accordance with Chapter I, Section 50G, by a former student member in accordance with Chapter I, Section 50C, and by a former affiliate member in accordance with Chapter I, Section 50E, and on compliance by a former active, life or retired member with the pertinent bylaws and regulations of the constituent and component societies involved.
c. An associate member whose dues and/or any special assessment have not been paid by March 31 of the current

year shall cease to be a member of this Association. An associate member who terminates full-time employment in dentally-related education or research at an accredited institution of higher education shall cease to be an associate member of this Association December 31 of that calendar year.

J. ACCEPTANCE OF BACK DUES AND SPECIAL ASSESSMENTS. Back dues and/or special assessments, except as otherwise provided in these *Bylaws*, shall be accepted for not more than the three years of delinquency prior to the date of application for such payment. The rate of such dues and/or special assessments, except as otherwise provided in these *Bylaws*, shall be in accordance with Chapter I, Section 50A of these *Bylaws*.

An active member, who had been such when entering upon active duty in one of the armed services or equivalent duty in the Public Health Service but who, during such military or equivalent duty, interrupted the continuity of active membership because of failure to pay dues and/or special assessments and who, within one year after separation from such military or equivalent duty, resumed active membership, may pay back dues and/or special assessments for any missing period of active membership at the rate of dues and/or special assessments current during the missing years of membership for the purpose of establishing continuity of active membership in order to qualify for life membership.

K. DUES AND SPECIAL ASSESSMENTS OF MEMBERS WHO SUFFER FINANCIAL HARDSHIP. Those members who have suffered a significant financial hardship that prohibits them from payment of their full dues and/or special assessments may be excused from the payment of fifty percent (50%), seventy-five percent (75%) or all of the current year's dues and/or special assessment(s) as determined by their constituent and component dental societies. The constituent and component society secretaries shall certify the reason for the waiver, and the constituent and component societies shall provide the same proportionate waiver of their dues as that provided by this Association.

L. PROVISIONAL MEMBER. The dues and/or special assessments of provisional members shall be the same as the dues and/or special assessments of active members.

M. PERCENTAGE DUES OR SPECIAL ASSESSMENTS. In establishing the dollar rate of dues or special assessments in this chapter expressed as a percentage of active member dues or special assessments, computations resulting in fractions of a dollar shall be rounded up to the next whole dollar.

N. PAYMENT DATE FOR DUES AND SPECIAL ASSESSMENTS. Dues and special assessments of all members are payable January 1 of each year, except that active and active life members may participate in an installment payment plan sponsored by their respective constituent or component dental societies. A constituent- or component-sponsored plan shall require monthly installment payments that conclude with the current dues and/or special assessment amount fully paid by June 30. Fees for transactional costs may be imposed, prorated to this Association and the constituent or component dental society. The installment dues and/or special assessment plan shall provide for expeditious transfer of each member's dues and/or special assessments to this Association and his or her constituent or component dental society, if such exists, as soon as commercially feasible.

and be it further

Resolved, that Chapter II. CONSTITUENT SOCIETIES, Section 30. POWERS AND DUTIES of the *Bylaws* be amended in Subsection E by adding the phrase "and special assessments" between the words "dues" and "for" in line 524, so the amended Subsection E reads as follows:

E. It shall be its duty to collect membership dues and special assessments for this Association in conformity with Chapter I, Section 50, of these *Bylaws*.

Division of Dental Practice

Council on Access, Prevention and Interprofessional Relations

Council on Dental Benefit Programs

Council on Dental Practice

Commission on Relief Fund Activities

Notes

Council on Access, Prevention and Interprofessional Relations

Grubb, Richard T., Washington, 1999, chairman
McFarland, Kimberly K., Nebraska, 2001, vice chairman
Conrardy, James J., Wisconsin, 2001
Culver, Jim L., Vermont, 1999
Iacono, John M., New York, 1999
Jones, Robert D., Maryland, 2000
Keenan, Allen C., Oklahoma, 2002
Lander, William W., Pennsylvania, 1999, American Medical Association
Meador, Robert C., Texas, 2002
Nelson, Robert L., Missouri, 2002
Nelson, Steven R., Colorado, 2001
Nurkin, Harry A., North Carolina, 1999, American Hospital Association
Parker, S. Edward, Jr., South Carolina, 2002
Paulson, Peter L., Illinois, 2000
Perry, David M., California, 2001
Scott, Edward R., II, Florida, 2000
Steinberg, Barbara J., Pennsylvania, 1999
Strayer, Michael S., Ohio, 2000
Klyop, John S., director
Jasek, Jane F., manager
Muraoka, Sharon G., manager
Wright, Marianne E., manager

Organization: The Council works to broaden the scope of oral health care within the health care system and to advance preventive dentistry and the delivery of oral health care in the community. The three focus areas are:

1. health care facilities and interprofessional affairs;
2. access to oral health and community health activities; and
3. fluoridation and preventive health activities.

The Council recommends policy and directs programs in these areas.

Meetings: The Council met in the ADA Headquarters Building on September 11-12, 1998 and March 19-20, 1999. The Council is scheduled to meet again September 17-18, 1999. Three subcommittees—Access to Dental Care, Preventive Dentistry and Interprofessional Relations—meet in conjunction with regularly scheduled Council meetings.

Personnel: The close of the 1999 annual session brings to an end the terms of four valued members of the Council: Dr. Jim L. Culver; Dr. Richard Terry Grubb; Dr. John M. Iacono; and Dr. Barbara J. Steinberg. These members have given unselfishly of their time and energy on behalf of the profession. Their efforts are acknowledged by the Council with great appreciation.

The Strategic Plan of the American Dental Association: In 1998 the Council adopted a mission statement, as based on its *Bylaws* duties, and developed an action plan keyed to the goals and objectives of the *ADA Strategic Plan: 1998-2001*. The Council's program activities support objectives in each of the five goals of the Strategic Plan. In 1999 the Council determined criteria for measuring the effectiveness of its activities. For many of the Council's activities, these criteria are quantitative, which will give the Council a defined framework within which it may work to evaluate these activities in the future, to determine the success of current activities and the direction of future activities.

However, because many of the Council's *Bylaws* responsibilities involve relationships with other dental and nondental organizations, quantitative criteria for activities that involve such relationships were deemed inappropriate. Rather, the Council determined that it will evaluate these activities on a qualitative basis, making a collective judgment as to whether the nature of the relationship is good, fair or poor, and use that evaluation to determine the success of current activities and the direction of future activities.

In response to Board of Trustees Resolution B-67-1998 (*Trans.*1998:338), which directed ADA councils to utilize Goal V., Objective v (Continue to optimize ADA processes and to focus financial resources on core activities to ensure successful achievement of the Association's strategic goals) as criteria for eliminating those programs that no longer contribute to the ADA Plan goals and objectives, the Council

examined its current programs and activities. The Council has determined that these are in alignment with the Association's Strategic Plan. The Council has historically planned its activities within the framework of the Association's beliefs, goals and objectives and will continue to do so. Annual review of programs and activities within this context is planned.

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

Organizations with which the Council liaises and/or collaborates include: Academy of Dentistry for Persons with Disabilities; Academy for Healthcare Quality; Academy for Sports Dentistry; Accreditation Association for Ambulatory Health Care; American Academy of Family Physicians; American Academy of Pediatrics; American Academy of Pediatric Dentistry; American Association of Hospital Dentists; American Association of Oral and Maxillofacial Surgeons; American Association of Public Health Dentistry; American College of Physicians–American Society for Internal Medicine; American College of Surgeons; American Dietetic Association; American Hospital Association; American Medical Association; American Nurses Association; American Public Health Association; American Society for Geriatric Dentistry; American Society of Association Executives; American Student Dental Association; Association for Professionals in Infection Control and Epidemiology; Association Forum of Chicagoland; Association of State and Territorial Dental Directors; Centers for Disease Control and Prevention; Center for Tobacco Free Kids; Coalition on Smoking OR Health; FDI World Dental Federation; Healthy Mothers/Healthy Babies Coalition; Federation of Special Care Organizations in Dentistry; Joint Commission on Accreditation of Healthcare Organizations; Joint Commission on Sports Medicine and Science; Joint Commission Resources; Maternal and Child Health Bureau; National Alliance for Oral Health; National Association of Medical Staff Services; National Cancer Institute; National Commission on Correctional Health Care; National Coordinating Committee on School Health; National Council on the Aging; National Dental Tobacco Free Steering Committee; National Foundation of Dentistry for the Handicapped; National Health Service Corps; National Heart, Lung and Blood Institute; National High Blood Pressure Education Program Coordinating Committee; National Institute of Dental and Craniofacial Research; National Oral Health Information Clearinghouse Coordinating Committee; U.S. Olympic Committee; U.S. Public Health Service; and U.S. Surgeon General's Office.

Alternative Dental Career Information: Since 1995, the Council has provided information and guidance to dentists who are interested in pursuing a nonclinical or nontraditional dental career. A resource packet is provided which discusses, in general terms, the issues and factors dentists need to take into consideration when investigating an alternative dental career. The *Alternative Dental Careers Packet* has been updated and now includes an Internet resource information sheet, U.S. Public Health Service information and an evaluation form to assist in continuing to improve the information provided. A Web link has been provided on ADA ONLINE through the Dental Practice section, as well as through the Education and New Dentists content areas. The packet is also featured as part of the ADA *Info-Paks* from the Office of Student Affairs. The *Alternative Dental Careers Packet* is provided as a member benefit, upon request. Since the initiation of this service, over 2,000 packets have been distributed.

Continuing Education for Members: In order to promote continuing education in areas related to the Council's *Bylaws* and mission, the Council regularly sponsors speakers at the Scientific Session at the ADA annual session. In 1998, the Council sponsored programs on: recognizing and reporting abuse and neglect; dental treatment of the medically compromised patient; and public oral health program success stories. The Council will sponsor three scientific programs at the 1999 Scientific Session. The programs include: medical considerations in dental treatment; oral medicine for the medically compromised patient; and oral cancer.

Interprofessional Relations

Interprofessional Relations: Interprofessional Relations program services support the Council's mission to broaden the scope of oral health care within the health care system. Activities fulfill the mission by maintaining liaison with a variety of health care organizations in interdisciplinary care settings, as well as fostering medical-dental cooperation. The Council provides technical assistance and support to members, Association agencies, constituent and component societies, hospitals and other health care individuals and organizations in the areas of interprofessional relations.

Related Activities of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO): The Council functions as the Association's primary liaison with the JCAHO, an independent, not-for-profit organization, and the nation's oldest and largest standards-setting and health care accrediting body. Dr. John F. Helfrick continues as the Association's Commissioner on the Joint Commission Board of Commissioners. He is an at-large member of their Executive Committee and serves on JCAHO Board committees and task forces including: the Accreditation Committee, Standards and Survey Procedures Committee, Finance and Audit Committee, Human Resources and Compensation Committee, Strategic Planning Committee, Nominating Committee, Corporate Governance Task Force, Oversight Task Force on Accreditation Process Improvement, Fiftieth Anniversary Task Force and Operational Plan and Budget Task Force. He also serves as vice chairman of the Joint Commission Resources Board of Directors, the Joint Commission's not-for-profit

subsidiary that provides consulting services for domestic and international clients. He routinely attends the Council's meetings and reports on JCAHO activities of interest.

The Association is well represented on numerous Joint Commission committees and task forces. Dr. Thomas W. Braun (Pennsylvania) is a member of the Hospital Accreditation Program Professional and Technical Advisory Committee (PTAC) with Dr. David Whiston (Virginia) serving as alternate; Dr. Douglas B. Berkey (Colorado) serves on the Long Term Care Accreditation Program PTAC with Dr. William Milner (North Carolina) serving as alternate; Dr. Jeffry E. Persons (California) serves on the Ambulatory Accreditation Program PTAC with Dr. Spencer W. Redding (Texas) serving as alternate; and Dr. Michael S. Strayer (Ohio) serves on the Home Care Accreditation Program PTAC with Dr. Robert Henry (Kentucky) serving as alternate. Serving on the Behavioral Health Program PTAC is Dr. Sanford J. Fenton (Tennessee) with Dr. Jerome Kleponis (Pennsylvania) as alternate. And finally, serving on the Health Care Network PTAC is Dr. Ronald Mito (California) with Dr. Richard Tempero (Nebraska) as alternate. Additionally, Dr. Jeffry E. Persons is a member of the Medical Staff Chapter Workgroup that is evaluating particular issues regarding the medical staff chapter of the *Comprehensive Accreditation Manual for Hospitals*. The Council is grateful to Dr. Wallin McMinn (Michigan) for serving a maximum of four years as the Association's representative to the Home Care Accreditation Program PTAC. The Council recommended Dr. Clive Ross (New Zealand), in coordination with the Department of International Activities, as a nomination for the International Accreditation Principles and Standards Development Task Force. The nomination was approved.

Association volunteers and/or staff attend the JCAHO meetings of the committees identified above. These meetings are attended by other major health care delivery and provider organizations which affords dentistry's representatives the opportunity to solidify the profession's role across the spectrum of the health care delivery environment.

The Academy for Healthcare Quality, a corporate "university without walls," has begun development of a graduate level curriculum in health care quality. Mr. John Klyop, director of the Council, serves as a member of the Academy's Board of Governors. The Academy is governed by the JCAHO in collaboration with Emory University, Northwestern University, Ohio State University, University of California–Los Angeles and the University of Pennsylvania.

Council consultant Dr. Peter Hurst and staff presented "Accreditation and Dental Services in the Hospital Setting" on March 23, 1998 to 50 new Joint Commission surveyors as part of their two-and-a-half week Hospital Surveyor Education Program.

The Association was invited to comment on several proposed Joint Commission standards. The Association responded to requests regarding the topics of restraint, sentinel events, clinical practice guidelines and in-hospital resuscitation efforts. The Association's Dental Practice Parameters were submitted to the Joint Commission's Department of Standards for consideration in their list of resources for clinical guidelines.

The Association cosponsored the Joint Commission program "Contemporary Quality, Evaluation, Management and Improvement in the Dental Office" on July 24-25, 1998 in San Diego. Dr. John Helfrick moderated the day-and-a-half conference, which presented opportunities for attendees to make recommendations to the Joint Commission on the topic of dental office accreditation. Dr. David Whiston, then ADA president, addressed the audience regarding the Association's Dental Practice Parameters and the developing Dental Indicators project. He also took the opportunity to present Dr. Helfrick with a Presidential Citation "for significant contributions to the oral health of the public and to the profession of dentistry." Three PTAC members, Dr. Douglas Berkey, Dr. Thomas Braun and Dr. Ronald Mito, and Council staff were able to attend the conference on behalf of the Council.

The Council announced the availability of an improved version of *Guide to Hospital Accreditation Resources – Department of Dentistry*, now known as *Guide to Joint Commission Hospital Accreditation Resources for Dentists*, jointly published with the Joint Commission. This publication was previously published in 1995. The *Guide* is intended to be used as a road map through the Joint Commission's accreditation resources for hospitals, with a special emphasis on the concerns of dentists. This document will guide dentists through: the relevant standards; the features of the *Comprehensive Accreditation Manual for Hospitals*; the survey process; the aggregation rules and decision rules for accreditation; and other education and evaluation resources.

Oral Health Care Series Development: The Council is continuing to develop new manuals and to revise existing Oral Health Care literature for patients with complex medical conditions. The Oral Health Care Series Development Committee met on November 3, 1998 and agreed that there is a need to revisit many of the existing manuals to assure that they are kept up-to-date. The Committee also discussed possible new topics and authors for the manuals. The Council thanks the Committee members for their continuing work on behalf of the Association: Dr. William Carpenter (California); Dr. Michael Glick (Pennsylvania); Dr. Malcolm A. Lynch (Pennsylvania); Dr. Steven Roser (New York); and Dr. Mark Tucker (Florida). The Department of Salable Materials assisted the Council with the promotion of the Series and featured the Series at a special package price for all nine publications. The Council identified several additional avenues which the profession could disseminate the Oral Health Care Series information.

National Health Service Corps: The Council responds to inquiries regarding the National Health Service Corps, including questions about application, dental health professional shortage areas and loan repayment through this program. The Council assembled an information package regarding loan repayment through the National Health Service Corps.

Liaison with National Organizations: The Association, through the Council, maintains liaison with various health care organizations in an effort to present and promote the interests of the profession. The Association has historically maintained liaison with the Joint Commission on Accreditation of Healthcare Organizations, American Hospital Association and American Medical Association. This program activity is intended to enhance lines of communication and to foster greater opportunities for cooperative efforts on issues of mutual interest. It is also intended to explore the potential for offering continuing education programs on oral health and to discuss the inclusion of oral health in the core curricula of various nondental health care disciplines as recommended by Resolution 20H-1995 (*Trans.*1995:609). As noted previously, staff continues to provide support for the Association's Joint Commission Professional and Technical Advisory Committee (PTAC) members. The Joint Commission PTACs are made up of representatives of dozens of health care professional associations. Meetings provide opportunities for staff and volunteers to meet with them and provide the groundwork for future cooperative activities in areas of mutual concern. Staff continues as a member of the Association of Professionals in Infection Control and Epidemiology and the Chicago Health Care Executives Forum that will enable future liaison activities. Staff monitors several organization lists and Web sites in this capacity. Staff has recently rejoined the National Association of Medical Staff Services. This will provide resources and opportunities to enhance activities in the areas of medical staff membership, credentialing and privileging.

Additionally, staff has been invited to attend the Committee on Hospital and Interprofessional Affairs of the American Association of Oral and Maxillofacial Surgeons and attended the Special Care Issues in Dentistry conference sponsored by the Federation of Special Care Organizations in Dentistry. At the request of the Council on Scientific Affairs, the Council provided the names and addresses of several potential contacts for the Oral Medicine/Systemic Disease symposia which is in the initial planning stages.

American Medical Association. Dr. Charles Cuttino served as the Association's Official Observer to the American Medical Association (AMA) in 1998 and attended the AMA Annual, Interim and Organized Medical Staff Section meetings last year and subsequently reported to the Board of Trustees on his experience at these meetings. Council staff also attends the Annual, Interim and Organized Medical Staff Section meetings of the AMA's House of Delegates and shares information with other interested agencies of the Association. Association president, Dr. S. Timothy Rose, appointed Dr. David Whiston as the Association's Official Observer to the 1999 AMA House of Delegates. The Council is grateful to Dr. Cuttino and Dr. Whiston for their extra service on behalf of the Association.

The Council considered the response from AMA staff regarding clarification on Resolution 210 (AMA House of Delegates Interim Meeting 1996), Comprehensive Physical Examinations by Appropriate Practitioners, as it relates to dentists. Upon further reflection and thoughtful discussion, the Council decided not to go forward to the AMA House of Delegates with a proposed resolution, but instead to monitor and assess the severity of the issue.

There were two resolutions of particular interest to the Council that passed the AMA House of Delegates at its Interim Meeting (I-98) and will be printed as policy in the AMA's "Official Proceedings." Resolution 216, Anesthesiology is the Practice of Medicine, consists of two resolving clauses:

> anesthesiology is the practice of medicine and that the American Medical Association seek legislation to establish the principle in federal and state law and regulation that anesthesia care requires the personal performance or supervision by an appropriately licensed and credentialed doctor of medicine, osteopathy or dentistry.

The original language of this resolution would have pertained only to physicians. American Dental Association representatives on-site at the meeting were able to dialogue with the resolution submitters, which led to resolution language inclusive of dentistry. Dr. Cuttino spoke in favor of the amended resolution at the Reference Committee. Resolution 427, Chemical Analysis Report of Public and Commercial Water, consists of two resolving clauses:

> the AMA request the appropriate federal agency to require analysis and appropriate labeling of the chemical content of commercially bottled water as well as of the water supplies of cities and towns and that the AMA work with the American Dental Association to promote the availability of fluoridated, commercially bottled water to consumers.

This resolution originally asked only for analysis and public notice of the chemical content of commercially bottled and municipally supplied water. One delegate testified in support of the resolution and added the comment that there is concern that many parents are giving bottled water to children without realizing they are depriving the children of fluoride. Directly after this delegate, Percy Wooten, M.D. (past president, AMA) rose to let the Reference Committee know that there was an Official Observer from the American Dental Association present and perhaps he would like to speak to this issue. Dr. Cuttino addressed the Reference Committee and informed them of the importance of this issue and the Association's concerns. Quoting from the Reference Committee's Report: "...Concern was also expressed about the lack of fluoride in most bottled water, thus presenting an opportunity to work with the American Dental Association."

American Hospital Association. The Council also maintains liaison with the American Hospital Association (AHA) and staff attends its annual membership and other appropriate meetings. The Association's Official Observer to the AHA, appointed by Dr. Rose, is Dr. Terry Grubb, who participated in the 1999 AHA membership meeting in Washington, D.C. He subsequently provided a written report to the Board of Trustees on his experience at this meeting. The Council wishes

to express its appreciation to Dr. Grubb for his extra service in this capacity on behalf of the Association.

Hospital Dentistry Issues: The Council monitors and responds to problems related to medical staff membership and/or privileges based on inappropriate hospital 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. The Association's Division of Legal Affairs assists the Council in helping individual dentists resolve adverse situations. The Council encourages members to report problems with medical staff membership and/or privileges in order that they may study the scope and severity of these issues. The Council reviewed the Guidelines for Hospital Dental Services and Guidelines for the Delineation of Clinical Privileges in Dentistry.

Guidelines for Hospital Dental Services. The Council last reviewed the Guidelines for Hospital Dental Services in 1995. It was a follow-up document to the *Manual for Dental Patient Care Units* which was first developed in 1976, by the predecessor Council on Hospital Dental Service, and served as the basis of its Patient Care Unit (PCU) accreditation program, a program that encompassed nursing homes or other post-acute care facilities, as well as hospital-affiliated dental services. This *Manual* incorporated criteria applicable in any institutional setting in which dental services are delivered and served as the basis for self-evaluation and PCU accreditation. In 1979, the American Dental Association became a corporate member of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). At that time, the Association strived to integrate the Council's accreditation program into that of the JCAHO. Thus, the Association discontinued its accreditation program for institutional dental services in 1982. However, it was felt that the criteria were useful in an advisory sense, and, as such, were revised to guidelines with numerous editorial changes. The Council submitted the Guidelines for Hospital Dental Services for consideration by the House of Delegates in 1991, and they were subsequently adopted (*Trans.*1991:618). The document Guidelines for Hospital Dental Services includes the guidelines as adopted in 1991, as well as interpretations of the guidelines. The Council reviewed and will revise this document.

Guidelines for the Delineation of Clinical Privileges in Dentistry. The Council last reviewed the Guidelines for the Delineation of Clinical Privileges in Dentistry (*Trans.*1993:692) in January 1995. These Guidelines have been in existence for many years and were produced in response to requests from members, hospitals and medical directors for specific American Dental Association guidance in credentialing and privileging dentists as members of the medical staff. The Council reviewed and will be revising this document.

Hospital Medical Staff Membership. The Council discussed several concerns related to active medical staff membership and privileging for dentists. The Council discussed several individual cases brought to its attention by the American Association of Oral and Maxillofacial Surgeons in which dentists are being moved from active medical staff to other categories such as courtesy staff and privileges that had been previously granted are being withheld upon reappointment without apparent objective reasons. The Council agreed that issues pertaining to credentialing and privileging appear to be increasingly complex, although limited data do not indicate a clear trend of any specific problem. However, the Council strongly recommended that a policy should provide support for qualified dentists that seek active hospital medical staff membership. The Council believes that this resolution is in keeping with the ADA Strategic Plan Goal V. The Association: Member and Support Services. Accordingly, the Council recommends adoption of the following resolution on Hospital Medical Staff Membership.

2. Resolved, that the American Dental Association supports active hospital medical staff membership for qualified dentists that request such appointment, and be it further
Resolved, that active medical staff membership for these dentists conveys upon them all appropriate rights and privileges of any other active medical staff member, including but not limited to: the right to vote, hold office, apply for clinical privileges and if necessary, the right to a fair hearing and appellate review, and be it further
Resolved, that the process and general criteria for medical staff membership and privileges for dentists should be the same as for any other medical staff member, and be it further **Resolved,** that dentists who receive such membership be encouraged to be active in the hospital and in its related committees in order to raise the profile of dentists as contributing medical staff members, and be it further
Resolved, that should cases of national significance concerning denial or revocation of privileges for qualified dentists be brought to the attention of the Association, the Board of Trustees be urged to direct appropriate legal action.

Access and Community Affairs

Access to Oral Health Care: The Council's goal regarding access to care is to help special population groups that need and want oral health care to receive it. To meet this goal, the Council identifies and promotes innovative programs to make care more accessible to individuals who are economically disadvantaged, disabled, homebound and/or institutionalized. Recognizing that the Association itself cannot deliver care, the Council serves to identify oral health needs and to foster appropriate outreach programs to meet those needs consistent with the Association's policies.

In addition to promoting public awareness of the oral health needs of vulnerable populations, the Council provides technical assistance and counseling to dental societies, dental schools, individuals and organizations interested in

development, implementation or maintenance of an access initiative. Further, the Council recommends policy and reviews legislation aimed at improving the availability of oral health care services to special patients, develops and distributes professional and patient resource materials and sponsors continuing education activities for the dental team.

Affiliation with the National Foundation of Dentistry for the Handicapped (NFDH): The Council functions as the Association's primary liaison with the NFDH, a charitable affiliate of the Association since 1988. The Foundation's executive director, Dr. Larry Coffee, serves as a Council consultant and regularly reports to the Council on NFDH activities.

The Foundation develops and implements programs that provide substantive dental care for needy, disabled, elderly and medically compromised individuals of all ages. The Foundation currently sponsors oral health programs in 24 states. During fiscal year 1997-98, approximately 26,000 people received almost $4.5 million in oral health services through the Foundation's three major programs: Donated Dental Services (DDS), Dental HouseCalls and BRIDGE (formerly the Campaign of Concern).

Over 22,000 people have benefited from $27.5 million in comprehensive dental care since DDS began as a small pilot program in Colorado slightly more than a decade ago. During 1998, 3,400 individuals received $4.5 million in pro bono care through DDS projects. Over 7,250 dentists and 1,300 dental laboratories are DDS program volunteers. The NFDH plans to expand the DDS program to 31 states within two years.

The Foundation's programs are relevant in any area of the country. The programs use dental and financial resources that are available to help vulnerable people unable to get needed care.

Constituent and component dental societies can request the NFDH's services to help plan, raise money for and implement any of its model access programs. Approval by the constituent dental society is the Foundation's only requirement for working, at its own expense, to organize a project.

Four Association representatives sit on the 13-member NFDH Board of Directors. They are: Dr. Ross J. DeNicola, Jr. (term expires June 30, 2001); Dr. Frank Maggio (term expires June 30, 2000); Dr. Myron L. Pudwill (term expires June 30, 2000); and Dr. David Whiston (term expires June 30, 1999).

At its April 1997 meeting, the Association's Board of Trustees renewed the ADA/NFDH affiliation agreement for a period of three years, 1998-2000. Financial support is determined on a year-to-year-basis.

DentaCheques. Beginning in 1990, the Foundation has been actively marketing the sale of a dental product coupon book called DentaCheques as a fund-raising activity. This successful activity is now in its tenth year. Various Association agencies help to promote this ongoing activity. Most recently, a DentaCheques promotion was added to ADA ONLINE.

Development of Access Resources: The Council continues to develop resources to assist the members in their efforts to serve those less fortunate. The Council is in the process of revising the *1991 Manual on Dental Care Access Programs: A Guide for Dental Societies*. The *Manual*, intended to provide dental societies and other organizations with suggested guidelines and program ideas for developing dental care access programs, is expected to be published in 2000 and will be available to members free of charge from the Council office.

Other resources are also available to members free of charge from the Council. The Council regularly distributes information on: access initiatives; establishing dental practices in nontraditional settings; portable and mobile dentistry; geriatric/nursing home dentistry; and dentistry in correctional facilities.

Promoting Successful Access Programs: The Council has stepped up its efforts to promote successful access initiatives with the hopes of stimulating the interest of others to develop similar activities and with the intention of promoting the charitable efforts of the profession. In addition to securing *ADA News* coverage for a variety of programs, the Council updated and republished the compendiums of winning entries of the Community Preventive Dentistry and Geriatric Oral Health Care Award programs. These efforts to promote successful access initiatives will be continued and additional promotional opportunities will be sought through ADA ONLINE.

Survey Activities: The Council has realized some success in having access-related questions added to surveys being conducted by other Association agencies. Access-related questions on the charitable efforts of dentists were included in the 1997 *Survey of Current Issues in Dentistry.* A report of the results, titled *1997 Survey of Current Issues in Dentistry: Charitable Dental Care,* was published in December 1998. The *1998 Survey of Dental School Satellite Clinics* and the *1998 Dental Society Survey of Dental School Satellite Clinics* also contained questions submitted by the Council on the dollar value of care provided by dental school satellite clinics to vulnerable populations. As of this writing, data collection and analysis is ongoing and therefore, no final results are available.

In late 1998, the Council was successful in obtaining funding to conduct a survey of oral health access programs sponsored by dental societies, state health departments and dental schools. The survey is an attempt to quantify the level of access programming nationwide. A formal access survey has not been conducted since 1990 and so no current information exists on the level of the profession's programmatic involvement in providing oral health services to needy and vulnerable individuals. Results are expected to be available in early 2000.

Council Award Programs: The Council administers a number of award programs designed to recognize those individuals and/or entities that have successfully furthered the Council's goals.

Access Recognition Award Program. In 1989, the Council launched an ongoing program designed to honor individuals who have shown particular leadership and inspiration in gaining access to dental care for those in need at the local level.

As of April 1999, 130 individuals from 35 states and Puerto Rico have received recognition. Recipients in 1998 were: Ms. Marianne M. Dudley, Alaska; Dr. Jere A. Erickson, Dr. Philip W. Baldwin and Dr. Eric J. Sandoval, California; Dr. David C. Large, Colorado; Dr. Ghassan Souri, Illinois; Dr. Mark R. Van Buskirk, Indiana; Mr. Galen Cole, Dr. Philip W. Higgins, Jr. and Dr. Howard C. Jackson, Maine; Dr. John K. Taylor, III, Senator Gloria Lawlah and Dr. Martin P. Wasserman, Maryland; Dr. William Metz, Michigan; Dr. Timothy P. McVaney, Nebraska; Dr. Jack Roemer, New Jersey; Dr. John S. McIntyre, New York; Ms. Mary E. Gwin, Ohio; Dr. D. Richard Wilson, Oregon; Dr. Henry Windell and Dr. Harold M. Kemple, Oregon; Dr. Michael D. Cerveris and Dr. Robert R. Zimmerman, Pennsylvania; Dr. Daniel J. Goede, South Dakota; and Ms. Nancy Walker and Dr. Duncan C. McInnis, Tennessee. Award recipients received a wall plaque containing a certificate signed by the Association's President, and have been mentioned in various Association publications.

The Council continues to aggressively promote this program to constituent dental societies and asks them to nominate outstanding individuals. This program assists the Council in identifying the increasing number of programs that provide oral health services to underserved individuals.

Community Preventive Dentistry Award. The Community Preventive Dentistry Award recognizes significant preventive dentistry programs. This award is sponsored by the Association through its Health Foundation with generous funding support from Johnson & Johnson Professional Division, a Division of Johnson & Johnson Consumer Products, Inc. This award program is administered by the Council. Four programs were recognized during 1998, the 26th year of the program. The highest award of $2,000 was presented to the North Carolina Seal the State in '98 program. Meritorious awards were granted to three worthy programs:

1. I. M. Sulzbacher Dental Center for the Homeless at the Salvation Army, Jacksonville, Florida;
2. Soroptimist Dental Project, Zanesville, Ohio; and
3. San Diego Children's Dental Health Initiative – Share the Care, San Diego, California.

Geriatric Oral Health Care Award. The Geriatric Oral Health Care Award recognizes those individuals and organizations that have improved the oral health of older adults through innovative health care delivery projects. This award is sponsored by the Association through its Health Foundation with the support of a generous grant from the Warner-Lambert Company Consumer Health Products Group. The award program is administered by the Council. In 1998, the highest award of $2,500 was presented to The University of Iowa College of Dentistry's "Geriatric Mobile Dental Unit – A Model of Service and Education," of Iowa City.

Council's Choice Award. In 1993, the Council developed and awarded the first Council's Choice Award. The award is a noncompetitive award given at the Council's discretion and issued to individuals, organizations, corporations and/or programs in recognition of their outstanding efforts in the areas of: access and community affairs; fluoridation and preventive health activities; and institutional and interprofessional affairs. The award is not an annual award, but is given only when the Council deems appropriate. As of this writing, no 1999 award recipient had been identified.

The Council expresses its heartfelt congratulations to all of the award recipients.

Collaboration with the ADA Health Foundation (ADAHF): During 1994, the ADAHF expanded its mission to include funding of access initiatives. Since that time, the Council has worked with the ADAHF to develop the necessary policies and procedures for achieving this mission. In late 1995, the Council assisted the ADAHF with the revision of a grant review form. In 1997, Council members Dr. Kimberly McFarland and Dr. Michael Strayer were appointed to the ADAHF's Grant Review Committee.

Most recently, in response to an ADAHF request, the Council offered suggestions for revising the ADAHF's *Guidelines/Application Criteria for ADA Health Foundation Access Program Support.* Further, the Council offered its assistance to the Health Foundation as it deliberates on access/charitable issues, similar to the assistance provided to the Health Foundation by the Council on Scientific Affairs. The Council also provided technical assistance to the Foundation by coordinating the judging for the Frederick S. McKay Award for Excellence in Preventive Dentistry.

In addition, the ADAHF administers the funding for the Council's two competitive awards programs, the Community Preventive Dentistry Award and the Geriatric Oral Health Care Award, previously described in this report.

The Council enjoys its collaborations with the ADAHF and looks forward to continuing these activities in the future.

National Commission on Correctional Health Care: The Association, through the Council, maintains liaison with the National Commission on Correctional Health Care (NCCHC) and is one of its supporting organizations. The NCCHC provides health care accreditation services for participating jails, prisons and juvenile correctional facilities nationwide. Dr. Thomas Shields, dental director, Florida Department of Corrections, is a Council consultant and the Association's representative to the Board of Directors of the NCCHC.

Working with Dr. Shields, the Council provides assistance to the NCCHC on issues of mutual interest pertaining to the oral health of incarcerated individuals. The Council recently provided input into the revision of the NCCHC's *Standards for Health Services in Juvenile Detention and Confinement Facilities*, published in 1999. The Council is extremely grateful to Dr. Shields for his efforts on behalf of the Association.

National Oral Health Information Clearinghouse: The National Oral Health Information Clearinghouse (NOHIC) is a resource for patients, health professionals and the public seeking information on the oral health of special care patients. A service of the National Institute of Dental and Craniofacial Research (NIDCR), NOHIC gathers and disseminates information from many sources, including voluntary health organizations, educational institutions, government agencies and industry.

NOHIC, in its sixth year of operation, is instrumental in marketing Association resources to consumers and oral health professionals. The Association is represented by Council staff on the Coordinating Committee for the National Oral Health Information Clearinghouse. The Coordinating Committee meets annually; most recently it met on November 20, 1998.

National Alliance for Oral Health: The Association, through the Council, has also maintained liaison with the National Alliance for Oral Health (NAOH). NAOH is a not-for-profit organization made up of voluntary health groups, professional health-related organizations and individuals concerned with the oral health needs and problems of people with systemic diseases and disabling conditions. The mission of NAOH is to improve the oral health of special patient populations through increased access to early comprehensive diagnosis, prevention strategies and appropriate therapies. Council staff currently holds a two-year at-large position on the Board of Directors.

The Alliance regularly submits testimony in support of funding for dental research, inclusion of medically necessary oral health care in any appropriate legislation being considered by Congress and continued funding for dental education programs.

National Council on the Aging: For many years, the Council has maintained liaison with the National Council on the Aging (NCOA). The NCOA is a private, not-for-profit organization, established in 1950, that serves as a national resource of information, training, technical assistance, advocacy and research on every aspect of aging. Through its participation in NCOA activities, the Association gains valuable insight, input and visibility on issues of significance to older adults.

Promoting Improvement in the Medicaid Program and the Children's Health Insurance Program: The Council, in conjunction with the Council on Government Affairs and the Council on Dental Benefit Programs, is convening a national conference, "AIM (Achieving Improvements in Medicaid) for Change," on August 2-3, 1999 at the ADA Headquarters Building. The goal of the conference is to promote changes in the Medicaid and Children's Health Insurance Program by enabling state and national Medicaid and dental health leaders to discuss ways to increase access to dental services for America's needy children. The Conference will build upon the discussions begun at the 1998 National Conference, "Building Partnerships to Improve Children's Access to Medicaid Oral Health Services," sponsored by the Health Care Financing Administration, the Health Resources and Services Administration and the National Center for Education in Maternal and Child Health. State dental associations were encouraged to send one representative to the Conference and invite one state legislator and one state official with responsibility for oversight and administration of the dental Medicaid Program.

Fluoridation and Preventive Health Activities

Fluoridation Activities: The Council is the focal point for water fluoridation technical assistance within the Association and acts as a resource to the profession and public health officials on this issue. This year, the Council provided educational materials and assisted active campaigns to initiate or retain fluoridation in 44 communities in 22 states. Direct assistance contributed to positive fluoridation decisions in Arizona, California, Colorado, Florida, Kansas, Massachusetts, Nebraska, Pennsylvania and Washington.

Federal Funding for Fluoridation: The Council supported the Washington Office as it lobbied for fiscal year 1999 federal funding for fluoridation. In the past few years, the Association has worked to recoup federal funding for fluoridation that has steadily decreased since the 1970s. The Council works closely with the CDC/DOH, which in fiscal year 1999, largely due to support from the Association, had its budget approximately doubled, in part to support state efforts in fluoridation and surveillance. Also during the 1999 fiscal year, six states received special federal funding for fluoridation because less than 25% of the population in those states benefit from fluoridated water. Grant funds from the Maternal and Child Health (MCH) Bureau's Special Projects of Regional and National Significance program helped California, Hawaii, New Hampshire, Nevada, Oregon and Utah work toward fluoridating communities. Council staff attended a meeting hosted by MCH in March 1999 to coordinate these states' efforts.

Fluoridation Technical Assistance: The Council develops content for the popular ADA ONLINE "Fluorides and Fluoridation" section, which provides members and consumers access to accurate fluoridation information electronically. The Council continues to monitor presentations and publications by fluoridation opponents, including numerous sites on the World Wide Web. In March 1999, at the request of the Washington State Dental Association, the Council provided support for fluoridation consultant, Dr. Michael Easley, to provide onsite technical assistance for Washington's state oral health coalition.

In assessing its program of support for state and local water fluoridation decision-making, the Council determined it needed to enhance available technical resources for managing political aspects of fluoridation decisions and challenges. This would augment the abundant scientific support available for fluoridation. Data collected by the Council indicates that many smaller communities are attempting to initiate fluoridation. Dental societies supporting small communities' efforts would benefit from audiovisual materials that would inform local

coalitions on how to guide public opinion and lobby decision-makers for fluoridation. Because small community efforts typically cannot afford onsite assistance by outside experts, instructional materials are needed to bring fluoridation and political expertise to their coalition. To fund development and distribution of political fluoridation resources, the "Fluoridation 2000" decision package was included in the Council's 2000 budget.

Revision of the *Fluoridation Facts* Booklet: The 1999 edition of *Fluoridation Facts*, the Council's premier communication tool on the safety and efficacy of fluoridation, was completed this year. Published by the Association since the 1950s and sold through the *ADA Catalog*, *Fluoridation Facts* is updated by the Council periodically. Approximately 4,000 copies of *Fluoridation Facts* are sold each year and the publication is particularly useful for members who need to educate patients or groups about the safety and benefits of fluoridation.

National Fluoridation Awards: The National Fluoridation Awards program is sponsored by the Association of State and Territorial Dental Directors, in cooperation with the American Dental Association (via the Council) and the Centers for Disease Control and Prevention's Division of Oral Health. The awards are presented annually during the National Oral Health Conference to recognize contributions made by states and/or coalitions in advancing water fluoridation. This year the Council determined it would like to continue to participate on the national fluoridation awards committee and also independently sponsor a "Fluoridation Merit Award" commencing in 2000.

Drinking Water Fluoride Concentrations: At its September 1998 meeting, the Council considered a request to develop an Association policy regarding ground water supplies that contain fluoride in concentrations higher than 2.0 parts per million (ppm). In considering this issue, the Council received input from the Chief Dental Officer of the U.S. Public Health Service and the Association of State and Territorial Dental Directors. The Council wished to develop a statement that would build on the Association's excellent track record for educating the profession and the public about optimal water fluoridation and appropriate exposure to topical and systemic fluoride. The following points were considered by the Council as it drafted proposed policy on drinking water fluoridation concentrations higher than 2.0 ppm.

- The dental literature has reported that consumption of water with fluoride concentrations greater than 2.0 ppm by very young children may increase risk for dental fluorosis in permanent teeth. However, children and adults are not at risk for dental fluorosis after the enamel of permanent teeth has formed, and dental fluorosis has not been associated with adverse health effects.
- Based on data collected by the Centers for Disease Control and Prevention's Division of Oral Health, the Council noted that a small number of areas in the United States (less than 2% of U.S. population) have groundwater sectors with naturally occurring concentrations greater than 2.0 parts fluoride per million parts water (ppm). These groundwater sources may serve community water systems or individual residential wells.
- Through the Safe Drinking Water Act, the U.S. Environmental Protection Agency and state agencies establish and enforce standards for natural fluoride levels in public water systems that exceed 2.0 ppm.

The Council believes its proposed policy is consistent with the Association's objectives regarding maintaining the recognition of the dentist as the oral health care expert and managing appropriate communications efforts related to critical issues (Goal III. Image). The Council therefore recommends adoption of the following resolution on Groundwater with Natural Levels of Fluoride Higher than 2.0 ppm.

3. Resolved, that the American Dental Association urge state dental societies to continue efforts to educate professionals and consumers about the role of fluoride in community oral health, and be it further

Resolved, that the Association urge state dental societies to encourage state and local dental public health and drinking water authorities to identify the state's groundwater sectors with natural fluoride levels that exceed 2.0 parts per million, and be it further

Resolved, that the Association encourage state and local dental societies to communicate with local health and drinking water authorities regarding standards for fluoride levels, and be it further

Resolved, that the Association urge dentists to become familiar with the water fluoride concentrations in their area of practice that exceed 2.0 parts per million and provide appropriate counseling to parents and caregivers of young children to reduce the risk of dental fluorosis in permanent teeth, and be it further

Resolved, that the Association encourage dentists to educate pediatric health care workers about groundwater sectors and water systems with fluoride levels that exceed 2.0 parts per million so that parents and caregivers of young children receive appropriate counseling to reduce the risk of dental fluorosis in permanent teeth.

Bottled Water, Filters and Fluoride Exposure: During 1998-99, the Council worked with the Council on Scientific Affairs to collect data on bottled water consumption, water filters and fluoride exposure. Data indicate that consumption of bottled water, which may contain only trace amounts of fluoride, is increasing in fluoridated communities. This may be of particular concern for persons at high risk of caries. Use of water filter systems that remove fluoride is also on the rise. The Councils are collaborating on development of a report addressing these issues.

National Fluoridation Advisory Committee (NFAC): The NFAC meets annually and is composed of a Council member and consultants to the Council. This Committee continues to serve the important role of assisting the Council with proactive community water fluoridation activities. In this regard, the NFAC assists the Council in monitoring scientific and community-based trends associated with state/local water fluoridation initiatives and provides the Council with valuable input for development and/or revision of fluoride/fluoridation education materials. This year's NFAC meeting will be held on June 11, 1999. The following members are serving one-year terms on the NFAC: Dr. Kimberly McFarland, chairman; Ms. Diane Brunson; Dr. Robert (Pete) Crawford, Jr.; Dr. Michael W. Easley; Dr. Herschel Horowitz; Dr. Jayanth (Jay) Kumar; Dr. Ernest Newbrun; and Mr. Thomas Reeves.

Early Childhood Caries: The Council initiated a three-year plan for early childhood caries prevention in 1999, including professional and public education activities. In doing so, the Council projected the need for additional funds during 2000 and included a decision package for "Prevention of Severe Childhood Caries" in its 2000 budget plan. Enhanced funding would allow the Council to conduct a national invitational workshop for child advocates focusing on early oral health intervention as well as further development of professional and consumer education materials. The Council continues to work with the Council on Communications to update existing public education materials on early childhood caries as needed.

In April, Council member Dr. David Perry represented the Association at an Early Childhood Caries Workshop sponsored by the National Institute of Dental and Craniofacial Research. Objectives for the workshop were to develop a new and comprehensive definition and diagnostic criteria for early childhood caries.

Child Abuse/Family Violence: The Council works in collaboration with the Council on Dental Practice on issues related to the prevention of family violence and child abuse.

In conjunction with constituent dental societies, the Council advocates for the development of state P.A.N.D.A. (Prevent Abuse and Neglect through Dental Awareness) coalitions. P.A.N.D.A. trains dentists and their staff members to recognize and report suspected victims of child abuse. The first P.A.N.D.A. program was developed in Missouri in 1993 as the public/private partnership with Delta Dental Plans of Missouri, the Missouri Bureau of Dental Health and the Missouri Dental Association, among others. Approximately 36 P.A.N.D.A. coalitions have been developed in the United Sates since 1993.

Dentists C.A.R.E. (Child Abuse Recognition and Education) Conference: Proceedings from the July 31-August 1, 1998 Dentists C.A.R.E. Conference were published during 1999 and are being distributed to state dental societies and other communities of interest. The conference was held with generous support from the ADA Health Foundation and the U.S. Maternal and Child Health Bureau. Additional copies of the proceedings are available from the Council office. The proceedings summarize remarks of speakers from dentistry, public health, medicine, law and the judiciary, on the importance of becoming familiar with state child protection laws where individuals practice and reporting abuse consistent with those laws. Also included are several state and local child abuse prevention coalitions and resources. The Council also transmitted conference proceedings to the ADA's Council on Dental Education and Licensure and the Commission on Dental Accreditation with a request to encourage predoctoral and continuing education in recognizing signs of abuse.

Dental Sealants: The Council continues to provide Dental Sealant Resource Packets to members upon request. On an ongoing basis, the Council works with other Association agencies to communicate the benefits of sealants to professionals and consumers. The Council also monitors the provision of dental sealants in the public sector through school-based or school-linked programs.

Sports Dentistry: The Council promotes greater awareness of sports dentistry issues and encourages widespread use of orofacial protectors. The Council maintains information on sports dentistry, including orofacial protectors, sports sanctioning bodies' rules and regulations, risks of smokeless tobacco use and the U.S. Olympic Committee's (USOC) Dental Consulting Group. The Dental Consulting Group is chaired by Dr. W. Robert Biddington and includes Dr. David Whiston and Mr. Nikolaj Petrovic.

Hypertension: The Association, through the Council, has been represented on the National High Blood Pressure Education Program's (NHBPEP) Coordinating Committee for many years. Established in 1972, NHBPEP is a cooperative effort between the National Institutes of Health's National Heart, Lung, and Blood Institute and approximately 50 professional and voluntary health organizations and agencies. The goal of NHBPEP is to reduce morbidity and mortality associated with uncontrolled hypertension through professional, patient and public education.

In April, Council consultant Dr. Michael Glick attended the meeting of the NHBPEP Coordinating Committee in Washington, D.C.

Oral Cancer Prevention Grant: The Council is responding to recommendations emanating from the 1996 National Strategic Planning Conference on the Prevention and Control of Oral and Pharyngeal Cancer. In 1999 the Council requested that its oral cancer consultant, Dr. Sol Silverman, Jr., act as principal investigator for an oral cancer education (R25) grant proposal to be submitted to the National Cancer Institute. The proposal "Oral Cancer Prevention Education," seeks to augment oral cancer prevention education in predoctoral dental education as well as in continuing education. If funded, the project will span five years and carry out an important oral cancer program.

Tobacco Issues: The Council represents the American Dental Association on several national steering committees and work groups dedicated to promoting the dental profession's

involvement with a variety of tobacco-related issues. These groups include: the National Dental Tobacco-Free Steering Committee; the Healthy People 2010 Tobacco Workgroup; and the National Cancer Institute/National Institute for Dental Research Initiative on Spit Tobacco Steering Committee. The Council, on behalf of the Association, has also supported, in principle, several nationally recognized tobacco use prevention and intervention programs designed for both the profession and the public.

Smokeless Tobacco. The Council remains involved with the national efforts designed to increase the public's awareness about the hazards associated with smokeless tobacco use. Additionally, the Council continues to distribute its Smokeless Tobacco Resource Packet, which is available to dentists on request. The Council distributed 35 smokeless tobacco resource kits this past year.

Tobacco Cessation. On an ongoing basis, the Council identifies opportunities for involving the Association with activities designed to support Association policy relating to tobacco use prevention in the dental environment. The Council distributes a Tobacco 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 to members upon request. The Council distributed 25 tobacco cessation packets this past year.

State Attorneys General Tobacco Settlement. At its March 1999 meeting the Council discussed the 1998 tobacco settlement between tobacco companies and attorneys general of 46 states. Immunity is provided in the settlement for tobacco companies from any lawsuit states may file to recoup Medicaid costs expended for tobacco-related illnesses. The Council noted, however, that the language of the settlement does not require states to target settlement funds for tobacco prevention or to reimburse Medicaid funds. The Council discussed the 1998 interim policy statement adopted by the Board of Trustees (Res. B-152-1998) and drafted an expanded policy that includes the Board of Trustees' concept and other community health issues.

The Council corresponded with the Council on Government Affairs to ask for its input regarding the proposed policy and to request that it collaborate in proposing suggested amendments to the Board's interim policy. The Council enthusiastically supported the concepts behind the Board's interim policy on the premise that tobacco-related diseases have drained state Medicaid budgets for decades, leaving dental Medicaid dramatically underfunded. In addition, given that states may include tobacco control issues in their budget plans, the Council believed that state dental societies may wish to advocate for tobacco education and prevention activities along with other health allies on the state level.

National Health Objectives for the Year 2010: The Association is a member of the consortium of organizations participating in the development of the U.S. Public Health Service's Healthy People 2010 National Health Promotion and Disease Prevention Objectives. Since 1987, the Council has been the focal point for this activity within the Association by identifying opportunities through which organized dentistry can assist in achieving the National Health Objectives, especially those related to oral health and tobacco. At the request of Executive Director Dr. John S. Zapp, several Councils reviewed the draft *Healthy People* report released for public comment on September 15, 1998. Those Councils were the Council on Access, Prevention and Interprofessional Relations, the Council on Dental Benefit Programs, the Council on Dental Practice, the Council on Government Affairs and the Council on Scientific Affairs. The Board of Trustees considered the Councils' comments at their December 1998 meeting. Subsequently, President S. Timothy Rose transmitted the Association's official comments to the U.S. Department of Health and Human Services.

Response to Assignments from the 1998 House of Delegates

Identifying Barriers To Care For Needy Children: Resolution 116H-1998 (*Trans.* 1998:747) directed the Council on Access, Prevention and Interprofessional Relations and other appropriate agencies to conduct a study to identify what barriers might account for an apparent lack of access to dental care for young children in the Medicaid and CHIP programs.

The Council was assigned primary responsibility for this activity. In fulfilling its directive, the Council has been working in close conjunction with the Survey Center and the Council on Government Affairs. In addressing the intent of the resolution, it was determined that an important first step would be to learn what studies had already been conducted that might provide some valuable information. The Survey Center has sent out a request for proposal to several individuals who could conduct a thorough literature review on this subject. The results of the review will determine what the next appropriate step in the study will be. Subsequently, the results of the literature search and additional actions taken to implement Resolution 116H will be reported to the House of Delegates.

Summary of Resolutions

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

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

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

Resolved, that dentists who receive such membership be encouraged to be active in the hospital and in its related committees in order to raise the profile of dentists as contributing medical staff members, and be it further
Resolved, that should cases of national significance concerning denial or revocation of privileges for qualified dentists be brought to the attention of the Association, the Board of Trustees be urged to direct appropriate legal action.

3. Resolved, that the American Dental Association urge state dental societies to continue efforts to educate professionals and consumers about the role of fluoride in community oral health, and be it further
Resolved, that the Association urge state dental societies to encourage state and local dental public health and drinking water authorities to identify the state's groundwater sectors with natural fluoride levels that exceed 2.0 parts per million, and be it further

Resolved, that the Association encourage state and local dental societies to communicate with local health and drinking water authorities regarding standards for fluoride levels, and be it further
Resolved, that the Association urge dentists to become familiar with the water fluoride concentrations in their area of practice that exceed 2.0 parts per million and provide appropriate counseling to parents and caregivers of young children to reduce the risk of dental fluorosis in permanent teeth, and be it further
Resolved, that the Association encourage dentists to educate pediatric health care workers about groundwater sectors and water systems with fluoride levels that exceed 2.0 parts per million so that parents and caregivers of young children receive appropriate counseling to reduce the risk of dental fluorosis in permanent teeth.

Council on Dental Benefit Programs

Vaclav, Michael D., Texas, 2001, chairman
Burns, Dennis A., Ohio, 1999, vice chairman
Cuttino, Charles L., Virginia, 2002
DeRose, Francesca, Wisconsin, 1999
Floyd, Thomas P., Florida, 1999
Hedlund, Steven, Iowa, 2002
Mason, Craig A., Hawaii, 1999
Olinger, Thomas J., California, 2001
Paulson, Julie A., Illinois, 2001
Rice, Joseph V., West Virginia, 2001
Sawyer, Ansley W., III, Maine, 2000
Shoemaker, Eugene B., 1999, *ex officio**
Smith, Mary Krempasky, Washington, 2000
Stoner, Donald A., Pennsylvania, 2000
Thompson, R. Wayne, Kansas, 2002
Tuber, Harry M., New Jersey, 2000
Volland, Lawrence, New York, 2002
Marshall, James Y., director
Ellek, Donalda, manager
Killam, Thomas, manager
Panepinto, Ellen, manager

Meetings: The Council on Dental Benefit Programs met on August 29-30, 1998, November 20-22, 1998 and April 23-25, 1999. The Council's next scheduled meeting is November 19-21, 1999.

The standing subcommittees and ad hoc committees of the Council that focus on major areas of activity have met on the following dates:

Purchaser Information Service Subcommittee	February 5-6, 1999
Subcommittee on the *Code*	February 19-20, 1999
Third-Party Issues Subcommittee	February 26-27, 1999
Quality Assessment and Improvement Subcommittee	March 5-6, 1999
Dental Practice Parameters Committee	April 16, 1999
ACODENIC	TBA

Chairman: At the April 23-25, 1999 meeting, Dr. Michael D. Vaclav was nominated as chairman of the Council for the 1999-2000 year.

Vice Chairman: Dr. Mary Krempasky Smith was elected vice chair of the Council for the 1999-2000 year.

Personnel: The close of the 1999 annual session brings to an end the terms of four valued members of the Council: Dr. Dennis A. Burns, who has served as vice chairman of the Council during the 1998-99 term; Dr. Thomas Floyd; Dr. Francesca DeRose; and Dr. Craig A. Mason. 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.

The Council welcomed a new staff member, Ms. Sharon Cullars, research analyst, to Purchaser Information Service (PINSERV).

The Strategic Plan of the American Dental Association: The Council activities continue to support the *ADA Strategic Plan: 1998-2001*, primarily Goal I. Advocacy, Goal II. Practice Support and Goal III. Image.

Each council of the Association was asked by the Board of Trustees to examine activities in relation to the Strategic Plan and eliminate those that did not support the Plan (Res. B-67-1998), and to develop criteria for measuring the effectiveness of their activities (Res. B-79-1998). None of the Council activities were eliminated because they all support the Strategic Plan. Evaluation criteria were developed and forwarded to the Strategic Planning Committee. Eighteen criteria were developed. They will be used in 2000 to evaluate the effectiveness of 1999 Council activities.

Goals and Objectives. The Council used a broad interpretation of the scope of the Strategic Plan's goals and objectives and identified connections with each of the goals and several of the individual objectives.

*Committee on the New Dentist member without the power to vote.

Federal Programs:

"AIM for Change" Medicaid Conference. The Council, along with the Council on Government Affairs and the Council on Access, Prevention and Interprofessional Relations, is sponsoring a national Medicaid conference entitled "AIM for Change—Achieving Improvements in Medicaid." The conference will enable state and national Medicaid and dental health leaders to gather and discuss ways of increasing access to Medicaid dental services. The goal of the conference is aimed, in part, at building from the Health Care Financing Administration (HCFA) sponsored Medicaid conference held in June 1998 in which participants identified barriers to accessing publicly funded oral health care. The conference will be held in the Association Headquarters Building August 2-3, 1999.

Military Dependents. The Council has been closely monitoring the TRICARE dental insurance program which offers benefits to active duty family members, select reserve and retirees of the military.

The Active Duty Family Member Dental Plan has been administered by United Concordia Companies, Inc. since February 1996. The program covers 1.7 million family members of active duty uniformed service personnel. The contract with United Concordia expires on January 31, 2001. Council staff and staff from the ADA Washington Office attended a forum coordinated by the TRICARE Management to provide input for prospective carriers relative to the TRICARE'S expectations for this future contract, which will be effective February 1, 2001. TRICARE will be accepting proposals from interested parties for this new contract beginning year-end 1999.

In October 1997, Delta Dental Plans began administering the Retiree Dental Insurance Program, which provides coverage to retired members of the uniform services. The Select Reserve Dental Program is administered by Humana Military Healthcare Services, Inc. and is available to the 600,000 members of the Selected Reserve and National Guard. The Council's main activity in monitoring these programs is to ensure that their administrative practices are fair to both participating and nonparticipating dentists, as well as to assure that a quality plan is negotiated with prospective carriers.

Health Insurance Portability and Accountability Act of 1996. The Council, in cooperation with other Association agencies, has been closely involved with the implementation of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The Council's efforts have focused on the Administrative Simplification portion of the legislation, which will simplify electronic claims processing for both public and private programs through standardization. The proposed regulations for the Act were released by the Department of Health and Human Services in May 1998. The final rules are expected to be released by the end of 1999. Health care plans, providers and insurers will then have 24 months to comply with the regulations. The proposed regulations identified the ADA's *Code on Dental Procedures and Nomenclature* as the standard for dental procedure codes.

The Association has also been asked by the Health Care Financing Administration to serve as the data content committee for dentistry. This committee would be responsible for approving any content changes to the electronic standards named in the HIPAA regulations. This includes the electronic transaction used to submit health care claims. The Association's Dental Content Committee is scheduled to meet in the summer of 1999.

Purchaser Information Service (PINSERV): The Service is established as the authority and primary resource for plan sponsors and patients in need of assistance in designing meaningful dental benefit plans. The goals of PINSERV are to:

- promote direct reimbursement (DR) and other dental benefit plan models in accordance with the policies of the American Dental Association;
- communicate with constituent dental societies regarding their efforts in the promotion of DR in their respective states;
- increase the number of individuals covered by dental benefit plans; and
- improve currently existing dental benefit plans where the level of benefits and extent of coverage are less than optimal.

Plan Review Service. PINSERV continues to offer employers a dental plan review service. The Council provides a written review, based on Association policy and guidelines, of any current or proposed dental plan submitted by the employer. This review is for the employer's internal use and is free of charge.

Other PINSERV Resources. PINSERV maintains numerous resources regarding dental benefit issues for distribution to employers and purchasers of dental benefit plans. Recently, a new publication entitled *Buyer's Guide to Dental Benefits* was created and published. This resource addresses issues in all types of dental benefit plans, including direct reimbursement, and is designed to provide a broad overview of available dental plans for prospective purchasers.

Direct Reimbursement. PINSERV staff assists constituent societies with DR promotion. Forty constituent societies are very active in their promotions of DR and are formally participating in the ADA's promotional campaign. A number of other constituent societies are in various stages of development of DR promotions for their respective states. PINSERV continues to distribute direct reimbursement promotional materials to both the public and Association members at no charge. These informational materials are intended to educate interested parties about the DR concept and to assist plan purchasers with implementing such plans.

PINSERV staff continues to offer their assistance and attendance at annual sessions and other meetings of constituent dental societies in order to conduct workshops and forums for

audiences of dentists and dental society staff. The forums are intended to educate interested members and their staff about the concept of direct reimbursement. Issues presented and discussed include various aspects of promoting DR to employers, identifying the best DR prospects, avoiding common mistakes when presenting DR to employers, using brokers and third-party administrators awareness of legal issues pertaining to DR promotion; the national campaign to promote DR; and the resource materials available from the Association.

Cost Estimation System. This service, managed by PINSERV, is designed to provide estimates to prospective plan purchasers of the cost of a proposed DR plan for their employees. To date, representatives and designated brokers from more than 30 constituent societies have been trained to use the computer software system. Technical assistance and ongoing training and support is provided by PINSERV staff. Planned enhancements and updates to the system will be undertaken in 1999.

DR DAYS '99. On August 27-28, 1999, the Council and the Alliance for Dental Reimbursement Plans (ADRP) will sponsor a forum (DR Days '99) for constituent and component dental society staff and leadership, brokers, consultants, third-party administrators (TPAs) and other parties interested in the promotion of DR. This one-and-one-half-day program will provide an opportunity for participants to learn about the Association's promotional campaign, network with individuals around the country who promote DR and introduce new tools and ideas to assist in the promotion of DR in all states. With the increase in the utilization of brokers, TPAs and consultants in the promotion of DR, an equal emphasis will be placed on issues pertinent to this group, as well as constituent dental society issues. New this year will be an orientation session designed for first-time attendees on Thursday afternoon, August 26, 1999.

The 1998 conference was attended by a record number of 180 people. Additionally, eight companies exhibited their respective products that enhance the implementations and administrative processes of direct reimbursement plans.

Presentation to Employers and Members. PINSERV staff provides presentations to member and employer groups across the country in an effort to inform all audiences about DR, as well as to inform members of the Association's campaign in response to Resolution 47H-1996 (*Trans.*1996:690). These presentations emphasize the differences between the provision and payment of dental and medical care. They also explain the consequences of various plan design deficiencies, including exclusions and limitations placed on treatment decisions. PINSERV staff visited with interested major national employers regarding direct reimbursement. In those states where the constituent society does not have an active DR staff person or broker/consultant network in place for follow-up and meetings with employers, PINSERV staff will continue to respond to such inquiries. In the past year, staff has mailed information regarding DR to 1,130 employers. Additionally, staff has personally discussed DR with more than 700 interested employers, either via telephone conversations or in person. These activities are additional promotional efforts not included in the Association's national DR promotional campaign as described below.

Direct Reimbursement Campaign—Overview. Previously, a DR Task Force, appointed by the Association President, provided oversight and guidance to the DR promotional campaign. In 1999, the Council's PINSERV Subcommittee has been assigned the role of overseeing issues involved with the promotional campaign.

The following information details the two major components of the Association's Promotional Campaign; advertising and direct mail.

Direct Reimbursement Campaign—Advertising. The 1999 campaign advertising schedule builds on exposure to key employee benefits decision-makers, consultants, brokers and CFOs. A mix of both human resource trade publications as well as broad-based business publications have again been selected for the ADA's media campaign. These publications include: *Employee Benefit News, Human Resource Executive, HR Magazine, Business Week, CFO Magazine, Forbes, Your Company, The Wall Street Journal* and *Barron's*. There are a total of 48 placements of the Association's DR ads in these publications scheduled for 1999, reaching more than 5.5 million subscribers. The schedule focuses on reaching readers primarily in the late spring and early fall.

A new ad introduced in 1999 focuses on the theme: "Two easy steps to help control the cost of dental benefits." The ad features a toothbrush with the caption "Use this at home" and then illustrates the direct reimbursement logo with the caption "Use this at the office." This new ad incorporates the same rich, blue color and toothbrush graphic that is consistent throughout all the DR marketing materials. This new ad, in combination with the two existing DR ads, is strategically placed in the above publications in 1999.

Direct Reimbursement Campaign—Direct Mail. Each year, the direct mail phase of the DR promotional campaign continues to grow. During the spring 1999 campaign, a total of 40 constituent societies, including four new constituents (District of Columbia, Idaho, Kansas and Maine), elected to participate in the mailing component of the promotion. The constituents participating in the direct mail campaign include: Alaska, Alabama, Arkansas, Arizona, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin and Wyoming. These constituents chose to participate in the campaign based on their ability to meet a number of criteria developed and monitored by the PINSERV Subcommittee. The criteria include having adequate support in place and functioning to follow-up on the leads generated by

the campaign, as well as the willingness of the constituent society to dedicate additional resources to this effort during the duration of the promotion. New participating constituents for the spring 1999 campaign were trained on the logistics of the DR campaign in conjunction with the training for the cost estimation system on-site at the constituent's offices.

Direct mail efforts are scheduled to coincide with the spring and early fall decision-making time periods. Mailing lists are procured from national database companies, Database America and Dunn and Bradstreet, as well as from subscriber lists of several of the aforementioned publications in which DR ads appear. These lists are forwarded to the designated DR staff person in each of the 40 constituents participating in the direct mail campaign. Over a period of two weeks, the designated constituent society staff reviews the list and submits any changes, as well as a complete list of names and addresses of prospects developed on a more local level to be included in the mailing. Constituent society staff are encouraged to submit custom lists for their own promotional purposes; these names take precedence over those purchased from the national database.

Based on focus group research, the components of the direct mailing efforts continue to be tested and enhanced for future promotions. The interactive disk, revised in 1998 to include more technical information on the characteristics/comparisons of DR with other dental benefit alternatives, continues to be a well-received resource that captures the attention of the target audience. The disk serves as a "core" piece with a letter customized to the interests of each of the four target markets: HR managers at smaller companies, HR managers at larger companies (greater than 500 employees), benefits consultants and brokers.

A newly created "teaser" piece serves as the precursor for the disk mailer and is sent to recipients approximately two weeks prior to the disk mailer. The "teaser" piece features the theme "Two ways to control the cost of dental benefits" as previously described in the advertising section. Additionally, it features a letter from Association President Dr. S. Timothy Rose, that provides a succinct summary of the advantages afforded by DR, as well as quotes from various benefits managers across the country touting the benefits of DR. The "teaser" also includes an actual toothbrush with "Direct Reimbursement" inscribed on the handle. Like the disk mailer, this "teaser" package will serve as a core piece customized with a specific letter directed toward HR managers, consultants, brokers and CFOs.

This spring, direct mail was sent to approximately 72,000 prospects at companies in the 40 participating constituents. Final numbers for the fall mailing are yet to be determined, as additional states will most likely be included at that time.

In response to Resolution 47H-1996, the House of Delegates authorized the expenditure of $2.5 million in each of the past three years (including 1999) for the promotion of direct reimbursement. These funds have been used exclusively for the development and placement of DR ads and the conduct of the direct mail portion of the campaign as described above. The following related DR support activities are funded through the Council's PINSERV budget.

Nonparticipating Constituent Societies. There are presently 11 constituent societies that are not participating in the direct mail portion of the ADA's DR promotional campaign. Staff continues to assist these constituents with their DR needs, and offer assistance in helping them to prepare for participation in the campaign as appropriate. Additionally, staff responds to DR inquiries as generated through the advertising campaign in those states which have no formal means of follow-up.

Communications with Constituent Dental Societies. To ensure consistency and ongoing communications with participating campaign states, PINSERV is in constant contact with the DR staff of the constituent dental societies participating in the Association's DR campaign. Regular phone conversations, faxes and written communications are part of this ongoing communication. On a more formal basis, the *DR NEWSLETTER* continues to be distributed to constituent society DR representatives, as well as brokers who represent them. Additionally, PINSERV staff conducts an annual midcourse evaluation of the campaign, which entails a lengthy phone conversation with DR staff, and focuses on campaign issues, concerns and enhancements, as suggested by the constituent society staff. Additionally, constituent staff are encouraged to attend the DR DAYS program in August to further communicate with Association staff and constituent DR staff from across the country.

DR Information Repository. PINSERV has created the Information Repository, which is a data resource of employers with existing DR plans. This information is used to respond to employers inquiring about other employers currently offering DR. Various reports can be generated based on request. The data resource includes information such as implementation date, plan design, industry type, employee size and cost savings information. The Repository has information on more than 2,300 DR plans.

Collateral Material. PINSERV continues to distribute DR material, brochures and kits to both the public and Association members at no charge. These informational materials are intended to educate interested parties and assist plan purchasers with implementing such plans. There is no charge to the requestor for the collateral material used in conjunction with the campaign. In the past year, over 100,000 pieces of DR-related material have been distributed to employers, dental societies and member dentists.

DR Promotional Co-op. As part of its ongoing support of DR, the Council is sponsoring a DR Promotional Co-op Program in 1999. This program was designed to further assist constituents participating in the Association's DR campaign in their local promotional efforts. In this program, each participating constituent society is eligible for an allowance of up to $2,000 for the calendar year of 1999. These funds can be used to augment the existing marketing efforts undertaken on the national level. Such constituent co-op activities which qualify for this $2,000 allowance include, but are not limited

to, advertisements placed at the constituent or local level, additional direct mail efforts and trade shows.

DR Exhibiting Resources. PINSERV continues to coordinate the use of the DR "traveling" displays that are available to constituent and component societies. These tabletop displays were designed to be consistent with the look of the national campaign and, upon request by the sponsoring state, are shipped to meetings and trade shows across the country. Many states continue to take advantage of this free resource as yet another means of promoting DR to employers and dentists alike.

National Trade Show Activity. PINSERV staff attended nine trade shows in 1999, which were attended by over 28,000 benefit decision-makers at corporations, consulting and brokerage firms. Major shows include meetings of the National School Boards Association, Society for Human Resource Managers, Self Insurance Institute of America, American Management Association, Benefits Expo (sponsored by *Employee Benefit News)* and the International Foundation of Employee Benefits Plan conference. PINSERV will also be staffing an informational exhibit at the Association's annual session in Honolulu. Member dentists are encouraged to stop by and take a look at the promotional materials developed during the 1999 campaign.

Future Promotional Campaign. The Council will be proposing a resolution to the 1999 House of Delegates to extend the national marketing campaign for Direct Reimbursement for an additional three years at the same funding levels ($2.5 million annually). This resolution will be presented in a supplemental report to the House.

An update report on the 1999 Direct Reimbursement Campaign will be provided by the Board of Trustees to the House of Delegates.

Third-Party Issues:

Procedure Codes (Current Dental Terminology "CDT-3"). The five-year review and revision process of *CDT-2* was completed in 1998. "CDT-3" is scheduled to be released to the membership in July 1999 through the ADA Catalog. The "Current Dental Terminology, Third Edition (CDT-3)" will have 73 new procedure codes and 68 revised codes and descriptors. Seven obsolete codes from *CDT-2* were deleted. In addition, it will feature the newly revised ADA claim form. The new procedure codes and claim form will be effective January 1, 2000.

Diagnostic Codes. The Council completed work on the first version of the Systematized Nomenclature of Dentistry (SNODENT). Approximately 50 SNODENT terms and codes will be included in "CDT-3." This will introduce dentists to SNODENT and provide examples of its intended purpose, use and structure.

SNODENT contains 6,490 terms and 3,931 codes, which means there are 2,559 synonym terms. There are 779 International Classification of Diseases (ICD) ninth edition codes that can be linked to the SNODENT codes.

SNODENT will serve as a tool for the dentist wishing to fully document patient diagnoses, including comorbidities that may have an impact on the outcome of treatment. SNODENT contains codes for identifying not only diseases and diagnoses, but also anatomy, conditions, morphology and social factors that may affect health or treatment. Coding this information gives a more complete picture of the patient's health and all the factors that may be affecting both the treatment decisions and outcome. When such information is available in the aggregate, the profession will be able to thoroughly and precisely analyze treatment outcomes under various clinical circumstances. Through the ADA Electronic Commerce Co. (ECCo), diagnostic information from electronic claims may be collected to develop a dental database that could eventually be used to study outcomes.

Revision of ADA Claim Form. The Council made revisions to the paper version of the dental claim form. The revisions reflect anticipated data requirements for electronic claims as specified in the Health Insurance Portability and Accountability Act of 1996. Other changes included changing the signature block language to allow the treating dentist to bill for procedures that are in progress. This would only apply to procedures that require multiple visits. The new form will be available in summer for implementation in January 1, 2000.

Managed Care. The Council continues its responsibility of monitoring the status and progress of the dental component of the HMO/PPO industry. The Council regularly assists members who are having difficulties with managed care, particularly with claims adjudication. The Council uses information gained from individual member practices to detect trends in the industry. This information is disseminated to the membership at large.

Carrier Liaison. The Council continues advocating issues that affect dentistry through its ongoing communications with third-party carriers. This year the Council met with third-party payer representatives during its April meeting to discuss issues including: electronic claims processing; language on explanation of benefits statements; the use of diagnostic coding; and implementation of "CDT-3" and the newly revised ADA claim form. The Council Chairman and staff attended the HIAA Dental Relations Committee meeting in March and the American Association of Dental Consultants meeting in May.

Claims Processing. Part of the Council's responsibilities include acting on problems dentists are experiencing with third-party payers in processing dental claims. This year the Council considered a variety of claims processing issues that were brought to its attention from members. The Council also addressed several resolutions related to claims processing that the 1998 House of Delegates either adopted or referred for further study and report to the 1999 House of Delegates.

One such resolution, 115H-1998, Dental Coding (*Trans.*1998:746), directed the appropriate agency of the ADA

to develop and implement advocacy efforts to insure that the insurance industry complies with the use of the most current *CDT* publication for appropriate claims processing. The resolution appropriated $1,000 for this activity to be accomplished. This has been an ongoing effort of the Council. In 1998, the ADA's *Code on Dental Procedures and Nomenclature* was named under the Health Insurance Portability and Accountability Act regulations as the standard for identifying dental procedures in electronic claims processing. This means that all carriers will be required to accept the most current version of the *Dental Code* when a claim is submitted electronically and will not be able to require a dentist to submit codes that are not contained in the most current version of the *Dental Code*. At recent meetings with carriers, the Council has discussed implementation of "CDT-3." Carrier representatives have indicated they intend to adopt "CDT-3" on January 1, 2000. Association staff has also been working with practice management vendors to ensure that they adopt new license agreements and begin incorporating "CDT-3" into their systems. The Council intends to use the funds appropriated in 115H to communicate with the third-party payer industry about the availability and use of "CDT-3."

The Council considered several resolutions which addressed specific third-party payment problems with third-party payers. Those resolutions are listed in the section Response to Assignments from the 1998 House of Delegates of this report.

Quality Assessment and Improvement: The Council's Office of Quality Assessment and Improvement serves to: (1) coordinate the quality assessment and improvement activities for the American Dental Association; (2) maintain a knowledge and information base on quality assessment and improvement; (3) develop policy recommendations, quality of care resources and assessment instruments; (4) maintain liaison with other national organizations concerned with quality assessment and improvement; and (5) provide the profession's perspective on quality assessment and improvement to governmental and other outside agencies.

Dental Indicators. Resolution 27H-1997 (*Trans.*1997:677) approved the development of indicators for oral health care in accordance with a plan developed by the Council on Dental Benefit Programs and submitted to the 1997 House of Delegates in its Supplemental Report 1 (*Supplement* 1997:313). The approved plan established a Dental Indicators Committee composed of members from the Council on Dental Benefits Programs (three members), the Council on Dental Practice (two members), and the Council on Dental Education and Licensure (two members).

During 1998, the Committee developed a draft of 54 dental indicators. The Committee then planned a Consensus Conference on indicators development and developed a protocol for field testing the indicators. The Consensus Conference was held June 5-7, 1998 to review and provide recommendations on the draft of dental indicators. The Consensus Conference Panel, composed of 35 volunteers, represented all trustee districts, all recognized specialties and academia. The Panel was nominated by the Dental Indicators Committee from a list of nominees submitted by the Board of Trustees and appointed by the Association's President. The Dental Indicators Committee refined the indicators and winnowed the number of indicators from 54 to 15, based on the recommendations that were provided during the Consensus Conference.

The 15 indicators were then field tested in ten general practice dental offices. The dental offices were all within a 100-mile radius of Chicago in order to reduce the costs and time of field testing. The offices were located in the states of Illinois, Indiana, Michigan and Wisconsin. In each office, the dentist and his or her staff collected data for each indicator. The purpose of field testing was to test the clarity of terms and specifications that are used in the indicators and the indicators' relevance to practice. Also, field testing was done to explore the availability of data that would be collected on each indicator, and the time and resources used in collecting data.

During January 1999, the Dental Indicators Committee met with the dentists and staff who had participated in field testing the indicators. The field testers reported that using the indicators in their practices was generally a positive experience. They reported that the data they gathered provided them with useful information about their practices, which could guide them towards improvements in their practice. They commented that the data collection process was not overly demanding of time or resources and that the indicators seem to aim at the "right" level of clinical care without being too intrusive regarding the assessment of clinical care.

The Dental Indicators Committee used information from the field testers to further refine the indicators and reduced the number of indicators from 15 to 11. The 11 indicators were approved for transmittal by the Council and will be forwarded to the Board of Trustees for transmittal to the 1999 House of Delegates. Along with the indicators, the Dental Indicators Committee developed a preamble that explains the purpose of indicators, a glossary of terms that clarifies terms used throughout the indicators and a list of references that were used in developing the indicators.

A user's manual was also developed to be distributed along with the indicators. The user's manual is designed to aid the dentist in applying the indicators in his or her practice. It discusses the principles that are common to clinical assessment programs and provides basic instruction in how to conduct an assessment, using dental indicators.

Peer Review Assistance Workshops. The Council's Office of Quality Assessment and Improvement conducts up to ten peer review assistance workshops each year for state dental societies. The purpose of the workshops is to explain the objectives of peer review and mediation and to facilitate skill development in conducting peer review and mediation. Two workshops have been held, in Chicago and Casper, Wyoming. As of May 1999, five others were scheduled for the dental societies of Delaware, Louisiana, New York, South Dakota and the U.S. Navy.

In order to improve the presentation of material at the workshops, the Council sought funding from malpractice insurers to develop peer review slides and peer review video

on CD-ROM. To date, some interest has been expressed by a few malpractice carriers in providing funding. The Council will take the next steps in clarifying the specific interests sought by those malpractice insurers and detailing the guidelines for funding.

National Practitioner Data Bank. The majority of responsibility for the National Practitioner Data Bank resides with the Council on Government Affairs. However, the Office of Quality Assessment and Improvement continues to monitor the status of the Data Bank and the Health Care Quality Improvement Act as it pertains to dental society peer review. The Office of Quality Assessment and Improvement provides information on the Data Bank in response to members' phone calls and through the peer review assistance workshops.

Liaison Activities. The Office of Quality Assessment and Improvement maintains informal liaison with the Health Care Quality Alliance, the National Committee for Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations.

Contract Analysis Service: Since its inception in 1987, the Contract Analysis Service has received and analyzed over 3,100 third-party dental provider contracts. In 1998, 231contracts were analyzed.

To maximize the Service's efficiency, member dentists are encouraged to submit requests through their state or local dental societies. Individual members submitting requests directly to the Service must pay $50 for an analysis. As expected, most members continue to submit their requests through the state and local societies and avoid the $50 charge.

The Service continues to provide seminars, articles, letters and interviews on dental provider contracting issues to inform members about managed care issues.

In 1999, the Service established the following strategies:

1. to continue to meet the current demand in a timely manner;
2. to develop new informational material regarding dental provider contracts; and
3. to work closely with the state and local societies to address member dental provider contracting concerns.

Response to Assignments from the 1998 House of Delegates

Definitions of Fraudulent and Abusive Practices in Dental Benefit Plans and Claims: Resolution 3H-1998 (*Trans.*1998:700) amended existing policy regarding potentially fraudulent and abusive practices in the handling of dental benefit claims. The amendment added examples of inappropriate practices such as issuing reimbursement checks to dentists that, when endorsed, committed the dentist to accepting that amount as payment in full and the practice of designing claim form signature block statements that when signed, would bind the dentist to the terms of the patients dental benefit program. This amended policy has been included in the Council's compendium of policies relevant to third-party issues.

Position Statement on the Appropriate Use of Assessment Data: Resolution 5H-1998 (*Trans.*1998:700) is included in the Council's compendium of relevant policy and is referenced when necessary in Council communications.

Marketing Direct Reimbursement to Patients (Employees): In response to Resolution 43H-1998 (*Trans.*1998:704), the Council has geared some of the marketing strategies and materials to the interests of employees as well as employers.

Benefits for Non-Metallic Restorations: Resolution 70-1998 (*Trans.*1998:628) directs the Association to initiate a program to educate third-party payers as to the benefits and long-term cost effectiveness of indirect bonded restorations. It also states that laboratory fabricated inlays, onlays and crowns made from composite or ceramic substances are valid and scientifically proven restorations that should be reimbursed the same as metal or porcelain restorations.

The 1998 Composite Resin Workshop addressed this issue for resin-based composites and the report has already been shared with the third-party payers. Furthermore, the Council did not agree that restorations using various materials should be reimbursed at the same level. The Council, therefore, believes that Resolution 70-1998 should not be adopted. Also see the Report of the Council on Scientific Affairs regarding Resolution 70.

Determination of Dental Benefits: Resolution 71-1998 (*Trans.*1998:628), which was referred for study and report to the 1999 House of Delegates, states that single unit inlays, onlays and crowns do not require preoperative x-rays in order to determine benefits and that pretreatment estimates for the aforementioned procedures should not be required by third-party payers. The resolution directs the Association to urge third-party payers to accept this payment policy.

The Council believes that Resolution 71-1998 should not be adopted because existing policies, Guidelines on the Use of Images in Dental Benefit Programs (*Trans.*1990:540; 1994:665; 1995:617) and Radiographs in Diagnoses (*Trans.*1974:653), already address this issue. The Council also cited existing policy, Preauthorization of Benefits *(Trans.*1992:597*)*, which addresses the issue of pretreatment estimates in determining benefits.

Payment for Temporary Procedures: Resolution 72-1998 (*Trans.*1998:628), which was referred for study and report to the 1999 House of Delegates, states that provisional or interim restorations and prostheses that are placed to promote healing, are valid and scientifically proven treatment modalities that should be covered at a fair reimbursement level. The resolution directs the Association to urge third-party payers to adopt this payment policy and develop procedure codes for provisional restorations.

The Council was concerned with the language "valid and scientifically proven treatment" in the original resolution so it was recommended that it be removed. Also the clause directing the Association to develop procedure codes was inappropriate, as there is a process for submitting procedure code requests that needs to be followed. It was recommended that this be deleted as well. The Subcommittee on the *Code* reviewed this resolution and pointed out that there are currently provisional codes in the *Code on Dental Procedures and Nomenclature* and one new code will be added for "CDT-3." The Council therefore recommends adoption of the following resolution, which supports Goal II., Practice Support of the Strategic Plan.

4. Resolved, that provisional or interim restorations and prostheses are valid treatment modalities that should be reimbursable, and be it further
Resolved, that the Association urge third-party payers to accept this policy.

Elimination of Endodontic Radiographs: Resolution 75-1998 (Trans.1998:629), which was referred for study and report to the 1999 House of Delegates, states that periapical x-rays of completed endodontic procedures are not necessary for consideration of payment and it directs the Association to urge third-party payers to eliminate this requirement.

As part of its ongoing review of policy, the Council cited existing policy, Guidelines on the Use of Images in Dental Benefit programs (*Trans.*1995:617) and Radiographs in Diagnosis (*Trans.*1974:653), which addresses this issue. The Council also expressed concern over the adoption of policies that are specific to one procedure to the exclusion of others and therefore believes that Resolution 75-1998 should not be adopted.

Interim Policy on Prioritization of Dental Care In Governmentally Sponsored Health Care Programs: The Council considered Resolution 111H-1998 (*Trans.*1998:705) and Report 7 of the Board of Trustees to the House of Delegates (*Supplement* 1998:444) which included an interim policy dealing with prioritization of dental care in governmentally sponsored health care programs. The Council believes that the interim policy should become official Association policy and, therefore, recommends adoption of the following resolution. The resolution supports Goal II., Practice Support of the Strategic Plan.

5. Resolved, that the Association recognizes that prioritization of dental care in governmentally sponsored health care programs may be required in addressing the fiscal restraints under which these plans operate and recommends that, when dental benefits are prioritized, they be prioritized as follows:

1. Care of emergency oral conditions;
2. Diagnostic and preventive oral care;
3. Care for nonemergency oral diseases;
4. Treatment of nondisease related oral conditions.

Dental Coding: Resolution 115H-1998 (*Trans.*1998:746) directs that the appropriate agency of the ADA develop and implement a plan to ensure that the insurance industry complies with the most current version of the ADA procedure codes. The Council is using the monies allocated by Resolution 115H to contact the insurance industry about the use of the new codes.

Summary of Resolutions

4. Resolved, that provisional or interim restorations and prostheses are valid treatment modalities that should be reimbursable, and be it further
Resolved, that the Association urge third-party payers to accept this policy.

5. Resolved, that the Association recognizes that prioritization of dental care in governmentally sponsored health care programs may be required in addressing the fiscal restraints under which these plans operate and recommends that, when dental benefits are prioritized, they be prioritized as follows:

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3. Care for nonemergency oral diseases;
4. Treatment of nondisease related oral conditions.

Council on Dental Practice

Norman, Charles H., III, North Carolina, 1999, chairman
Smith, Jeffery W., California, 2000, vice chairman
Altieri, Jeanne P., Connecticut, 2001
Arcand, Albert R., Rhode Island, 1999, *ex officio**
Burton, John F., South Carolina, 2001
Calnon, William R., New York, 2002
Eads, John S., III, Texas, 2001
Keim, Douglas K., Minnesota, 2000
Okano, David K., Wyoming, 2002
Peterson, Janet D., Oregon, 2000
Raibley, Bruce D., Indiana, 1999
Rainwater, Michael T., Georgia, 2002
Sherwood, Cynthia E., Kansas, 1999
Smith, Richard D., West Virginia, 2000
Suchy, Keith W., Illinois, 1999
Swanson, Loren C., Wisconsin, 2002
Weber, Charles R., Pennsylvania, 2001
Guay, Albert H., director
Block, Joan M., manager
Cheers, Lisa N., manager
Collins, Donald, manager
Collins, Susan, manager
Kittelson, Linda E., manager

Meetings: The Council on Dental Practice met in the Association Headquarters Building on November 12-14, 1998 and May 6-8, 1999. Dr. John W. Staubach, Third District trustee, serves as the Board of Trustees' liaison to the Council.

Organization: The Council is organized into five subcommittees to facilitate its work activities. The Subcommittee on Dental Team Members and Practice Management Publications (Committee A) and the Subcommittee on Special Projects (Committee B) met in conjunction with regularly scheduled Council meetings immediately prior to the plenary sessions. Another subcommittee, the Dentist Well-Being Advisory Committee (DWAC), meets annually in February. Two Council members serve on this Committee and the remaining members are consultants. A fourth subcommittee, the Dental Management Service Organization Committee, met in June and August 1998. The Ergonomics and Disability Support Advisory Committee was appointed in May 1999 and will meet for the first time in June. Two Council members serve on this Committee and the remaining members are consultants to the Council.

Personnel: At the May 1999 meeting of the Council, Dr. Jeffery W. Smith, Sonora, CA was unanimously nominated as chairman for 1999-2000. The 1999 ADA annual session will mark the retirement of Dr. Charles H. Norman, III, Dr. Bruce D. Raibley, Dr. Cynthia E. Sherwood and Dr. Keith W. Suchy. The Council wishes to express its appreciation to these individuals for their thoughtful, determined leadership and for the many contributions during their tenure. In September, Dr. Albert H. Guay, interim director, was appointed director of the Council on Dental Practice. In November, Ms. Deborah Szalkiewicz joined the staff as coordinator, Ergonomic and Disability Support Services.

The Strategic Plan of the American Dental Association: The Council activities continue to support the ADA *Strategic Plan: 1998-2001*, primarily Goal I. Advocacy, Goal II. Practice Support and Goal III. Image.

Each council of the Association was asked by the Board of Trustees to: examine its activities in relation to the Strategic Plan; eliminate those that did not support the Plan (Res. B-67-1998); and develop criteria for measuring the effectiveness of their activities (Res. B-79-1998). None of the Council activities were eliminated because they all support the Strategic Plan, although one publication was discontinued because the need that it had fulfilled was now being addressed by other Association resources. Evaluation criteria were developed and forwarded to the Strategic Planning Committee. Thirty criteria were developed. They will be used in 2000 to evaluate the effectiveness of 1999 Council activities.

*Committee on the New Dentist member without the power to vote.

Response to Assignments from the 1998 House of Delegates

Biennial Workforce Needs Assessment: The Council responded to Resolution 73H-1998 (*Trans.*1998:709) by requesting that the Survey Center gather information on this subject. When the results of the field survey are available, the data will be analyzed and reported to the House of Delegates and sent to each constituent society. Recommendations will also be made concerning the most appropriate interval between surveys.

Council Activities

SUCCESS 1998-99: Completing 16 successful years of operation, the SUCCESS Program has continued to grow in both popularity and impact. Initially known as OPTIONS, the SUCCESS Program concentrates on the items and issues that a pending graduate would face as he or she enters private practice. Response from corporate sponsors, dental students, dental schools and organized dentistry continues to be extremely positive. Senior and junior dental students throughout the United States benefited from the efforts of SUCCESS 1998-99. 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.

SUCCESS 1998-99 continued to focus upon business training for junior and senior dental students. The Program conveyed this information to students in two ways. First, through the Association's publication *Starting Your Dental Practice: A Complete Guide* was distributed to approximately 4,100 senior and junior dental students during the year. The publication is a comprehensive 116-page manual that 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 is appropriately recognized in this publication.

Second, a one-day practice management seminar, "Starting Your Dental Practice," was presented at 21 dental schools in 1998-99. This concentrated seminar covers such topics as: life after dental school; associateships; dental management service organizations; the office dental team; accounting information; basics of dental prepayment and managed care; practice purchase; managing money; and practice financing and marketing for new dentists. A comprehensive seminar manual was distributed to all seminar attendees for their future use in practice as a gift from the corporate sponsors and organized dentistry. Corporate sponsorship is also recognized in this publication.

In response to the recommendation of the Administrative Review Committee that the funding of the Council on Ethics, Bylaws and Judicial Affairs SUCCESS/Ethics Program be transferred to the SUCCESS Program budget, the Council on Dental Practice sponsored the SUCCESS/Ethics seminars for 1998-99.

Corporate Sponsors. The following corporate sponsors made a financial contribution to the SUCCESS Program: 3M Dental Products; ADA® 1 PLAN℠; A-dec, Inc.; The CNA Insurance Company; DENTSPLY International; The Equitable Life Assurance Society of the United States, New York; Great-West Life & Annuity Insurance Company; Sullivan-Schein Dental, a Henry Schein, Inc. Company; John O. Butler Company; Patterson Dental Company; Procter & Gamble Company; Ultradent Products, Inc.; 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 appreciates their generous involvement over the years.

Seminar Site Selection. SUCCESS 1998-99 seminars were presented on the dates indicated below (the first school listed after each date is the seminar site and the others are schools whose students were also invited): September 18, Case Western Reserve University; October 3, University of Pittsburgh; October 5, Marquette University; October 7, University of Kentucky/University of Louisville; October 9, Tufts University; October 31, University of Detroit Mercy/University of Michigan; November 4, Medical College of Georgia; November 5, Virginia Commonwealth; November 7, University of California San Francisco/University of the Pacific; November 10, Howard University; November 10, Southern Illinois University; January 30, University of Southern California; February 4, Creighton University; February 5, University of California at Los Angeles (UCLA); February 5, University of Pennsylvania; February 6, University of Connecticut; February 9, Loma Linda University; and February 26, University of Puerto Rico.

Seminar Presenters. Instructors were selected by the Council based upon their recognized expertise in practice management. In addition, representatives of the respective constituent societies were invited to discuss the important role of organized dentistry. Each seminar was presented by two professionals selected from the Council's list of consultants.

Six new speakers were selected in the spring of 1998, and on September 11, 1998, a SUCCESS speaker orientation meeting was held in Chicago at the Association's Headquarters Building for the new presenters. An additional new speaker was selected in May 1999.

SUCCESS 1998-99 Program Revisions. Each year the SUCCESS Program is reviewed in light of the changing dental practice environment and student needs. At its November 1997 meeting, the Council recommended that staff add a question to the SUCCESS Program evaluation form to determine student interest in a more comprehensive half-day or 90-minute managed care presentation. It was ascertained from the 1998-99 student evaluation forms that only 38% of the students surveyed were interested. The Council determined that an extended presentation on managed care would not be developed.

In response to Resolution 74H-1998 (*Trans.*1998:701) Mentor Program, information on DMSOs was developed and

incorporated into the SUCCESS Program in February 1999. The Dental Practice Parameters Committee requested that a section on the Parameters be added to the SUCCESS Program. The Council decided that a Parameters section will not be added to the SUCCESS presentations, but that some means of providing the Parameters to dental students would be sought.

The SUCCESS Manual was updated this past year and sent to speakers along with revised presentation slides. Chapter five of the Manual, "Basics of Dental Prepayment and Managed Care," was rewritten in accordance with a May 1998 Council recommendation that the SUCCESS Manual be revised, particularly the managed care section. The managed care presentation slides were redone accordingly and sent to the presenters. Comments from student evaluation forms and feedback from seminar presenters are also used as a basis for revisions to the SUCCESS Program.

The distribution of a coupon for a free copy of a volume from the Council's Success Practice Management Series was done this year. This coupon was given to those students in attendance at the conclusion of the Program.

With continued corporate support, this Program will again be offered to dental schools throughout the United States and Puerto Rico and will continue to grow in its program offerings. The overall goal remains the same—to make available a quality practice management program for junior and senior dental students who will be entering private practice in the near future.

Seminar Series 1998-99: The ADA Seminar Series is provided by the Council on Dental Practice. The Council's Seminar Services cosponsors over 150 practice management and clinical seminars with state, local and national dental organizations. Completing its 12th successful year of operation, the ADA Seminar Series has continued to grow in both popularity and impact. Seminar Series programs were sponsored in 46 states and Canada. The number of dentists and dental team members attending the Association seminar programs has increased from 5,500 participants in 1988 to 35,000 participants in 1998. Program quality remains very high. Seminar attendees continue to rate the overall program and speaker quality a 4.7 on a 5.0 scale of excellence.

Objective. The Council's primary objective is to offer tripartite organizations nationally known speakers and the Association-developed/Association-approved continuing education programs as a tangible member benefit at below-market rates to help local dental organizations generate nondues revenue. Program fees range from $1,500 to $3,000. To date, the American Dental Association Seminar Series' speakers have also agreed to present a limited number of programs at a reduced fee. This has served as a valuable membership benefit, especially for those societies with limited resources and difficult access to top quality programs.

Program Growth. Program bookings attained a record high of 190 for 1998 and 150 programs have been scheduled thus far in 1999. Because of increased demand, the Council added 12 new seminars to the 1998-99 catalog. The program's growth is attributed to the wide array of speakers and programs offered through the series, the caliber of the speakers, additional program marketing and an increased utilization by state organizations.

Programs are continually evaluated by both the Council and staff to ensure timeliness and marketability of speaker and topic. Ms. Debra Crumpton, an ADA Seminar Series speaker, will present "Achieving Leadership Excellence: Solutions for Maximizing Profit, Performance and People" at the 1999 annual session in Hawaii.

Corporate Sponsors. The 1998-99 Seminar Series clinical programs are sponsored by the American Dental Association through its Health Foundation with the support of Sullivan-Schein Dental, a Henry Schein company and the Colgate-Palmolive Company.

Seminar Presenters. Program speakers are selected by the Council based upon their recognized expertise in the areas of clinical practice and practice management. Potential new speakers were selected at the November 1998 meeting of the Council and forwarded to the Association President, who approved 11 speaker consultants to the Council for the 1999-2000 catalog. Seven additional new seminar speakers were selected by the Council in May.

ADVANTAGE Seminar. The ADVANTAGE Seminar "How to Run Your Dental Practice Like a Business: A New Seminar for New Dentists" was added into the 1998-99 Seminar Series catalog this year. Two programs were held in California and Tennessee in 1998 and programs are scheduled for Louisiana and a repeat request seminar in Tennessee for 1999. Due to the increased exposure of this program in the Seminar Series catalog, a program is already confirmed in Oregon for 2000.

To further promote this seminar, catalogs and personalized letters will be sent to the Chairman of the Committee on the New Dentist and to dental schools in an attempt to bring alumni back to the school and promote continued exposure for this business seminar. Two articles in the *ADA News* have also mentioned this seminar specifically and sponsorship by Sullivan-Schein Dental, a Henry Schein company.

Program Promotion. An annual catalog and preview card is produced and mailed to the executive leadership of tripartite organizations and program sponsors. Programs are also promoted via: quarterly mailings; internal and external agency publications, e.g., *Benefit Briefs*, ADA ONLINE, *ADA News*; various specialty newsletters and journals; and internal and external agency activities, e.g., President-Elect's Conference, President's Conference, Management Conference, Field Representative programs, the Association's annual session and the Conference on Dental Meetings.

Attendance at Dental Meetings. Council staff attended: the New Orleans Dental Conference in September 1998; the ADA annual session in October 1998; the Greater New York Dental Meeting in November 1998; the Yankee Dental Congress in January 1999; and the Chicago Midwinter Meeting in February 1999. Staff continues to attend, evaluate and scout new programs for the benefit of the membership.

Council Publications: The Department of Salable Materials assisted the Council with the promotion of its publications and featured the practice management series books at a special package price for all eight publications.

The Council's publication *Employee Office Manual: A Guide for the Dental Practice,* along with the new companion publication *Recruiting and Retaining Staff* have continued to be top sellers in 1998. The *Employee Office Manual* is being revised in 1999, with special attention devoted to sections on "at will" employment and sexual harassment. These team-oriented handbooks for the dentist and team members answer questions about topic items and include discussions of the following: methods of finding employees; methods of interviewing and hiring employees; compensating and motivating employees; optional benefits for employees; ways to recognize employees; improving communication within the office; conflict resolution; and termination of employees. A third new publication, "Basic Training for New Dental Office Staff," is expected to be available in the fall of 1999. The audience for this book is new employees of a dental office who lack dental experience and/or education. These employees might include the newly hired receptionist, business manager or dental assistant. The publication's purpose will be to give a broad overview on the dental health team, basic customer service, communicating with patients, appointment scheduling, infection control, dental insurance and asking for referrals. It is intended as an introductory publication, not as a substitute for an OSHA course, for example. Of the practice management materials developed by the Council, *Valuing a Practice: A Guide for Dentists* and *Associateships: A Guide for Owners and Prospective Associates* continue as strong sellers. Both were updated in 1997.

All of the publications in the series were revised with up-to-date cover designs, title changes and eye-catching presentations. A new publication, *Practice Options for the New Dentist: A Financial Guide,* focuses on new dentists who may be transitioning from dental school to private practice, from an associateship to practice ownership or from the military to private practice. It concentrates on choosing advisors, different types of practice arrangements, developing business plans, evaluating assets and projecting growth, obtaining practice financing and insurance coverage. The publication *Multi-Practitioner Arrangements: A Guide for Growing Your Practice*, written in 1992, will be updated and retitled to make it more valuable to members.

Closing a Dental Practice: A Guide for the Retiring Dentist or Surviving Spouse is a new 38-page publication from the Council that was produced in-house at minimal cost. This publication enhances the image of dentists (ADA Strategic Plan Goal III. Image) by assisting the surviving spouse of a recently deceased dentist in properly closing a dental practice. The manual also could be useful to retiring dentists who wish to personally close, not sell their dental practice. The publication contains sample letters and tips on what to do with dental records, how to dismiss staff and appropriate ways of disposing of equipment and supplies. It is distributed free and is very popular. Since being made available in January 1999, more than 500 copies have been requested and sent out. Dental societies, individual dentists and study groups are among those who have contacted the Council office for copies.

Marketing Publications: Currently 14 marketing publications, developed through the Council, are available for purchase through the Department of Salable Materials. Two new publications, *Internal Marketing: A Step-by-Step Guide* and *Dental Letters With Impact!,* have been codeveloped by the Council and the Department of Salable Materials.

Internal Marketing: A Step-by-Step Guide is currently available for sale through the *ADA Catalog.* This publication provides information on key strategies to assist the dental team in creating positive word-of-mouth promotion and generating patient referrals. This book provides readers with easy-to-follow practice building ideas. It covers such topics as measuring patient satisfaction, developing practice newsletters, creating effective dental office correspondence and much more.

The new publication *Dental Letters With Impact!* is a revision of the original *Dental Letters* handbook offered through the *ADA Catalog.* This revised edition includes updated versions of many of the letters from the original handbook, as well as some new dental letters that address topics relevant to today's dental practice. This book will be for sale starting in May 1999.

Directory of Dental Practice Appraisers and Valuators: The Council continues to biennially publish a directory of individuals and companies engaged in dental practice valuation. Valuators listed in the *Directory of Dental Practice Appraisers and Valuators* complete a form that describes their organization and the services they provide. The form is reproduced exactly as submitted and without endorsement by the Council. Essential background information includes a valuator's experience, valuation methodology, fee range and contacting information. A modest fee is paid by valuators wishing to be included in the *Directory.* This fee helps defray expenses connected with printing and distributing the publication free to members. The *Directory* is now in its fourth edition.

Dentistry as a Business Conference: The Council presented its second Dentistry as a Business Conference on July 17-18, 1998. This conference educates dentists about practice management and business subjects. The program attracted 260 attendees for two days of seminars on the latest and best dental practice management, marketing and technology, and money and investing ideas available anywhere.

Nineteen speakers appeared on the program, which included in 1998, a special track on DMSOs. The track on DMSOs gave dentists attending the Conference an opportunity to hear from proponents and opponents of the DMSO concept. Other tracks of the 1998 Conference addressed how dentists can better involve the dental team to achieve practice success, technology pearls and marketing ideas that work. ADA® 1 PLAN℠ underwrote a luncheon on the first day for all conference attendees.

The "1999 Dentistry As A Business" conference will be held on July 23-24. The program will be organized into three tracks: Money and Investing, Practice Administration and Marketing and Technology.

Human Bite Mark Conference: In March 1999, the Council presented a dental forensic conference on human bite marks. Four outstanding presenters covered subjects such as how a dentist can develop familiarity with documenting, reporting and preserving victim evidence in a homicide or in instances of elder or child abuse. Others topics included: information on how to collect dental exemplars from suspects and victims that are admissible in court; an update on saliva DNA research; and a summary of pertinent legal cases involving human bite marks. This was the third Council-sponsored conference in recent years to focus on the dentist's role and responsibility in forensic investigations that benefit the public.

Team Building Conference: The Councils on ADA Sessions and International Programs and Dental Practice cosponsored the national "Team Building Conference III" on October 23-24 at the 1998 ADA annual session held in San Francisco. This was the third consecutive year for the Conference. Some two years in development, the Conference originated within an Association-wide dental team committee created in 1993 by the Council on Dental Practice to explore ways in which the profession can enhance the team concept. Scheduling the Conference during the annual session facilitated the scheduling of well-known speakers and also fit well into the travel plans of dental teams attending the program.

With attendance a sell-out at 375, the Conference was a resounding success. Much of the program's success was attributed to the array of nationally recognized speakers and the topics they covered. Through a combination of lectures, breakout sessions and roundtable discussions, the Conference taught dental team members how to increase productivity, share responsibility, gain total commitment and generate creative ideas and solutions to practice challenges. Attendees learned how to maximize each team member's strengths and to develop team cohesiveness, turn conflicts into advantages and share a common vision. Attendees overwhelmingly agreed that the Conference met their expectations and that they would recommend other teams to attend, as reported in the post-Conference evaluation forms.

Institutional Advertisements: The Council has developed a series of institutional advertisements to recognize and show appreciation to the dental team members. The advertisements are directed toward dentists to help them recognize their dental team members. The idea behind these advertisements is to foster the concept of the entire dental office working as a team; highlighting each individual team member's contribution.

The advertisements are featured on ADA ONLINE in the Dental Practice area and are included in literature requests for Council materials.

Attendance at the American Dental Hygienists' Association (ADHA) Meeting: Council staff attended the ADHA's 76th Annual Session held in San Diego, June 18-23, 1999.

Liaison with the American Dental Assistants Association (ADAA): The Council continues its collaboration with the ADAA in promoting the recognition of dental assistants by annually sponsoring Dental Assistants Recognition Week (DARW). The 1999 DARW incorporated the addition of an international sponsor, the Canadian Dental Assistants' Association. This recognition week occurred March 7-13, 1999. The Council worked in cooperation with the American Dental Association's Department of Salable Materials to promote DARW recognition calculators and tote bags. Advertisements for DARW appeared in the *ADA News*. DARW kits were distributed by both ADAA and the Council to dental offices requesting them. Awards in each of four categories are given to dental offices and dental schools that utilize creative, innovative ways of celebrating this week. First-place, second-place and honorable mention winners will be selected this spring in the following categories: dental assisting associations; dental assisting schools; dental offices with four or fewer assistants; and dental offices with more than four assistants. Categories for 1999 have been changed to increase dental office participation. Previously categories for dental offices were for 11 or fewer assistants; and dental offices with more than 11 assistants.

The executive director of ADAA, Mr. Lawrence Sepin, and Ms. Carla Schneider, ADAA president, attended the Team Building Conference on October 24, 1998 during the Association's annual session in San Francisco. The ADAA sponsored the morning coffee break on Saturday. One Council staff member will attend the ADAA Annual Meeting, to be held on July 22-25, 1999 in Salt Lake City.

Liaison with the Dental Laboratory Industry: The Council continues to maintain formal liaison activities with the dental laboratory industry.

The National Association of Dental Laboratories (NADL) held its 48th annual session in Pittsburgh on June 18-20, 1998. Dr. A.J. Smith, then Council chairman, and one staff member attended the meeting. Dr. Smith addressed the NADL delegates. This year, two Council staff members and Dr. Charles H. Norman, III, Council chairman, will attend the NADL meeting on September11-12, 1999 in Las Vegas.

The Council continues to annually implement Resolution 28H-1987 (*Trans.*1987:496) regarding recognition for certified dental technicians (CDT). With assistance from NADL, the Association individually recognizes each certified dental technician who reached their 25th anniversary working in the dental laboratory industry. NADL provides the Council with these names. This past year, 323 CDTs were given a recognition certificate and letter from the ADA President. During the coming year, the Association will also participate in the recognition of those certified dental technicians who have reached their 35th anniversary. The NADL and the National Board for Certification of Dental Laboratories (NBC) provide valuable assistance in helping the Association recognize the important contribution of the dental laboratory technician to the dental team.

Dr. Jeffery Smith was recommended by the Council chairman, appointed by the Association President and approved by the NBC, to serve a three-year term as an NBC

trustee. He attends NBC biannual meetings. The Council is very supportive of Dr. Smith's representation with this organization since it allows for expanding communication between NBC and the Council.

Representatives from the NADL attended the November 1998 Council meeting and presented the NADL Guidelines For Dentist/Dental Laboratory Relations as a model for the Council to use in its review of current American Dental Association policy on dentist-laboratory relations. Recommendations for revisions of current ADA policy will be presented in a supplemental report to the 1999 House of Delegates.

Well-Being Issues: Well-being program services support the Council's mission to "enhance (members') personal and professional lives for the betterment of the dental team and the patients they serve." Resources, support networks and continuing education activities are directed to the issues of chemical abuse/dependency, infectious disease and mental health problems (including stress and burnout) as they affect the dentist's ability to practice safely and effectively.

The Council nominated the following members to its Dentist Well-Being Advisory Committee (DWAC) for 1998-99: Dr. Jeffery Smith, chairman, California; Dr. Stephen Abel, New York; Dr. J. Henry Clarke, Oregon; Dr. Omar Jones III, Maryland; Dr. David Okano, Wyoming; Dr. James Oles, Michigan; Dr. Andrew Pickens, Montana; and Dr. James Tracy, Nevada. Sheldon Miller, M.D., Chicago, is the psychiatric consultant. Dr. Jones has since resigned.

The composition of the DWAC is designed to ensure competent professional input on a broad scope of dentist well-being issues. There are significant challenges in promoting consistency of well-being activities across the country, with wide variation in the type, scope and quality of constituent and component programs. Consequently, the Committee composition must also take these factors into account. The Committee held its meeting in Chicago on February 5-6, 1999.

The Council sponsored the well-being booth at the Association's annual session in San Francisco, as it has for the last several years. A variety of literatures on chemical dependency, mental health, infectious diseases and stress management was available. Visitor comments support this activity as a valuable asset.

The annual survey of dentist assistance programs was conducted. There are presently four states with no identified assistance services for dentists. Structure, funding, utilization, relationship to dental society and staffing vary widely from state to state so that some programs are well supported and utilized and others are not. In the last year, some of the smaller states have entered into contracts or referral agreements with programs for physicians. In some cases, this arrangement provides services for dentists where they had been lacking, though such agreements may mean providers of services to dentists are not familiar with crucial dental practice issues and resources.

Planning is well underway for the Eighth National Institute on Dentist Well-Being, sponsored by the Council, and a concurrent continuing education conference updating dentists on new developments in the treatment and management of HIV-infected patients. This second Conference is cosponsored with the Council on Scientific Affairs. Both conferences will be held at Association Headquarters. The Well-Being Institute is scheduled for August 19-21, 1999 and the HIV conference, August 19, 1999.

The Council has been monitoring the activities of the Citizen Advocacy Center (CAC) regarding the regulation of chemically dependent licensed health care workers. The CAC presents itself as an association for the public members of professional licensing boards. Its members have taken the position, in two convened forums, that peer assistance and board-authorized alternatives to discipline programs protect impaired providers to the detriment of the safety of the public. This is contrary to the position of the Association and one that would undermine the efforts of the Association and constituent societies in this area. The CAC seeks to influence public policy by advocating the adoption of standards for treatment, monitoring and regulation of affected practitioners. They have also advocated that the majority of regulatory board members be public members. The current president was one of the drafters of the October 1998 Pew Report, *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation.*

Other general activities include the publication of a well-being newsletter, *In Touch,* directed primarily to the network of constituent well-being volunteers. The Council also annually publishes a directory of state and dental school well-being contact persons and volunteers in the infected dentist support network.

Ergonomics and Disability Support Services Program: Development of the Ergonomics and Disability Support Services Program in the Council began several years ago. Implementation of the program began in November 1998 with the hiring of the coordinator and the organization of the Advisory Committee. This new program further supports the Council on Dental Practice's mission "to provide resources to empower members to continue development of their dental practice and to enhance their personal and professional lives for the betterment of the dental team...."

One of the first scientific research articles relating specifically to ergonomics in the dental office was published in the February 1998 issue of *The Journal of the American Dental Association,* and was based on research developed by the Council and funded by the Association and the Health Foundation. The article, "Evaluating Dental Office Ergonomic Risk Factors and Hazards," reported the results of the HumanTech dental office ergonomics research study. A follow up commentary, "Ergonomically Related Disorders in Dental Practice," written by the director of the Council on Dental Practice, was also published in that issue of *The Journal of the American Dental Association*, Volume 129.

As part of the development of the Ergonomics and Disability Support Program, the Council commenced identification of prospective members for its forming Advisory Committee. Concurrently, the Council on Scientific Affairs desired the formation of such an expert panel specifically to develop a research plan for ergonomics. This new Advisory Committee will recommend an ergonomics research agenda to

the Council for consideration and transmittal to the Council on Scientific Affairs.

This new Advisory Committee will help provide expertise to the Association for the development of a more refined research agenda as related to dentistry and ergonomics. It will also supply advisory services to the Council when dental ergonomics and physical disability issues or concerns arise. Dr. Janet Peterson was appointed chairman of the new Advisory Committee.

In addition, development began on a general clearinghouse, which will provide resource information on topics related to physical disabilities and ergonomics issues in dentistry. Information has been gathered on disability claims filed by dentists and analysis of these data has begun. Information has been provided in response to requests by physically disabled dentists and their families.

Dr. Charles H. Norman, III, Council chairman, appointed the new members of the Ergonomics and Disability Support Advisory Committee at the May 1999 Council meeting. The new members include: Dr. William Calnon, assistant chairman; Dr. Connie Verhagen, member, Council on Scientific Affairs; Dr. William J. Sullivan, physical and occupational medicine and rehabilitation physician; Dr. David L. Ahearn, a member dentist in private practice and dental ergonomics consulting; and Scott W. Smith, an ergonomist. The first meeting of this Advisory Committee is scheduled to take place in June 1999.

Recommendation for Policy Rescission: The ADA House of Delegates adopted Resolution 15H-1995 (*Trans.*1995:659) requesting periodic review of current Association policy positions to ensure that policies are up-to-date. Each year the Council does a policy review in line with this request. During the Council's fall 1998 review, no rescission recommendations were made.

Dental Management Service Organizations (DMSOs): The Council, in fulfillment of its strategic mission to provide practice support that enhances dentists' practice and management skills, conducted several regional focus group meetings with an invited panel of dentists and specialists on the subject of business practices of DMSOs. DMSOs can provide a range of management services for dentists such as billing, hiring, day-to-day management and ordering of supplies. In some cases, a DMSO may wholly own or maintain a partial equity interest in a dental practice. The panel members at the regional meetings freely recalled their reasons for selling to a DMSO and discussed their current experiences working in a DMSO. Additionally, the panels made recommendations via the Council for Association policy regarding DMSOs.

Resolution 55H-1998 (*Trans.*1998:701) American Dental Association Assistance to Members Regarding Dental Management Service Organizations (DMSOs), was referred to the Board of Trustees DMSO Task Force for implementation. The DMSO Task Force assigned the development of the informational packet to the Council on Dental Practice. The Council responded to this assignment through the development of a comprehensive informational packet on dental management service organizations that will be distributed to the profession upon request. This packet contains articles on this subject written by experts in the field, a "white paper" on DMSOs written especially for the packet, a publication *Dental Management Service Organization (DMSO): What You May Need to Know before You Sign Up or Sell, The Options Available for Entering Dental Practice* and several items or portions of items, from American Dental Association publications. During the course of the year, input on this subject was received from individuals who are involved in the operation of DMSOs and members of the ADA Dental Economics Advisory Group (DEAG). these activities were coordinated with the Board of Trustees DMSO Task Force.

Resolution 74H-1998 (*Trans.*1998:701), Mentor Program, was referred to the Board of Trustees DMSO Task Force for implementation. The Task Force assigned the development of a model mentor program and the addition of a section on DMSOs in the SUCCESS Program to the Council. In response to this assignment, the Council developed a section on DMSOs to be included in the SUCCESS Program geared specifically to students. This new section was completed in January and was included in the SUCCESS Program in February. In addition, a prototype mentor program was developed for use by the constituent societies. The prototype includes an organizational structure and a comprehensive educational program for mentors to enable them to effectively assist new dentists. The prototype allows constituent societies to develop a program that meets their individual needs and resources. Both of these activities were coordinated with the DMSO Task Force.

The Council completed these tasks within the required time frames.

Health Information Privacy/Confidentiality: The Council on Dental Practice reviewed draft policies on health information privacy/confidentiality that were developed in cooperation with the council on Government Affairs and sent to the Board of Trustees. This policy is being forwarded by the Council on Government Affairs to the House of Delegates

Health Information Privacy/Confidentiality: The Council on Dental Practice reviewed draft policies on health information privacy/confidentiality that were developed in cooperation with the Council on Government Affairs, and sent to the Board of Trustees.

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

Commission on Relief Fund Activities

Thomas, Joe C., Arkansas, 1999, chairman
Ferris, Geraldine M., Florida, 1999, vice chairman
Banks, Michael P., Nevada, 2001
Cavalaris, C. J., Ohio, 2000
Ellwein, Orin W., South Dakota, 2002
McDermott, Charles E., Pennsylvania, 2001
Pickett, Charles E., California, 2000
Pierce, Jack L., Texas, 2002
Guay, Albert H., director
Mountz, Marsha L., manager

Meetings: The Commission met in the Headquarters Building on August 13-14, 1998 and March 11-12, 1999. Dr. Richard A. Smith, Board of Trustees liaison to the Commission, attended the March meeting. The next meeting of the Commission is scheduled for August 19-20, 1999.

Election of Chairman and Vice Chairman: The 1989 House of Delegates adopted Resolution 44H-1989 (*Trans.*1989:557) which amended the *Bylaws* to allow the Commission on Relief Fund Activities to elect its chairman. Dr. Joe C. Thomas was elected chairman and Dr. Geraldine M. Ferris was elected vice chairman for 1998-99.

Personnel: The Commission announced the addition of two new members: Dr. Orin W. Ellwein, South Dakota, and Dr. Jack L. Pierce, Texas. The 1999 annual session will mark the completion of the terms of service of Dr. Joe C. Thomas and Dr. Geraldine M. Ferris. The Commission expresses its gratitude to these individuals for their leadership and contributions during their tenure.

Program Activity: The ADA Relief Fund, in concert with constituent and component dental society relief funds, provides financial assistance to dentists and their families when illness, accidental injury or advanced age prevents them from employment and results in their inability to be self-sustaining. Grants are awarded to meet daily living expenses.

For the 12 months from July 1, 1997 to June 30, 1998, the total number of persons receiving grants was 58, of which 13 were initial grants and the balance were renewal grants. The combined grant amount given by the ADA Relief Fund and constituent society relief funds to eligible recipients was $405,128 as of June 30, 1998. The average monthly grant awarded in 1998 was $802, while the largest monthly grant was $4,000.

Financial Operations: As of June 30, 1998, the ADA Relief Fund contributions generated by the 1997-98 annual fund-raising campaign were $347,081, of which $271,534 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, $206,552 was disbursed in the form of grants for year-end 1998. Other expenses included: general and administrative, $239,333; solicitation campaign expenses, $72,904; investment administration fees, $57,289; and professional audit and accounting fees, $23,059. As of December 31, 1998, the Relief Fund had an unaudited balance of $6,786,321 to support its charitable program activity.

Investment Activities: The Relief Fund's portfolio is currently managed by: Rorer Asset Management LLC (hired in October 1998), value equity investment manager; Cutler & Company LLC, fixed income manager; and LaSalle National Bank, custodian. Services provided by the Commission's growth equity manager, Westfield Capital Management, were terminated in March 1999. A search for a growth equity manager is currently in process.

The Commission employs a portfolio monitoring firm, Performance Analytics, Inc. (PAI), which evaluates the performance of the Relief Fund's investment managers; compares the portfolio performance of the Fund's managers with that of other money managers who have accounts similar in make up to the Relief Fund; and reports to the Commission on a quarterly basis. In addition, the firm conducts manager searches and provides the Commission with investment trends which allows it to execute its fiduciary responsibilities.

The Fund's investment managers invest the portfolio's holdings in accordance with the Master Statement of Investment Policy and Objectives adopted by the Commission. As a matter of Commission policy, the investment managers do not purchase securities in any corporation which, as a major activity (i.e., 15% of total corporate sales), manufactures, fabricates, processes, sells or furnishes dental supplies, machinery, equipment and materials; dentifrice or other agents related to oral hygiene; or tobacco products.

In 1998, the asset distribution of the Relief Fund's portfolio comprised 61% high-grade stocks, 36% fixed income securities and the remaining 3% in cash equivalents. In the fixed income segment, the portfolio's return for 1998 matched that of the Merrill Lynch Intermediate Government/Corporate Bond Index return of 7.8%. The Fund's value equities had a return of 5.3% while growth equities had a 16.3% return when

compared to the S&P 500 performance of 28.6% for 1998. Total equity assets were distributed over 17 major industries.

1998-99 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 November 10, 1998, the second on February 15, 1999, with the third mailing planned for mid-May. Acknowledgment letters are sent to those dentists who contribute $5 or more. Total contributions through April 15, 1999 amounted to $280,786.

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.

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

Notes

Division of Education

Commission on Dental Accreditation

Council on Dental Education and Licensure

Joint Commission on National Dental Examinations

Notes

Commission on Dental Accreditation

Rossa, Joseph W., Illinois, 2000, chairman, American Association of Dental Examiners
Fields, Henry W., Jr., Ohio, 2000, vice chairman, American Association of Dental Schools
Ammons, William F., Jr., Washington, 2002, American Academy of Periodontology
Anker, Edward, New York, 2000, American Dental Association
Avery, William A., Michigan, 2002, American Dental Association
Beemsterboer, Phyllis L., California, 1999, American Dental Hygienists' Association
Bell, Homer Clark, III, North Carolina, 2002, American Association of Dental Examiners
Bergen, Stephen F., New York, 2001, American College of Prosthodontists
Bridges, Sidney R., Pennsylvania, 2001, American Dental Association
Christensen, Mark, Utah, 1999, American Association of Dental Examiners
Curtis, Ben W., Oregon, 2001, American Association of Dental Examiners
Garrison, Raymond, North Carolina, 2001, American Association of Dental Schools/American Association of Hospital Dentists
Goldblatt, Lawrence I., Indiana, 2002, American Association of Dental Schools
Hovland, Eric J., Louisiana, 2001, American Association of Dental Schools
Hutchinson, Rowland A., Kentucky, 1999, American Association of Dental Schools
Jancar, Susan L., Nevada, 1999, American Dental Association
Lew, Daniel, Iowa, 2001, American Association of Oral and Maxillofacial Surgeons
Madison, Sandra, North Carolina, 2000, American Association of Endodontists
Marks, Clifford, Florida, 1999, American Association of Orthodontists
McKillop, Lucille, Illinois, 1999, public member
McTigue, Dennis J., Ohio, 1999, American Association of Pediatric Dentistry
Niessen, Linda, Texas, 2000, American Association of Pubic Health Dentistry
Savage, Thomas J., California, 2000, public member (deceased)
Sims, Barbara, Florida, 2002, public member
Stallings, James E., Georgia, 2001, National Association of Dental Laboratories
Tomich, Charles E., Indiana, 2002, American Academy of Oral and Maxillofacial Pathology
Walls, Rose A., Florida, 2000, American Dental Assistants Association
Werner, David J., Illinois, 2001, public member
Wolf, Karen, Iowa, 1999, student member
Hart, Karen M., director
Horan, Catherine A., manager
Licari, Frank W., manager
Monehen, Rosemary, manager
Parker, Cheryl R., manager
Soeldner, Peggy, manager

Meetings: The Commission conducted its meetings on July 29-30, 1998 and January 29, 1999. The Commission's 13 discipline-specific review committees, which provide comments and recommendations on policy and accreditation matters, met two to three weeks prior to the July 1998 and January 1999 meetings of the Commission.

The Commission liaisons from the Board of Trustees, Dr. Robert M. Anderton, trustee, Fifteenth District, and Dr. Victor J. Barry, trustee, Eleventh District, attended the Commission's July 1998 meeting. Board of Trustee liaison Dr. T. Howard Jones, trustee, Fifth District, attended the January 1999 Commission meeting.

Personnel: The Commission acknowledges with appreciation the many significant contributions made by those members who will complete their terms in 1999: Dr. Phyllis L. Beemsterboer, Dr. Mark Christensen, Dr. Susan L. Jancar, Dr. Clifford Marks, Dr. Lucille McKillop, Dr. Dennis J. McTigue and Dr. Karen Wolf. Special recognition is also extended to Dr. Rowland A. Hutchinson. His term as a Commission member concluded seven months early, in March 1999, when he was elected by the American Association of Dental Schools (AADS) to the position of President-elect. The Commission wishes Dr. Hutchinson success during his terms as President-elect and President of the AADS. In accord with the Association's *Bylaws*, Dr. Lonnie H. Norris was appointed by the AADS to fill the vacancy. Also, the Commission deeply regrets the death of Dr. Thomas J. Savage on Monday, May 10, 1999. His contributions as a public representative to the Commission were greatly appreciated and will be missed.

Based on actions taken at the 1996 House of Delegates, Resolution 84H-1996 (*Trans.* 1996:722), the Commission no longer shares a core membership with the Council on Dental Education and Licensure. The July 1998 and January 1999 meetings were the second and third meetings of the newly structured 29-member Commission. Appreciation is extended

to all members and their appointing organizations for their support of the Commission during this transition.

The Strategic Plan of the American Dental Association: The Commission's activities are consistent with Goal I. Advocacy, Objective viii of the Association's Strategic Plan, 1998-2001. At its January 1999 meeting, the Commission considered strategic planning for the agency and determined that its mission statement should be reviewed and revised. The Commission then expects to develop goals and objectives reflective of the revised mission statement. The Commission determined that it should devote considerable time to strategic planning activities at its July 1999 meeting. The House of Delegates, as well as all of the Commission's communities of interest, will be kept informed about this agency's strategic planning initiatives.

Summary of Accreditation Actions: The Commission's accreditation actions from July 1998 through January 1999 are summarized in Table 1. At the July 1998 and January 1999 meetings, 515 accreditation actions were taken. These actions were based on site visit reports and progress reports submitted by educational institutions detailing the degree to which specific recommendations included in previous evaluation reports had been implemented. Reports of major change and applications for initial accreditation of education programs were also reviewed. Initial accreditation was granted to: 15 dental hygiene programs; nine dental assisting programs; three advanced specialty programs; and nine advanced general dentistry programs. As indicated in Table 2, the total number of educational programs currently accredited is 1,325, representing an increase of five programs from the previous reporting period. The Commission *Rules* stipulate that when the Commission votes to deny or withdraw accreditation, it must inform the institution of that decision and its right to appeal the action. There were no such appeals during this reporting period. Because accreditation is voluntary, accreditation may also be discontinued at any time during the process upon written request of the sponsoring institution. During this time period, 21 programs discontinued their participation in the Commission's accreditation program.

Enrollment: Dental, advanced dental and allied dental education programs' enrollment and graduate figures for 1998-1999 can be obtained from the Survey Center.

Table 1: Accreditation Actions: July 1998—January 1999

	Dental	Advanced Education Specialty/General		Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Accreditation Eligible	2				15		17
Preliminary Provisional Approval		3	9	9			21
Approval	18	113	92	82	77	9	391
Conditional Approval		11	7	12	5	2	37
Provisional Approval		13		9		1	23
Accreditation Denied				4			4
Discontinued Programs		2	15	2		2	21
Accreditation Withdrawn				1			1
Accreditation Appeal							0
Number of Accreditation Actions	20	142	123	119	97	14	515

Source: Commission on Dental Accreditation

Table 2: Number of Accredited Programs: January 1999

	Dental	Advanced Education Specialty/General		Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Accreditation Eligible	1				17		18
Preliminary Provisional Approval		20	14	15			49
Approval	54	392	301	225	224	33	1,229
Conditional Approval		6	2	8	3	1	20
Provisional Approval		6		3			9
Number of Accreditation Actions	55	424	317	251	244	34	1,325

Source: Commission on Dental Accreditation

Revision of Accreditation Standards: The Commission has *Bylaws* authority for the development and revision of educational standards for all programs falling within its accreditation purview. Accreditation standards are revised when there is a specific demonstrated need for a revision. Because of the significant impact of new standards on the resources of postsecondary institutions, the Commission considers the revisions with care and does not initiate the process unless the need for revision has been adequately documented.

In recent years, the Commission has conducted a number of activities related to standards revision. The impetus for the revisions was linked to requirements specified by the United States Department of Education (USDE) in its *Procedures and Criteria for Recognition of Accrediting Agencies*. As an accrediting agency recognized by USDE, the Commission must ensure that its accredited programs are in compliance with every accreditation standard. If a program does not meet each standard within a specified time frame, the Commission is required by USDE to take adverse action (i.e., withdraw accreditation) against the program. Because of this more stringent interpretation by USDE, the Commission determined that the accreditation standards for all dental disciplines needed review and revision to ensure that each standard is critical to a quality education program and that noncritical elements are not included in accreditation standards. Progress on this activity was reported to the 1997 House of Delegates (*Reports* 1997:81) and the 1998 House (*Reports* 1998:73). The Commission completed this comprehensive revision process in July 1998.

Revision of Accreditation Standards for Advanced Education Programs and Allied Dental Education Programs. The Commission has adopted revised accreditation standards for programs in the following disciplines: general practice residency; advanced education in general dentistry; dental public health; endodontics; oral and maxillofacial pathology; oral and maxillofacial surgery; orthodontics and dentofacial orthopedics; pediatric dentistry; periodontics; prosthodontics; dental assisting; dental hygiene; and dental laboratory technology, with implementation dates of January 1, 2000. The revised documents emphasize the importance of student achievement and program outcomes, while encouraging innovation and flexibility.

Accreditation Standards for Dental Education Programs. The Commission's revised *Accreditation Standards for Dental Education Programs* were implemented on January 1, 1998. Programs site visited in the fall of 1997 were given the option of using the revised standards. Since the fall of 1997, ten dental education programs have been site visited and evaluated in accord with the revised document. Six dental education programs are scheduled for site visits in 1999; another eight will be evaluated in 2000.

Accreditation of Oral and Maxillofacial Surgery Residency and Clinical Fellowship Training Programs. As requested by the American Association of Oral and Maxillofacial Surgeons, the Commission adopted *Accreditation Standards for Clinical Fellowship Training in Oral and Maxillofacial Surgery* in July 1997 with an implementation date of July 1, 1998 (*Reports* 1997:82). Subsequent to implementation of the standards, one OMS clinical fellowship training program has applied for and received initial accreditation.

At its January 1999 meeting, the Commission considered additional revisions to the recently adopted *Accreditation Standards for Advanced Education in Oral and Maxillofacial Surgery Programs (residency programs)* as well as revisions to the *Accreditation Standards for Clinical Fellowship Training in Oral and Maxillofacial Surgery*. The Commission approved the revisions in principle and directed that they be circulated to the communities of interest for review and comment. Open hearings on the proposed revisions were held during the annual meeting of the American Association of Dental Schools and the International Conference on Oral and Maxillofacial Surgery, sponsored by the American Association

of Oral and Maxillofacial Surgeons and the International Association of Oral and Maxillofacial Surgeons. The Commission will consider the comments at its July 1999 meeting. The implementation date of January 1, 2000 is anticipated for both documents.

Revision of Policies and Procedures Related to the Accreditation Process: The Commission is responsible for developing and publishing policies and procedures in order to conduct the accreditation process.

Revised Accreditation Status Terms and Definitions. In response to changes in the requirements of the United States Department of Education (USDE), the Commission has been considering the revisions of the accreditation status terms and definitions. This was reported to the House of Delegates in 1997 and 1998 (*Reports* 1997:83; 1998:72). In January 1999, the Commission again studied the issue and determined that further modifications, as suggested by the USDE, would clarify the Commission's commitment to ensuring program compliance with the accreditation standards within specified time periods. The Commission adopted the following Accreditation Status Terms and Definitions:

APPROVAL Without Reporting Requirements: An accreditation classification granted to an educational program indicating that the program achieves or exceeds the basic requirements for accreditation.

APPROVAL With Reporting Requirements: An accreditation classification granted to an educational program indicating that specific deficiencies or weaknesses exist in one or more areas of the program. Evidence of compliance with the cited standards must be demonstrated within 18 months if the program is between one and two years in length or two years if the program is at least two years in length. If the deficiencies are not corrected within the specified time period, accreditation will be withdrawn, unless the Commission extends the period for achieving compliance for good cause.

The Commission also adopted revised policy statements on the Accreditation Cycle, Progress Reports, and Special Site Visits to complement the revised accreditation status terms and definitions. An implementation date of July 1, 1999 was established for all. The revised policies, and accreditation status terms and definitions were communicated to the accredited programs and sponsoring institutions following the January 1999 Commission meeting. As noted below, the Commission has forwarded the revised policies to the USDE's National Advisory Committee on Institutional Quality and Integrity for consideration at its December 1999 meeting.

Commission's Re-recognition Reviews by USDE: The Commission is recognized by the Secretary of the United States Department of Education as the only recognized accrediting agency for dentistry (*Reports* 1995:71). In February 1996, the Secretary of the USDE informed the Commission that its recognition had been renewed for a period of five years, the maximum recognition period. At that time, the Secretary requested that the Commission submit an interim progress report by November 1, 1996 demonstrating strengthened compliance with several of the USDE *Criteria for Recognition.* The interim report was considered by the Department's National Advisory Committee on Institutional Quality and Integrity (NACIQI) in June 1997. The NACIQI and the Secretary found the Commission in full compliance with ten of the 14 issues cited and requested a second interim report on progress addressing criteria: §602.21(b)(2); §602.26(c)(3); §602.26(c)(4); and §602.27(f).

In accord with House Resolution 72H-1997 (*Trans.* 1997:684), a detailed report on progress made by the Commission at its January 1998 meeting to strengthen compliance with the cited criteria was submitted to the 1998 House of Delegates (*Reports* 1998:73).

The requested interim report was considered by the NACIQI at its December 7-9, 1998 meeting. The NACIQI and the Secretary found the Commission to be full compliance with three of the four issues cited and requested that another report on progress addressing criterion §602.26(c)(4) be submitted for review at the NACIQI's May 2000 meeting.

In accord with House Resolution 72H-1997, the following is a detailed report on progress made by the Commission at its January 1999 meeting to strengthen compliance with Criterion §602.26(c)(4).

Strengthening Compliance with Criterion §602.26(c)(4). The Department believed that Commission policies and accreditation status definitions should be clarified to state that all programs must come into compliance with the accreditation standards *within* the time frames outlined, unless the period for achieving compliance is extended for good cause. Further, the policies should clearly state that the Commission will take adverse action against any program that does not come into compliance *within* the time frames outlined, unless the period for achieving compliance is extended for good cause. The Department also urged that the Commission use two accreditation statuses, e.g., "Approval Without Reporting Requirements" for programs with no deficiencies and "Approval With Reporting Requirements" for programs with deficiencies. The Commission carefully considered the recommendations of the Department of Education. As reported previously in this report, accreditation status terms and definitions as well as policies on the Accreditation Cycle, Progress Reports and Special Site Visits were modified.

The Commission transmitted the requested interim report to the USDE prior to May 1, 1999 with a request that the report be considered at the NACIQI's December 1999 meeting rather than the May 2000 meeting. Recommendations made by the NACIQI and actions taken by the Secretary will be reported to the 2000 House of Delegates.

Activities of the Council on Higher Education Accreditation: Since 1954, the Commission on Dental Accreditation has been recognized by the Secretary of the United States Department of Education as the agency responsible for the accreditation of dental and dental-related educational programs. In addition, the Commission has sought and received recognition from a nongovernmental recognition agency since the 1960s. These nongovernmental agencies have included the National Commission on Accrediting (NCA), the Council on Postsecondary Accreditation (COPA) and the Commission on Recognition of Postsecondary Accreditation (CORPA).

The Commission submitted continued recognition materials for review by CORPA at its February 1996 meeting. In March 1996, the Commission received notification that CORPA had granted the Commission re-recognition for the maximum period of five years and cited no areas of noncompliance (*Reports* 1996:70). The Commission's next re-recognition review by CORPA was scheduled for the year 2001. On December 31, 1996, CORPA filed Articles of Dissolution. Subsequently, the Commission was informed that CORPA's recognition function would become a responsibility of the newly established Council on Higher Education Accreditation (CHEA).

At its January 1999 meeting, the Commission considered a report on the recently established CHEA and its newly approved *Recognition of Accrediting Organizations Policy and Procedures.* The Commission noted that accreditation agencies are eligible to apply for recognition by CHEA if the majority of the accredited programs are degree granting. Because only 41.3% of Commission-accredited programs grant degrees, the Commission is not eligible for recognition by CHEA and would have to pursue an exemption from the eligibility requirement if CHEA recognition were to be sought. The Commission determined not to request an exemption from the Eligibility Policy at this time, but to continue to monitor issues being addressed by the higher education community through attendance at CHEA conferences. Pending clear acceptance of CHEA by the higher education communities, the Commission may consider pursuing CHEA recognition at a later date.

Request from the California State Board of Dental Examiners: In January 1999, the Commission considered a request from the California State Board of Dental Examiners asking for assistance in developing guidelines to be used by the California Board to comply with 1998 California State Law AB1116. The California Board wished to use the Commission's 1975-1983 accreditation requirements as broad guidelines in developing its own guidelines and survey document by which it would approve foreign dental education programs. The Commission directed that the requested accreditation requirements and guidelines be forwarded to the California Board with a disclaimer statement to be placed in their guidelines and related documents. The disclaimer statement indicates that foreign dental education programs approved by the California Board of Dental Examiners are not accredited or eligible for accreditation by the Commission on Dental Accreditation of the American Dental Association. The California Board of Dental Examiners agreed to place the disclaimer statement in the applicable documents. The Commission also directed that its assistance be offered to the California Board in developing their guidelines. To date, no assistance has been requested.

Comprehensive Revision of Site Visitor Training Materials: In July 1998, the Commission considered the report of its subcommittee charged with developing a plan to implement a new system of site visit evaluators to include a "mixed approach" of paid independent site visit evaluators and discipline-specific peer volunteer evaluators (*Reports* 1998:73). After careful study of the issues and financial implications, the subcommittee recommended that the use of peer volunteers to conduct site visits be retained and that the use of paid independent (nondental) evaluators not be pursued at this time. The Commission adopted the subcommittee recommendations as supported by the Review Committees and directed the development of a comprehensive training program, including training materials, for all site visitors. In January 1999, the Commission considered a progress report on the development of the new training materials. The training materials will be distributed to all Commission-appointed site visitors during the summer of 1999. Each site visitor will be required to complete the manual's series of self-instructional units and quizzes, attend a training workshop and/or serve as a trainee on a site visit prior to serving as a member of a visiting committee. The Commission believes that increased training efforts will further enhance the calibration and consistency among site visit teams and their understanding of Commission policies and procedures.

Pilot Study on the Use of Scoring Grids: In 1996, the Commission endorsed a two-year pilot study calling for the use of a scoring grid in the evaluation of accredited oral and maxillofacial surgery programs. The Commission believes that such a system might afford a more objective determination of a program's compliance with the accreditation standards and a greater level of calibration and consistency among site visitors (*Reports* 1996:70; 1998:73). In July 1998, the Commission received a progress report on its pilot study. Thirty-eight OMS programs scheduled for site visits in 1998 and 1999 are participating in the pilot study. Results of the study will be reported to the House of Delegates.

Site Visit Fees: When an institution, which has a program accredited by the Commission on Dental Accreditation, plans to initiate a similar program in which all or the majority of the instruction occurs at another location, the Commission must be informed. When such approval is granted, the Commission conducts a site visit to off-campus location(s) where 20% or more of the students'/residents' clinical instruction occurs, or if other causes exist for such a visit. The Commission has also recently granted initial accreditation to an advanced education in general dentistry (AEGD) program sponsored by the Navy in Japan and an AEGD program sponsored by the Army in Germany. The Commission determined that additional expenses are incurred when site visits are conducted at these

locations. Accordingly, in January 1999, the Commission directed that accredited programs with multiple sites which must be site visited and programs sponsored by the U.S. military in international locations be assessed a fee at the time of a site visit to offset the additional costs.

Response to Assignments from the 1997 House of Delegates

Commission's Compliance with USDE Criteria for Recognition: Resolution 72H-1997 urged the Commission on Dental Accreditation to make an annual report to the House of Delegates detailing progress being made to come into full compliance with the United States Department of Education (USDE) and that the reports continue until such time that the Commission comes into full compliance with the USDE requirements (*Trans.*1997:684). In 1998, the Commission submitted a detailed report to the House on progress made by the Commission at its January 1998 meeting (*Reports* 1998:73). The Commission has also submitted a report to this House of Delegates related to its recognition by the USDE as the accrediting agency for dentistry. The Commission has transmitted its interim report addressing one criterion to the USDE for consideration by the National Advisory Committee on Institutional Quality and Integrity (NACIQI) at its December 1999 meeting. Recommendations made by the NACIQI and actions taken by the USDE Secretary will be reported to the 2000 House of Delegates.

Response to Assignments from the 1998 House of Delegates

Evaluation of Hygiene Educational Training Programs: Resolution 32H-1998 (*Trans.*1998:719) requested the Commission to review the accreditation standards for dental hygiene programs to ensure that the requirements focus on outcomes. At its January 1999 meeting, the Commission and its Review Committee on Dental Hygiene Education considered the resolution and carefully reviewed the newly adopted *Accreditation Standards for Dental Hygiene Education Programs*. The Commission believed that its commitment to outcomes assessment should be demonstrated and communicated to the House of Delegates by providing a historical summary, the newly-adopted Accreditation Standard on Institutional Effectiveness and a listing of outcomes assessment instruments and methods routinely used by programs to demonstrate compliance with the standard.

History of Outcomes-Based Education/Accreditation. Since its inception, accreditation has focused on evaluation of the education process; that is, institutions were evaluated based on what they were *teaching*. However, the evaluation of what was being taught did not measure how effective the educational programs were in producing graduates who were prepared for their professional responsibilities.

During the past two decades, accrediting bodies have embraced the concept of assessing educational outcomes; that is, institutions are being asked to describe and document what their students have *learned*. It is no longer sufficient that subject matter has been presented (or taught) in a course. What is of critical importance is whether the students have learned that subject matter. Demonstrating that students have, indeed, learned what has been taught is part of what entitles institutions the confidence of the educational community and the public.

In the early 1970s, the Commission on Dental Accreditation began to focus on the results of the educational process, as well as on the process itself. This added evaluation emphasis was formalized in 1986 when the Commission adopted an outcomes assessment standard, implemented in January 1988. Since then, the Commission has observed that those schools/programs that most successfully meet this standard treat assessment as an ongoing process that has value apart from accreditation. These schools/programs have found that data collected and used in the planning and decision-making activities also assists in the accreditation review process. These schools/programs have developed comprehensive plans of assessment that include a variety of measures, both internal and external. As part of an outcomes process, each program needs to address the following questions: What skills should students learn? How well are they learning them? How does the school/program know that they are learning the skills? Answers to these questions and trend data are then studied; changes are made to address identified weaknesses.

Dental Hygiene Accreditation Standards and Outcomes Assessment. Standard 1—Institutional Effectiveness of the recently adopted *Accreditation Standards for Dental Hygiene Education Programs*, effective January 1, 2000, states:

> The program must demonstrate its effectiveness using a formal and ongoing planning and assessment process that is systematically documented by: a) developing a plan with goals and/or objectives which are consistent with the goals of the sponsoring institution and appropriate to dental hygiene education addressing teaching, patient care, research and service; b) implementing the plan; c) assessing the outcomes, including measures of student achievement; and d) using the results for program improvement.

The Commission believes that assessment, planning, implementation and evaluation of the educational quality of a dental hygiene education program that is broad-based, systematic, continuous and designed to promote achievement of program goals will maximize the academic success of the enrolled students in an accountable and cost effective manner. The Commission expects each program to define its own goals and objectives for preparing individuals in the discipline and that one of the program goals is to comprehensively prepare competent individuals in the discipline of dental hygiene.

Outcomes Assessment Instruments and Methods Routinely Used by Programs to Demonstrate Compliance with the Standard. Programs demonstrate their compliance with the outcomes standards through program completion rates; job placement rates; success of graduates on state/regional

licensing examinations; success of graduates on national boards; and surveys of alumni, students, employers and clinical sites. To meet the intent of the outcomes standard, dental hygiene education programs must submit surveys of employers, graduates and patients; state and regional board reports; and job placement rates. Additionally, site visitors on dental hygiene program onsite evaluations are provided with the National Board Dental Hygiene Examination performance data for the five years prior to the site visit.

Employer surveys ask, for example, how the graduate performs in specific areas such as scaling, patient management, exposing radiographs and other job-related duties. Student surveys ask the graduate if they feel that they were properly prepared by the program to take their licensing boards and to practice. Patient surveys ask how the patients feel they were treated. All surveys usually include a section of suggested ways to improve the program.

The data collected from these various sources is carefully analyzed by program administration and faculty and then used to make specific, positive changes to the program and the curriculum. For example, if the data demonstrated that students consistently performed poorly on the microbiology section of the National Board, program administration would review and revise the microbiology content within the curriculum. Another example might be if data collected from an employer survey demonstrates that program graduates do not do well using the ultrasonic scaler, program administration would reevaluate the instructional content provided in that area and may look at increasing the clinical education/evaluation of students using ultrasonic scalers.

In summary, the Commission on Dental Accreditation has a long history of using outcomes based evaluation. Although a quality educational program evaluates process as well as end product, the Commission's standards mandate that programs have an appropriate, detailed and outlined ongoing outcomes assessment plan in place. This plan, when followed through to the end, results in the continuous improvement of the educational program and the production of competent graduates. The Commission concurs with the intent of Resolution 32H-1998 and hopes that its commitment to outcomes assessment in the accreditation process has been demonstrated to the House.

Comprehensive Policy Statement of Dental Auxiliary Personnel and Development of Alternate Pathways for Dental Hygiene Training: In regard to other dental hygiene accreditation issues, the Commission also noted the House of Delegates' adoption of Resolutions 80H-1998 (*Trans.*1998: 713) and Resolution 31H-1998 (*Trans.*1998:714). The Commission believed that the Association's adoption of these resolutions appears to be in conflict with the Association's Strategic Plan, Goal I. Advocacy, Objective viii. Further, the Commission believed that the Association's encouragement to state boards of dentistry to accept dental hygiene programs that are approved by state boards, rather than accredited by the Commission, may be perceived as a lack of commitment by the Association to the accreditation program. The Commission noted that in 1997, 5,023 students graduated from 237 dental hygiene programs, compared to 3,880 graduates from 196 programs in 1987. This represents a 29.5% increase in the number of graduates and a 21% increase in the number of programs during the past ten years. In January 1999, accreditation was granted to seven more programs, bringing the total to 244 accredited programs. The Commission anticipates that the number of programs, as well as number of graduates will continue to rise. Institutions interested in sponsoring a dental hygiene program are offered the technical assistance of Commission staff and the consultative services of Commission-appointed program development specialists. The Commission directed that a letter be sent to the Board of Trustees in this regard. Further, the Commission wished to communicate this information to the House of Delegates.

Review of Predoctoral Education Standards Regarding Pain and Anxiety Control: The Commission and its Review Committee on Predoctoral Dental Education considered Resolution 81H-1998 (*Trans.*1998:730) at its January 1999 meeting and determined that a survey of the 55 dental education programs should be conducted to evaluate the present status of dental undergraduate clinical skills (student clinical competency) in the use of oral anti-anxiety agents and nitrous oxide analgesia. The Commission approved a draft survey and directed that it be disseminated to the dental school deans. At its July 1999 meeting, the Commission will consider results of the survey. Actions taken by the Commission in regard to Resolution 81H-1998 will be provided to the Board of Trustees and the 1999 House of Delegates.

Advanced Education in General Dentistry Students: At its January 1999 meeting the Commission and its Review Committee on Postdoctoral General Dentistry Education carefully considered Resolution 117H-1998 (*Trans.*1998:747) and whether the accreditation standards for general practice residency (GPR) programs and advanced education in general dentistry (AEGD) programs should be revised to prevent hospitals from sponsoring AEGD programs and to emphasize hospital sponsorship of GPR programs.

Inaccuracies in the background narrative that accompanied Resolution 117H-1998 were noted, including the statement that "AEGD positions were created as a means to make an accredited 'fifth year' of dental school-based education available to graduates seeking additional training." The Review Committee and Commission believed that this is not, and never has been, the purpose of these programs. The *Accreditation Standards for Advanced Education Programs in General Dentistry* includes a statement describing the goals of an AEGD program. AEGD programs are expected to prepare graduates to function effectively and efficiently in multiple health care environments with interdisciplinary health care teams. Further, the *Accreditation Standards for Advanced Education Programs in General Practice Residency* indicates that a goal of GPR programs is to prepare graduates to function effectively within the hospital and other health care environments.

The Commission also believed that the background narrative implied that it is inappropriate for ambulatory or

community clinics to receive Graduate Medical Education funding. Organizations including the American Dental Association and the American Association of Dental Schools have supported expanding government funding for educational programs that take place in ambulatory and community settings. The Health Care Financing Administration has adopted new regulations in the past few years that support Graduate Medical Education funding for dental residency (AEGD and GPR) positions in traditional, ambulatory and community settings, as long as the accredited programs are sponsored by hospitals or dental schools affiliated with hospitals, and the hospitals incur the costs for the program residents and supervisors. Many hospitals have responded to the changing health care environment and the need to provide integrated comprehensive health services by instituting ambulatory programs or moving traditional programs to ambulatory settings. In that regard, sponsorship or establishment of AEGD residency clinics by hospitals is consistent with changing philosophies and strategies in health care.

The Commission agreed with the background statement in that AEGD and GPR programs are not interchangeable. The final clause of the background statement referred to an inappropriate designation of AEGD positions as "residencies," and the role played by AEGD programs that have placed students in community clinics, which have been perceived to compete with private patients. In that regard, concerns related to real or perceived competition of AEGD residencies with local dental practices are strictly outside the realm of Commission responsibilities. The accreditation standards are intended to ensure the quality of educational programs. Accordingly, consideration of an accreditation standard revision based upon non-educational criteria could conceivably compromise the agency's integrity and jeopardize the accreditation process.

The Commission wished to report to the House that 35 of the 78 accredited AEGD programs are not sponsored by dental schools. The Armed Forces and the Department of Veterans Affairs sponsor 25 programs (many with hospital affiliations); five are sponsored by university medical centers and five are sponsored by hospitals. Without documented evidence that the educational experiences are not consistent with the goals and purpose of AEGD programs, the existence of these 35 accredited AEGD programs cannot be jeopardized.

In summary, the Commission carefully studied Resolution 117H-1998 and considered all of the implications of revising the accreditation standards to restrict GPR programs to hospital-based activities and specify that AEGD programs must be offered only within schools of dentistry or other facilities not affiliated with a hospital. The Commission considers such proposed revisions with care and does not initiate the process unless the need for revision has been adequately documented. In this case, without documented evidence to support the proposal, the Commission was unable to direct that such a revision be initiated at this time. Accordingly, the Commission reaffirmed that the accreditation standards for AEGD and GPR programs as adopted in July of 1998, which take effect January 1, 2000, appropriately describe the goals, sponsorship requirements and organization of AEGD and GPR programs.

The Commission also requested that the members of the House of Delegates be reminded that the Commission's mission is to ensure and encourage quality dental education programs. Whether a student is in an AEGD or GPR program, it is expected that the quality of the educational experience will meet the appropriate accreditation standards. If this is not the case, then a mechanism is already in place to address such concerns. Students, faculty, constituent dental societies, state boards of dentistry and other interested parties may submit an appropriate signed complaint to the Commission regarding any Commission-accredited program if they perceive a deficiency in a particular program or a failure to comply with established standards. Complaints must be related to a required accreditation procedure, to one or more accreditation standard(s) or portion of a standard. The Commission's *Policy on Complaints Directed at CDA-Accredited Educational Programs* can be found on ADA ONLINE.

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

Council on Dental Education and Licensure

Demkee, Donald E., Ohio, 2000, chairman, American Association of Dental Examiners
Buchanan, Richard N., Texas, 2000, vice chairman, American Association of Dental Schools
Anderson, Allen W., Illinois, 2002, American Association of Dental Schools
Bachman, Lillian H., New York, 1999, American Association of Dental Examiners
Baker, Arnold, Michigan, 1999, American Dental Association
Dolinsky, Herbert B., New Jersey, 2002, American Dental Association
Dyer, Jay Henry, West Virginia, 2001, American Dental Association
Fonseca, Raymond, Pennsylvania, 1999, American Association of Dental Schools
Goldberg, Louis J., New York, 2001, American Association of Dental Schools
Goorey, Nancy J., Ohio, 2000, American Dental Association
Hinrichs, R. Mark, Nebraska, 1999, *ex officio**
Marks, Ronald B., Louisiana, 2002, American Association of Dental Examiners
Kelly-Mueller, Carolyn, Pennsylvania, 1999, American Dental Association, *ad interim*
Ohtani, Deron J., Hawaii, 2002, American Dental Association
Tarver, Earl L., Louisiana, 2001, American Dental Association
Vorhies, Carl B., Oregon, 2000, American Dental Association
Woodworth, Gerald A., Idaho, 2001, American Association of Dental Examiners
Nix, Judith A., director
Boehm, Diane M., manager
Fitzgerald, Mary T., manager
Ulrey, Lois J., manager

Meetings: The Council on Dental Education and Licensure (CDEL) met in the ADA Headquarters Building on November 22-23, 1998 and April 16-17, 1999. Dr. Ronald M. Chaput, First District, serves as the Board of Trustees' liaison to the Council.

Organization: As directed by the ADA *Bylaws*, the Council is organized into committees to facilitate its work activities. Two of its committees are the Committee on Dental Education and the Committee on Licensure. These committees meet in conjunction with regularly scheduled Council meetings immediately prior to the plenary sessions. The Council's other committees include the Committee on Educational Measurements, the Committee on Specialty Recognition, the Anesthesiology Task Force and the Continuing Education Recognition Program (ADA CERP) Committee. These committees meet separately from the Council. Subsequently, reports and recommendations from these committees are forwarded to the Council for action.

Personnel: The 1999 annual session will mark the retirement of Dr. Lillian H. Bachman, Dr. Arnold Baker, Dr. Raymond Fonseca and Dr. Carolyn Kelly-Mueller and the resignation of Dr. Allen Anderson. The Council wishes to express its appreciation to these individuals for their thoughtful, determined leadership and for their many contributions during their tenure.

*Committee on the New Dentist member without the power to vote.

The Strategic Plan of the American Dental Association: The Council conducted strategic planning activities during its November 1998 and April 1999 meetings. These activities are intended to support implementation of the *ADA Strategic Plan: 1998-2001.* During its two meetings, the Council continued to clarify its action plans and suggested strategies associated with implementation of specific objectives under Goals I., II., IV. and V. of the Strategic Plan. The Council also carefully considered its action plans in conjunction with its 2000 budget request. As directed by the Board, the Council reviewed existing programs to determine if these programs continue to contribute to the Strategic Plan goals and objectives. Additionally, as requested the Council began adopting criteria for measuring the effectiveness/success of its action items. The criteria established will require further modification as the Council's action plans continue to evolve. The criteria established are both quantitative and qualitative. The Council will continue its efforts during the coming year. Throughout the process, the Council has sought guidance from the Office of Quality and Strategic Planning.

Association Policies Recommended for Rescission

In accordance with Resolution 15H-1995 (*Trans.*1995:659), the Council on Dental Education and Licensure reviewed two current Association policies to determine whether any redundancies or irrelevancies existed.

Dental Auxiliary Master Plans. This 1973 policy calling for dental auxiliary educational programs to be developed on the basis of state or regional master plans was adopted at a time

when there was a considerable amount of state and federal funding available throughout the country to support the development of dental assisting and dental hygiene programs. Further, while new allied dental programs continue to be developed, the Council believed that circumstances today are vastly different than they were 26 years ago when this policy was adopted and determined that this policy was no longer relevant. The Council therefore recommends adoption of the following resolution.

6. Resolved, that Resolution 88-1973-H (*Trans.*1973:726), Dental Auxiliary Master Plans, be rescinded.

Implementation of Recommendations Contained in the Institute of Medicine (IOM) Report. This 1995 policy cautioned interested organizations and institutions against accepting any conclusions or implementing any recommendations contained in the 1995 IOM Report until the Association could complete its study of the report. The Special Board Committee appointed in 1995 completed its study of the recommendations contained in the Institute of Medicine Report in 1996 and presented Board Report 6 to the 1996 ADA House of Delegates (*Supplement* 1996:450). The Council, therefore, concluded that this policy is no longer necessary and recommends adoption of the following resolution.

7. Resolved, that Resolution 91H-1995 (*Trans.*1995:643), Implementation of Recommendations Contained in the Institute of Medicine Report, be rescinded.

Dental Education

1998/99 Update of the January 1994 Report of the Cost of Higher Education and its Implication for Dental Education: In conjunction with the Council's strategic planning activities related to the cost of dental education and student debt, during the past year the Council updated its January 1994 Cost of Higher Education Report (*Supplement* 1993:489, *Reports* 1994:72). Additionally, the Council reviewed progress made to implement recommendations contained in the 1994 Cost Report and based on its findings, revised the list of recommendations and included some additional recommendations. As noted in the 1994 report, the educational community should address some of the recommendations and other recommendations must be addressed by the profession and/or other agencies. Further, the Council reorganized the recommendations under the following headings: Dental Schools Budget Management; Increase of Revenue Sources; Debt Management/Reduction; Evaluation of Admissions/Curriculum; Student Assistance; and Value of the Dental School. The Council has approved the 1998/99 Update Report for distribution; it is expected to be mailed to the communities of interest in August.

Minority Recruitment and Retention Program: As reported in 1997 (*Reports* 1997:84) and in 1998 (*Reports* 1998:81) an ADA/American Association of Dental Schools (AADS) Joint Steering Committee on Minority Recruitment and Retention was appointed in 1997 and charged with the responsibility to develop a national minority recruitment proposal for dentistry, including a proposed budget and possible sources of funding. The committee met three times: September 1997, March 1998 and August 1998. In December 1997, the committee presented a progress report to the Board of Trustees outlining the steps toward establishing a recruitment/retention proposal and in February 1999, presented its final report to the Board.

The committee's detailed proposal to the Board outlines a joint ADA/AADS activity to be titled, ACHIEVING DIVERSITY: Partnerships for the Future. The proposal includes a mission statement that supports a commitment to achieving a dental workforce that represents the diversity of the nation. The report emphasizes that it is not necessary to increase overall dental school enrollments to meet the goals of this program. Additionally, the proposal outlines the goals and strategies for this program and stresses that the goals are consistent with the ADA's Strategic Plan.

The proposal outlines four critical reasons why dentistry needs a national minority recruitment and retention program: 1) to ensure access to health care; 2) to provide culturally competent care; 3) to ensure access to the profession; and 4) to ensure future leadership. To achieve its goal of recruiting and retaining an increased number of under-represented minorities (African Americans, Hispanics and Native Americans) into dentistry, it is proposed that foundation support of approximately $1.5 million be sought to sustain grant awards for the program. The proposed program is modeled after medicine's Project 3000 by 2000 minority recruitment program. The project proposes that grants be awarded to applicants (dental schools) that utilize a variety of resources in the development and implementation of new recruitment and retention programs. This includes establishing partnerships with the educational community (K-12 and undergraduate education), utilizing a variety of community resources and collaborating with the practicing dental profession (individuals and constituent and component level dental societies).

In February 1999, the Board adopted resolutions to endorse the continuation of this joint effort with the AADS. Additionally, the Board provided start-up funding for the program with an equal amount to be provided by the AADS. Further, the Board authorized the ADA representatives of the currently constituted ADA/AADS Joint Steering Committee to serve as the ADA/AADS Joint Oversight Committee during the start–up phase of the project.

The Joint Oversight Committee is scheduled to meet in May 1999 and will present a progress report to the Board in August 1999.

Specialty Recognition

The American Academy of Oral and Maxillofacial Radiology's Request for Recognition as a Dental Specialty: An application from the American Academy of Oral and Maxillofacial Radiology (AAOMR) was received on May 29,

1998, for recognition of oral and maxillofacial radiology as a dental specialty. The application included information and documentation relating to the six requirements for dental specialty recognition as specified in the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists*.

In accordance with Council policy, notification of receipt of the application was transmitted to ADA constituent and component societies, recognized specialty organizations and certifying boards, the American Association of Dental Examiners and the American Association of Dental Schools through a letter from the Council Director dated June 15, 1998. A notice to the profession regarding receipt of the application was published in the June 15, 1998 issue of the *ADA News*. Comments on the application from interested individuals and organizations were invited.

All submitted information was evaluated in light of the established requirements. The AAOMR previously submitted an application for specialty recognition for consideration in 1996. The 1996 ADA House of Delegates considered Resolution 19-1996 (*Trans.*1996:696) submitted by the Council recommending that the AAOMR's request for the recognition of oral and maxillofacial radiology as a dental specialty be approved. The House referred Resolution 19 back to the Council for further consideration.

The 1997 ADA House of Delegates considered supplemental information submitted by the Council specifically related to compliance with Requirement 4 and reconsidered Resolution 19-1996 (*Trans.*1997:651,653). Following discussion, the House voted to defeat the resolution and subsequently, oral and maxillofacial radiology was not recognized as a dental specialty.

The Council's Committee on Dental Specialty Recognition (Committee G) reviewed the application during meetings held at the ADA Headquarters on July 20, 1998, and March 19, 1999. At its November 23, 1998 meeting, the Council reviewed the application, the comments from the communities of interest and the report of Committee G. Committee G's report stated that in its judgment, the AAOMR had demonstrated compliance with all requirements for recognition as a dental specialty. Further, Committee G recommended that the AAOMR's request for recognition as a dental specialty be approved. Based on review of all information, the Council determined that the application failed to demonstrate compliance with three of six requirements for recognition as specified in the *Requirements*. Subsequently, the Council recommended that the AAOMR's request for recognition as a dental specialty be denied and transmitted this action to the AAOMR along with a written report. In correspondence dated January 26, 1999, the AAOMR requested a special appearance before the Council on Dental Education and Licensure at its April 16-17, 1999 meeting. The AAOMR submitted additional written materials at its special appearance. In its deliberations, the Council considered all information submitted by the AAOMR, the April 1999 report of Committee G and all information presented during the April 17, 1999 special appearance.

The following comments by Council members during its discussion of this application were among the reasons for the decision articulated at the April 1999 Council meeting.

Summary of Assessment of Compliance with Each Requirement.

Requirement 1: In order for an area to be recognized as a specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.

After review of all information contained in this section of the application, the Council believed that the AAOMR demonstrated that its organization is reflective of the special area of practice and has demonstrated the ability to establish a certifying board. The Council concluded that the AAOMR demonstrated compliance with this requirement.

Requirement 2: A specialty must be a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards.

According to the application, oral and maxillofacial radiologists receive more in-depth education to attain levels of knowledge and skill beyond those commonly possessed by the dental school graduate. The Council believed that based on information provided by the AAOMR, there is evidence to support that the knowledge and skills of the oral and maxillofacial radiologist for all imaging techniques are beyond those of the dental school graduate. Further, the Council believed that although dental students acquire certain core competencies, they do not achieve competency in more sophisticated radiology techniques. Following review of all information presented, the Council was of the judgment that the AAOMR provided sufficient evidence to demonstrate that this requirement has been met. The Council therefore concluded that the AAOMR has demonstrated compliance with this requirement.

Requirement 3: The scope of the specialty: (a) is separate and distinct from any recognized specialty or combination of recognized specialties; (b) cannot be accommodated through minimal modification of a recognized specialty or combination of recognized specialties.

The Council believed that the AAOMR application demonstrates that the scope of knowledge and skills of the oral and maxillofacial radiologist is broader and more in-depth than what is required in the accreditation standards of some of the other specialties, especially in terms of interpretative skills. The Council noted that, according to the application, the level of knowledge required in the standards for some of the recognized specialties was at the *understanding* or *familiarity* level, whereas the oral and maxillofacial radiologist must have

in-depth knowledge in all areas of radiology of a vast array of advanced imaging modalities.

The Council also believed that, while some recognized specialties have some level of knowledge and skill in radiology, the application provides sufficient evidence that the scope of oral and maxillofacial radiology is separate and distinct from any recognized dental specialty or combination of recognized specialties, especially in terms of current advanced imaging techniques and interpretative skills. For these reasons, the Council concluded that the AAOMR has demonstrated that there is no single specialty or group of specialties that could, through minimal modification, accommodate the full scope of oral and maxillofacial radiology. The Council therefore concluded that this requirement has been met.

Requirement 4: In order to be recognized as a specialty, substantial public need and demand for services which are not adequately met by general practitioners or dental specialists must be documented.

The application defines several categories of services that AAOMR believes are not currently being delivered by other dental specialties. According to the application, some of these services include: plain film investigations, tomographic investigations, computed tomographic investigations, magnetic resonance imaging and digital imaging enhancement and analysis.

The Council believed that data from a survey conducted by AAOMR in 1995 on practice trends and referral patterns supports the fact that most requests for radiology services come from referrals from mainly two dental specialties, from general dentists and from physicians. Further, the data reflects that 70% of the oral and maxillofacial radiologists' practices are located in dental school clinics.

The Council believed that the information contained in this section of the application provides documentation that there is substantial need and demand for the services of an oral and maxillofacial radiologist which are not adequately met by general practitioners or dental specialists. Based on all information provided, the Council was of the opinion that the majority of oral and maxillofacial radiologists provide a valued academic service in teaching radiology to predoctoral and graduate dental students and provide diagnostic services on a referral basis within a dental school clinic practice. Additionally, the Council concurred with Committee G's judgment that most new techniques and procedures in dentistry evolve from an academic environment and that academic needs translate into public need and demand. Based on all information provided, the Council concluded that there is sufficient evidence to demonstrate that there is a substantial public need and demand for radiology services not currently met by general practitioners or dental specialists. Accordingly, the Council concluded that AAOMR has demonstrated compliance with this requirement.

Requirement 5: A specialty must directly benefit some aspect of clinical patient care.

The application documented that oral and maxillofacial radiology services are provided in a variety of settings including: dental school clinics, private offices, hospitals and other medical institutional settings. Based on information presented in this section of the application, the Council believed that the services provided by the oral and maxillofacial radiologist directly benefit certain aspects of patient care. The Council concluded that the AAOMR has demonstrated compliance with this requirement.

Requirement 6: Formal advanced education programs of at least two years beyond the predoctoral curriculum as defined by the Commission on Dental Accreditation's *Standards for Advanced Specialty Education Programs* must exist to provide the special knowledge and skills required for the practice of the specialty.

The Council concluded that, based on the information contained in this section of the application, the AAOMR has demonstrated compliance with this requirement.

Summary. Following careful review of the application for recognition of oral and maxillofacial radiology as a dental specialty, the Council determined that:

- The AAOMR has *demonstrated* that it is represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.
- The AAOMR has *demonstrated* that oral and maxillofacial radiology is a distinct and well-defined field, which requires knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards.
- The AAOMR has *demonstrated* that the scope of oral and maxillofacial radiology: (a) is separate and distinct from any recognized specialty or combination of recognized specialties; and (b) cannot be accommodated through minimal modification of a recognized specialty or combination of recognized specialties.
- The AAOMR has *demonstrated* substantial public need and demand for oral and maxillofacial radiology services, which are not adequately met by general practitioners or dental specialists.
- The AAOMR has *demonstrated* that oral and maxillofacial radiology directly benefits some aspect of clinical care.
- The AAOMR has *demonstrated* that formal advanced education programs of at least two years beyond the predoctoral curriculum exist to prepare individuals for the practice of oral and maxillofacial radiology.

For these reasons, at its April 1999 meeting, the Council concurred with Committee G's recommendation regarding the AAOMR's request for recognition as a dental specialty and approved the following resolution for transmittal to the 1999 House of Delegates.

8. Resolved, that the American Academy of Oral and Maxillofacial Radiology's request for the recognition of oral and maxillofacial radiology as a dental specialty be approved.

The American Society of Dentist Anesthesiologists' Request for Recognition as a Dental Specialty: On June 1, 1998, an application was submitted by the American Society of Dentist Anesthesiologists (ASDA) for recognition of dental anesthesiology as a dental specialty. The application included information and documentation relating to the six requirements for dental specialty recognition as specified in the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists.*

In accordance with Council policy, notification of receipt of the application was transmitted to ADA constituent and component societies, recognized specialty organizations and certifying boards, the American Association of Dental Examiners and the American Association of Dental Schools through a letter from the Council Director dated June 15, 1998. A notice to the profession regarding receipt of the application was published in the June 15, 1998 issue of the *ADA News.* Comments on the application from interested individuals and organizations were invited. All submitted information was evaluated in light of the established requirements.

The application notes that the ASDA has previously submitted applications in 1994 *(Trans.*1994:608*)* and 1997 *(Trans.*1997:652*)*. In 1994 and 1997, the ADA House considered resolutions submitted by the Council recommending that the ASDA's request for specialty recognition be approved. These resolutions were defeated and subsequently, dental anesthesiology was not recognized as a dental specialty.

The Council's Committee on Dental Specialty Recognition (Committee G) reviewed the application during a meeting held at the ADA Headquarters on July 20, 1998, and March 19, 1999. At its November 23, 1998 meeting, the Council reviewed the application, the comments from the communities of interest and the report of Committee G. Committee G's report stated that in its judgment, the ASDA had demonstrated compliance with all requirements for recognition as a dental specialty. Further, Committee G recommended that the ASDA's request for recognition as a dental specialty be approved. Based on review of all information, the Council determined that the application failed to demonstrate compliance with two of six requirements for recognition as specified in the *Requirements*. Subsequently, the Council recommended that the ASDA's request for recognition as a dental specialty be denied and transmitted this action to the ASDA along with a written report. In accordance with established procedures, the ASDA, in correspondence dated February 2, 1999, requested a special appearance before the Council on Dental Education and Licensure at its April 16-17, 1999 meeting. The ASDA submitted a written response in correspondence dated March 1, 1999 and distributed additional written materials at its special appearance before the Council. In its deliberations, the Council considered all information submitted by the ASDA, the April 1999 report of Committee G and all information presented during the April 17, 1999 special appearance.

The following comments by Council members during its discussion concerning the application were among the reasons for the decision articulated at the April 1999 Council meeting.

Summary of Assessment of Compliance with Each Requirement.

Requirement 1: In order for an area to be recognized as a specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.

After review of all information in this section of the application, the Council believed that ASDA demonstrated that its organization is reflective of the special area of practice and has demonstrated the ability to establish a certifying board. The Council concluded that the ASDA demonstrated compliance with this requirement.

Requirement 2: A specialty must be a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards.

The application presented an analysis of the differences between the knowledge and skills possessed by a dental school graduate versus the depth and breadth of knowledge and skills possessed by the dental anesthesiologist. The information presented in the application describes the level and depth of instruction in the predoctoral curriculum by comparing the *Accreditation Standards for Dental Education Programs,* effective January 1, 1998 and Part One (predoctoral level) of the ADA Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry with Part Two of the Guidelines (advanced education level). In the Council's opinion, differences in the level of knowledge (i.e., in-depth vs. familiarity) between the proposed specialty and predoctoral didactic biomedical sciences curricula demonstrate that the knowledge level required is beyond that possessed by dental school graduates.

The Council believed that the information provided in this section of the application documents that dental anesthesiology is a distinct and well-defined field which requires knowledge and skills beyond those commonly possessed by dental school graduates. Accordingly, the Council concluded that the ASDA has demonstrated compliance with this requirement.

Requirement 3: The scope of the specialty: (a) is separate and distinct from any recognized specialty or combination of recognized specialties; (b) cannot be accommodated through minimal modification of a recognized specialty or combination of recognized specialties.

The application presented a comparison of the advanced knowledge and skills as described in the accreditation standards for endodontics, pediatric dentistry, periodontics and oral and maxillofacial surgery. Further, information in this section of the application also compares dental anesthesiology knowledge and skills to general practice residency training. In the Council's judgment, some of the recognized dental specialties have strengthened the depth and scope of training in the management of pain, anxiety and behavior control. Specifically, this includes oral and maxillofacial surgery, pediatric dentistry and periodontics. However, in the accreditation standards of the aforementioned recognized specialties, training to the level of proficiency is not specifically addressed. The information presented in the ASDA application indicated that none of the recognized specialties require the in-depth knowledge of topics and level of skills compared to the dental anesthesiology curriculum. According to the information provided by the ASDA, the proposed specialty of dental anesthesiology emphasizes training to the level of proficiency in the full scope of office-based anesthesia.

The application includes data regarding dentists with anesthesia certificates or permits and notes that this area of practice is regulated in all states. According to ASDA's information, the laws regulating general anesthesia and deep sedation have worked to eliminate these services from the scope of practice of every group of practicing dentists other than oral and maxillofacial surgeons since other dental specialists and general practitioners typically have not completed the required training. During its discussion, the Council noted that, although anesthesia permits are issued to appropriately trained general dentists and specialists, information presented during the special appearance indicated that in eight of the most populated states in the country only 0.5% of dentists other than oral and maxillofacial surgeons have obtained general anesthesia permits.

Following review of all information provided, the Council concluded that ASDA has provided evidence to support that the scope of this specialty is separate and distinct from any recognized specialty or combination of recognized specialties and further, that it cannot be accommodated through minimal modification of a recognized specialty or combination of recognized specialties. Therefore, the Council concluded that the ASDA has demonstrated compliance with this requirement.

Requirement 4: In order to be recognized as a specialty, substantial public need and demand for services, which are not adequately met by general practitioners or dental specialists, must be documented.

In describing referral patterns, the application cites data resulting from a 1992 ADA survey conducted in conjunction with the American Dental Society of Anesthesiology.

During the Council's discussion related to this requirement, data from the 1990 ADA Survey of Dental Services Rendered was also reviewed. The ASDA's written response states that in its opinion the survey data is flawed regarding the number of general anesthetics performed by general dentists and specialists. The ADA Survey Center provided the ASDA and the Council with information regarding survey methodology. The Council was of the opinion that the survey methodology used and the resulting data is statistically valid. The Council believed that some dental anesthesiology needs are being met by a small number of general dentists and by some dental specialists, but in the Council's judgment, this does not diminish the demand for nonoral and maxillofacial related services provided by dental anesthesiologists.

Additionally, in documenting the demand for services, sample estimates from one city within the U.S. were used. According to the application, this particular city was selected because the area is served by a long-standing dental anesthesiology training program. The sample is intended to demonstrate that where dental anesthesiology services are available to the dental community, a need and demand for such services subsequently emerges.

Data compiled by and presented during the ASDA's special appearance notes the amount of anesthesiology services being provided by oral and maxillofacial surgeons in conjunction with oral and maxillofacial procedures. According to the data presented in the application and in the supplemental information presented by ASDA, there is no evidence to support that oral and maxillofacial surgeons or other dental specialists routinely provide dental anesthesiology services to general dentists, pediatric dentists or nonoral and maxillofacial surgery dental specialists. The Council believed this further supports the need and demand for the services of the dental anesthesiologist.

Based on all the information provided, the Council believed that the ASDA provided evidence to support that there is substantial need and demand for the services of a dental anesthesiologist, which are not adequately met by general practitioners or dental specialists. For these reasons, the Council concluded that the ASDA has demonstrated compliance with this requirement.

Requirement 5: A specialty must directly benefit some aspect of clinical patient care.

The Council believed that the services provided by the dental anesthesiologist directly benefit aspects of clinical patient care and therefore concluded that the ASDA has demonstrated compliance with this requirement.

Requirement 6: Formal advanced education programs of at least two years beyond the predoctoral curriculum as defined by the Commission on Dental Accreditation's *Standards for Advanced Specialty Education Programs* must exist to provide the special knowledge and skills required for the practice of the specialty.

The Council noted that ten dental schools/institutions (including one Canadian dental school) currently sponsor formal advanced education programs in dental anesthesiology of at least two years beyond the predoctoral curriculum. Based on current enrollments, the application notes that approximately 12 anesthesia-trained dentists will graduate per

year. The Council concluded that, based on the information contained in this section of the application, the ASDA has demonstrated compliance with this requirement.

Summary. Following careful review of the application for recognition of dental anesthesiology as a dental specialty, the Council determined that:

- The ASDA has *demonstrated* that it is represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.
- The ASDA has *demonstrated* that dental anesthesiology is a distinct and well-defined field, which requires knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards.
- The ASDA has *demonstrated* that the scope of dental anesthesiology: (a) is separate and distinct from any recognized specialty or combination of recognized specialties; and (b) cannot be accommodated through minimal modification of a recognized specialty or combination of recognized specialties.
- The ASDA has *demonstrated* substantial public need and demand for dental anesthesiology services that are not adequately met by general practitioners or dental specialists.
- The ASDA has *demonstrated* that dental anesthesiology directly benefits some aspect of clinical care.
- The ASDA has *demonstrated* that formal advanced education programs of at least two years beyond the predoctoral curriculum exist to prepare individuals for the practice of dental anesthesiology.

For these reasons, at its April 1999 meeting, the Council concurred with Committee G's recommendation regarding the ASDA's request for recognition as a dental specialty and approved the following resolution for transmittal to the 1999 House of Delegates.

9. Resolved, that the American Society of Dentist Anesthesiologists' request for the recognition of dental anesthesiology as a dental specialty be approved.

The American Academy of Oral Medicine's Request for Recognition as a Dental Specialty: An application from the American Academy of Oral Medicine (AAOM) was received on June 1, 1998, for recognition of oral medicine as a dental specialty. The application included information and documentation relating to the six requirements for dental specialty recognition as specified in the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists.*

In accordance with Council policy, notification of receipt of the application was transmitted to ADA constituent and component societies, recognized specialty organizations and certifying boards, the American Association of Dental Examiners and the American Association of Dental Schools through a letter from the Council Director dated June 15, 1998. A notice to the profession regarding receipt of the application was published in the June 15, 1998 issue of the *ADA News.* Comments on the application from interested individuals and organizations were invited. All submitted information was evaluated in light of the established requirements.

The AAOM previously submitted an application for specialty recognition for consideration in 1996. The 1996 ADA House of Delegates considered Resolution 80 *(Trans.* 1996:697*)* submitted by the Council recommending that the AAOM request for the recognition of oral medicine as a dental specialty be denied. The 1996 ADA House of Delegates adopted Resolution 80H-1996 (*Trans.* 1996:697) denying specialty status to oral medicine.

The Council's Committee on Dental Specialty Recognition (Committee G) reviewed the application during meetings held at the ADA Headquarters on July 20, 1998, and March 19, 1999. At its November 23, 1998 meeting, the Council reviewed the application, comments from the communities of interest and the report of Committee G. Committee G's report stated that in its judgement, the AAOM failed to demonstrate compliance with three of six requirements for recognition as a dental specialty as specified in the *Requirements* and recommended that the AAOM's request for recognition as a dental specialty be denied. Based on review of all information, the Council determined that the application failed to demonstrate compliance with two of six requirements for recognition as specified in the *Requirements.* Subsequently, the Council recommended that the AAOM's request for recognition as a dental specialty be denied and transmitted this action to the AAOM along with a written report. In accordance with established procedures, the AAOM, in correspondence dated February 4, 1999, requested a special appearance before the Council on Dental Education and Licensure at its April 16-17, 1999 meeting. The AAOM submitted additional written materials prior to the special appearance. In its deliberations, the Council considered all information submitted by the AAOM, the April 1999 report of Committee G and all information presented during the April 17, 1999 special appearance. Committee G's recommendation was consistent with its November 1998 recommendation.

The following comments by Council members during its discussion concerning the application were among the reasons for the decision articulated at the April 1999 Council meeting.

Summary of Assessment of Compliance with Each Requirement.

Requirement 1: In order for an area to be recognized as a specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.

After review of all information submitted, the Council noted that the membership of the AAOM has remained fairly constant over the last ten years, totaling approximately 800

members, including 375 board-certified diplomates and 95 members who have achieved fellowship status. According to the application, the AAOM is the only national organization of oral medicine attracting practitioners interested in this area. In the Council's judgment, information provided by the AAOM demonstrates that the majority of the AAOM's members are diplomates and fellows with advanced training in oral medicine and less than 10% of its membership is represented by dental specialists.

The Council also noted that in 1955 the AAOM founded the American Board of Oral Medicine (ABOM), which is modeled after the Association's recognized dental specialty certifying boards. The application documents that over 95% of the ABOM's diplomates are members of the AAOM.

According to the AAOM, a single dental specialty is needed to represent the medical aspects of dentistry and that few general dentists can manage the multiple complex problems presented in some patients.

In discussion of the information contained in this section of the application and the additional information submitted, the Council concluded that the AAOM's membership is reflective of the area of oral medicine. In its judgment, the Council believes that the AAOM has satisfactorily demonstrated that its membership is reflective of the proposed special area of dental practice and has demonstrated the ability to establish a certifying board, and therefore, has demonstrated compliance with this requirement.

Requirement 2: A specialty must be a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards.

The Council agreed the application provided evidence that the breadth and depth of knowledge and skills of the oral medicine practitioner may be beyond the minimum competencies expected of a new dental school graduate. However, the Council also noted that in its judgment the same knowledge and skills are within the scope of a general dentist who has several years of practice experience. Following discussion of the perceived differences in level of instruction and experience, the Council concluded that the AAOM has demonstrated compliance with this requirement.

Requirement 3: The scope of the specialty: (a) is separate and distinct from any recognized specialty or combination of recognized specialties; (b) cannot be accommodated through minimal modification of a recognized specialty or combination of recognized specialties.

In its discussion concerning all the information presented regarding Requirement 3, the Council believed that there were some distinctions in the required knowledge and skills of the specialties of oral and maxillofacial pathology, periodontics and oral and maxillofacial surgery when contrasted with oral medicine. However, the Council was of the opinion that there is significant overlap in scope between oral medicine and the aforementioned recognized specialties, particularly oral and maxillofacial pathology and that through minimal modification can be combined with one or more other recognized specialties.

The Council noted that the AAOM states that its uniqueness is due to its emphasis on diagnosis and management of chronic medical and oral disease manifestations and advanced pharmacological management skills. The Council is of the opinion that the core of general dentistry is diagnosis and management of oral diseases.

After review of all information presented, the Council concluded that neither the application nor the supplemental information presented during the sponsoring organization's special appearance presented sufficient evidence to support that the proposed specialty is separate and distinct from any recognized specialty or combination of recognized specialties. Further, the Council also concluded that the proposed specialty could be accommodated through minimal modification of a recognized specialty or combination of recognized specialties. The Council therefore determined that the AAOM has not demonstrated compliance with this requirement.

Requirement 4: In order to be recognized as a specialty, substantial public need and demand for services, which are not adequately met by general practitioners or dental specialists, must be documented.

The AAOM noted that the data presented in the application indicated that the services offered by oral medicine practitioners are not routinely provided by the general dentist or the dental specialist. The Council disagreed with this claim and was of the opinion that the data presented was very broad-based and that most of the health conditions described are currently being treated by the general dentist. The Council also noted during its discussion that graduates of general practice residency programs are trained to treat medically compromised patients and, in some instances, are trained with the oral medicine student.

According to the data presented in the application, there are currently 141 AAOM members in the full-time practice of oral medicine. The AAOM estimates that the need of oral medicine practitioners can range from 300 to 2,400 in the next five to ten years as the population ages and taking into account disease trends. However, the Council noted that the AAOM did not present a compelling argument or sufficient documentation to demonstrate that other dentists and dental specialists cannot meet these needs.

Based on all information provided, the Council concluded that the AAOM failed to demonstrate that there is substantial public need and demand for the services provided by the dentist who practices oral medicine. Additionally, the Council believed the application and supplemental information provided failed to demonstrate that these needs and demands for services are not being or cannot be met by the general dentist or the dental specialist. Accordingly, the Council concluded that this requirement has not been met.

Requirement 5: A specialty must directly benefit some aspect of clinical patient care.

Based on the information provided in this section of the application, the Council agreed that the AAOM has demonstrated that the proposed specialty directly benefits some aspect of clinical patient care. Accordingly, the Council concluded that this requirement has been met.

Requirement 6: Formal advanced education programs of at least two years beyond the predoctoral curriculum as defined by the Commission on Dental Accreditation's *Standards for Advanced Specialty Education Programs* must exist to provide the special knowledge and skills required for the practice of the specialty.

The Council noted that there are ten advanced education programs in oral medicine in the United States of at least two years or more in length. The training for these curricula requires at least two years beyond the predoctoral curriculum. Although the Council believed that some of the didactic and clinical presentation regarding management of chronic orofacial pain was not well supported in the sample curricula, the Council concluded that the AAOM has demonstrated compliance with this requirement.

Summary. Following careful review of the application for recognition of oral medicine as a dental specialty, the Council determined that:

- The AAOM has *demonstrated* that it is represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.
- The AAOM has *demonstrated* that oral medicine is a distinct and well-defined field which requires knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards.
- The AAOM has *not demonstrated* that the scope of oral medicine (a) is separate and distinct from any recognized specialty or combination of recognized specialties; (b) cannot be accommodated through minimal modification of a recognized specialty or combination of recognized specialties.
- The AAOM has *not demonstrated* substantial public need and demand for oral medicine services which are not adequately met by general practitioners or dental specialists.
- The AAOM has *demonstrated* that oral medicine directly benefits some aspect of clinical care.
- The AAOM has *demonstrated* that formal advanced education programs of at least two years beyond the predoctoral curriculum exist to prepare individuals for the practice of oral medicine.

For these reasons, at its April 1999 meeting, the Council concluded that the AAOM failed to demonstrate compliance with two of six requirements and concurred with Committee G's April 1999 recommendation that the AAOM's request for recognition as a dental specialty be denied. The Council approved the following resolution for transmittal to the 1999 House of Delegates.

10. Resolved, that the American Academy of Oral Medicine's request for the recognition of oral medicine as a dental specialty be denied.

Proposal for Periodic Review of Specialty Education and Practice: Resolution 144H-1992 (*Trans.*1992:620) directs that the Association maintain a mechanism for the periodic review of specialty education and practice. Further, the resolution directs that beginning in 2001, the Council on Dental Education and Licensure forward recommendations from this review to the House of Delegates for its consideration.

In response to this directive, the Council has developed a proposal to conduct a comprehensive review of specialty education and practice. The Council's proposal includes a time frame for the study and an outline of information to be collected in conjunction with its review of specialty education and practice. The Council recognizes that its comprehensive study will require input and cooperation from the recognized dental specialty organizations and certifying boards.

The eight recognized dental specialties will be requested to provide general information about the specialty, such as: trends in membership; efforts to promote the improvement of quality in the specific field; and changes, if any, in board certification requirements. Additionally, each specialty will be requested to provide an overview of: trends in advanced education; changes in the scope of practice; recent epidemiological data; disease patterns; and changes in technology affecting the practice environment. It is intended that information provided by each dental specialty organization will be used in the development of the Council's report. As stated in the Council's 1992 report to the House on the *Study of the Specialty Recognition Process* (*Reports* 1992:75), "Based on the recommendations and conclusions drawn from such a comprehensive study, the Council will determine if any of the currently recognized specialties should be reviewed for re-recognition."

Additionally, during its discussions related to this activity, the Council determined that its study will also include a review of the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists* and the specialty recognition process and procedures.

The Council will correspond with the specialty organizations and certifying boards this summer and will meet with the leadership of these organizations in August 1999 to seek further input regarding this study. The Council's Committee on Specialty Recognition (Committee G) will have primary responsibility for conducting this study and will subsequently present its report and recommendations to the Council. As directed in Resolution 144H-1992, the Council

will transmit its report and recommendations to the 2001 House of Delegates.

Establishing a Fee for Application for Specialty Recognition: The Council considered establishing a specialty recognition application fee to help recover some of the costs associated with the specialty recognition process. This procedure would be consistent with fees charged by other Association agencies and programs (e.g., ADA CERP, ADA Seal Program). Further, the Council believed that it is reasonable to require such a fee as long as the fee does not unduly limit an applicant's ability to participate in the process. Accordingly, the Council directed that an application fee of $3,000 be established for organizations applying for specialty recognition. Applicants who begin the specialty recognition process by submitting an application in conjunction with the June 1, 2000 application deadline and thereafter will be required to pay the application fee. The application fee will be required each time an application is submitted for consideration.

Advanced Education

Annual Meeting of Specialty Certifying Boards: In August 1998, the Council hosted a joint meeting of the representatives of the eight recognized dental certifying boards and the dental specialty organizations at the Association Headquarters in Chicago. In addition, at the Council's invitation, the examiner-in-chief and the registrar of the Royal College of Dentists of Canada were in attendance.

Agenda topics at this meeting included: a presentation on the use of the RASCH Model Score Setting Analysis; the American Dental Association Department of Testing Services' use of computer-based testing; and a discussion on the philosophy of testing on ethical issues. In addition, participants received an overview of events leading to the adoption of Advisory Opinion 5.I.1, information about the proposed Advisory Opinion 5.H.2 and an update on recent actions by the Commission on Dental Accreditation.

Additionally, certifying board representatives provided a brief report about their respective board's liability insurance coverage. Participants also discussed possible agenda topics for the next meeting, which will be held on August 13, 1999, at the Association Headquarters Building in Chicago.

Allied Dental Education

Development and Distribution of Allied Career Brochures: In response to Resolution 41H-1997 (*Trans.*1997:688, *Reports* 1998:89), the Council oversaw final production and distribution of the revised allied dental career brochures for dental assisting, dental hygiene and dental laboratory technology. Sample copies of each brochure were mailed to officers and members of the Board of Trustees, Council members, ADA constituent and component societies, allied dental program directors and dental deans. Since then, up to ten copies of each brochure have been mailed upon request at no charge unless a specific need for more was identified. Based on data collected over a four-month period, detailing the number of requests, the number of brochures sent for each discipline and the individual comments made by requestors, the Council directed that the ADA Department of Salable Materials be requested to manage requests for 50 or more brochures. The Council is currently working with the Department of Salable materials to facilitate this revised procedure. The Council will continue to monitor its brochure requests and information will be provided periodically to the Council.

Activities Related to Dental Hygiene Education and Personnel: Resolution 80H-1998 and Resolution 31H-1998 (*Trans.*1998:713, 714, 718) support activities related to alternate pathways of dental hygiene training. In response to the Association's ongoing interest in these activities, the Council directed that two documents, *New Faces for Allied Dental Education* and *Dentist and Educators: Communicating Ideas about Innovations in Allied Dental Education*, originally developed in the early 1990s, be revised to incorporate new information on distance learning opportunities and other innovative approaches to allied dental education.

Additionally, in conjunction with its discussions related to allied career recruitment and workforce issues, the Council has developed a comprehensive report exploring the possible shortage of dental hygiene personnel. The report references numerous studies on this issue conducted by various agencies/organizations over a ten-year period. The Council believes that this issue is extremely important to the Association and therefore should be monitored. The Council also determined it should carefully review the results of the Association's *1999 Workforce Needs Assessment Survey* being conducted in response to Resolution 73H-1998 (*Trans.*1998:709). This survey is expected to provide current data from a more comprehensive study of the depth and number of dental hygiene shortage areas.

In conjunction with all the information provided on this issue, the Council also noted that 42 new accredited dental hygiene programs have been initiated over the last five years. The Council believes the new graduates of these programs will help to alleviate shortages of available practicing dental hygienists in certain areas of the country. The Council will continue to monitor trends related to the numbers enrolling and graduating from accredited dental hygiene programs. Additionally, the Council will continue to work with the Council on Dental Practice and other appropriate agencies to determine what steps should be taken to further address the dental hygiene workforce issues.

Licensure

Annual Survey of Clinical Testing Agencies: Since 1995 the Council has been collecting examination pass/fail rates for candidates taking initial licensure examinations (*Supplement* 1996:462). In 1997, an expanded survey was sent to all

clinical testing agencies to collect additional information about the testing agencies' compliance with the 1992 ADA/American Association of Dental Examiners Guidelines for Valid and Reliable Dental Licensure Clinical Examinations. In 1998, the survey instrument was again modified to address concerns expressed by two testing agencies regarding accuracy of some of the reported pass/fail data due to the manner in which an agency tracks candidates and exam results. To address this concern the 1998 survey collected data only on current U.S. graduates who took the examinations for the first time in 1998. The 1998 survey results indicate that the majority of clinical testing agencies are in compliance with the Guidelines. The final report of the *1998 Annual Survey of Clinical Testing Agencies* is available through the Association Survey Center.

In response to Resolution 36H-1998 (*Trans.*1998:713), the 1999 survey was further expanded to collect data regarding the testing agencies' compliance with the ADA/AADE Guidelines for Examiner Standardization. The 1999 survey was mailed to clinical testing agencies in May 1999. It is anticipated that the 1999 survey will be available through the Association's Survey Center in fall 1999.

Survey on Licensure by Credentials: In 1998 the Council directed that the state boards of dentistry be surveyed on licensure by credentials. In developing the survey instrument, input was sought from the Department of State Government Affairs, the Committee on the New Dentist and the American Student Dental Association. In December 1998 the survey was mailed to 54 executive directors and administrators of the state boards of dentistry. A follow-up mailing was sent to nonrespondents in January 1999 with a final response rate of 72%. The final report and survey data will be available through the Association's Survey Center in late spring/early summer 1999.

Invitational Conferences for Clinical Testing Agencies: In 1996 the Association began to sponsor Invitational Licensure Conferences for Clinical Testing Agencies. The initial conference was used to present the Association's Agenda for Change in the Clinical Licensure Examination Process (*Trans.*1996:584). Since the initial conference, five more conferences have been convened by the Association in March and November of 1997 and 1998 and March 1999. Participants at the conferences have included representatives and observers from the four regional testing agencies and ten of the unaligned licensing agencies (nine states and one U. S. territory). In addition, participants have included the Association's president and president-elect, presidents of the American Association of Dental Examiners (AADE), American Association of Dental Schools (AADS), American Student Dental Association (ASDA) and representatives of the Committee on the New Dentist (CND) and the Council on Dental Education and Licensure (CDEL). Each conference has included presentations on specific issues and in-depth discussion on the 12 objectives contained in the Agenda for Change. The Agenda for Change has received support from all conference participants.

November 1998 Invitational Conference. "The Fifth Invitational Conference for Clinical Testing Agencies" was held on November 9, 1998, at the Hyatt Regency O'Hare in Rosemont, Illinois. Hosted by Dr. S. Timothy Rose, president, the meeting drew a total of 32 participants representing four regional testing agencies, ten unaligned licensing agencies, the AADE, AADS, ASDA, CND and CDEL. The primary focus of the meeting was on addressing objectives 2, 4, 8 and 12 of the Agenda for Change.

The agenda included an Association proposal calling for the creation of a national clinical examination database that would contain pass/fail information about candidates who sit for a clinical dental examination. During discussion, several issues were brought forward that meeting participants believed needed further investigation, such as how to collect data and maintain confidentiality, who would have access to the data, and which organization/agency would maintain the database. It was agreed that this topic would be addressed again at the March 1999 conference.

Additional topics addressed at the November meeting included: the comparability of clinical procedures among the examinations; appeals processes used by the testing agencies; and a presentation on the use of clinical simulation in dental schools to teach and evaluate students. As is the custom, representatives from ASDA and the Association's CND reported on their respective agencies' licensure-related activities.

March 1999 Invitational Conference. "The Sixth Invitational Licensure Conference for Clinical Testing Agencies" was held on March 2, 1999, at the ADA Headquarters Building in Chicago immediately following the American Association of Dental Examiners' Mid-Year Meeting. Hosted by Dr. S. Timothy Rose, ADA president, the meeting drew a total of 35 participants representing four regional testing agencies, nine unaligned licensing agencies, the AADE, AADS, ASDA, CND and CDEL.

The conference agenda built on topics discussed at the November 1998 conference, in particular, issues associated with development of a national database, a review of the minimum common core test requirements found in the ADA/AADE *Guidelines for Valid and Reliable Dental Licensure Examinations* and information about the appeals processes used by the testing agencies. Additionally, representatives from the Committee on the New Dentist and the American Student Dental Association reported on their agencies' recent activities related to the Agenda for Change and licensure issues in general.

Regarding the Common Core, participants determined that the content remains current and does not require revision at this time. Participants agreed that there is considerable similarity in content across the clinical examinations, which supports the goal of standardization of examinations. Participants believed the next step in standardizing the clinical examinations would be to examine scoring criteria and exam administration. Conference participants indicated their strong support for the Council on Dental Education and Licensure's recommendation that an interagency task force be appointed

for the purpose of developing a guidelines document that describes the characteristics ("best practices") of a scoring system. It was noted that funding for this activity has been requested in the Council's 2000 budget.

Participants determined that the next licensure conference should be held in 2000. This would allow time for the proposed interagency task force to progress on the development of guidelines related to scoring criteria and exam administration. Issues associated with development of a national database will also continue to be addressed at the 2000 conference.

Proposed Changes to the Association's Guidelines for Licensure: The 1998 House of Delegates referred Resolution 10RC-1998 (*Trans.*1998:722) to the Council on Dental Education and Licensure for further study. This resolution proposed revisions to the section on "Licensure by Credentials," item a., of the Association's Guidelines for Licensure *(Reports* 1998:86). (A copy of the Guidelines policy is included in this report as Appendix 1.)

The Council had proposed revisions to the policy in response to a request from the Council on Membership and with the intent that the language of the revised policy would make the policy consistent with the Association's 1984 Policy on Licensure of Graduates of Nonaccredited Dental Schools *(Trans.*1984:539).

In conjunction with its consideration of Resolution 10-1998, the House of Delegates also considered two substitute resolutions, 10B and 10RC. Resolution 10B supported the language of the Council and added a clause that provided an additional option for state boards to grant licensure by credentials to candidates who have "successfully met the requirements for licensure in another state and who currently hold a valid license to practice dentistry in that state." Resolution 10RC added language to further clarify the statement regarding the level of education required of a candidate for licensure by credentials.

Following debate regarding the intent of the language contained in all three versions of the resolution, the House voted to refer Resolution 10RC-1998 to the appropriate agency of the Association for further study. Accordingly, the resolution was referred to the Council on Dental Education and Licensure for study and report to the 1999 House of Delegates.

In reconsidering this issue, the Council determined it would be beneficial to seek comments from the communities of interest. The communities of interest included the Council on Government Affairs, the Council on Membership, the Committee on the New Dentist, constituent dental societies, state boards of dentistry, the American Student Dental Association, the American Association of Dental Schools, the American Association of Dental Examiners, the National Dental Association, the American Association of Women Dentists, the Society of American Indian Dentists, the Hispanic Dental Association, the Indian Dental Association, the National Association of Filipino Dentists of America and the Spanish American Medical Society of New York, Inc. A total of 13 responses were received in response to the call for comments.

As in 1998, the Council focused its discussion on the section of the policy that addresses "Licensure by Credentials." The Council carefully reviewed and considered all comments received from the communities of interest and determined that Resolution 10RC-1998 should be further amended. Specifically, the Council has included language that is intended to simultaneously address the needs of the state dental boards as well as the issues cited by underrepresented groups within the Association's membership that consider the language of the current policy as a barrier to membership in the Association. The Council agreed with its earlier conclusion that some language in the current policy should be retained because it is necessary and appropriate to ensure the protection of the public, as the licensure examination process can only address selected elements of theoretical knowledge and clinical competency. For this reason the Council believed that the proposed language to amend this policy must also incorporate language that addresses the educational qualifications of foreign-trained dentists so it is consistent with the language in the 1984 Policy. Additionally, the Council believed that the proposed language would clarify that the same educational standards should apply for both initial licensure and licensure by credentials.

The Council recognizes that some compromise is needed in order to arrive at revised language that addresses the variety of viewpoints regarding this important matter. However, the Council believed its proposed amendments support accredited dental education, while at the same time give the state boards sufficient latitude to accept graduates of United States dental schools and potentially those graduates of foreign programs. For these reasons, the Council recommended that the Guidelines for Licensure, section on "Licensure by Credentials," item a, be revised as follows (underlined text represents additions):

> All candidates for licensure by credentials are required to fulfill basic education and practice requirements. Further, it is recommended that licensure by credentials be available only to a candidate who:
>
> a. has graduated from a dental school accredited by the Commission on Dental Accreditation, or has completed a supplementary predoctoral education program of at least two academic years in an accredited dental school and has been certified by the dean of an accredited dental school as having achieved the same level of didactic and clinical competence as expected of a graduate of the school, or has completed an educational experience that is recognized by the respective state dental board as equivalent to the above.

Accordingly, in response to referral of Resolution 10RC-1998, the Council approved the following resolution for transmittal to the Association's 1999 House of Delegates. This resolution supports ADA Strategic Plan goals I. Advocacy and V. The Association: Member and Support Services.

11. Resolved, that the Guidelines for Licensure (*Trans.*1992:632) be amended as follows to incorporate language into the Section on "Licensure by Credentials," item a, related to the educational qualifications required of candidates for licensure by credentials that is consistent with the 1984 Policy on Licensure of Graduates of Nonaccredited Dental Schools (*Trans.*1984:539), while at the same time provides sufficient latitude to state boards in granting licensure by credentials to foreign-trained dentists.

All candidates for licensure by credentials are required to fulfill basic education and practice requirements. Further, it is recommended that licensure by credentials be available only to a candidate who:

a. has graduated from a dental school accredited by the Commission on Dental Accreditation, or has completed a supplementary predoctoral education program of at least two academic years in an accredited dental school and has been certified by the dean of an accredited dental school as having achieved the same level of didactic and clinical competence as expected of a graduate of the school, or has completed an educational experience that is recognized by the respective state dental board as equivalent to the above.

Proposed Policy Statement on Lifelong Learning

As an outcome of the Council on Dental Education and Licensure's strategic planning activities, the Council concluded that it should study issues associated with lifelong learning. The Council believed that an Association policy on lifelong learning and resources to assist members with their professional obligations to remain current and to enhance skills would be a valued membership benefit. The Council believed that one of its first goals should be to urge the adoption of a policy statement on lifelong learning. Subsequently, over the past year the Council drafted a proposed statement. With the Board's approval, the statement will be circulated to the communities of interest for comment. Based on the comments received from the communities of interest, the Council expects to finalize the proposed policy statement during its year 2000 meetings for transmittal to the 2000 House of Delegates. Additionally, the Council expects to finalize short-term and long-term goals associated with its lifelong learning initiatives.

Continuing Dental Education

Report on the ADA Continuing Education Recognition Program: The ADA CERP Committee meets twice annually; its report and recommendations are subsequently forwarded to the Council for final action. During the past year, the Council adopted modifications to the *ADA CERP Recognition Standards and Procedures.* These additions include: 1) discontinuing assignment of a provider code number to recognized providers, and 2) requiring additional information in verification of attendance documentation. Additionally, the Council adopted revisions to eligibility criteria so that a provider must offer a planned program of continuing dental education consisting of more than a single course offered multiple times.

Currently, 326 continuing education providers are ADA CERP-recognized. Nearly 80% of the ADA constituent dental societies and 90% of the U.S. and Canadian dental schools have been recognized to date. With the inclusion of a Canadian dental representative on the ADA CERP Committee, the Canadian Dental Association markets ADA CERP to Canadian continuing dental education providers and encourages provincial licensing bodies to accept ADA CERP approval.

The ADA CERP includes an extended approval process through which CERP-recognized constituent dental societies and specialty organizations represented on the ADA CERP Committee can extend approval to their component societies and affiliates. This is the third year of the extended approval process, and during this period constituent dental societies, the American Academy of Oral and Maxillofacial Pathology and the American Association of Endodontists have extended recognition to over 80 of their component societies or affiliates.

Twice a year, following each Council meeting, the *ADA CERP List of Recognized Continuing Education Providers* is published and distributed to state dental boards, national dental organizations, constituent and component dental societies, dental schools and other interested parties. In addition, the current *List of Recognized Continuing Education Providers*, a description of the ADA CERP and a Fact Sheet about the program are available on the Internet through ADA ONLINE. ADA CERP-recognized sponsors also receive a semiannual newsletter which highlights program benefits and provides updates on recent policy changes and resources.

Continuing Education Course Listing: Since 1991, the Council has compiled, published and distributed the semiannual *Continuing Education Course Listing* as a resource for dentists and allied dental personnel. Typically, between 1,100 and 1,500 courses offered by approximately 150 sponsors are included in the course list. The listing has been provided to Association members free-of-charge and is available for purchase by nonmembers. Additionally, members of the Association may access the *Continuing Education Course Listing* in the members-only section of ADA ONLINE.

To maintain the *Continuing Education Course Listing* as a revenue-neutral cost center, beginning in 2000, the information will be available for purchase through the ADA Department of Salable Materials. Effective with the January–June 2000 issue, the *Continuing Education Course Listing* will be available for order through the *ADA Catalog.* ADA members will be charged a nominal fee for a print copy of the *Continuing Education Course Listing.* Members will continue to have access to the *Continuing Education Course Listing* information in the members-only section of ADA ONLINE.

Nonmembers will be assessed a 50% surcharge over the subtotal for orders placed through catalog sales.

Dental Admission Testing Program

Dental Admission Testing Program (DAT) Trends: In 1998, the number of candidates participating in the DAT Program decreased for the second consecutive year. The number of candidates (9,491) represented 7% fewer candidates than in 1997. The number of candidates had decreased by 10% between 1996 and 1997, to record the first decrease since 1989. This number includes candidates who took the written test and those who took the computerized test. The percentages of males and females participating in the testing program have been changing slightly each year, with the female candidates now constituting approximately 40% of the DAT candidate pool. There have also been changes in the ethnic distribution of the candidates participating in the program. During the past eight years, the percentage of candidates identifying themselves as Asian has gradually increased from 19% to 30%. These annual increases are being largely offset by decreases in the percentages of white candidates, which have declined from 67% to 59%. The percentages of Native American, black and Hispanic candidates have remained relatively stable during this period at 1%, 5% and 6% respectively.

Average candidate performance has increased steadily in recent years, but these annual increases are slight. For example, over the past five years, the mean DAT Academic Average score for first-time candidates increased from 16.5 to 17.1. Likewise, the mean DAT Academic Average of candidates who were accepted into dental schools during the same period increased from 17.0 to 18.3. This suggests that dental schools are selecting applicants with higher DAT scores.

Dental Admission Testing Program Development and Research Activities: Increasingly, national testing agencies are converting from the print to the computer medium to deliver their testing materials. In 1999, the printed version of the DAT was discontinued, and the DAT is currently offered only via the computer medium. There are many advantages associated with the use of computer-based testing. To name a few, it allows for testing on virtually any day of the year, provides increased test security and reports test results immediately. Research comparing performance on the printed versions of the DAT to performance on the computer-based versions has indicated no significant differences between the two.

Research on the DAT continues in other areas: annual validation studies concerning the degree to which the DAT predicts performance in dental-school didactic and technique courses; analyses to determine if the items on the DAT are differentially familiar to any particular group of candidates; and research on alternate formats to test critical thinking.

Dental Hygiene Admission Test Validity Study (DHAT): During 1998 and 1999, the Department of Testing Services conducted a validity study for the DHAT, as operationalized in a pilot test. The pilot test battery was administered at a representative sample of accredited dental hygiene educational programs. Validity research was conducted by comparing performance on this test to performance in the dental hygiene programs. A report of the study is being sent to all program directors with a request for information to determine how many programs would require the admission test, if it were officially initiated. The appropriate use of such a test battery would enable program directors to select those applicants who are most likely to succeed in the program.

Response to Assignments from the 1997 House of Delegates

Differences in the Dental and Medical Education Process: Resolution 55H-1997 (*Trans.*1997:695) was referred to the Council on Dental Education and Licensure for development of an action plan in conjunction with the American Association of Dental Schools to help dental school leaders communicate to the leadership of parent institutions the differences between the medical and dental education process *(Reports* 1998:89*)*. The ADA/AADS Joint Committee to Address Resolution 55H-1997 met in August 1998 to address this resolution. The Joint Committee is currently finalizing its draft report. The report explores the differences between medical education and dental education, the value of the dental school within the university and outlines the many other issues facing dental education today. In particular, these issues relate to funding dental education, issues associated with a school's use of affiliated/satellite dental clinics and the need for dental schools and practitioners to form collaborative partnerships. The report concludes with several recommendations intended to address the intent of this resolution. Issues being studied by the Joint Committee and the ADA/AADS Task Force Study of Satellite Dental Clinics as directed by Resolution 84H-1997 (*Reports* 1998:90) are closely related. For this reason, the Joint Committee's report will be provided to the Board of Trustees and the House of Delegates in conjunction with consideration of the report of Task Force Study of Satellite Dental Clinics.

Task Force Study of Dental School Satellite Clinics: Resolution 84H-1997 (*Trans.*1997:684) directed that the Task Force to Study Dental School Facilities and Programs, appointed in 1997 be continued to conduct an expanded survey of dental schools and dental associations. The survey was conducted in late spring and early summer of 1998. Subsequently, the Task Force met in December 1998 to begin analyzing the responses received from these surveys. The Task Force has not yet completed review of the survey data. The Task Force and will provide a report and the results of this study to the Board of Trustees and the House of Delegates.

Response to Assignments from the 1998 House of Delegates

Revision of Association Policy Statement on Requirements for the Approval of a Certification Board for Dental Laboratory Technicians: Resolution 7H-1998 (*Trans.*1998:713) approved revised requirements for a certifying board for dental laboratory technicians. Subsequently, the Council notified the National Board for Certification (NBC) of the adoption of the revised requirements. Further, the NBC was advised that it would be necessary to reapply for approval as a certifying board using these revised requirements. The Council's recommendation regarding an application for approval of a certifying board for dental laboratory technicians will be transmitted to the Association's House of Delegates for action. This policy will be included in the next edition of *Current Policies*.

Policy on Dental Licensure: Resolution 8H-1998 (*Trans.*1998:720) updated the Association's policies on dental licensure by combining several policies into a comprehensive statement. The revised policy has been provided to constituent dental societies, state boards of dentistry, regional testing agencies and other communities of interest. Further, the policy has been included in the Council's compilation of licensure related materials, *Facts on Dental Licensure*, which is distributed to members upon request and will be included in the next edition of *Current Policies*. Additionally, this resolution directed rescission of a number of outdated and redundant Association policies. All pertinent documents have been modified to reflect rescission of these Association policies.

Rescission of Licensure Policies: Resolution 9H-1998 (*Trans.*1998:721) rescinded four licensure policies. The 1998 House rescinded these policies because it was determined that the policies were outdated and/or redundant or the language has been incorporated into the revised Policy on Licensure (*Trans.*1998:721). All pertinent documents have been modified to reflect the rescission of these Association policies.

Amendment to the Guidelines for Licensure: Resolution 10RC-1998 (*Trans.*1998:722) calling for revision of the Association's Guidelines for Licensure was referred to the Council for further study. The Council's report regarding this matter is provided on page 93 of this report.

Revision of the Association Policy Statement on Continuing Dental Education: Resolution 11H-1998 (*Trans.*1998:722) amended the Policy Statement on Continuing Dental Education. The revised policy has been provided to constituent dental societies, state boards of dentistry, dental deans and all ADA CERP recognized continuing education sponsors. In addition, the revised policy will be included in the next edition of *Current Policies*.

Development of Guidelines for Examiner Standardization: Resolution 36H-1998 (*Trans.*1998:713), directs the Association to work with involved agencies and organizations to actively endorse and urge all dental clinical testing agencies and their participating licensing boards to follow the recommendations of the Guidelines for Examiner Standardization. In response to this directive, the Council has added a new section to its *1999 Annual Survey of Clinical Testing Agencies*. The new section is intended to allow the Council to annually monitor testing agencies' use of the new Guidelines. The results of the *1999 Annual Survey* will be reported to the House in the Council's 2000 annual report.

Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists: In response to Resolution 37H-1998 (*Trans.*1998:723), copies of the revised Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists have been provided to the communities of interest. Additionally, this document has been placed on ADA ONLINE. This resolution also directed that the appropriate agency of the Association revise the Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry (*Trans.*1992:610) to be consistent with the newly revised Guidelines for Dentists. The Council expects to complete this directive in July. Subsequently, the Council will provide a report to the Board of Trustees and the 1999 House of Delegates in response to this directive.

Policy Statement on the Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry: In response to Resolution 38H-1998 (*Trans.*1998:724), correspondence has been sent to the communities of interest informing them of this revised Association policy. This document is also available on ADA ONLINE. Additionally, in conjunction with revision of the Association's Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry, it was determined that the policy statement also requires further amendment. The Council expects to complete this directive in July. A copy of the proposed revised document will be provided to the Board of Trustees and the 1999 House of Delegates.

Acceptance of Successful Completion of State or Regional Licensure Examination by State Boards of Dentistry: Resolution 56H-1998 (*Trans.*1998:725) directs that all constituents be urged to submit formal proposals to their respective state dental licensing agencies that would provide for acceptance of successful completion of a licensure examination by any recognized individual state or regional testing agency for the purpose of licensure in their state. Constituent dental societies were notified of the adoption of this resolution in January 1999 correspondence from the Association's Department of State Government Affairs.

To implement this directive, the Council is working with the Council on Government Affairs, through its Department of State Government Affairs (DSGA). Specifically, a resource packet is being developed that constituent dental societies can use in providing information to state legislatures and state dental boards about the need for changes in state laws and regulations regarding licensure and the acceptance of results of

clinical licensure examinations. The resource packet will be similar to other resource packets developed by the DSGA for legislative purposes. Information to be contained in the packet includes: relevant ADA policies on licensure; strategies; suggested strategies for addressing this matter with both legislators and state dental boards; questions and answers related to this subject; and other reference materials as identified. It is anticipated that the revised packet will be available for distribution to constituent dental societies this summer.

Programs to Recruit Allied Personnel to Dentistry: Resolution 57H-1998 (*Trans.*1998:713) directs the Association to develop programs to recruit qualified allied personnel to dentistry. In response to this directive, the Association's president appointed an Interagency Committee comprised of members from the Council on Dental Education and Licensure and the Council on Dental Practice to develop program proposals for the recruitment of allied dental personnel. The Interagency Committee is scheduled to meet in May. In conjunction with its assignment, the Committee will review materials from career guidance activities previously conducted by the Association. It is intended that the Committee's proposal will include opportunities for constituent and component societies and member dentists to be actively involved. The Committee's proposal will be provided to the Board of Trustees and the 1999 House of Delegates as directed by the resolution.

Development of Criteria to Allow High School Dental Assisting Programs to Become Accredited: Resolution 59H-1998 (*Trans.*1998:728) directs the Association to urge its constituents to promote and support high school-level dental assisting training programs approved through state vocational education recognition programs. The Interagency Committee appointed by the Association president to address Resolution 57H-1998 *(Trans.*1998:713*)* will provide input regarding this directive. Actions taken to implement this resolution will be provided to the Board of Trustees and the 1999 House of Delegates.

Amendment to Comprehensive Policy Statement on Dental Auxiliary Personnel: Resolution 80H-1998 (*Trans.*1998:713) amended the Association's Comprehensive Policy Statement on Dental Auxiliary Personnel. The revised statement has been circulated to constituent dental associations and state boards of dentistry. In addition, the policy statement is available on ADA ONLINE. Further, the policy will be included in the next edition of *Current Policies.*

Summary of Resolutions

6. Resolved, that Resolution 88-1973-H (*Trans.*1973:726), Dental Auxiliary Master Plans, be rescinded.

7. Resolved, that Resolution 91H-1995 (*Trans.*1995:643), Implementation of Recommendations Contained in the Institute of Medicine Report, be rescinded.

8. Resolved, that the American Academy of Oral and Maxillofacial Radiology's request for the recognition of oral and maxillofacial radiology as a dental specialty be approved.

9. Resolved, that the American Society of Dentist Anesthesiologists' request for the recognition of dental anesthesiology as a dental specialty be approved.

10. Resolved, that the American Academy of Oral Medicine's request for the recognition of oral medicine as a dental specialty be denied.

11. Resolved, that the Guidelines for Licensure (*Trans.*1992:632) be amended as follows to incorporate language into the Section on "Licensure by Credentials," item a, related to the educational qualifications required of candidates for licensure by credentials that is consistent with the 1984 Policy on Licensure of Graduates of Nonaccredited Dental Schools (*Trans.*1984:539), while at the same time provides sufficient latitude to state boards in granting licensure by credentials to foreign-trained dentists.

All candidates for licensure by credentials are required to fulfill basic education and practice requirements. Further, it is recommended that licensure by credentials be available only to a candidate who:

a. has graduated from a dental school accredited by the Commission on Dental Accreditation, or has completed a supplementary predoctoral education program of at least two academic years in an accredited dental school and has been certified by the dean of an accredited dental school as having achieved the same level of didactic and clinical competence as expected of a graduate of the school, or has completed an educational experience that is recognized by the respective state dental board as equivalent to the above.

Appendix 1

Guidelines for Licensure

(*Trans.*1992:632)

Dental licensure is intended to ensure that only qualified individuals provide dental treatment to the public. Among qualifications deemed essential are satisfactory theoretical knowledge of basic biomedical and dental sciences and satisfactory clinical skill. It is essential that each candidate for an initial license be required to demonstrate these attributes on examination, a written examination for theoretical knowledge and a clinical examination for clinical skill. These guidelines suggest alternate mechanisms for evaluating the theoretical knowledge and clinical skill of an applicant for licensure who holds a dental license in another jurisdiction. Requiring a candidate who is seeking licensure in several jurisdictions to demonstrate his or her theoretical knowledge and clinical skill on separate examinations for each jurisdiction seems unnecessary duplication.

Licensure by Examination: Written examination programs conducted by the Joint Commission on National Dental Examinations have achieved broad recognition by state boards of dentistry. National Board dental examinations are conducted in two parts. Part I covers basic biomedical sciences; Part II covers dental sciences. It is recommended that satisfactory performance on Part II of the National Board dental examinations within five years prior to applying for a state dental license be considered adequate testing of theoretical knowledge. National Board regulations require a candidate to pass Part I before participating in Part II. Consequently, this recommendation excludes Part I only from the time limit.

No clinical examination has achieved as broad recognition as have National Board written examinations. Clinical examinations used for dental licensure are conducted by individual state boards of dentistry and by regional clinical testing services. It is recommended that satisfactory performance within the last five years on any state or regional clinical examination at least equivalent in quality and difficulty to the state's own clinical examination be considered adequate testing for clinical skill provided that the candidate for licensure:

a. is currently licensed in another jurisdiction.
b. has been in practice since being examined.
c. is endorsed by the state board of dentistry in the state of his or her current practice.
d. has not been the subject to final or pending disciplinary action in any state in which he or she is or has been licensed.
e. has not failed the clinical examination of the state to which he or she is applying within the last three years.

Licensure by Credentials: The American Dental Association believes that an evaluation of a practicing dentist's theoretical knowledge and clinical skill based on his or her performance record can provide as much protection to the public as would an evaluation based on examination. Issuing a license using a performance record in place of examinations is termed licensure by credentials.

All candidates for licensure by credentials are required to fulfill basic education and practice requirements. Further it is recommended that licensure by credentials be available only to a candidate who:

a. has graduated from a dental school accredited by the Commission on Dental Accreditation.
b. is currently licensed in another jurisdiction.
c. has been in practice or full-time dental education for a minimum of five years immediately prior to applying.
d. is endorsed by the state board of dentistry in the state of current practice.
e. has not been the subject of final or pending disciplinary action in any state in which he or she is or has been licensed.
f. has not failed the clinical examination of the state to which he or she is applying within the last three years.

Additional criteria to determine the professional competence of a licensed dentist could include:

g. Information from the National Practitioner Data Bank and/or the AADE Clearinghouse for Disciplinary Information.
h. Questioning under oath.
i. Results of peer review reports from constituent societies and/or federal dental services.
j. Substance abuse testing/treatment.
k. Background checks for criminal or fraudulent activities.
l. Participation in continuing education.
m. A current certificate in cardiopulmonary resuscitation.
n. Recent patient case reports and/or oral defense of diagnosis and treatment plans.
o. No physical or psychological impairment that would adversely affect the ability to deliver quality dental care.
p. Agreement to initiate practice in the credentialing jurisdiction within a reasonable period of time to ensure that licensure is based on credentials that are current at the time practice is initiated.

q. Proof of professional liability coverage and that such coverage has not been refused, declined, canceled, nonrenewed or modified.

Alternate ways that current theoretical knowledge might be documented follow. It is recommended that for a candidate who meets eligibility requirements for licensure by credentials, these methods be considered as possible alternatives to the written examination requirement.

1. Successful completion of an accredited advanced dental education program in the last ten years.
2. A total of at least 180 hours of acceptable, formal scientific continuing education in the last ten years, with a maximum credit of 60 hours for each two-year period.
3. Successful completion of a recognized specialty board examination in the last ten years.
4. Teaching experience of at least one day per week or its equivalent in an accredited dental education program for at least six of the last ten years.

Possible documentation for current clinical skill appears in the following list. Provided that eligibility requirements for licensure by credentials are met, it is recommended that these methods be considered as possible alternatives to satisfactory performance on a clinical examination.

1. Successful completion of an accredited general practice residency or dental internship within the last ten years.
2. Successful completion of an accredited dental specialty education program in a clinical discipline within the last ten years.
3. A total of at least 180 hours of acceptable clinically-oriented continuing education in the last ten years, with a maximum credit of 60 hours for each two-year period.
4. Clinical teaching of at least one day per week or its equivalent in an accredited dental education program, including a hospital-based advanced dental education program, for at least six of the last ten years.
5. Presenting case histories of patients treated by the candidate in the last five years, with preoperative and postoperative radiographs, covering procedures required on the state clinical examination, for discussion with the state board.

Joint Commission on National Dental Examinations

Kalkwarf, Kenneth L., Texas, 1999, chairman, American Association of Dental Schools
Williamson, Carol E., Florida, 1999, vice chairman, American Association of Dental Examiners
Campbell, W. Lynn, South Carolina, 2001, American Dental Association
Dorvinen, Harry, Minnesota, 2002, American Association of Dental Examiners
Dvorak, Marvin B., Nebraska, 2001, American Association of Dental Examiners
Franklin, Sanford M., Ohio, 1999, American Dental Association
Hobbs, Evelyn, Arizona, 2002, American Dental Hygienists' Association
Hume, W. Rory, California, 2001, American Association of Dental Schools
Leeper, Stephen H., Nebraska, 2000, American Association of Dental Schools
Lefcoe, Sanford L., Jr., Virginia, 2001, American Association of Dental Examiners
Neil, David, Illinois, 1999, American Student Dental Association
Pattalochi, Robert E., Wyoming, 2000, American Association of Dental Examiners
Stamatelakys, Constantine, Wisconsin, 2002, American Dental Association
Wood, Martha, Texas, 2002, public representative
Wyman, Ross G., Maine, 2000, American Association of Dental Examiners
DeMarais, David R., director, Department of Testing Services

Support of Association's Strategic Plan: The primary objective of the Joint Commission on National Dental Examinations is to provide high quality and state-of-the-art National Board Dental and Dental Hygiene Examinations. In this way, the Joint Commission supports the Association's Strategic Plan by furthering the Association's commitment to quality dental care, by promoting excellence and consistency in the education and evaluation of the dental team members, by providing uniform written licensure examinations and by working with other dental organizations in a collegial relationship concerning initial licensure.

Meetings: The Joint Commission on National Dental Examinations met in the Headquarters Building, Chicago, on March 3, 1999. Most of the topics considered by the Joint Commission had been thoroughly reviewed by one of four committees. The Committees on Administration, Dental Hygiene and Examination Development met on the previous day, March 2. The fourth standing committee, the Committee on Research and Development, met in September 1998.

The Annual National Dental Examiners' Advisory Forum, sponsored by the Joint Commission, met in Chicago on the morning of March 2. Approximately 110 state board representatives and dental educators from more than 40 states attended the Forum. The program addressed various aspects of the National Board Dental and Dental Hygiene Examinations: examination structure; scoring method; examination reliabilities; and trends in pass/fail rates. Presentations regarding a validity study of the Part II examination and progress on the research and development of the Dental Interactive Simulations Corporation (DISC) computerized patient simulations were included.

Twenty-three test development committees met during the year to develop new editions of National Board Dental and Dental Hygiene Examinations. A test development committee also met to study the feasibility and propose a structure of a test of professional ethics and responsibility.

Acknowledgments: The Joint Commission acknowledges with appreciation the contributions made by Dr. Sanford Franklin, Dr. Kenneth Kalkwarf, Mr. David Neil and Dr. Carol Williamson, who complete their service on the Joint Commission this year.

Trends in Numbers of Test Candidates and Pass Rates:

National Board Dental Examinations, Part I. The number of Part I candidates in 1998 was the highest in the past ten years. However, the number of candidates from accredited dental schools (4,897), as well as candidates who graduated from nonaccredited dental schools (2,593), increased minimally as compared to the previous year. Part I performance of candidates from accredited schools has been fairly stable from 1993 to 1998 with an overall pass rate of 86%. Part I performance of graduates of nonaccredited dental schools declined from a pass rate of 49% in 1993 to only 36% in 1998.

National Board Dental Examinations, Part II. The number of 1998 Part II candidates from accredited dental schools (5,078) was similar to the previous year. The Part II performance of candidates from accredited dental schools was also similar to the previous year, with an overall pass rate of 82%. The number of candidates from nonaccredited dental schools was the highest in the past ten years (1,554). Part II performance of candidates from nonaccredited dental schools has remained relatively stable during the past four years, with pass rates between 40% and 45%.

National Board Dental Hygiene Examination. The numbers of candidates taking the dental hygiene examination in 1998 reached a ten-year high (6,006). A new comprehensive examination, which included dental hygiene patient cases, was introduced in 1998. The new format has enhanced the validity of the examination by assessing problem-solving skills more reflective of those required in the practice of dental hygiene. At the same time, the new examination has provided a highly reliable score, with a Kuder Richardson-20 index of 0.91. Performance on this new examination (88% pass rate), while lower than in recent years, was similar to performance on the examinations between 1989 and 1992.

Virtually all candidates for the dental hygiene examination are students or graduates of accredited dental hygiene programs, because the examination eligibility requirements require that candidates from nonaccredited programs be graduates of programs that are equivalent to accredited programs. The Joint Commission changed this requirement during its meeting in 1999. Beginning in January 2000, candidates will also be eligible for the examination if they graduate from nonaccredited programs that have been approved by the state board as fulfilling the educational requirement for licensure.

Pass Rates of Repeating Candidates. Historically, candidates who fail the examinations and choose to repeat the examinations have pass rates significantly lower than first-time candidates. For the most recent complete testing year (1998), Part I candidates from accredited dental schools who were taking the examination for the first time had a pass rate of 91%, while repeating candidates had a pass rate of only 60%. Part II candidates from accredited schools who were taking the examination for the first time had a pass rate of 87%, while repeating candidates had a pass rate of only 57%.

Graduates of nonaccredited dental schools who were taking Part I for the first time in 1998 had a pass rate of 61%, while repeating candidates from nonaccredited schools had a pass rate of only 25%. Part II candidates from nonaccredited schools who were taking the examination for the first time had a pass rate of 52%, while candidates from nonaccredited schools who were repeating the examination had a pass rate of only 35%.

Repeating dental hygiene candidates also had pass rates significantly lower than first-time candidates. In 1998, the repeating dental hygiene candidates had a pass rate of only 56%, while the pass rate for first-time candidates was 92%.

Selection of Test Constructors for National Board Examinations: Each year, the Joint Commission communicates with constituent dental societies, dental schools, dental hygiene programs and state boards of dentistry requesting applications for new test constructors to fill vacancies on a rotating basis. During its recent meeting, the Joint Commission reappointed 67 dental test constructors and 16 dental hygiene test constructors to another one-year term and selected ten new dental test constructors and three new dental hygiene test constructors.

Research and Development Program: Each year, the Department of Testing Services performs routine research studies on the National Board examinations. The examinations are monitored to maintain standards of validity and reliability. During 1998, a validity study of the Part II Examinations was completed. A sample of general practitioners and state board examiners were surveyed to identify the competencies important to initial licensure and to the practice of general dentistry. Recommendations for revisions in the structure of the Part II Examinations were reviewed and acted upon by the Joint Commission. The Joint Commission also initiated the computerized testing of the Part II Examinations on the Sylvan Prometric network. The biannual administration of the Part II Examinations in printed format will continue for at least another year.

Continuation of Support for the Dental Interactive Simulations Corporation (DISC): The Joint Commission will continue its financial support of DISC with funds generated through a National Board candidate assessment. The contribution agreement, begun in 1995, will terminate with a final payment after the December 1999 examination. The Joint Commission has directed the Committee on Research and Development to recommend ways to develop applications of the DISC technology for the National Board Examinations.

Assistance to Other Agencies: One of the duties of the Joint Commission is to serve as a resource for the dental profession for written examinations. During the past year, staff assisted other dental organizations in developing new examinations, revising test specifications, reviewing examination procedures, scoring examinations and analyzing examination quality. This support was provided to: the American Board of Endodontics; the American Academy of Pediatric Dentistry; the American Board of Periodontology; the Academy of General Dentistry; and the American Association of Hospital Dentists. This assistance is provided for a fee to cover costs. Special examinations for licensure are also provided to state boards of dentistry upon request.

Response to Assignment from the 1998 House of Delegates:

Independent Study to Determine the Comparability of the National Board Dental Examination Part II and the Written Simulated Clinical Examination. Resolution 58H-1998 (Trans.1998:727) was referred by the Board of Trustees to a Joint Steering Committee consisting of one member of each of the ADA Board of Trustees, the Joint Commission on National Dental Examinations and the Northeast Regional Board for implementation. The Joint Steering Committee held its first meeting on May 24, 1999, to review the charge to the Committee and to prepare a Request for Proposal for the independent study. A report will be made to the 1999 House of Delegates.

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

Division of Finance and Operations

Council on Insurance

Notes

Council on Insurance

Abelson, Sigmund H., California, chairman, 1999
Feldman, Mark J., New York, vice chairman, 2000
Barth, Tom L., Kansas, 1999
Broadbent, Charles D., Arizona, 2001
Ciampa, Joseph H., Massachusetts, 2001
Comar, Terence R., Michigan, 2002
Haas, David G., Ohio, 2002
Kenney, Lawrence M., Pennsylvania, 2000
Kolb, Ronald G., Minnesota, 2002
Malinowski, Andrew S., Delaware, 2000
Moon, G. Rodger, Illinois, 1999
Smith, Richard M., Texas, 2001
Stanislav, Leon E., Tennessee, 1999
Trager, Peter S., Georgia, 2002
Wandell, Timothy E., Washington, 2000
Willis, Charles S., North Carolina, 2001
Dwyer, David R., director

Meetings: The Council met at the Headquarters Building on August 21-22, 1998 and March 26-27, 1999. It is scheduled to meet again August 27-28, 1999.

Vice Chairman: Dr. Mark J. Feldman was elected vice chairman of the Council at the March 1999 meeting.

The Strategic Plan of the American Dental Association: The Council supports the Strategic Plan's goal of providing products and services that help members manage the business aspects of their practices and their personal well-being. It does this by offering competitively priced insurance and retirement programs designed to meet the specific needs of dentists and their families. It is assisting dentists be more effective consumers of professional liability insurance by making available directories of insurance companies selling coverage in each state, and by offering information that helps dentists better understand professional liability insurance policies as well as the events that occur in malpractice litigation. In the professional liability section of *ADA ONLINE,* the Council maintains a library of articles that can help dentists improve their ability to defend themselves against unfounded allegations of malpractice. As all of these programs and services are available exclusively to Association members, they support the Strategic Plan's goal of maintaining high levels of membership.

At its March 1999 meeting, the Council reviewed its major programs and activities and concluded that each contributes to the Strategic Plan's goals and objectives. The Council further agreed that the most appropriate measure of membership utilization of the Association-sponsored insurance and retirement programs was the total number of members participating in each program at year-end.

ADA Member Group Insurance Programs

The four ADA member group insurance programs are available exclusively to members of the Association and are underwritten and administered by the Great-West Life & Annuity Insurance Company. They offer coverage designed to meet the needs of dentists and their families at rates that are lower than those of comparable policies generally available in the market. The programs are marketed without the use of agents and are experience rated. When claim experience is favorable, surplus funds may be returned to participants through premium credits and/or benefit enhancements.

Group Life Insurance Program: The Group Life Insurance Program consists of: the Term Life Insurance Plan; the Term Plus Insurance Plan; and the Noncontributory Life Insurance Plan for Dental Students. As of December 31, 1998, nearly $23.5 billion of insurance was in force under the Program, an increase of over 4% as compared to 1997.

At year-end, 64,383 member dentists were participating in the Term Life Plan and the average amount of coverage carried per member was approximately $282,000. In addition, 22,102 members were insuring their spouse and 10,773 were insuring their eligible, dependent children.

Participating in the Noncontributory Life Insurance Plan for Dental Students were 6,509 student members. 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 Student Plan is borne by the ADA Group Life Insurance Program. In 1998, approximately 45% of the Student Plan participants who graduated in 1997 elected to continue coverage under the ADA Term Life Plan.

The Term Plus Insurance Plan had 2,410 participants as of December 31, 1998 and the average amount of coverage in force per member was $292,552. The Plan combines life insurance protection with a tax-advantaged savings account.

Participants may make premium contributions that exceed the cost of the life insurance protection and administrative fees. These excess contributions are invested in one-, three- and/or five-year fixed income accounts that provide a rate of interest competitive with yields offered by major banks on certificates of deposit having comparable maturities. Participants deposited approximately $3.4 million to their cash accumulation accounts in 1998, raising the Plan's total invested assets to nearly $36.9 million.

Benefits totaling nearly $31 million were paid to the beneficiaries of the 339 Life Insurance Program participants who died during 1998. The deceased included 316 members, 17 spouses and six children. Based upon the financial experience of the Life Insurance Program in 1998, the Council determined that a premium credit of 45% should be applied in 1999.

Declining Participation in the Life Insurance Program. The Council is concerned that participation in the Life Insurance Program has been declining as a consequence of the lack of growth in the number of Association members under 60 years of age. Over the past ten years, the total number of member dentists participating in the Program has fallen by 6%. At the same time, the average age of the participating members has been rising, probably as a result of a similar trend among the membership as a whole. Over 41% of the participants are now ages 51 and older, compared to just 29% in 1989. Although these trends do not present an immediate problem, over time, they will cause an increase in the Life Insurance Program's loss ratios.

The problems these demographic trends present for the Life Insurance Program are exacerbated by intensely competitive conditions in the life insurance market. Using the Internet, television and national publications, an increasing number of insurance companies are aggressively marketing policies by quoting extremely low premiums as a means of generating leads. These low premiums, called "super select" rates, are only available to individuals who can meet stringent medical underwriting guidelines, but at some ages, they are lower than the premiums offered by the ADA Term Life Insurance Plan. This is having an adverse impact upon enrollment as well as the Plan's reputation for offering outstanding value. In order to address this competition, the Council has taken a number of measures. It has made the Plan's accidental death and waiver of premium coverage optional, which facilitates cost comparisons with policies not having these features. The Council has also introduced, for no additional premium, a benefit that allows terminally ill participants the option of receiving up to $100,000 of their benefits while still living. This eliminates the need for those in financial hardship to consider viatical settlements. The Council has also sought to offer the highest premium credit possible given the Plan's financial experience and has increased marketing and advertising expenditures. While the Council believes these measures will help maintain the Plan's competitive position, it remains concerned about the long-term effect unfavorable membership trends will have on the Life Insurance Program.

Income Protection Plan: As of December 31, 1998, 22,281 members were participating in the Income Protection Plan as compared to 23,367 members one year earlier. During the year, over $22 million in benefits were paid to participants who became disabled on or after November 1, 1992. Additional benefits were paid to participants disabled prior to that date by the Plan's previous underwriter, the Life Insurance Company of North America.

The Income Protection Plan offers monthly benefits as high as $8,000 that are payable when an injury or illness prevents the insured dentist from working in his or her special area of practice. Payments are not reduced if the dentist is able but chooses not to return to work in another occupation. Because this "own occupation" definition of disability is increasingly rare in the market, it is one of the major advantages of the ADA Plan over alternative policies. The Plan also offers residual disability benefits when the disabled dentist returns to work in his or her special area of practice on a part-time basis or obtains employment in a new occupation.

Declining Enrollment. The Income Protection Plan's liberal coverage features, combined with its very competitive rate structure, make it an outstanding value. The Council is not aware of any policies that offer comparable benefits at lower cost. However, until recently, conditions in the disability market have been very competitive and many dentists have elected to be insured under individually issued policies rather than group plans. In part, this is attributable to the instability of some group plans, a problem often cited by insurance agents as a reason for purchasing high cost policies that guarantee premium and benefit structures. The popularity of individually issued policies also reflects the reluctance of some dentists to purchase disability insurance that can be canceled if Association membership is not renewed. Possibly for this reason, some constituent dental societies now endorse individually issued policies that do not have membership requirements.

From a marketing perspective, the perceived competitive disadvantages of group disability insurance arrangements are difficult to overcome. The result has been a steady decline in participation in the Income Protection Plan since the early 1980s. This problem has been exacerbated by the lack of growth and aging trends among the Association's membership. Of particular concern is that a substantial percentage of new dentists are not Association members and thus ineligible to participate in the Income Protection Plan in the years they are most likely to be shopping for disability insurance.

In recent years, competition in the market has significantly abated. Many insurers have stopped writing policies and those that remain have substantially increased premiums and restricted benefits. Dentists and physicians in particular have been identified as high risk. The Council is hopeful that these conditions, while unfavorable for the profession, will cause a rebirth in interest in the Income Protection Plan and a rising enrollment.

Improving Financial Experience. In its 1998 report to the House of Delegates (*Reports* 1998:101), the Council explained that the cost of providing benefits under the Income Protection Plan has been much greater than was anticipated by the Plan's premium structure. This necessitated rate increases averaging approximately 25% on both May 1, 1997 and May 1, 1998. At its March 1999 meeting, the Council was advised by Great-West Life that the early indications are that the premium increases have stemmed the deterioration of the Plan's financial position. While additional time will likely be needed to assure that the Plan is now appropriately priced, it was not necessary to make further changes to the premium structure in May 1999.

Student Disability Insurance Plan. The Student Disability Insurance Plan offers a choice of a monthly benefit of either $1,000 or $2,000, payable for up to two years when the student is unable to continue school because of an accident or an illness. Thereafter, benefits can continue if the student is then totally disabled from obtaining gainful employment. The insurance can remain in force without interruption until the first day of active practice, at which time it can be converted to the Income Protection Plan for practicing dentists. In this way, a member can be insured under an Association-sponsored disability insurance plan without interruption from the first day of dental school until the date of retirement from active practice.

Despite an intensive advertising and promotional effort that includes dental school deans and American Student Dental Association representatives, it has been difficult to increase participation in the Plan. During 1998, enrollment increased marginally to 539. As most dental students have no access to disability insurance and as the Association's Plan offers coverage at the lowest possible cost, the Council can only attribute the difficulty in increasing enrollment to the financial challenges facing dental students.

Hospital Indemnity Insurance Plan: The Hospital Indemnity Insurance Plan offers coverage that is intended to supplement major medical insurance policies. It provides participants with benefits of up to $300 for each day they or one of their insured dependents is confined in a hospital. Full benefits are also payable if the individual undergoes surgery on an out-patient basis; and 50% of the benefit can be paid when treatment is received in an emergency room.

As of December 31, 1998, there were 7,632 members insured under the Hospital Indemnity Plan. Also insured were the spouses of 3,800 participants, including 66 who are widowed, and 3,377 children. During 1998, benefits totaling $1,504,725 were paid to participants.

Premium Reduction. As a result of the favorable financial experience of the Hospital Indemnity Insurance Plan, premiums for participating members were reduced by a 45% credit during 1998. Despite these high credits, additional surplus funds have accrued during the year. This is the result of the significant investment income generated by the Plan's retained surplus. Based upon an analysis of claim and investment experience conducted by Great-West Life, the Council determined that premiums could be reduced by 20% and the 45% premium credit could be continued without jeopardizing the Plan's long-term financial stability. Therefore, the Council approved a 20% reduction in coverage costs for all participants effective with the March 15, 1999 premium renewal.

Office Overhead Expense Insurance Plan: The Office Overhead Expense Insurance Plan provides up to $15,000 in monthly benefits to cover the expense of maintaining the dental office when a participating dentist is totally disabled. This complements disability insurance, which is intended to replace net income. 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.

As of December 31, 1998, participation in the Office Overhead Expense Plan totaled 8,921 members, 100 less than at the end of 1997. During the year, benefits totaling $4,153,445 were paid to disabled participants. As a result of the favorable financial experience of the Office Overhead Expense Plan, premiums were reduced during 1998 by a 15% credit. Based upon year-end financial results, the Council determined that the credit could be increased to 17% effective with the February 1, 1999 premium renewal.

Members Retirement Savings Programs

The Association offers members and their employees two programs that provide tax-advantaged ways of saving for retirement. The ADA Members Retirement Program is a tax-qualified plan that offers pension, profit sharing and/or 401(k) arrangements. The ADA-endorsed Individual Retirement Account (IRA) can be adopted as a traditional IRA or a Roth IRA.

ADA Members Retirement Program: At the end of 1998, 7,875 members were participating in the ADA Members Retirement Program. Their retirement plans covered a total of 25,284 individuals and held assets totaling approximately $1,358,440,000.

The Program offers a choice of retirement plans that have been preapproved by the Internal Revenue Service and designed especially for dentists. It also provides full record keeping and tax reporting services. The master plans include pension, profit sharing, and 401(k) plans, including the "Simple 401(k)" and "Safe Harbor 401(k)" arrangements. All of these services are provided by the Equitable Life Assurance Society of the United States. The Company also serves as custodian of all of the Program's assets except those that are invested in the Guaranteed Rate Accounts. Assets for which Equitable serves as custodian are held in separate accounts of the Company and thus under New York law are protected from the claims of the Company's creditors and other policyholders and may only be used for the benefit of the Program's participants.

The Program offers participants and their employees a choice of ten investment funds and accounts. These

investment options are also available to members not participating in the Program but who wish to use them for money held in individually designed tax qualified retirement plans. As trustees of the Program, the Council determines its investment options with the goal of providing a diversified choice of funds and accounts offering a range of risk levels across a variety of asset classes. It monitors the performance of each of these funds and accounts to assure that they provide competitive returns and that investment managers are adhering to the objectives and guidelines established for each fund. Performance is measured against standards set forth in a Statement of Investment Policy adopted by the Council. To assist in these reviews as well as the development of performance standards, the Council retains the services of the William M. Mercer Investment Consulting, Inc.

As of December 31, 1999, the participants invested 29.4% of their assets to the Program's two fixed income investment accounts that offer a guarantee of principal and interest. These accounts and their year-end deposits were as follows.

Money Market Guarantee Account. Participants allocated 20.8% of their funds, or $282.1 million, to the Money Market Guarantee Account. It offers yields comparable to those of money market funds; and the credited rate of interest changes monthly.

Three-year and Five-year Guaranteed Rate Accounts. Participants allocated 8.6% of their funds, or $116.6 million, to the Guaranteed Rate Accounts (GRAs), which provide a guarantee of both principal and interest. The credited rate of interest remains unchanged until maturity and is competitive with bank certificates of deposit of similar duration. At the end of 1998, these deposits were as follows.

Dates of Issuance	Insurance Company	Account Value as of December 31, 1998
February 2, 1993–August 2, 1994	Principal Mutual	$ 8,170,078
August 2, 1994–August 2, 1995	Metropolitan Life	$16,432,857
August 2, 1995–July 31, 1996	New York Life	$12,475,741
July 31, 1996–July 30, 1997	Principal Mutual	$35,848,264
July 30, 1997–July 29, 1998	Metropolitan Life	$32,339,672
July 29, 1998–December 31, 1998	John Hancock	$11,289,084

As of December 31, 1998, the participants deposited the remaining 70.6% of their assets in the Program's equity and real estate investment funds. The allocation of assets among these funds was as follows.

Fund	Year-End Balance
Growth Equity	$444.6 million (32.7%)
Aggressive Equity	$168.5 million (12.4%)
Equity Index	$130.3 million (9.6%)
Foreign	$72.4 million (5.3%)
Lifecycle Conservative	$13.5 million (1%)
Lifecycle Moderate	$125.2 million (9.2%)
Real Estate	$5.2 million (0.4%)

The following summarizes the performance of these funds as represented by changes in the value of the investment units held by participants. The reported changes in unit values assume that deposits were invested for the entire period and are not an indication of future performance. Unless otherwise noted, they do not reflect the subtraction of investment management fees, the ADA Members Retirement Program's expense charges, or direct expenses incurred by the funds.

Growth Equity Fund. The Growth Equity Fund is invested in a portfolio managed by the Alliance Capital Management Corporation that primarily consists of stocks of intermediate- to large-size domestic companies. Its investment strategy is growth-oriented and its return is mostly derived from capital appreciation. For calendar year 1998, the Account's unit value decreased by 2.2%, as compared to a 19% increase in the Standard & Poor's Midcap Stock Index (S&P Midcap) and a 28.6% increase in the S&P 500 Stock Index (S&P 500). For the five-year period ending December 31, 1998, the Account's unit value increased by an annual average of 14% as compared to average annual increases of 18.8% in the S&P Midcap and 24.1% in the S&P 500.

ADA Aggressive Equity Fund. The Aggressive Equity Fund is entirely invested in shares of the Massachusetts Financial Services Emerging Growth Fund. This Fund invests primarily in stocks of small- and medium-sized companies that are early in their life cycle but which have the potential to become major enterprises. For calendar year 1998, the value of a share in the MFS Emerging Growth Fund increased by 24.5%. This compares to a 2.6% decline in the Russell 2000 Stock Index (Russell 2000) and a 19% increase in the S&P Midcap Index. Over the five-year period ending December 31, 1998, the Fund produced an average annual return of 20.6% as compared to average annual increases of 11.9% in the Russell 2000 and 18.8% in the S&P Midcap.

ADA Equity Index Fund. The ADA Equity Index Fund is entirely invested in shares of the Seven Seas S&P 500 Index Fund managed by State Street Global Advisors, a subsidiary of the State Street Bank of Boston. This Fund invests in a portfolio of common stocks that is intended to track the performance of the S&P 500. During 1998, the value of a share of Seven Seas S&P 500 Index Fund increased 28.4%, as compared to a 28.6% increase in the S&P 500. Over the five-year period ending December 31, 1998, the Fund produced an

average annual return of 23.8% as compared to an average annual increase of 24.1% in the S&P 500.

ADA Lifecycle Funds. The Lifecycle Fund Moderate and the Lifecycle Fund Conservative invest in five investment portfolios that are managed by State Street Global Advisors. Each of these portfolios holds securities that replicate the performance of the broad market for a particular class of assets. These asset classes and the markets the portfolios seek to replicate are as follows: stocks of large-capitalization domestic corporations as represented by the S&P 500; stocks of small-capitalization domestic corporations as represented by the Russell 2000; stocks of foreign corporations as represented by the Morgan Stanley Capital International Europe, Australasia and Far East Stock Index (EAFE); investment grade domestic government and corporate bonds as represented by the Lehman Brothers Government/Corporate Bond Index (LBGC); and short-term money market instruments as represented by yields on 90-day Treasury Bills (T Bills).

Each Lifecycle Fund is re-balanced monthly to maintain the allocation of its assets among the five investment portfolios in the following percentages.

Investment Portfolio	Lifecycle Fund Moderate	Lifecycle Fund Conservative
S&P 500	35%	15%
Russell 2000	10%	5%
EAFE	15%	10%
LBGC	30%	50%
T Bills	10%	20%

For the calendar year ending December 31, 1998, the Lifecycle Fund Moderate produced a return of 16.2% after deduction of investment management fees. For the three-year period ending December 31, 1998, the Fund produced an average annual return of 15.1% after deduction of investment management fees.

For the calendar year ending December 31, 1998, the Lifecycle Fund Conservative produced a return of 11.7% after deduction of investment management fees. For the three-year period ending December 31, 1998, the Fund produced an average annual return of 10.2% after deduction of investment management fees.

ADA Real Estate Fund. The ADA Real Estate Fund invests at least 90% of its assets in shares of the Prime Property Fund managed by Lend Lease Real Estate Investments, Inc. The remaining assets are held in a money market fund. The Prime Property Fund is a portfolio of high-quality commercial real estate, with 121 properties having a value of approximately $2.4 billion. For the 1998 calendar year, the Prime Property Fund's unit value increased by 18.8% as compared to a 16.3% increase in the National Council of Real Estate Investment Fiduciaries (NCREIF) Index. For the five-year period ending December 31, 1998, the Prime Property Fund produced an average annual return of 9.8% as compared to an average annual return of 11.5% for the NECREIF index.

ADA Foreign Fund. The ADA Foreign Fund invests 100% of its assets in shares of the Foreign Fund managed by the Templeton Investment Counsel Corporation. For the 1998 calendar year, the Templeton Foreign Fund's unit value decreased by 4.9% as compared to a 20.3% increase in the EAFE Index. For the five-year period ending December 31, 1998, the Templeton Foreign Fund produced an average annual return of 6% as compared to a 9.5% average annual increase in the EAFE Index.

Introduction of New Investment Fund. At its March 1999 meeting, the Council selected the Putnam Equity Income Fund as a new investment option under the ADA Members Retirement Program. The goal of the Fund is to produce current income by investing mainly in the stocks of companies having large capitalization and which are low in price relative to dividend yield and future earnings power. However, capital growth is also a consideration. The portfolio managers seek low priced companies they believe can successfully implement change and in so doing increase the price of their stock. The Fund may also hold bonds, mainly to limit risk and augment its income. At the end of 1998, the 88.2% of the Fund's assets were invested in stocks, 7.7% in bonds and 4.1% in cash.

The Putnam Equity Income Fund is among the class of mutual funds that are described as having a "value" as opposed to a "growth" investment style. Value funds are expected to exhibit a lower level of volatility as compared to the S&P 500 (i.e., a market "beta"), and therefore, to have appeal to conservative investors. The Putnam Equity Income Fund has a market beta of .79 which means it is expected to increase 79% as much as the S&P 500 in a rising market and to decline by 79% as much as the S&P 500 in a falling market.

During 1998, a share of the Putnam Equity Income Fund increased by 12.7% after deduction of fees as compared to a 14.7% increase in the S&P 500 Value Index. Over the five-year period ending December 31, 1998, the average annual increase in a share of the Fund was 18.7% after deduction of fees as compared to an average annual increase of 19.9% in the Index.

Although most investors in the Putnam Equity Income Fund must pay a front-end load of up to 4.5% of the price of a share, this load will be waived for participants in the ADA Members Retirement Program. The new fund will become available for contributions from Program participants beginning July 1, 1999.

ADA-Endorsed Individual Retirement Account: The ADA-endorsed Individual Retirement Account (IRA) is available to members, their spouses and employees. It is administered by The Equitable Life Assurance Society.

The ADA-endorsed IRA offers participants 16 investment options. They include ten funds managed by the Alliance Capital Management Corporation as well as the Lazard Small

Cap Value Mutual Fund, the MFS Emerging Growth Mutual Fund, the Bankers Trust Equity 500 Index Mutual Fund and the T. Rowe Price International Stock Mutual Fund. The ten funds managed by Alliance Capital are portfolios offered to pension plans as part of the Hudson River Trust. They include: Money Market; Common Stock; Aggressive Stock; Balanced; Government Securities; Global; High Yield Funds; Growth & Income; Conservative Investor; and Growth Investor Funds. The Equitable Life Assurance Society serves as custodian of all money invested in the aforementioned funds, which it holds in a separate account. In addition to these funds, participants may also invest one- or three-year guaranteed rate accounts that are invested with Equitable in its general account.

As of December 31, 1998, there were 1,801 participants in the ADA-endorsed IRA. The total value of their investments was in excess of $106.4 million. These assets were invested as follows: One- and Three-year Guaranteed Rate Accounts, 4.7%; Money Market Fund, 8.3%; Common Stock Fund, 55.4%; Government Securities Fund, 1.7%; Balanced Fund, 11.8%; High Yield Fund, 1.5%; Aggressive Stock Fund, 5.2%; Global Fund, 3.7%; Growth Investors, 1.3%; Conservative Investors, 1.2%; Growth & Income, 4.7%; Equity Index, 0.4%; Small Cap Value, 0.02%; Emerging Growth, 0.002% and International Stock, 0.01%.

The percentage change in unit values for the following investment funds for calendar year 1998 were as follows: Money Market Fund, 4.9%; Common Stock Fund, 28.9%; Government Securities Fund, 7.4%; Balanced Fund, 17.6%; Aggressive Stock Fund, -0.2%; Global Fund, 21.2%; High Yield Fund, -5.7%; Growth Investors, 18.3%; Conservative Investors, 13%; and Growth & Income, 20.2%. The reported changes in the unit values for the aforementioned funds are net of fees and expenses, assume that deposits were invested for the entire period and are not an indication of future performance. Returns are not reported for the Lazard Small Cap Value Mutual Fund, MFS Emerging Growth Mutual Fund, Bankers Trust Equity 500 Index Mutual Fund and T. Rowe Price International Stock Mutual Fund as these funds were not offered through the ADA-endorsed IRA until July 1, 1998.

Activities Relating to Professional Liability

Conditions in the Dental Professional Liability Insurance Markets: The dental professional liability insurance markets continue to be characterized by high levels of competition among insurers. Both large, multiline commercial insurers as well as doctor-owned companies, are expanding the territories in which they offer policies. Based upon information it has gathered from various insurers, the Council is unaware of significant trends in the incidence and severity of claims that are likely to lead to a substantial increase in premiums.

Trends in Dental Professional Liability: The Council is attempting to gather information about the causes of dental malpractice incidents. It believes such information is essential to the profession's efforts to improve the quality of care as well as to assist dentists in defending themselves against unfounded allegations. The problem is there is no source of publicly available data on the claims reported to professional liability insurance companies. The data that is being accumulated by insurers is generally not publicly disclosed. Moreover, this data is not captured in such a way that it can be aggregated or even, in some cases, to facilitate useful analysis. Because of this problem, the Council has sought to learn more about the incidence, frequency and causes of dental malpractice by meeting with major underwriters of dental professional liability insurance and asking them to volunteer information about their claim experience. At its March 1999 meeting, the Council met with the Frontier Insurance Company. At prior meetings, the Council has met with the CNA Insurance Companies, the Medical Protective Insurance Company, the Physicians Insurance Company of Michigan (now called ProNational), The Dentists Insurance Company, the Safeco Insurance Company and the Eastern Dentists Insurance Company.

Based upon its discussions with these companies, the Council believes there is consensus that the greatest cause of claims among dentists is not substandard care but, rather, poor record keeping. In a significant number of cases where claims have been paid, adequate treatment records do not exist. As a result, it usually was not possible for the dentist's defense counsel to refute allegations of malpractice even when the standard of care was met. One insurer also noted that poor quality of radiographs is a significant problem among claims it has paid.

Another major source of paid claims is poor communications between the dentist and the patient. Insurers have concluded that when the doctor/patient relationship is strong, an unfavorable result or even a treatment error is less likely to develop into a malpractice lawsuit. A second aspect of the communication problem leading to paid claims are the failure of the dentist to obtain the patient's informed consent to treatment or informed refusal of treatment.

In terms of the type of treatments that are most frequently involved in claims, the Council has found less consistency among insurers. This is probably attributable to variances among the demographic characteristics of the dentists they insure, such as the numbers of general practitioners and specialists. Several companies have reported that, when claims are sorted based upon the treatment being performed, endodontic procedures were involved in the highest percentage of claims. However, other insurers have cited crowns and bridges or extractions as the treatments involved in the highest percentages of claims.

The Council has been seeking to determine whether managed care has any effect on the incidence or severity of professional liability allegations. At this time, what evidence exists of any causative relationship between malpractice allegations and the nature of the patient's insurance, is largely anecdotal. A number of insurers have expressed concern that managed care may have an adverse effect on the doctor/patient relationship which, as previously noted, appears to be a factor leading to lawsuits when an unfavorable result occurs. They noted problems with the doctor/patient relationship can occur where the initial examination and the

treatment are done by different dentists, there is a lack of continuity of treatment due to patients changing from one plan or dentist to another, the patient fails to understand or accept copayment provisions, or when the dentist fails to obtain the patient's informed refusal of optimal care.

The Council will continue to meet with dental professional liability insurers at future meetings. It intends to meet with all major underwriters and to continue its efforts to gather information about this aspect of dental practice.

Professional Liability Risk Management Seminar: As part of its effort to assist the membership reduce the likelihood of a malpractice allegation, the Council sponsors a professional liability risk management seminar during the scientific program at the annual session.

The seminar conducted at the 1998 scientific program was developed and presented by The Dentists Insurance Company and the Safeco Insurance Companies. It focused on professional liability exposures arising from the managed care environment. The seminar was well attended and received a very favorable review in the audience evaluation. For their efforts in making the 1998 seminar a success, the Council wishes to acknowledge with appreciation: Ms. Robyn Crimmons, director of risk management and communications of The Dentists Insurance Company; Mr. Eric Ummel, senior underwriter, the Safeco Insurance Companies; and Mr. Arthur Curley, senior partner of the San Francisco law firm of Bradley, Curley & Asiano.

As a result of the success of the 1998 seminar, the Council on ADA Sessions and International Programs has granted permission for another risk management seminar during the 1999 scientific session. The 1999 seminar will be developed and presented as a joint effort of The Eastern Dentists Insurance Company and the CNA Insurance Companies. It will focus on professional liability risk exposures arising from new dental technologies.

Acknowledgments

The close of the 1998 annual session concluded the terms of service of four valued members of the Council: Dr. Harvey A. Akerson; Dr. Mervyn J. Dixon; Dr. Albert C. Niedhamer; and Dr. Ronald P. Stifter. The success of the Association-sponsored insurance and retirement programs is due in no small part to the sound judgment and decisions of these members.

Support for the ADA Health Foundation: The Council wishes to acknowledge with gratitude the very generous support given the ADA Health Foundation by the Great-West Life & Annuity Insurance Company and The Equitable Life Assurance Society.

Support for the American Dental Association SUCCESS 97-98: The Council also wishes to express its appreciation to The Equitable Life Assurance Society and the Great-West Life & Annuity Insurance Company 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.

Notes

Divisions of Government Affairs and Legal Affairs

Council on Ethics, Bylaws and Judicial Affairs

Council on Governmental Affairs and Federal Dental Services

Council on Ethics, Bylaws and Judicial Affairs

Gross, Ronald B., Pennsylvania, 1999, chairman
Bluitt-Foster, Juliann S., Illinois, 1999, vice chairman
Chichetti, Richard J., Florida, 2002
Cortegiano, Louis J., New York, 2001
Cutler, A. Riley, Idaho, 1999
Deitch, Stanton, New Jersey, 2001
Dunn, Bruce R., Colorado, 2001
Eklund, Richard A., Texas, 2000
Fields, Gerald L., South Dakota, 2000
Fields, Dean S., Jr., Michigan, 2000
Hamlin, Christopher, Virginia, 2002
Lee, Darryl L., California, 2002
McConnell, Mark S., New Mexico, 1999, *ex officio**
Merritt, Grant W., Missouri, 1999
Roberts, Gary, Louisiana, 2000
Schwartz, Arthur I., Massachusetts, 2002
Shaffer, C. David, Ohio, 2001
Todd, Kathleen M., director
Wils, Wendy J., manager

Meetings: The Council on Ethics, Bylaws and Judicial Affairs (CEBJA) met on February 26-27, 1999 at the ADA Headquarters Building in Chicago. The Council's second regularly scheduled meeting will take place on June 26-27 in Chicago. Between meetings, the Council makes use of mail ballots to take official action on items that do not require debate. Occasionally, the chairman will call a special meeting of the Council via telephone conference call to consider urgent business that cannot wait until the next regularly scheduled meeting. For example, the Council met by telephone conference call on April 28 to consider the motion of a party to an appeal pending before the Council. The Council also makes extensive use of subcommittees to prepare material for full Council consideration. The subcommittees generally meet at least once by telephone conference call between Council meetings and again in conjunction with Council meetings. The Council has adopted guidelines for the operation of its subcommittees.

Vice Chairman: Dr. Juliann S. Bluitt-Foster was elected to serve as the Council's vice chairman until the close of the 1999 annual session.

Personnel: The Council welcomed four new members: Dr. Richard J. Chichetti, Florida; Dr. Christopher Hamlin, Virginia; Dr. Darryl L. Lee, California; and Dr. Arthur I. Schwartz, Massachusetts. The 1999 annual session will mark the completion of the terms of service of four Council members: Dr. Ronald B. Gross, chairman; Dr. Juliann S. Bluitt-Foster, vice chairman; Dr. A. Riley Cutler; and Dr. Grant W. Merritt. The Council expresses its gratitude to these members for the exemplary manner in which they performed their duties in furthering the interests of the profession.

The Strategic Plan of the American Dental Association: The activities of the Council are fundamental to the Association's mission statement, which reads in part: "The ADA promotes the profession of dentistry by enhancing the integrity and ethics of the profession...." Although the Council's activities have implications for a number of ADA goals, three in particular stand out: Goal II. Practice Support, Goal III. Image and Goal V. The Association: Member and Support Services.

The Council supports Goal II. Practice Support by providing practicing dentists and dental students with the means to maximize their practice skills. The Council achieves this by providing dentists and students with seminars and other educational materials to help them analyze and respond to ethical issues that arise in the practice of dentistry.

The Council supports Goal III. Image by fostering public perception of dentistry as a trusted and respected profession. One of the hallmarks of a profession is its commitment to put the patient's welfare first. The Council fosters this commitment through the development of a relevant code of ethics and the issuance of advisory opinions that apply the code to contemporary ethical problems in the practice of dentistry. Another hallmark of a profession is effective self-regulation. The Council supports self-regulation of the dental profession by providing guidance to the constituent and

* Committee on the New Dentist member without the power to vote.

component dental societies on judicial matters and serving as the appellate body in the tripartite system's disciplinary process. Through its activities, the Council helps to maintain dentistry's public image as a highly respected profession.

In support of Goal V. The Association: Member and Support Services the Council enhances the Association's relationships with associated organizations by sponsoring the Golden Apple Award for Outstanding Achievement in the Promotion of Dental Ethics.

The Council conducted a strategic planning session at its February meeting. Pursuant to Resolution B-67-1998 (*Trans.*1998:626), the Council examined its new and ongoing activities in relation to the Association's Strategic Plan. The Council determined that each activity supported the Plan and eliminated no activities at this time. In response to Resolution B-79-1998 (*Trans.*1998:632), the Council began to develop both qualitative and quantitative criteria for measuring the effectiveness of its activities. The criteria will be finalized at the Council's June meeting.

Judicial Procedures

Appeals from Constituent Disciplinary Actions: One of the Council's *Bylaws* responsibilities is to sit as the ultimate appellate body in review of disciplinary decisions rendered by the constituent and component societies. The Council has two appellate hearings scheduled for its June meeting and two more are likely to be scheduled next January. The Council anticipated an increase in judicial activity at the constituent and component level and a concomitant increase in the number of appeals once the uncertainty over enforcement of the *ADA Principles of Ethics and Code of Professional Conduct* (*Code*) was removed. This occurred when the Federal Trade Commission closed its investigation of the Association in December 1997 following Council adoption of Advisory Opinion 5.I.1. However, none of the cases currently on appeal to the Council involves that advisory opinion.

In April, the Council held a special meeting to rule on the motion of a constituent society, a party to one of the appeals pending before the Council. The constituent moved to conditionally dismiss the appeal because the accused member had not paid his 1999 membership dues. The Council decided that the ADA *Bylaws* are clear that only members have the right to appeal to the Council. The Council has no authority under the *Bylaws* to hear the appeal of a nonmember. The Council ruled that the appeal would be dismissed unless the member paid his dues by a fixed date.

Judicial Manual: As a high priority, the Council has begun work on a judicial manual for the constituent societies. The manual will replace the Council's current publication *Guidelines for Disciplinary Hearings* with an updated, user-friendly loose-leaf binder. The manual will contain information on how to establish and operate a judicial function at the state and local levels. Under the tripartite system, the constituent and component societies are responsible for investigating complaints, bringing charges and holding hearings on alleged violations of the *Code* and other matters which may result in disciplinary sanctions. The Council's role is to provide guidance to the constituents and components and to serve as the highest body within the Association for member appeals.

The Council was prompted to make the judicial manual a high priority by recent negative publicity regarding the deaths of several children in dental offices from anesthesia. The ADA and the constituent and component societies were challenged in these and other cases to explain why the dental society failed to take disciplinary action against dentists who were found guilty of serious legal infractions. The judicial manual will contain sample bylaws language, based on language adopted by the Dental Society of the State of New York, for routinely reviewing dental board decisions for potential disciplinary action. In May, the Council wrote to the constituents urging them to monitor dental board cases and offering Council guidance on procedural issues. The Council continues to make available at cost to the constituents a workshop for volunteers and staff involved in the judicial process. The Council plans to distribute the judicial manual to the constituents by year-end.

Response to Assignments from the 1998 House of Delegates

Revision of Association Documents: The Council incorporated all of the amendments to the ADA *Constitution and Bylaws* (ADA *Bylaws*) that were approved by the 1998 House of Delegates in the new edition of the ADA *Bylaws* revised to January 1, 1999. Complimentary copies of the revised *Bylaws* have been distributed to the constituent and component societies. The Council incorporated the single amendment to the *ADA Principles of Ethics and Code of Professional Conduct* (*Code*) that was approved by the 1998 House of Delegates in the new edition of the *ADA Code* revised to January 1999. This edition also contains all new and revised Council advisory opinions adopted through January 1999. Complimentary copies of the revised *Code* were distributed to the constituents and components and to the dental schools for use in ethics courses. The *Code* is also available on ADA ONLINE. The Council uses inserts to keep the *Code* abreast of changes in Council advisory opinions between printings.

Amendment of the *Code* Regarding Use of Organization Leadership Titles: Resolution 41-1998 (*Trans.*1998:731) was referred to the Council for study and report to the 1999 House of Delegates with recommendations concerning a specific amendment to the *ADA Code*. The resolution deals with advertising and other uses of dental society leadership titles. In order to prepare a comprehensive response, the Council requested information about the legal implications of the use of leadership titles, which it will consider with the ethical implications at its June meeting. The Council will submit its recommendations in a supplemental report.

Study of Education Standards for Announcement of Credentials: Resolution 49H-1998 (*Trans.*1998:734) asked the Council to reexamine, with input from the appropriate agencies of the Association and the communities of interest, the educational standards contained in Advisory Opinion 5.I.1 and to report its findings to the Task Force on Advisory Opinion 5.I.1. The Council is preparing an issues paper to send to the communities of interest for comment. Input has already been received from the Council on Dental Education and Licensure. The Council will provide its report to the meeting of the Task Force in August.

State Regulation of Announcement of Credentials: Resolution 50H-1998 (*Trans.*1998:734) directed the development of materials for use by the constituents in lobbying state legislatures and dental boards for the adoption of advertising standards based on Advisory Opinion 5.I.1. The Council, with input from the Council on Government Affairs, is in the process of developing these materials.

Dentist Obligation to Disclose Seropositive Status: Resolution 62-1998 (*Trans.*1998:731) was referred to the Council on Scientific Affairs (CSA), the Council on Dental Practice (CDP) and the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) for study and report to the 1999 House of Delegates. The resolution deals with the ethical obligations of a dentist when a patient is exposed to the dentist's blood or other potentially infected bodily fluid. CEBJA addressed the concept in the form of a draft amendment to the *ADA Code*, which it forwarded to CSA and CDP for review. The three councils will forward their findings and recommendations to the House of Delegates in the form of a joint report.

Editorial Review of the ADA *Constitution and Bylaws*

Chapter V. HOUSE OF DELEGATES, Section 120A(e): One of the Council's responsibilities is to recommend editorial corrections to the ADA *Constitution and Bylaws*. The Council reviewed the *Bylaws* at its February meeting and recommended an editorial change to eliminate awkward construction in Chapter V, Section 130A, Subsection (e) as follows:

12. Resolved, that the ADA *Bylaws*, Chapter V. HOUSE OF DELEGATES, Section 120. RULES OF ORDER, Subsection A. STANDING RULES AND REPORTS, subsection (e) be amended by deleting the words "for consideration by" on lines 1070-1071 and substituting in their place the word "to" and by adding the words "for consideration" after the words "ADA House of Delegates" and before the period on line 1071, so the amended subsection reads as follows:

e. RESOLUTIONS. A resolution becomes the property of the American Dental Association when submitted to the ADA House of Delegates for consideration. If adopted by the House of Delegates, this Association shall be the sole owner of the resolution which shall constitute "work made for hire" under copyright laws. This Association shall have the exclusive right to seek copyright registration for the resolution and to secure copyrights and retain ownership of such copyrights in its own name.

Elimination of References to the Panama Canal: Another Council-recommended editorial change reflects the fact that the Panama Canal area will revert to Panama at the end of the year. At that time, the language in the *Bylaws* treating the Panama Canal Society as a constituent society will be outdated. Accordingly, the Council recommends the following revisions:

13. Resolved, that the ADA *Bylaws*, Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection A. ACTIVE MEMBER be amended by deleting on lines 87-89 the punctuation and words "(including until December 31, 1999, the Panama Canal area where citizens of the United States are assigned by the United States Government and reside)," and be it further

Resolved, that Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection G. RETIRED MEMBER be amended by deleting on lines 184-187 the punctuation and words "(including until December 31, 1999, the Panama Canal area where citizens of the United States are assigned by the United States Government and reside)," and be it further

Resolved, that Chapter II. CONSTITUENT SOCIETIES, Section 10. ORGANIZATION be amended by deleting on lines 500-502 the punctuation and words "(including until December 31, 1999, the Panama Canal area where citizens of the United States are assigned by the United States Government and reside)," and be it further

Resolved, that Chapter II. CONSTITUENT SOCIETIES, Section 40. MEMBERSHIP, Subsection B. REMOVAL FROM ONE JURISDICTION TO ANOTHER, be amended by deleting on lines 563-565 the punctuation and words "(including until December 31, 1999, the Panama Canal area where citizens of the United States are assigned by the United States Government and reside)," and be it further

Resolved, that Chapter II. CONSTITUENT SOCIETIES, Section 110. CHARTERED CONSTITUENT SOCIETIES, be amended by deleting on line 686 the words "Panama Canal Dental Society," and be it further

Resolved, that Chapter IV. TRUSTEE DISTRICTS, Section 30, COMPOSITION be amended on line 786 by deleting the words "Panama Canal Dental Society," and be it further

Resolved, that these amendments take effect on January 1, 2000.

Chapter I. MEMBERSHIP, Section 50A: The Council noted an inconsistency in how the *Bylaws* refer to the dues of active members. In most places, the *Bylaws* refer to "active member dues." In a few places, they incorrectly refer to "active members dues." Accordingly, the Council recommends the following revisions:

14. Resolved, that the ADA *Bylaws*, Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, paragraph (4) be amended by substituting the word "member" for the word "members" on line 382, and be it further

Resolved, that the first footnote to Chapter I, Section 50A be amended by substituting the words "level of active member dues" for the words "level of active members dues," and be it further

Resolved, that the second footnote to Chapter I, Section 50A be amended by substituting the words "level of active member dues" for the words "level of active members dues."

Advisory Opinions and Proposed Amendments to the *Code*

Review of Advisory Opinions Relating to Human Immunodeficiency Virus (HIV): The Council considered reports on recent scientific and legal developments dealing with HIV/AIDS to ensure that its advisory opinions continue to reflect current scientific thinking about the disease and modes of transmission. The Council decided to amend Advisory Opinion 2.D.1 to emphasize the ongoing ethical obligations of a dentist who has been advised by a qualified physician or other authority to limit the activities of practice. As amended, Advisory Opinion 2.D.1 reads as follows (new material is underlined; deleted material is struck through):

2.D.1. ABILITY TO PRACTICE.
A dentist who ~~becomes ill from~~ contracts any disease or becomes impaired in any way that might endanger patients or dental staff 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. A dentist who has been advised to limit the activities of his or her practice should monitor the aforementioned disease or impairment and make additional limitations to the activities of the dentist's practice, as indicated.

The Council amended Advisory Opinion 5.F.5 to provide more guidance to members on the type of disclaimer that would satisfy the advisory opinion. As amended by the Council, Advisory Opinion 5.F.5 reads as follows (new material is underlined; deleted material is struck through):

5.F.5. INFECTIOUS DISEASE TEST RESULTS.
An advertisement or other communication intended to solicit patients 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.

For example, an advertisement to the public of HIV negative test results, without conveying additional information that will clarify the scientific significance of this fact contains a misleading omission. A dentist could satisfy his or her obligation under this advisory opinion to convey additional information by clearly stating in the advertisement or other communication: "This negative HIV test cannot guarantee that I am currently free of HIV."

Announcement of Credentials by General Dentists: A major activity of the Council this year is developing a report to accompany Advisory Opinion 5.I.2. FELLOWSHIPS. The advisory opinion, which addresses the announcement of credentials in the broad area of general dentistry, was adopted by the Council last June (*Supplement* 1998:303). It is traditional for the Council to issue a report with its advisory opinions to provide background and an explanation of key concepts. Because of the importance of this issue to the profession, the Council decided to circulate the report in draft form to the communities of interest for comment. This was done April 13, with a June 4 deadline for comment. The Council will adopt final report language after it has an opportunity to review and carefully consider the comments received from the communities of interest at its June meeting.

Financial Incentives for Staff: The Council was informed that some practice management experts advise dentists to provide financial incentives to dental office staff for the sale of dental services. After seeking and receiving input from the Council on Dental Practice, this Council identified a number of ethical implications of this practice. Depending on the facts and circumstances involved, the use of financial incentives might lead to a misrepresentation of care, rendition of unnecessary services or improper delegation of duties to auxiliary personnel. The Council agreed that the ethical concepts are similar to those expressed in Advisory Opinion 5.D.2. MARKETING OR SALE OF PRODUCTS. Accordingly, the Council expanded Advisory Opinion 5.D.2 to cover the use of financial incentives and recommended to the Council on Dental Practice that it include information about these ethical considerations in its relevant publications. As amended by the Council, Advisory Opinion 5.D.2 reads as follows (new material is underlined; deleted material is struck through):

5.D.2. MARKETING OR SALE OF PRODUCTS OR PROCEDURES. Dentists who, in the regular conduct of their practices, engage in or employ auxiliaries in the marketing or sale of products or procedures to their patients must take care not to exploit the trust inherent in the dentist-patient relationship for their own financial gain.

Dentists should not induce their patients to ~~buy a~~ purchase products or undergo procedures by misrepresenting the product's therapeutic value, the necessity of the procedure or the dentist's professional expertise in recommending the product or procedure.

In the case of a health-related product, it is not enough for the dentist to rely on the manufacturer's or distributor's representations about the product's safety and efficacy. The dentist has an independent obligation to inquire into the truth and accuracy of such claims and verify that they are founded on accepted scientific knowledge or research.

Dentists should disclose to their patients all relevant information the patient needs to make an informed purchase decision, including whether the product is available elsewhere and whether there are any financial incentives for the dentist to recommend the product that would not be evident to the patient.

Honorary Fellowships: The Council has been asked for guidance on the announcement of honorary fellows under the ADA *Code*. The Council's response will be submitted to the House in a later report.

Other Council Activities

Feasibility of a Recognition Program for Organizations that Grant Credentials that Meet the Requirements of Advisory Opinion 5.I.1: The Board of Trustees asked the Council on Dental Education and Licensure and the Council on Ethics, Bylaws and Judicial Affairs to study and report to the Board on the feasibility of a recognition program for organizations that grant credentials in nonspecialty interest areas. The Council Chairmen appointed members of their respective agencies to a joint subcommittee, which met in March. After considering the subcommittee's findings and recommendations, the Councils will submit a report to the Board of Trustees in August.

Codes of Ethics for Dental Society and Member Web Sites: Also at the request of the Board of Trustees, the Council is studying development of a code of ethics for component, constituent and individual member's Web sites and will report to the Board of Trustees in August.

Request for Interpretation of ADA *Bylaws* Regarding Component Society Membership: The Council responded to a request from a constituent for an opinion on whether the ADA *Bylaws* mandate that active membership in a component society be limited to dentists who practice or reside in the geographic area of the component society. The Council reviewed the relevant sections of the ADA *Bylaws* and the opinion previously rendered by the ADA Division of Legal Affairs on this issue. The Council concluded that the ADA *Bylaws* do not mandate a geographic requirement for component society membership for the following reasons:

- The ADA *Bylaws*, Chapter II. CONSTITUENT SOCIETIES, Section 30. POWERS AND DUTIES expressly states that a constituent society shall have the power to organize its members into component societies within the limits imposed by Chapter III, Section 10 of the *Bylaws*.
- Chapter III. COMPONENT SOCIETIES, Section 10. ORGANIZATION states that component societies may be organized in conformity with a plan approved by the constituent society.
- The only limitation placed by Chapter III, Section 10 on the constituent's power to organize its members into component societies is the requirement that the active, life or retired members of each component society be members in good standing of their respective constituents and the ADA.
- Chapter III, Section 10 is silent concerning any geographic requirement for component society membership. This contrasts with Chapter II. CONSTITUENT SOCIETIES, Section 40. MEMBERSHIP, which expressly states that the active, life and retired membership of a constituent society shall consist solely of dentists practicing within the territorial jurisdiction of the constituent society. If the House had intended to impose the same requirement for component society membership, it would have said so.

In summary, under the tripartite system, the constituents are given the responsibility to approve a plan for the organization of their components. The constituents may determine that the plan should include a geographic membership requirement, but they are not required by the ADA *Bylaws* to do so. The Council is aware of the political and practical difficulties that can arise if the constituent does not limit active membership in its components to dentists who practice or reside in the geographic area of the component society. The Council is informed that the majority of constituents do impose a geographic requirement for component society membership, probably for these very reasons. For example, a component may have difficulty conducting judicial proceedings involving a member who practices outside the component's geographic area. However, as long as the constituent is willing to intervene as needed to assure compliance with the ADA *Bylaws*, the Council would not object.

In reviewing the ADA *Bylaws* for purposes of this opinion, the Council concluded that they should be amended to clarify any remaining ambiguity over a constituent's authority to organize its components according to a plan adopted by the constituent. The Council is developing such an amendment, which it will submit to the House in a supplemental report.

Request for Guidance on Advertising: The Council periodically provides guidance to constituents and components, related dental organizations and members on ethical aspects of professional advertising. In response to a constituent's inquiry, the Council provided guidance on dentist compliance with the disclaimers required under Advisory Opinion 5.I.1 of the ADA *Code*. The Council also explained that it does not recognize a distinction between

advertising to the general public and to patients of record. Both groups are at a potential risk to be solicited to accept services based on claims that are false or misleading in a material respect.

Subcommittee on Advertising: The Subcommittee on Advertising is a standing subcommittee of the Council. Its role is to provide advisory letters to the constituents on dental advertisements and their compliance with the ADA *Code*. Constituents who receive a complaint about a particular advertisement may forward it to the subcommittee for analysis and a response in the form of a confidential advisory letter. This opinion letter is strictly advisory and is not binding on either the Council or the society that requests the opinion. Should the matter proceed to a disciplinary hearing which results in an appeal to the Council, members of the subcommittee do not participate in the appeal. Constituent societies are encouraged to contact the Council office for further information.

Golden Apple Award for Outstanding Achievement in the Promotion of Dental Ethics: The Council serves as the sole judge for the Golden Apple Award for Outstanding Achievement in the Promotion of Dental Ethics. The award recognizes a component or constituent dental society for outstanding efforts in the promotion of dental ethics through such media as workshops, articles or other activities. The deadline for submissions is June 1. Nominations submitted to the Council for the 1999 award will be voted upon by the Council at its June meeting.

Ethics Component of the SUCCESS Program: For the fifth year the Council has offered an ethics seminar as a part of the SUCCESS Program for junior and senior dental students. The ethics component is a half-day program presented by a practicing dentist and an attorney/staff member. The program relies primarily on a case study method to prompt student discussion of realistic ethical problems that are likely to confront the new dentist. The program was presented at 14 dental schools during the 1998-99 school year: University of Illinois College of Dentistry; University of Alabama School of Dentistry; Louisiana State University School of Dentistry; University of Washington School of Dentistry; University of Texas Houston Dental Branch; Indiana University School of Dentistry; Ohio State University College of Dentistry; University of Maryland Dental School; Medical University of South Carolina College of Dental Medicine; West Virginia University School of Dentistry; Meharry Medical College, School of Dentistry; University of Mississippi School of Dentistry; University of Florida College of Dentistry; and University of Colorado Medical Center, School of Dentistry.

Through the fund-raising efforts of the Council on Dental Practice, corporate underwriting was obtained for all 14 seminars. The Council gratefully acknowledges this assistance.

Current Ethical Topics for the Practicing Dentist: At its February meeting, the Council updated its ethics seminar for practitioners. Some of the ethical topics explored in the program are management service organizations, advertising, the sale and marketing of products and procedures in the dental office and personal impairment. Constituent societies desiring more information about the workshop are invited to contact the Council office.

Update of Sample Component Bylaws: The Council is revising its publication *Sample Bylaws for a Component Dental Society* to bring it into line with the current ADA *Bylaws* and contemporary concepts of draftsmanship. The revised document will be available after the Council's June meeting.

Summary of Resolutions

12. Resolved, that the ADA *Bylaws*, Chapter V. HOUSE OF DELEGATES, Section 120. RULES OF ORDER, Subsection A. STANDING RULES AND REPORTS, subsection (e) be amended by deleting the words "for consideration by" on lines 1070-1071 and substituting in their place the word "to" and by adding the words "for consideration" after the words "ADA House of Delegates" and before the period on line 1071, so the amended subsection reads as follows:

> e. RESOLUTIONS. A resolution becomes the property of the American Dental Association when submitted to the ADA House of Delegates for consideration. If adopted by the House of Delegates, this Association shall be the sole owner of the resolution which shall constitute "work made for hire" under copyright laws. This Association shall have the exclusive right to seek copyright registration for the resolution and to secure copyrights and retain ownership of such copyrights in its own name.

13. Resolved, that the ADA *Bylaws*, Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection A. ACTIVE MEMBER be amended by deleting on lines 87-89 the punctuation and words "(including until December 31, 1999, the Panama Canal area where citizens of the United States are assigned by the United States Government and reside)," and be it further

Resolved, that Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection G. RETIRED MEMBER be amended by deleting on lines 184-187 the punctuation and words "(including until December 31, 1999, the Panama Canal area where citizens of the United States are assigned by the United States Government and reside)," and be it further

Resolved, that Chapter II. CONSTITUENT SOCIETIES, Section 10. ORGANIZATION be amended by deleting on lines 500-502 the punctuation and words "(including until December 31, 1999, the Panama Canal area where citizens of the United States are assigned by the United States Government and reside)," and be it further

Resolved, that Chapter II. CONSTITUENT SOCIETIES, Section 40. MEMBERSHIP, Subsection B. REMOVAL FROM ONE JURISDICTION TO ANOTHER, be amended by deleting on lines 563-565 the punctuation and words "(including until December 31, 1999, the Panama Canal area

where citizens of the United States are assigned by the United States Government and reside)," and be it further
Resolved, that Chapter II. CONSTITUENT SOCIETIES, Section 110. CHARTERED CONSTITUENT SOCIETIES, be amended by deleting on line 686 the words "Panama Canal Dental Society," and be it further
Resolved, that Chapter IV. TRUSTEE DISTRICTS, Section 30, COMPOSITION be amended on line 786 by deleting the words "Panama Canal Dental Society," and be it further
Resolved, that these amendments take effect on January 1, 2000.

14. Resolved, that the ADA *Bylaws*, Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, paragraph (4) be amended by substituting the word "member" for the word "members" on line 382, and be it further
Resolved, that the first footnote to Chapter I, Section 50A be amended by substituting the words "level of active member dues" for the words "level of active members dues," and be it further
Resolved, that the second footnote to Chapter I, Section 50A be amended by substituting the words "level of active member dues" for the words "level of active members dues."

Council on Government Affairs

Player, T. Carroll, South Carolina, 1999, chairman
Crawford, Felix C., Texas, 1999, vice chairman
Dilsaver, Alan V., Pennsylvania, 2001
Donohoo, Michael, Wisconsin, 2000, *ex officio**
Dumas, James Russell, Jr., Mississippi, 2000
Eddy, Arthur F., Massachusetts, 2000
Evans, Neal B., Utah, 2001
Frey, James D., Indiana, 2001
Golden, Julia, Pennsylvania, 2000, *ex officio*†
Hadnot, Douglas S., Montana, 2002
Manning, Dennis E., Illinois, 2000
McGinty, Charles C., Missouri, 2002
Nolan, Michael F., Louisiana, 2002
Puglisi, Arthur W., New York, 1999
Sadowski, John L., Wisconsin, 2000
Schafhauser, Michael W., Minnesota, 2001
Simms, Richard A., California, 1999
Sterritt, Frederic C., New Jersey, 2002
Spangler, Thomas J., director

Personnel: The Council on Government Affairs (CGA) announces the addition of four new members: Dr. Douglas S. Hadnot, Montana; Dr. Charles C. McGinty, Missouri; Dr. Michael F. Nolan, Louisiana; and Dr. Frederic C. Sterritt, New Jersey. The 1999 annual session will mark the completion of the terms of service of four Council members; Dr. T. Carroll Player; Dr. Felix C. Crawford; Dr. Arthur W. Puglisi; and Dr. Richard A. Simms. The Council expresses its gratitude to these members for the exemplary manner in which they performed their duties in furthering the interests of the profession.

Ms. Linda Lowe, representative from the Alliance of the American Dental Association, Dr. Ryan Hughes and Mr. Christopher Rouse, representatives of the American Student Dental Association, also served on the Council in a liaison capacity.

Meetings: The Council met February 5-7, 1999 in Washington, D.C. The Council's second and third meetings are scheduled for May 21-23, 1999 and September 10-12, 1999.

In February, the Council hosted its annual meeting with the Dental Chiefs of the tri-services (including both active duty and reservists), Veterans Affairs (VA), Public Health Service (PHS), and the Senior Consultant for Dentistry, Department of Defense (DoD). The representatives spoke of their concerns and expressed appreciation for the Association's ongoing legislative and regulatory efforts.

The Strategic Plan of the American Dental Association: At its February meeting, the Council reviewed the Association's 1998-2001 Strategic Plan in order to identify how the Council's activities support the Plan's goals and objectives. A summary of these activities follows.

Goal I. Advocacy

Objective i. This objective seeks to increase the effectiveness of the Association's legislative and regulatory advocacy efforts through extensive lobbying activities. The Council activities support this objective primarily through interaction with staff of the Division of Government Affairs and by providing recommendations on policy issues and proposed legislation and regulations.

The Council developed criteria for measuring the effectiveness and success of the ADA's advocacy efforts. Tangible signs of whether the Association's position is being properly delivered are if representatives of the ADA (staff and volunteers):

- meet with members of Congress and their staff;
- meet with senior federal agency officials and their staff;
- testify before Congressional committees and federal regulatory bodies;
- write letters, testimony, position papers, etc. that communicate the ADA's position;
- attend ADPAC-related functions;
- work with grassroots members;
- participate in and lead coalitions;
- seek to have bills introduced and advocate for legislative passage;
- when appropriate, advocate for defeat/change of legislation/regulation;
- recognize opportunities where legislative advocacy can be used to leverage the ADA's position with federal regulatory agencies; and

* American Dental Political Action Committee chairman without the power to vote.

† Committee on the New Dentist member without the power to vote

- use the regulatory process to properly interpret and implement laws.

With regard to state issues—to assist ADA constituent societies in the advocacy of issues that promote dentistry and oral health care, the Department of State Government Affairs will seek to maximize the number of:

- constituents and members assisted;
- training programs conducted;
- dentists reached through presentations, publications, etc.;
- charts created, requested and disseminated;
- presentations to the Alliance of the American Dental Association;
- Alliance members as Action Team Leaders (ATLs); and
- Alliance members attending the Grassroots Conference.

Health Information Privacy/Confidentiality: At its February meeting the Council recommended and the Board of Trustees subsequently adopted interim policy on health information privacy and confidentiality. The Council's recommendation was developed jointly with the Council on Dental Practice.

The Council saw a need for such policy to enable the Association to respond to legislation related to health information privacy and confidentiality, which is expected in the 106th Congress. In addition, a federal law requires the Department of Health and Human Services to submit to Congress detailed recommendations on standards with respect to privacy of individually identifiable health information.

Therefore the following resolution is forwarded in accordance with the ADA *Bylaws* which requires that interim policies be presented for review and consideration by the House of Delegates at its next session.

15. Resolved, that the following be adopted as the American Dental Association's policy on health information confidentiality and privacy:

Federal legislation

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

Limits on disclosure and use of patient-identifiable information

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

Patients' rights

- Patients should have the right to know who has access to their personally identifiable health information and how that information has been used.
- A patient's general consent to the release of confidential health information to a third party, such as a health plan, should not be legally sufficient to permit subsequent release by that third party of the information.
- Patients should have the right to see their records, obtain copies, and append brief comments or proposed corrections.

Unauthorized disclosure of patient-identifiable health information

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

Use of health information for research

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

Use of health information by law enforcement

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

Practice considerations

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

Responses to Assignments from the 1998 House of Delegates

Listed below are the responses to some of the resolutions assigned to the Council. The remainder of the resolutions will be addressed in the Council's May or September meetings and will be included in the supplemental reports to the House of Delegates.

Federally Qualified Health Centers (FQHCs): Resolution 86H-1998 (*Trans.*1998:736) calls for the Association to actively pursue and prepare legislation that requires FQHCs to offer services on a priority basis to indigent patients or to patients with no other access to care; pursue rule changes with federal agencies regarding operations of FQHCs; create a databank to track rule changes and legislative issues in FQHCs; and on an annual basis report to the House of Delegates all Association actions related to this resolution through the annual report of the Council on Government Affairs.

In response to this resolution, the Council approved a resource packet on FQHCs that was sent to all constituent and component societies.

The ADA also sought to amend S. 1035, the "Dental Health Access Expansion Act," introduced by Senator Russ Feingold (D-WI), in an effort to limit FQHCs to serving the indigent and those without access. The Senator did not accept the ADA's proposal. If the legislation begins to move through the legislative process, the Association will seek another amendment causing FQHCs to give priority consideration to indigents and those without access.

Regarding rule changes, Health Resources and Services Administration (HRSA) staff provided assurances that the agency's revised policy for FQHCs will include a provision that gives priority care to indigent patients.

A databank has been created; however, only the actions described above have taken placed at the time of this writing.

In addition to specific legislative and regulatory actions by the ADA, the Council has made an attempt to address members' concerns surrounding FQHCs by designating Dr. Douglas Hadnot of Montana as the Council's contact person when individual members have problems. Dr. Hadnot, with staff support, will be able to seek specific solutions to specific problems working with personnel at HRSA.

Relationship Between Active Duty Military Dentists and Component Dental Society Members: Resolution 90H-1998 (*Trans.*1998:738) urges military dentists and component society members to establish and maintain regular lines of communications; urges active duty military dentists to keep civilian dental officials informed of military activities of relevance to area dentists, when information is not restricted; directs the ADA to monitor and assure that military contracts (that affect dental practices) will continue to be established with proper adherence to government policies and guidelines; and directs the ADA to notify constituent and component dental societies and facilitate the establishment of a process for input.

The service Dental Corps Chiefs periodically visit local bases and attend regional meetings at which time they stress the need to communicate and meet with local societies.

The ADA is successfully working with the military and dental societies when there have been discussions concerning the formation of on-base dental clinics.

Local dental commanders know to contact dental headquarters when discussions of an on-base dental clinic take place. In turn, the Corps Chiefs notify the ADA and the Association works with the appropriate societies to address the issue. For example, the dental commander at the Lemoore Naval Air Station (a remote base in the desert near Fresno, CA) recently notified the ADA staff directly when the base commander raised the issue of an on-base clinic. Preparations are underway for a meeting that will include the local society.

Announcement of Credentials by General Dentists: Resolution 50H-1998 (*Trans.*1998:734) directs the Association to develop materials for use by the constituent societies in lobbying state legislatures and dental boards for the adoption of advertising standards based on Advisory Opinion 5.I.1.

Advisory Opinion 5.I.1 of the *ADA Principles of Ethics and Code of Professional Conduct* permits general dentists to advertise credentials in non-ADA-recognized specialty interest areas provided the dentist specifies educational and training requirements and includes certain disclaimers. The resolution was assigned to the Council on Ethics, Bylaws and Judicial Affairs and the Council on Government Affairs. Both Councils are jointly developing a resource packet to assist constituent dental societies that wish to modify their state laws/regulations based on the model of Advisory Opinion 5.I.1.

Dental Board Acceptance of Licensure Examinations by Testing Agencies: Resolution 56H-1998 (*Trans.*1998:725) urges constituent societies to submit formal proposals to their respective state dental licensing agencies that would provide for acceptance of successful completion of a licensure examination administered by any recognized individual state or regional testing agency for the purpose of licensure in their

state. At present, only a few states accept the results of all regional clinical exams for initial licensure.

The Council on Dental Education and Licensure and the Council on Government Affairs have developed a resource packet to assist constituent societies in implementing this resolution. The packet is expected to be ready for distribution in summer 1999.

Dental Hygiene Training Programs: Resolution 31H-1998 (*Trans.*1998:714, 718) expresses ADA support for the alternative pathway model of dental hygiene education as used in Alabama. The resolution, among other provisions, requests the Board of Trustees to consider providing nonfinancial assistance to constituent societies seeking changes in their state practice acts to allow alternatively trained hygienists to be licensed. ADA President, Dr. S. Timothy Rose appointed the Committee to Develop an Alternative Pathway Education Model Workbook for Dental Hygiene, which worked with staff of the Council on Government Affairs to develop a resource packet to be forwarded to the Board for approval and, ultimately, to be distributed, upon request, to constituent societies.

Dental Management Services Organizations (DMSOs): Resolution 55H-1998 (*Trans.*1998:701) directs appropriate agencies of the Association to expand research, compile data and educate members about DMSOs and to develop comprehensive informational materials and a packet/manual on DMSOs for members. This resolution was referred to the Board of Trustees' DMSO Task Force. The Council on Government Affairs assisted the DMSO Task Force in implementing Resolution 55H-1998 by revising a resource packet for constituent societies on corporate practice to include additional information relating to DMSOs.

Update on State Issues

Child Health Insurance Program (CHIP)/Medicaid: As of May, 1999, 48 states had submitted their plans to the Health Care Financing Administration (HCFA) for approval of the states' Child Health Insurance Program (CHIP). All have been approved, with the exception of Tennessee.

- Twenty-four states (plus D.C.) have chosen to expand Medicaid as a means to access CHIP funding.
- Ten states have "hybrids," in which programs are a combination of Medicaid and non-Medicaid programs.
- Fourteen states have modeled their CHIP program coverage on the state employee benefit program or another benchmark as specified in the Title XXI legislation.
- Legislatures in Washington State and Wyoming passed CHIP programs this year, but neither has yet submitted them for HCFA's approval
- Colorado does not include dental in its CHIP plan. The Florida Dental Association changed its mind and is now working to include dental services in its CHIP program.

Patient Protection/Managed Care: Although Congress could not agree on patient protection legislation, at least three-quarters of the states now have many of the protections sought by Congress. However, these laws do not apply to multi-state and self-insured plans which are governed by ERISA, and, therefore, they are exempt from the reach of state insurance laws.

Common provisions of comprehensive state laws include: ban on gag clauses; procedures to facilitate patient appeals; guaranteed access to medical specialists; and expanded emergency room procedures.

Liability of health insurance plans and requirements for external review of patient grievances have received considerable attention from state legislatures in 1999. As of May 1999, three states Georgia, Missouri and Texas had enacted laws that allow patients to sue an HMO for damages; bills were introduced in more than half the states in 1999.

Licensure: Nevada amended its dental practice act earlier this year to allow the dental board to issue 20 licenses by credential each year. The board can also issue limited licenses to dentists and hygienists from other states to enable them to be employed full-time by state schools.

Montana agreed in 1998 to grant licensure by credentials; bringing to 34 the number of states, plus D.C., that allow licensure by credentials as of mid-1999. Utah will now consider for licensure applicants who pass any regional clinical exam as long as the dental board determines it is not inferior to the Western Regional Examination Board test.

Dental Hygiene: Dental hygienists in New Mexico who have attained a sufficient level of education and experience (to be determined by dental board regulations) will be certified to engage in "collaborative practice" with a consulting dentist. Dental supervision is not required for certified hygienists, except for local anesthesia, which still would require a dentist to be present.

Last year, the California legislature approved creation of a new category of "Registered Dental Hygienist in Alternative Practice" (RDHAP). A 1999 California bill would require dental health care plans to pay for services performed by RDHAPs and allow them to join plans if the plan requires membership as a condition for reimbursement.

Organized dental hygiene lobbied for expanded duties and greater autonomy in 1998 and 1999, with an emphasis on trying to create separate boards of dental hygiene. All separate board proposals failed, but a few states enacted laws to establish separate dental hygiene committees of the dental board that have some real authority.

Iowa, Louisiana and Wisconsin changed their laws or regulations to permit dental hygienists to administer local anesthesia, and Alaska permits administration of nitrous oxide. At the close of 1998, 26 states allowed hygienists to administer local anesthesia and 18 allow them to administer nitrous oxide.

Anesthesia and Associated Medical Costs: Constituent dental societies pushed hard the last two years for laws to require health insurance plans to cover the costs of anesthesia and associated medical costs for dental treatment provided to young children and/or the disabled. As of mid-May 1999, laws were enacted in 14 states and bills were introduced in a dozen more.

Denturism: Dental associations in Kentucky, Mississippi and Wyoming successfully fought efforts to legalize denturism in their states last year. The number of states legalizing the practice remains at six: Arizona, Idaho, Maine, Montana, Oregon and Washington.

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Practice considerations

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

Notes

Division of Science

Council on Scientific Affairs

American Dental Association Health Foundation

ADA Health Foundation Research Institute

ADA Health Foundation Paffenbarger Research Center at the National Institute of Standards and Technology

Notes

Council on Scientific Affairs

Armitage, Gary C., California, 1999, chairman
Thompson, Van P., New Jersey, 2000, vice chairman
Anusavice, Kenneth J., Florida, 2001
Chan, Jarvis T., Texas, 1999
Drisko, Connie Hastings, Kentucky, 2002
Gage, Tommy W., Texas, 2000
Glick, Michael, Pennsylvania, 1999
Grammer, Frank C., Arkansas, 2001
Hand, Jed S., Iowa, 2000
Hutter, Jeffrey, Massachusetts, 2002
Kelly, John R., Maryland, 2001
Menke, Richard A., Ohio, 2002
Powell, G. Lynn, Utah, 1999
Silverman, Sol, Jr., California, 2000
Trowbridge, Gordon P., III, Maine, 2001
Tussing, Gerald J., Nebraska, 2002
Verhagen, Connie M., Michigan, 2000
Burrell, Kenneth H., senior director
Shearer, Brian G., director, Information and Policy
Whall, Clifford W., Jr., director, Product Evaluations
Wozniak, Wayne T., director, Evaluations Criteria
Vogt, Andrew, assistant director, Product Evaluations
Walker, Rosemary, assistant director, Information

Meetings: The Council on Scientific Affairs met October 6-8, 1998, January 19-21, 1999 and May 12-14, 1999 at the Association Headquarters in Chicago. The Council's final meeting of 1999 is scheduled for September 14-16.

Personnel: Four new representatives replaced outgoing Council members in 1998. Dr. Connie Hastings Drisko, Dr. Jeffery Hutter, Dr. Richard Menke and Dr. Gerald Tussing replaced Dr. B. Ellen Byrne, Dr. Sebastian Ciancio (vice chairman), Dr. Bruce Rothwell (chairman) and Dr. Robert Schallhorn, whose terms expired with the 1998 annual session.

The Strategic Plan of the American Dental Association: Many of the Council's recent activities support multiple goals and objectives as outlined in the current Strategic Plan. The Council, however, views itself primarily as a resource of scientific information for the Association and, therefore, sees Goal IV. Information, objective i—"be the premier source of information on oral health"—as one of its main charges. Virtually all of its activities can be tied to this objective.

As directed in Resolution B-79-1998 (*Trans.*1998:632), the Council has devised a series of quantitative measures for assessing the effectiveness of its various scientific activities in meeting the Goals and objectives of the Strategic Plan.

Emerging Issues. The concept of emerging issues, as addressed under Goal III., objectives iii and vi, of the Strategic Plan, will be measured by Council responses via reports to the profession; position statements and scientific presentations, for example, through oral presentations; other Council-sponsored lectures; and abstracts on Council-endorsed Association research.

Dissemination of Information. Looking to articles published in the *ADA News*, *The Journal of the American Dental Association* and other scientific and public media can gauge the success of this program in meeting Goal II., objective i, and Goal IV., objective ii, of the Strategic Plan.

Scientific Presentations. In response to Goal II., objective i, the Council sponsors and contributes to a variety of educational programs. The headway made in these activities can be gauged by the quantity of programs presented, academia/industrial feedback on content and formal written audience evaluations.

Dental Research. Council actions toward dental research meet Goal IV., objective i. Its support of studies of the Association's Research Institute and laboratories, American Dental Association Health Foundation (ADAHF)-supported programs and work with liaison organizations can be measured by assessing implementation of the items outlined in the Research Agenda as well as by the information passed on to the profession through various presentations and publications.

Product Evaluation and Information. The Association's Seal of Acceptance Program meets Goal V., objective vi, of the Plan. Success of this Council-administered program may be measured by manufacturer participation. In addition, surveys on public and professional awareness and use of Seal products offer

perspective on the Association's image and its efforts toward promoting oral health and safe, effective dental products. The Council's efforts in this area meet Goal IV., objective ii, of the Strategic Plan.

Evaluations Criteria. As directed under the *Bylaws*, the Council remains active in the development of dental product standards and guidelines for the Seal Program. These activities meet Goal III., objective i, and Goal V., objective iii, of the Strategic Plan. A review of new and revised guidelines would provide an indication of how well the Council and, in turn, the Seal Program, is keeping abreast of advances in product development as well as safety and efficacy issues related to dental materials, instruments, equipment and therapeutics.

Liaison with Allied Organizations. The Council maintains liaison with several regulatory, research and allied health care organizations, including the American Association for Dental Research (AADR), the American Association of Dental Schools (AADS), the American Heart Association (AHA), the American National Standards Institute (ANSI), the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the International Institute for Dental Research (IADR), the International Organization for Standardization (ISO) and the National Institute of Dental and Craniofacial Research (NIDCR). Such endeavors, which meet Goal VI, objective iv, of the Strategic Plan, can be measured by the success of joint meetings, responses to cross-agency requests for comments and information, and appropriate dental depiction in the regulatory and advisory actions of other agencies.

Liaison with ADAHF. Under its *Bylaws* duties to serve as an advisory body to the ADAHF, the Council provides scientific guidance, assistance and support in product development, meeting Goal V., objective iii, of the Strategic Plan. The success of the Council's efforts may be assessed through reviews of ADAHF requests for assistance as well as ADAHF requests for proposals consistent with Council recommendations.

In addition to outlining measures for monitoring the effectiveness of its various activities in implementing the Strategic Plan, the Council was asked by the Board of Trustees (Resolution B-67-1998) to eliminate programs that do not directly support the Association's goals and objectives for 1998 through 2001. Finding strong correlation between the Strategic Plan and all its current programs, the Council opted to retain all existing programs at this time.

Response to Assignments from the 1998 House of Delegates

ADA Policy Statement on Intraoral/Perioral Piercing: In response to Resolution 15H-1998 (*Trans.* 1998:743), the Council continues to monitor literature and assess reports of morbidity associated with oral piercing. The statement has been posted on ADA ONLINE, the Association's Web page, and is available to members upon request.

Role of Sugar-Free Foods and Medications in Maintaining Good Oral Health: In response to Resolution 30H-1998 (*Trans.* 1998:745), the statement has been provided to interested parties and posted on ADA ONLINE.

Ethical Responsibilities of Dentists Following Potentially Infectious Exposure Incidents: Referred to the Council on Scientific Affairs, the Council on Ethics, Bylaws and Judicial Affairs and the Council on Dental Practice, Resolution 62-1998 (*Trans.* 1998:731) addresses a dentist's obligation to inform patients of exposure to the potentially infectious body fluids. This item will be addressed in a separate joint report to the 1999 House of Delegates.

Benefits for Non-Metallic Restorations: Resolution 70-1998 (*Trans.* 1998:703) was referred to the Council on Dental Benefits Programs and the Council on Scientific Affairs. A working group of the Council on Scientific Affairs met with the Council on Dental Benefits Programs to address the resolution's statement that laboratory-fabricated inlays, onlays and crowns made from composite or ceramic substances are valid and scientifically proven restorations that should be reimbursed the same as metal or porcelain restorations. The consensus of the two Councils is outlined within the annual report of the Council on Dental Benefit Programs.

Payment for Temporary Procedures: Resolution 72-1998 (*Trans.* 1998:701) was referred to the Council on Dental Benefits Programs and the Council on Scientific Affairs. A working group of the Council on Scientific Affairs met with the Council on Dental Benefits Programs to address the resolution's statement that provisional or interim restorations and prostheses that are placed to promote healing are valid, scientifically proven treatment modalities that should be covered at a fair reimbursement level. The consensus of the two Councils is outlined within the annual report of the Council on Dental Benefit Programs.

Attainable Levels of Nitrous Office in Dental Offices: In response to Resolution 94H-1998 (*Trans.* 1998:743), the Council forwarded to the ADAHF a request for proposals for the second phase of a research project to determine the attainable level of nitrous oxide exposure in the dental office. The Council also urged the ADAHF to seek funding from government, industry and other sources to support this research. The Association's $67,300 appropriation to support this research has been allocated to the ADAHF.

Controlling Nitrous Oxide in the Dental Office: Resolution 95H-1998 directed the Council to "urge manufacturers of nitrous oxide delivery and scavenging systems to design systems to minimize the amount of nitrous oxide that escapes into ambient air." As such, the Council sent letters requesting increased efforts in this area to manufacturers of these systems as well as to the relevant dental trade associations. A follow-up meeting

with manufacturers also is being planned. The Accredited Standards Committee Medical Devices 156 (ASC MD156) of the ANSI also was contacted and encouraged, in its development of relevant standards, to bear in mind the Association's initiatives toward minimizing nitrous oxide exposure.

To meet Resolution 95H-1998's directive for renewed efforts toward member education, Council requested that the publisher of the *ADA News* consider preparing an article on Association efforts toward further minimizing occupational exposure to nitrous oxide. The article, which is tentatively scheduled to appear in a summer issue of the publication, will include a summary of current Council guidelines for nitrous oxide in the dental office.

Scientific Information and Research

Oral and Systemic Health Interactions: The relationship between oral and systemic conditions is recognized but not always well understood. As such, the Board of Trustees directed the Council on Scientific Affairs to explore ways of addressing issues of oral-systemic health interactions. With Resolution B-40-1998 (*Trans.*1998:611), the Board supported the concept of multidisciplinary symposia, which would bring together general dentists and specialists, pharmacists, public health experts, researchers and other health care professional groups to share current knowledge between the professions, educate health professionals about the interplay between oral and systemic conditions, and serve as a vehicle for identifying additional research needs.

Of the 26 national health care organizations contacted, 13 groups—mainly dental professional groups—expressed interest in collaborating with the Association to clarify the facts and myths of oral and systemic health associations. The Board has approved a meeting of a planning committee to study the feasibility of organizing and cosponsoring these symposia. The committee is charged with developing a proposed outline of symposia, including a session devoted to future research needs, as well as suggested speakers and expenses for each program.

Also in the area of oral and systemic relationships, the Council has submitted the course title "Emerging Issues of Importance to the Practicing Dentist: The Influence of Oral Conditions on Systemic Disease and Medical Treatment Outcomes" for the 1999 ADA annual session. The half-day summary symposium will present an overview of current science and inform the profession of any adjunctive, subject-specific symposia in the works.

Evidence-Based Dentistry: Efforts to explore evidence-based dentistry could possibly lead to Association policies regarding treatment indicators, outcome measures and benefits. The Council put forth a proposal to the Board to convene an interagency task force to collect information from experts and determine the Association's role in evidence-based dentistry as it relates to patient care.

Latex Hypersensitivity: To inform, educate and assist the profession, the Council on Scientific Affairs developed a report titled "The Dental Team and Latex Hypersensitivity." Published in the February 1999 issue of *The Journal of the American Dental Association*, the report reviews the problem of natural rubber latex allergy, suggests means to definitively diagnose the condition and proposes common-sense options for reducing exposure to latex in the dental office. Development of a parallel report addressing management of latex-hypersensitive patients in the dental office is on the Council's agenda.

In other measures aimed at curbing latex hypersensitivity, the Council recently adopted revised safety criteria for natural rubber latex gloves submitted for evaluation under the ADA Seal of Acceptance Program. The revised criteria state that:

- total protein level cannot exceed 200 μg per gram of glove when tested according to American Society for Testing Materials (ASTM) D5712, and
- gloves claiming to be "powder-free" must contain no more that 0.7 mg of particulate per gram of glove when tested according to ASTM D6124.

Products applying for the Seal must meet these revised criteria for Acceptance. Manufacturers of products already in the Seal Program were notified of the changes and given until January 4, 2000 to come into compliance. Deadlines also were set for complying with labeling and promotional claims with regard to powder and protein content. In a related action, the Council decided not to allow "reduced protein" or "low protein" claims, which would imply that the gloves lower the risk of latex allergy, in the absence of a scientifically justified protein level that would reduce sensitization and allergic reaction to natural rubber latex.

Medically Compromised Dental Patients: In December 1998, the Board referred to the Council a proposal for a collaborative effort with the NIDCR to develop a program on the scientifically based management of the medically compromised dental patient. The Council reviewed the two-part initiative, which includes a November 1999 workshop of experts to review the scientific literature, evaluate the scientific basis for managing medically compromised patients and identify and prioritize research needs. Subsequently, Part 2 of the initiative would provide dentists with comprehensive training in managing these patients.

In February 1999, the Council was named as lead Association agency in this collaborative effort, and Council members Dr. Glick and Dr. Silverman were appointed by the Board to represent the Association in this endeavor, as was Council consultant Dr. Joan Phelan.

Mercury Hygiene: The Council updated its 1991 guidelines for mercury hygiene, incorporating several changes consistent with the FDI World Dental Federation's 1998 recommendations. Titled "Recommendations for dental mercury hygiene," the amended report details the potential sources of mercury vapor in the dental operatory and provides recommendations for handling amalgam, storing amalgam scrap and monitoring the operatory for mercury

vapor. It also highlights the dentist's potential legal liability as a generator of amalgam waste.

The report has been accepted by *The Journal of the American Dental Association* for publication in July 1999. Moreover, to provide further information on the rationale behind its recommendations, a detailed paper on mercury hygiene, including the basis for the Council's recommendations, is being prepared for posting on ADA ONLINE and in response to members who wish to receive additional information on the subject.

Antibiotics and Oral Contraceptives: In 1991, the Research Institute published a report titled "Antibiotic Interference with Oral Contraceptives," warning practitioners of a potential interaction between systemic antibiotics and oral steroid contraceptives that could result in pregnancy. Since the publication of this document, however, a review of current literature has indicated that the failure rate for oral contraceptives during the administration of antibiotics (except rifampin, an antibiotic used to treat staphylococcal infections and tuberculosis) is comparable to the failure rate for oral contraceptives taken without potentially confounding medications.

Late last year, the Council revised its 1991 report, concluding that "based on a review of current scientific literature, it no longer appears necessary or appropriate to warn women of child-bearing age who are taking oral contraceptives of a possible drug interaction between oral contraceptives and antibiotics, except for rifampin, which is seldom if ever used in dentistry." The Council is seeking support for the scientific content of the document from the American Medical Association (AMA) prior to submitting the report to *The Journal of the American Dental Association* for publication consideration. The report was referred to the AMA's Council on Scientific Affairs for comment. Pending its comments, the report will be made available to member dentists in both print and electronic formats.

Expert Panel on Dental Unit Waterlines: On October 5, 1998, the Board-appointed Expert Panel on Dental Unit Waterlines met at Association Headquarters in Chicago. Chaired by Dr. Gordon P. Trowbridge III, member, Council on Scientific Affairs, the panel consisted of experts representing the academic and research communities, industry, allied public health and infection control organizations, and interested governmental agencies. Panelists included: Dr. Jennifer Cleveland, CDC; Dr. Janie Fuller, FDA; Chris Miller, Ph.D., Indiana University; Dr. Shannon Mills, United States Air Force colonel and Board member of the Organization for Safety and Asepsis Procedures; Jeff Williams, Ph.D., Michigan State University; and Jeff Zawada, Ph.D., A-dec, Inc.

The panel reviewed the clinical relevance of waterline contamination, agreeing that sufficient evidence exists to warrant voluntary action, and discussed currently available options for improving the quality of dental treatment water. Various panelists also provided overviews of advances in research, ongoing studies into possible chemical and mechanical solutions, and the future direction of research. As directed by the Board, a report to the profession was prepared by the panel, reviewed by the Council on Scientific Affairs and forwarded to the Board of Trustees in time for its June 1999 meeting. Pending Board approval of the report, it will be offered to *The Journal of the American Dental Association* for publication.

NIDCR Oral Health Technology Forum: The Association was represented on the NIDCR-sponsored executive committee formed to develop an Oral Health Technology Forum. The committee, which met in April 1999, comprised members of professional constituencies with an interest in the development of new products and technologies.

In July 1997, the NIDCR and FDA signed a Memorandum of Understanding to pursue development of an oral, dental and craniofacial forum to allow the NIDCR and the FDA to interact with representatives of the Department of Health and Human Services Agencies, research societies, academia, professional associations, provider (i.e., practitioner-oriented) organizations, regulatory agencies and the regulated industry. The model for the forum is the Technology Forum previously organized by the National Eye Institute. Issues for the forum include technology development and transfer, regulatory processes for acquiring market clearance, product utilization, treatment outcomes, adverse event reporting and related activities.

The Technology Forum is tentatively scheduled for fall 1999.

Scientific Sessions: The Council sponsored two educational programs—under the title "Emerging Issues of Importance to the Practicing Dentist"—at the 1998 annual session, assembling panels of experts on dental lasers and latex hypersensitivity to share current knowledge and address the questions and concerns of clinicians in the audience. Both programs were well-received.

In addition to its 1999 program on the influence of oral conditions on systemic disease and medical treatment outcomes, the Council has submitted the titles "Provision of Dental Care of Medically Complex Patients" and "Detection and Treatment of Early Caries and 'Hidden' Caries," as topics for programs at the 2000 annual session.

Waste Management Activities: Amalgam-containing solid waste and amalgam wastewater continue to be the major issues in dental office waste management. Regionally, the Great Lakes Dental Mercury Reduction Project invited dental societies and several environmental agencies in the region to participate in a September 1998 meeting. The project was conducted by the Western Lake Superior Sanitary District and funded by the Great Lakes Protection Fund. The Association representatives served as observers. The focus of the project is to develop and promote programs for collecting and recycling amalgam waste, including amalgam in traps and filters. Participants agreed to undertake surveys to identify barriers that may pose obstacles to greater participation by dentists in waste management practices. With the surveys completed, the findings will be reviewed and draft guidelines developed for waste management in dental offices.

The Council, as well as the Association's Division of Science, Division of Legal Affairs and Division of Government Affairs,

continues to assist state dental societies in reviewing draft waste management recommendations for dental offices. Other activities include analyzing data from wastewater samples, developing protocols to evaluate amalgam separators and drafting proposals to assess the contribution of dental office wastewater on the mercury content of effluent from wastewater treatment plants. In addition, the Association agencies also recently reviewed and provided comments on a draft Water Environment Federation monograph on controlling wastewater discharges from dental facilities.

Dental Students' Conference on Dental Research: Aimed at making students aware of the wide scope of careers in dental research, the Association's Dental Students Conference on Dental Research introduces outstanding dental students to leading dental educators, scientists and administrators. It also presents a wide array of educational and vocational opportunities available to those preparing for a career in dental research. This year, students from 54 dental schools in the United States and Canada recently took part in the 35th annual conference. The meeting was held April 10-13, 1999 at the University of Washington School of Dentistry in Seattle. As part of this year's scientific program, participants heard diverse presentations on topics such as periodontal research, children's health, and career opportunities in dental research, the behavioral sciences and dentistry. Students also had an opportunity to tour the university's research facilities, interact with the staff scientists and discuss current projects.

The program is sponsored by the American Dental Association through its Health Foundation with support from the Warner-Lambert Company.

Research Issues of Importance to the Practicing Dentist: The Council on Scientific Affairs, guided by the *ADA Strategic Plan 1998-2001* and the *Bylaws* of the Association, continues to review the Association's Research Agenda, forwarding suggested changes to the Board of Trustees. The Council acknowledges that although this list of research priorities is not exhaustive, the following areas of research urgently need to be addressed.

Issues of Infection Control and Patient and Provider Safety

- Continue research to improve procedures for the protection of patients and providers against air- and bloodborne pathogens (TB, HIV, etc.).
- Study the use of antibiotics and the development of antibiotic resistance, and reassess the need for development of guidelines for the use of antibiotics in dental practice.
- Study contamination of waterlines in dental equipment and develop methodologies to assure high-quality water in coolant and irrigant systems.
- Promote studies aimed at ascertaining what, if any, are the health effects in patients, practitioners and allied health personnel from exposure to aerosols generated during dental procedures.
- Develop a sound, comprehensive research plan to investigate the acceptable and attainable levels of nitrous oxide in the dental office.

Issues of Health Services Research

- Develop means to increase prevention activities in dental practice, such as sealant use, tobacco cessation, use of mouth guards in contact sports and recognition and reporting child abuse and neglect.
- Develop simulation models to compare various oral health care delivery systems (such as solo, multispecialty, institution and hospital practices as well as dental hygienists and various combinations of auxiliary personnel) for assessment of long-term efficacy.
- Study the socioeconomic, geographical and cultural barriers to oral health care and develop strategies for extending quality care to all Americans.
- Study the effect of managed care on the cost of practicing, academic and public health dentistry, and its ultimate effect on oral health of the American people.

Issues in Research on Management of Oral Diseases

- Evaluate the relationship of oral infections to systemic conditions.
- Promote research and development of sealants, adhesives and effective mercury-free biocompatible dental materials for posterior restorations.
- Expand the research on the infectious nature of caries and periodontal disease in vulnerable populations, e.g., children, in order to develop appropriate individual patient risk-based assessments for their treatment and prevention.
- Continue research on the mechanisms of action of fluorides and the total fluoride exposure in order to re-evaluate optimal fluoride levels in various prevention protocols.

Issues of Science Transfer

- Collaborate with AADS, NIDCR, AADR, CDC and other relevant agencies/organizations in order to implement the concept that caries is an infection and should be managed as such.
- Continue collaboration with AADS, NIDCR, AADR, CDC and other relevant agencies/organizations in order to communicate the latest science to the practitioner at the ADA annual session.

The aforementioned research priorities were adopted by the Board of Trustees in June 1998 as part of the Association's Research Agenda, which bears the title "Research Issues of Importance to the Practicing Dentist." In January 1999, the Council voted to routinely forward its recommendations for revision to the Board each December.

Aerosols in Dentistry: As previously reported, the American Society of Heating, Refrigeration and Air-conditioning Engineers (ASHRAE) proposed adding two sections to its 1999 applications handbook, one addressing indoor air quality in dental facilities, the other on nitrous oxide levels in the dental office.

The implications surrounding the inclusion of sections related to dental facilities were troubling, as the ASHRAE handbook is often utilized in formulating voluntary standards that are routinely incorporated into building codes. The proposed additions to the handbook would likely have had a significant impact on the cost of construction and maintenance of all dental facilities.

The Council on Scientific Affairs, with assistance from the CDC, reviewed the proposed sections for dental facilities and formulated comments on the draft documents. The Association's response to the document centered on the lack of scientific data upon which any standards for dental-office indoor air quality could be based. Although ASHRAE acknowledged that many of the Association's comments were valid, it still proposed to proceed with publishing the new sections in 1999. The Council subsequently asked that scientific staff prepare another letter to ASHRAE expressing concerns over these obviously premature documents. The reply has delayed ASHRAE action on indoor air quality for dental facilities. The engineering organization has dropped its plans to address dental facilities in its 1999 handbook, opting to look again at these issues for its 2003 handbook.

Although this issue remains unresolved, the Association has established liaison with ASHRAE through experts with both dental and construction experience. In addition, funding has been allocated in the 1999 budget for an Association study on aerosols in dentistry.

ADA Representation at Dental Caries Conference: New methods of detecting early dental caries have been developed and employed in clinical caries trials. Indiana University's Oral Health Research Institute hosted a May 1999 conference on these new methods and the technology behind them. Appointed by President Rose at the recommendation of the Council, Dr. Anusavice represented the Association, presenting information on the type of scientific evidence the ADA Seal of Acceptance Program views as necessary to validate, through clinical trials, new early caries detection methods.

Product Evaluation and Evaluations Criteria

ADA Seal of Acceptance Program: The Association, through the Council-administered Seal of Acceptance Program, continues to provide both practitioners and consumers with information on safe, effective dental materials, instruments, equipment and therapeutic agents. To promote this program, the Council published *Products of Excellence*, a complete catalog mailed to members and senior dental students with their copy of *The Journal of the American Dental Association* in summer of 1998. Feedback from members has been positive, and manufacturers have been pleased with the publication, considering it a concrete demonstration of the Association's commitment to publicizing the Seal Program to its membership. To further support this effort, the list of ADA-Accepted products also has been placed on ADA ONLINE.

The Seal Program has grown in recent years, at least in part to Association promotion of the program through the *Products of Excellence* catalog. In 1996, 119 new product applications were received. In 1997, when an abridged version of the catalog was published, 121 products were submitted. In 1998, corresponding with publication of the complete, 88-page catalog, 257 products were received for Seal consideration. Between 1996 and 1998, the number of products in the Seal Program increased from approximately 1,250 to 1,374 (with 55% representing professional products and 45% available to consumers). During 1998, approximately 425 manufacturers participated in the Acceptance Program, a 25% gain from the previous year.

The Council is considering a series of measures to expedite the Acceptance process. At its October 1998 meeting, the Council voted to increase its use of conference call meetings of the full Council to accelerate the Acceptance process for time-sensitive, straightforward product submissions and resubmissions. The Council will be considering other potential time-saving measures throughout 1999.

Novocol Anesthetics Recall: In early 1999, Novocol Pharmaceuticals of Canada Inc., Cambridge, Ontario, notified the Association that it was voluntarily recalling approximately 230 lots of its lidocaine and mepivacaine local anesthetics that carry the ADA Seal of Acceptance. An FDA audit of the Ontario manufacturing facility called into question the application of Good Manufacturing Practices (GMP) and raised concerns about the sterility of the company's dental anesthetic products. Novocol and four distributors of private-label Novocol anesthetics (Schein, Patterson, Carlisle and Meer) were affected.

According to Novocol representatives, to date no cases of adverse reactions had been reported with any of the affected lots, and no immediate health threat was apparent from the anesthetics. Nonetheless, the Association encouraged dentists to participate in the recall.

Novocol was notified that, until further written notice from the Association, the company and its distributors were not to use the ADA Seal or make reference to ADA Acceptance in connection with any of the recalled local anesthetic products. Throughout the recall, the company remained highly cooperative with the Association.

At its May 1999 meeting, the Council discussed options for evaluating product safety once the company resumes production at the Ontario facility. The Council voted to base its evaluation on the test results of the independent laboratory Novocol is using to test the sterility of newly manufactured lidocaine and mepivacaine local anesthetics. The Council also will require written verification of favorable FDA review of the facility's GMP.

Use of Biodegradable Materials: The Association's concern with the widespread use of nonbiodegradable materials in the

manufacture and packaging of disposable dental products, as expressed in Resolution 93H-1991 (*Trans.*1991:586), prompted the Council to propose amending the *Provisions for Acceptance of Products by the Council on Scientific Affairs*, General Provisions for Acceptance (*Trans.*1994:313, 676; 1996:322, 732).

The Council presents the following resolution.

16. Resolved, that the *Provisions for Acceptance of Products by the Council on Scientific Affairs* (*Trans.*1994:313, 676; 1996:322, 732), General Provisions for Acceptance, be amended by insertion of a new Section V. Use of Biodegradable Materials to read as follows:

V. Use of Biodegradable Materials

A. The American Dental Association is concerned about the environment and about the negative impact that the widespread use of nonbiodegradable materials for the manufacture and packaging of disposable products can have on the environment. Therefore, the Association encourages all dental manufacturers, especially those with Accepted products, to use, whenever possible, materials that are biodegradable in both the manufacture and packaging of disposable products.

and be it further

Resolved, that existing Sections V. through VII. be renumbered Sections VI. through VIII., respectively.

FDA Report to Congress on Implementation of the FDAMA: The FDA Modernization Act of 1997 (FDAMA) is a Congressional act requiring the FDA to significantly improve execution of its functions. Under the FDAMA, the FDA must implement methods to speed the approval process without decreasing its thoroughness. One method suggested by Congress is to utilize expertise outside the FDA, both in devising a plan to implement the FDAMA and, subsequently, in complying with that plan.

Last fall, Dr. Bruce Rothwell, then-chairman of the Council, delivered a presentation to the FDA at a stakeholders meeting. He proposed that "the FDA could benefit by taking a close look at our Seal of Acceptance Program, which evaluates dental products based on safety and efficacy, the main evaluation criteria used by the FDA. The agency could, for example, expedite the approval of any dental products that have already earned the ADA Seal." Furthermore, he encouraged the FDA to utilize ADA guidelines and specifications for product reviews. It is noteworthy that the Association was the only organization represented at the stakeholder meeting to offer concrete suggestions on implementing the FDAMA.

The FDA's Plan for Statutory Compliance with the FDAMA appeared in the November 24, 1998 *Federal Register* (Vol. 63:65000-65040). The plan clearly states that the FDA will strive to work with and utilize the expertise of external stakeholders as much as possible. It further states that engaging the FDA's stakeholders and receiving feedback will be ongoing, and that regular contacts will continue to be maintained. The plan will be reviewed biannually and revised as necessary, in consultation with appropriate scientific and academic experts, health care professionals, representatives of patient and consumer advocacy groups and the regulated industry.

Because the comment period on how the FDA can meet the FDAMA requirements will remain open, organizations such as the Association can continue to provide input in the future. The Council voted to encourage the Association to continue to explore ways to assist the FDA in its efforts to comply with the FDAMA.

Standards Activities: As directed in its *Bylaws* duties, the Council encourages the development and improvement of materials, instruments and equipment for use in dental practice and coordinates the development of national and international standards programs. The vehicles for Council standards activities are the ASC MD156 and the International Organization for Standardization/Technical Committee 106, Dentistry (ISO/TC106).

ASC MD156. The Association, through the Council, is sponsor and Secretariat of ASC MD156, which develops and revises standards for dental products in the United States. The committee met in March 1999 to review its new operating procedures and work program, which currently has more than 95 projects registered with the ANSI. During the past year, new standards for dental operatory lights, nonsterile nitrile gloves, nonsterile polyvinyl chloride gloves and ethyl silicate investment materials were submitted to the ANSI for approval as American National Standards. In addition, standards on orthodontic wire, dental wrought gold wire alloy, and alloy and mercury dispensers for amalgam were withdrawn.

The ASC MD156 has 34 representatives from 22 dental-related organizations, including three voting members representing the Association.

ISO/TC106. Through the Council, the Association sponsors U.S. participation in ISO/TC106, serving as Secretariat of the U.S. Technical Advisory Groups (US TAGs). The Association also is Secretariat for Subcommittee 2, Prosthodontics, within ISO/TC106.

The 34th ISO/TC106 meeting was held September 28-October 3, 1998. Seven ISO/TC106 Subcommittees, including Subcommittee 2, and 42 Working Groups met during the conference. The plenary session of the committee was chaired by U.S. delegate Dr. J. W. Stanford. Twenty-one countries were represented by 260 delegates, with 57 delegates and/or observers from the United States. Dr. Kenneth Anusavice, Council member and chairman of Subcommittee 2, presented the prosthodontics report at the plenary session. The United States successfully defended its positions in all ISO Working Group meetings by ensuring that standards were based on data obtained from scientifically valid tests. Actions taken by the U.S. TAG resulted in casting the U.S. vote on 28 draft international standards, 12 committee drafts and nine new work items.

Guideline Development: The Council develops guidelines for the evaluation of products in its Seal Program when applicable standards have not been established. Currently, the Council has more than 50 product categories for which Acceptance Program guidelines exist or are in development. During the past year, guidelines were completed or revised for infection control products, dental equipment and products as aids in the treatment of temporomandibular disorder. Guidelines are under development to evaluate orthodontic products and products for the control of oral malodor. Guidelines also have been approved for the determination of efficacy in product evaluation.

Review of Association Policies

Use of ADA Name in Promotional and Educational Materials: As part of the mandate that all ADA policy statements be reviewed every five years, the Council examined the 1962 Statement of Policy on Use of Name of American Dental Association (*Trans.* 1962:210, 284) and noted that part of the policy conflicted with the goals of the ADA Acceptance Program.

Item 5 of the policy states:

> 5. Use of the Association's name must be in keeping with good taste and professional dignity. In advertisements, the name generally should be used no more than once during any radio or television program, and not more than once in any printed material. Only that amount of advertising time or space should be devoted to the Association name which is necessary to fulfill the basic purpose outlined in item 4 above.

Item 5 places limits on both the number of times the Association's name can by used in advertising and educational materials as well as on the total time (in television and radio advertisements) or space (in print ads) that can be devoted to mention of the Association. The Council believes that the use of the ADA Seal and Association's name in advertising for Accepted products provides an excellent opportunity to create awareness of both the Association and its Seal Program, as set forth in Goals III. and IV., Image and Information, of the Strategic Plan. As such, the Council recommends amending the 1962 policy as follows:

17. Resolved, that Item 5 of the Statement of Policy on Use of Name of American Dental Association (*Trans.* 1962:210, 284) be amended to read:

> 5. Use of the Association's name must be in keeping with good taste and professional dignity.

Association Policy on Research Funds: At its January 1999 meeting, the Council reviewed the 1984 policy on research funds, which directs the Board of Trustees to "reevaluate the expenditures currently being made by the Association for and in support of basic and applied scientific laboratory research and consider supporting in the future only those Association applied research scientific laboratory activities relating to the practice of dentistry" (*Trans.* 1984:519).

As the Association now maintains a Research Agenda, which is regularly reviewed by the Council on Scientific Affairs and approved by the Board of Trustees, the Council believes that current policy should reflect the Association's research priorities as outlined in its Research Agenda. Such an amendment would continue to support Goal IV., Information, of the Association's Strategic Plan. The Council proposes that the 1984 policy be amended.

18. Resolved, that Resolution 21H-1984 (*Trans.* 1984:519), Research Funds, be amended by deleting the phrase "and consider supporting in the future only those Association applied scientific laboratory research" and adding the phrase "as outlined and prioritized by the Association's Research Agenda titled 'Research Issues of Importance to the Practicing Dentist'" so that the amended resolution reads:

> **Resolved,** that the Board of Trustees reevaluate the expenditures currently being made by the Association for and in support of basic and applied scientific laboratory research activities relating to the practice of dentistry as outlined and prioritized by the Association's Research Agenda titled "Research Issues of Importance to the Practicing Dentist."

Summary of Resolutions

16. Resolved, that the *Provisions for Acceptance of Products by the Council on Scientific Affairs* (*Trans.* 1994:313, 676; 1996:322, 732), General Provisions for Acceptance, be amended by insertion of a new Section V. Use of Biodegradable Materials to read as follows:

> **V. Use of Biodegradable Materials**
> A. The American Dental Association is concerned about the environment and about the negative impact that the widespread use of nonbiodegradable materials for the manufacture and packaging of disposable products can have on the environment. Therefore, the Association encourages all dental manufacturers, especially those with Accepted products, to use, whenever possible, materials that are biodegradable in both the manufacture and packaging of disposable products.

and be it further
Resolved, that existing Sections V. through VII. be renumbered Sections VI. through VIII., respectively.

17. Resolved, that Item 5 of the Statement of Policy on Use of Name of American Dental Association (*Trans.* 1962:210, 284) be amended to read:

> 5. Use of the Association's name must be in keeping with good taste and professional dignity.

18. Resolved, that Resolution 21H-1984 (*Trans.* 1984:519), Research Funds, be amended by deleting the phrase "and consider supporting in the future only those Association applied scientific laboratory research" and adding the phrase "as outlined and prioritized by the Association's Research Agenda titled 'Research Issues of Importance to the Practicing Dentist'" so that the amended resolution reads:

Resolved, that the Board of Trustees reevaluate the expenditures currently being made by the Association for and in support of basic and applied scientific laboratory research activities relating to the practice of dentistry as outlined and prioritized by the Association's Research Agenda titled "Research Issues of Importance to the Practicing Dentist."

American Dental Association Health Foundation

Volpe, Anthony R., New Jersey, 2000, president, *ex officio**
Lamacki, Walter F., Illinois, 1999, vice president, *ex officio**
Anderton, Robert M., Texas, 1999, (ADA Board member)
Austin, G. Ken, Oregon, 1999, (outside director)
Bletsas, George L., Michigan, 2001, (ADA Board member)
Finley, Leo R., Jr., Illinois, 2002, (ADA Board member)
Jones, D. Harry, Kentucky, 2002, (outside director)
Kess, Steven W., New York, 2000, (outside director)
Maggio, Frank A., Illinois, 2002, (outside director)
Metro, Patrick S., Ohio, 2000, (ADA Board member)
Reinhardt, Richard A., Nebraska, 2001, (outside director)
Rosas, Rene M., Texas, 2000, treasurer, *ex officio**
Stamm, John W., North Carolina, 2002, (outside director)
Sudzina, Michael R., Ohio, 2002, (outside director)
Tarrson, E. "Bud", Illinois, 1999, (outside director)
Zapp, John S., secretary, *ex officio**
Payne, R. Barkley, senior director, fundraising and development
Czarnecki, Robert N., director, administration
Edwards, Dwight S., director, development
Nelligan, Raymond J., controller

Meetings: The ADA Health Foundation (ADAHF) Board of Directors met in the ADA Headquarters Building, Chicago, on August 12, 1998 and February 17, 1999. These meetings were held in conjunction with sessions of the ADA Board of Trustees.

Personnel: The close of the 1999 annual session brings to an end the tenures of three valued members of the Foundation's Board of Directors: Dr. Robert M. Anderton, Mr. G. Ken Austin and Mr. E. Bud Tarrson. The Foundation wishes to express its gratitude and appreciation to these retiring Board members. Their leadership and direction have greatly contributed to the success of the Foundation.

Prior to the February 1999 Board of Directors meeting, Mr. R. Barkley Payne joined the staff of the ADA Health Foundation. Mr. Payne assumed the position of senior director for fundraising and development.

The Strategic Plan of the American Dental Association: The ADA Health Foundation is a State of Illinois chartered, 501(c)(3) organization. As such, the Foundation is a separate entity from the American Dental Association and not specifically referenced in the Association's Strategic Plan. However, in providing administrative and financial assistance for the activities and programs of the Paffenbarger Research Center (PRC) in Maryland and the Research Institute (RI) in Chicago, the Foundation supports the objective of the Association as outlined in it's *Constitution.* Specifically, the Foundation's programs "encourage the improvement of the health of the public and promote the art and science of dentistry." The Foundation's management of its trusts, endowments and extramural programs reflects its Mission Statement and commitment to a variety of worthwhile programs. Programs in dental research, educational scholarships and conferences, health screening and access activities demonstrate the Foundation's commitment to its goals and objectives. By sustaining and broadening these activities and programs, the Foundation mirrors the overall goals and objectives of the Association's Strategic Plan.

Foundation Governance: During the reporting period, the governance structure of the Health Foundation was reviewed and subsequently modified by the Member. Adopting amendments to the Foundation's *Bylaws* and *Standing Rules*, the Member amended the governing hierarchy of the Foundation by increasing the number of Foundation Board member positions from seven to 15. Additionally, the Member established a Foundation Board member Nominating Committee to study the leadership requirements of the Health Foundation and to review and select nominees for Board director positions. Nominating Committee recommendations will be considered by the entire Foundation Board prior to final action by the Member.

Foundation Development Activities: Seeking contributions from individual, corporate, foundation and government sources is critical to the success of the ADAHF. To secure this financial support, a multipronged Development Campaign was planned and executed.

*Nonvoting member; the president may vote to break a tie vote of the Board membership

Solicitation letters were sent to targeted audiences encouraging their support of the Foundation's research, education and patient-care programs, including the Dr. Samuel D. Harris Trust Fund. To complement this campaign, solicitations were made on behalf of the ADAHF by the leadership of the American Dental Association, its constituent and component societies, and several national dental organizations, including: the American Society of Dentistry for Children; American Academy of Pediatric Dentistry; Dental Manufacturers of America; Dental Dealers of America; and American Dental Trade Association.

Ten companies participated as corporate partners in a dollar-for-dollar matching gift program: A-dec; Block Drug; Church & Dwight; Colgate-Palmolive; Equitable Life Assurance Society; Great-West Life; Optiva; Patterson Dental; Procter & Gamble; Sullivan-Schein Dental; and Warner-Lambert. In total, these companies provided $100,000 through this matching gifts program. Planned giving opportunities were made available to interested members at an annual session program and via several informational flyers distributed upon request.

To further increase the awareness of the ADAHF among its target audiences, an exhibit booth was provided during the ADA annual session, Chicago Dental Society Midwinter Meeting and at several ADA leadership conferences. In addition, several special event fund-raisers coordinated by ADA1 PLAN, Colgate-Palmolive Co., Dental Manufacturers of America and Zila Dental Supply helped to create goodwill and financial support for the Foundation.

This Development Campaign generated approximately $925,232 in support. Of this amount, $121,871 was received from Association members and/or dental organizations, $157,681 donated by nonmembers, and $626,899 was received from companies and representatives from the dental industry. Approximately $856,240 of this support was earmarked to support specific Health Foundation programs.

Dr. Samuel D. Harris Trust Fund: As reported in the *1998 Annual Reports and Resolutions*, the ADA Health Foundation established the Samuel D. Harris Fund for Children's Dental Health to support activities and programs dedicated to the prevention of caries and other oral diseases in children. The trust fund's corpus, established in 1998 and 1999, would be the result of the Foundation's solicitation activities on behalf of the trust and matching funds pledged by Dr. Harris. Dr. Harris pledged to match Foundation solicited funds directed to the Harris Trust Fund over the two-year period, at $250,000 each year.

Following the formulation of an overall promotional strategy and the development of a brochure informing prospective donors of Dr. Harris' matching program, solicitation activities were initiated. Between the formal announcement of the establishment of the fund and the Foundation Board's February 1999 meeting, over 425 recorded donations to the Harris Trust Fund corpus had been realized, totaling the $250,000 goal. In March 1999, the Foundation received a $250,000 check from representatives of Dr. Harris, thus successfully completing the Foundation's $500,000 first-year goal in the development of the Samuel D. Harris Fund for Children's Dental Health. As of the preparation of this report, promotional strategies and program activities are being reviewed to both address the second-year of Dr. Harris' matching pledge, and implement the mission of the trust, children's oral health care.

Office of Management and Budget Compliance Audit: In accordance with the Office of Management and Budget (OMB) Circular A-133, *Audits of Institutions of Higher Education and Other Nonprofit Institutions*, Grant Thornton performed an audit of the ADA Health Foundation federal assistance program for the years ending December 31, 1997 and 1998. This Circular requires an annual independent audit addressing financial, internal control and compliance matters. Concerning compliance with specific requirements, the auditor's opinion stated that the Foundation complied, in all material respects, with the requirements described in the *U.S. Office of Management and Budget (OMB) Circular A-133 Compliance Supplement* that are applicable to its major federal program.

The auditor's report and recommendations for 1997 and 1998 were presented to the Audit Committee of the ADA Board of Trustees. The 1997 report was presented at a December 1998 meeting and the 1998 report was distributed at the April 1999 meeting. No audit findings were disclosed in the reports.

Federal and Corporate Sponsored Funding: The Foundation annually receives awards from federal and corporate sponsors to carry out research, educational and other supporting projects. The tables appended to this report indicate that for the year ending December 31, 1998, $2,648,714 was expended for sponsored purposes. The major areas of expenses were federal government funded research totaling $1,532,143 and corporate and donor sponsored programs amounting to $1,116,571. The following activities reflect some of the corporate and donor sponsored programs.

Foundation Grant Requests: During its August 1998 and February 1999 meetings, the Health Foundation Board of Directors considered 25 requests for financial support for scientific research, educational and access-related projects. Reflecting a diverse range of activities, all of the grant requests were designed to enhance the quality of oral health care provided the public by the profession. Grant requests submitted to the Foundation for consideration were reviewed at several levels: to ensure compliance with the Foundation's 501(c)(3) charter; to determine the scientific significance and care delivery potential of a proposed research protocol; and the general merit of the project. The Foundation's Grant Administration Committee reviewed each proposal prior to final action by the Board of Directors.

Scientific Research Grants. The Board reviewed several requests for financial support of worthy dental research projects and equipment needs. The Board determined that a study entitled "Bioactive Polymeric Dental Composites Based

on Amorphous Calcium Phosphate" should be supported by the Foundation. In addition to awarding support for the research project, the Board reviewed and authorized the acquisition of an Acoustic Transducer Unit and a Mobile Electric Handpiece System, enhancing the capabilities of the Paffenbarger Research Center.

Dental Education Grants. During the reporting period, the Foundation Board reviewed several proposals aimed at broadening educational opportunities for the profession and the public. This review resulted in the Board adopting resolutions providing $15,000 in support of the Forsyth County Dental Society DentalWorks Exhibit and $10,000 to expand the National Museum of Dentistry's Web site. The Board saw support of the projects as a reaffirmation of the Foundation's desire to foster public dental health education.

In addition to its activities in support of predoctoral dental education opportunities, the Board approved support for the Annual National Conference on Special Care Organizations. Workshops scheduled for the conference addressing a variety of patient health care issues were seen by the Board as valuable continuing educational opportunities, enhancing the clinical care rendered the public by conference attendees.

Access-Related Grants. Among the grant applications considered by the Foundation's Board were a number of requests for financial assistance submitted by access-related programs. While acknowledging the merit of each program and the dedication of members of the profession in providing oral health care to underserved patient populations, the Board determined that Foundation support would continue to be limited to those programs operating on a national or regional level. As a result, the Board awarded support to the National Foundation of Dentistry for the Handicapped and the Special Olympics/Special Smiles programs.

Funding for Research Fellowships:

American Association for Dental Research (AADR). The Foundation Board of Directors approved funding for three AADR research fellowship positions. Each fellowship position is provided $3,000 that includes a stipend, supplies and travel funds so that the recipient may present research results at the annual AADR meeting. Funding for these fellowship positions is provided through the ADA Health Foundation, with a $9,000 educational grant awarded by the Optiva Corporation.

Young Investigator Award. As a requirement of the Specialized Materials Science Research Grant from the National Institute of Dental Research, the Paffenbarger Research Center annually appoints two young investigators to the industrial scholars program. The program, begun in 1940, brings industrial and dental research together in an environment outside the dental school. This program is supported by the ADA Health Foundation, with a $7,800 educational grant provided by the Colgate-Palmolive Company.

Research Training Fellowship. The Research Training Fellowship program is conducted at the Foundation's Paffenbarger Research Center. The program includes a full-time fellow working in conjunction with the Paffenbarger Center's scientific research staff. Funding for this program is supported through a $30,000 education grant provided the Foundation by Great-West Life and Annuity Insurance Company.

New Dentist-Scientist Award. The New Dentist-Scientist Award was established by the Foundation in 1995. The award is designed to support research conducted by dentists who have recently completed a National Institute of Dental Research (NIDR) dentist scientist program. Candidates must have completed the NIDR program within the past three years and have not received grant funding. In addition to the $5,000 awarded by the Foundation, each recipient was provided a $5,000 matching award from the researchers' institution. In 1998 the three research protocols receiving Foundation support included studies entitled: "Role of Src in Calcium-Induced Chemotaxis of Osteoblasts, Molecular Studies of Tetracycline Analogs in Osteoporosis and Oral Bone Loss," and "Melatonin Effects on Human Osteoblasts." Support for these awards was provided through the Health Foundation as a result of an educational grant from Warner-Lambert Consumer Healthcare.

Funding for Extramural Programs and Awards: In fulfilling its cooperative commitments to other Association agencies and outside organizations, the Foundation conducts several ongoing fundraising and solicitation activities. By providing financial support to these extramural programs and awards, the Foundation succeeds in addressing its stated mission, the enhancement of clinical dentistry.

Dental Student Research Conference. Managed by the Association's Council on Scientific Affairs, the Dental Student Research Conference is conducted as a means to introduce predoctoral dental students to the wide range of educational opportunities available to those preparing for entry into careers in dental research. In 1998, the conference was held at the National Institute of Dental Research. Foundation funding in support of the conference exceeded $46,000 through an educational grant from Warner-Lambert Company and participating dental schools from the United States and Canada.

Dental Student Scholarship Program. Since 1995, the ADA Health Foundation and the ADA Endowment and Assistance Fund Inc. have been collaborative partners in managing the scholarship programs conducted by the ADA Endowment Fund. Participating on the Endowment Fund Scholarship Steering and Application Review Committees, Foundation Board members and appointees have served to enhance and broaden the scholarship programs. For the 1998-99 scholarship program cycle, the Foundation provided $63,750, or one-half of the total amount awarded in scholarships by the Endowment Fund. This support was made possible in part through

educational grants provided the Foundation by the Colgate-Palmolive Company, Handler Manufacturing Company, Procter & Gamble Company and Oral-B Laboratories.

Health Screening Program. The Health Screening Program has been conducted at the Association's annual session since 1964. During that time, information gathered by the Health Screening Program has become the largest national database on the health of dental professionals. Serving as the basis for defining numerous dental practice policies for protecting the patient and health care provider, the Program has well served the public through early detection of oral cancers, cardiac disease and latex allergies. In 1998, over $90,000 in Health Screening direct costs were assumed by the Health Foundation. This support was made possible through the generous contributions of many Foundation business partners.

Community Preventive Dentistry Award. The Community Preventive Dentistry Award program, begun in 1972, recognizes individuals and organizations who have created and/or implemented significant community preventive dentistry programs. Judged by the ADA Council on Access, Prevention and Interprofessional Relations, first place honors of $2,000 were given to the "Seal the State in '98" program of North Carolina. Also presented during the 1998 annual session in San Francisco were three meritorious awards winners which included: "Children's Dental Health Initiative – Share the Care" of San Diego; "Soroptimist Dental Project" of Zanesville, OH; and "I. M. Sulzbacher Dental Center for the Homeless at the Salvation Army" of Jacksonville, FL. Each meritorious winner receives $300. The award is funded by the ADA Health Foundation with a grant provided by Johnson & Johnson Professional Division, a division of Johnson & Johnson Consumer Products Inc.

Geriatric Oral Health Care Award. The Geriatric Oral Health Care Award was initiated in 1984. The award recognizes those individuals and organizations who have improved the oral health care of older Americans through innovative community health care delivery projects. During the 1998 annual session, the ADA Council on Access, Prevention and Interprofessional Relations identified "The Geriatric Mobile Dental Unit – A model of Service and Education" sponsored by the University of Iowa, School of Dentistry, Iowa City, Iowa as the $2,500 award recipient. The award is financed by the ADA Health Foundation with a grant provided by the Warner-Lambert Company, Consumer Health Products Group.

Gold Medal Award. The Gold Medal Award for Excellence in Dental Research was first awarded in 1981, and is bestowed every three years. Professor Takao Fusayama, of the Tokyo Medical and Dental University, was presented the Gold Medal Award in 1997. The next award will be bestowed during the annual session in 2000. In addition to the gold medal, recipients of the award receive $25,000. This award is supported in part by the ADA Health Foundation, through a grant provided by Unilever Home & Personal Care and the American Dental Association.

Norton M. Ross Award. The Norton M. Ross Award for Excellence in Clinical Research was established in 1990. The award acknowledges outstanding accomplishments in clinical investigation that have significantly contributed to the prevention of oral diseases. The Foundation Board of Directors, based on a six-member selection committee recommendation, named Dr. Roy C. Page, University of Washington, School of Dentistry, Seattle, the 1998 award recipient. The $5,000 award was funded by the ADA Health Foundation with a grant provided by the Warner-Lambert Company.

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

American Dental Association Health Foundation

Federal Government and Corporate Sponsored Activity

For The Year Ended December 31, 1998

Table 1: Federal Government Sponsored Research Program Expenditures

	Expenditures [1]
U.S. Department of Health and Human Services:	
National Institute of Dental Research	
Prevention of Dental Caries	$ 42,026
Phosphate Activity in Biological Fluids	2,839
	89,180
Fluoride Effects On Plaque Cariogenic Potential	178,098
Improvement of Preventive and Restorative Materials	146,223
Calcium Phosphate Cements	76,309
	149,141
Center of Excellence for Materials Science Research	536,933
	138,853
Ceramic Whisker Reinforcement of Dental Composite Resins	24,230
	1,383,832
National Heart, Lung and Blood Institute	
Calcification in the Cardiovascular System	126,911
Total Federal Awards and Expenditures U.S. Department of Health and Human Services	**$ 1,510,743**
U.S. Department of Commerce:	
Formulation of Research Glasses for Chemical Standards	21,400
TOTAL FEDERAL SPONSORED RESEARCH ACTIVITY EXPENDITURES	**$ 1,532,143** [2]

[1] Expenditures include purchases of capital equipment for governmental and corporate sponsored projects.

[2] Federal Sponsored Research Activity is comprised of direct costs of $987,050 and indirect costs of $633,905. The recovered indirect costs are reimbursed to the American Dental Association for financial and administrative services rendered.

Table 2: Corporate Sponsored Program Expenditures

	Expenditures [1]
Research:	
Patent Royalties	
Patent Legal Affairs	$ 125,000
Staff Transition Funds	72,177
PRC Equipment Purchases	48,348
Foundation Equipment Maintenance	28,841
Calcium Phosphate Cements	43,450
ACP Enamelon (Remineralization)	15,000
ACP SmithKline (Remineralization)	47,728
Dentin Bonding	126,126
Glass Ceramic Inserts	1,760
Radiation Shielding	750
	509,180
Paffenbarger Research Center	
Micro Equipment Fabrication	1,856
Acid Calcium Phosphate Fluoride Treatment	28,394
Young Investigators Award	36,130
SmithKline Beecham R & D Plan	15,516
Osteogenics R & D Project	53,313
Etex Corp Project	37,667
NMR Facility	693
Instrument Fabrication	39,361
	212,930
Subtotal—Research	**$ 722,110**
Extramural Programs:	
Conference on Child Abuse	5,151
Dental Student Research Conference	46,070
Health Screening Program	99,417
Community Preventive Dentistry	7,556
Seminar Program	6,436
Subtotal—Extramural Programs	**$ 164,630**
Awards:	
National Museum of Dentistry	$ 65,000
General Fellowship/Grant Project	24,000
Frederick McKay Award	1,562
Gold Medal	82
Norton M. Ross Award	10,187
Subtotal—Awards	**100,831**
TOTAL CORPORATE SPONSORED PROGRAM EXPENDITURES	**$ 987,571**

Table 3: Other Program Expenditures

	Expenditures [1]
Education:	
Dental Education—Unrestricted	5,000
Dental Education—Unrestricted	63
Student Scholarship Program	20,000
Subtotal—Education	**25,063**
Access:	
Access Program—Unrestricted	**6,000**
Trusts and Endowments:	
Harper Trust (Public Education in Dental Health)	**6,000**
Other:	
Prior Year Balance	27,937
Unrestricted Contributions	44,000
Special Events	20,000
Subtotal—Other	**91,937**
TOTAL OTHER PROGRAM EXPENDITURES	**129,000**
TOTAL CORPORATE AND DONOR SPONSORED PROGRAMS	**1,116,571**
TOTAL SPONSORED ACTIVITY EXPENDITURES (Tables 1, 2 and 3)	**$ 2,648,714**

ADA Health Foundation Research Institute

Fan, P. L., senior director
Siew, Chakwan, director, Toxicology Department
Batchu, Hanu, assistant director, Critical Issues

The Research Institute (RI) is part of the Division of Science and is located in the Association's Headquarters Building. Eighty percent of the Research Institute is budgeted through the Division of Science with the remaining 20% coming from the American Dental Association Health Foundation (ADAHF). The Research Institute conducts research in accord with the Association's Research Agenda and in response to critical and emerging issues as identified by the ADA Council on Scientific Affairs. It also conducts collaborative research with the Paffenbarger Research Center (PRC). The Research Institute also reviews research proposals received by the ADA Health Foundation through its requests for proposals and other research funding programs. These activities are in accord with the overall goals and objectives of the Association's Strategic Plan.

Research Institute findings are reported in publications, abstracts and presentations at scientific meetings. (Copies of published materials are available on request.) Current and ongoing projects focus on: occupational health (via the Health Screening Program); safety and effectiveness of dental materials and therapeutic agents; waste management; and safety in the dental office. With the opening of the Association's renovated laboratory in spring 1999, the Research Institute will continue its work in addressing issues of importance to the practicing dentist.

Health Screening Program: The Research Institute, through the ADA Health Foundation, conducts a Health Screening Program (HSP) at the ADA annual sessions. The Health Screening Program, which began 35 years ago, has generated a unique longitudinal database on the health of the profession. This database is also the most extensive for health care professionals. In addition, the Health Screening Program serves as a screening tool for each individual participant. Through the voluntary participation of dentists across the country, data are generated on the seroprevalence of hepatitis B markers and antibodies to the human immunodeficiency virus (HIV). Data on latex hypersensitivity and urinary mercury levels also are obtained. Information obtained from the HSP database has been the basis of many Association policies on health issues. It is also shared with government agencies to assist them in deliberating issues related to the practice of dentistry and the health of the public.

The 1998 Health Screening Program in San Francisco had 1,600 participants. Results revealed that almost 90% of participants had protective antibody against the hepatitis B virus via vaccination. Another 9% were immune through natural exposure to the virus. No participants in 1998 tested positive to HIV. Since 1987, over 17,000 participants have been tested for HIV. Only one individual who did not report known high-risk behavior at that time has tested positive. Therefore, the seroprevalence of HIV among participants is very low, implying an extremely low potential for occupational infection. The most recent HSP latex-hypersensitivity data available (from the 1994 and 1995 programs) indicated that approximately 6% of participating dentists and auxiliaries were hypersensitive to natural rubber latex proteins. Of the small sample of 107 participants who were screened over the two consecutive years, nearly 4% who tested negative in 1994 were positive for latex hypersensitivity in 1995. This indicates a slight but unmistakable increase in the incidence of this problem. Finally, urinary mercury levels in participant dentists have shown a more than 40% decrease over a decade.

Safety of Materials and Therapeutic Agents: The Research Institute is working with the PRC in evaluating the biocompatibility of a metallic direct-filling amalgam alternative developed at the PRC. In order to address the issue of latex hypersensitivity, the Research Institute is collaborating with the Council on Scientific Affairs to evaluate the protein content and the amount of particulate in powder-free latex gloves. In addressing concerns about bisphenol A (BPA) in dental sealants and composites, the Research Institute developed the most sensitive analytical method on record for determining BPA levels. In a study to detect BPA in dental sealants carrying the ADA Seal of Acceptance, the RI identified trace levels of BPA in one particular brand of sealant. Following the ADA's identification, RI staff consulted with the manufacturer, and it took corrective actions to remove BPA from the product. Current test results show that there are no detectable levels of BPA in dental sealants carrying the ADA Seal of Acceptance. Continuing its work in BPA, the Research Institute collaborated with the University of Nebraska Dental School in a clinical study funded by the ADA Health Foundation to assess BPA in blood and saliva samples after applying a sealant reported to contain detectable levels of BPA. Trace amounts were detected in some saliva samples up to three hours post-application. No BPA was detected in any of the saliva samples five hours after sealant placement. No BPA was detected in blood samples at any time. In addition, no BPA was detected in blood samples collected at the Health Screening Program from participants who have sealants or composite restorations. Although work is continuing with this project at the Research Institute, it is reasonable to conclude at this time that BPA is not a health threat to patients exposed to dental sealants.

Effectiveness of Materials and Therapeutic Agents: The Research Institute is researching methods to evaluate the amount of active ingredients in desensitizing toothpaste and new formulations of fluoride toothpaste. Protocols are being developed to evaluate novel or advanced formulations and accurately measure new active ingredients in products submitted to the Acceptance Program. Research on a method to measure the intensity of curing light units and the effect of intensity on the depth of cure of composites is ongoing. This important effort results from the demand to improve the quality and longevity of dental restorative materials. Another study is comparing the physical properties of powder-free and powdered latex gloves.

Waste Management: The Research Institute is conducting several projects on amalgam waste. A study is underway to assess the effectiveness of amalgam separators in preventing amalgam scrap from entering the wastewater stream. Both commercially available and prototype separators are being evaluated. The Research Institute also is evaluating the effectiveness of a chemically active mesoporous material to remove amalgam and dissolved mercury from dental office wastewater. In addition, the RI has instituted a study to identify an appropriate and practical method for storing and recycling amalgam waste. Dry storage and storage under photographic fixer solution are among the methods being evaluated. The results will serve as the basis for a recommendation on storing amalgam scrap and treating dental office wastewater.

The Research Institute assists constituent and component dental societies by providing scientific support in reviewing documents such as draft waste management recommendations, research protocols and reports related to dental waste. California, Massachusetts, Maine, Minnesota, Vermont and Virginia are some of the states whose constituent dental societies were assisted by the Research Institute in addressing waste management issues.

Safety in the Dental Office: RI research projects addressing dental office safety include studies on nitrous oxide and dental aerosols. The Research Institute is beginning research into the attainable level of nitrous oxide in ambient operatory air when ADA recommendations for controlling nitrous oxide exposure are in place. Another study is aimed at characterizing and quantifying aerosols in dental office air; it also will look at the effectiveness of various control methods for reducing the amount of aerosol generated. Results of these studies could provide guidance toward an even safer working environment in the dental office.

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

ADA Health Foundation Paffenbarger Research Center at the National Institute of Standards and Technology

Eichmiller, Frederick C., director
Bowen, Rafael L., distinguished scientist
Chow, Laurence C., assistant director and chief research scientist, dental chemistry
Dickens, Sabine H., chief research scientist, polymer chemistry
Mathew, Mathai, chief research scientist, dental crystallography
Schumacher, Gary E., chief research scientist, clinical research

The Paffenbarger Research Center (PRC), which is located on the campus of the National Institute of Standards and Technology (NIST) in Gaithersburg, Maryland, is an agency of the American Dental Association Health Foundation (ADAHF) and a department of the Division of Science. The PRC receives funding through the Association's annual grant to the Health Foundation, from National Institutes of Health grants, from industrial contracts and grants and from service contracts and in-kind contributions from NIST. The PRC also has access to royalties paid to the Health Foundation from the sale of products based on patents emanating from research at the PRC.

PRC scientists conduct basic and applied studies in clinical research, dental chemistry, polymer chemistry and dental crystallography. Projects address the dental materials needs of practitioners and are increasingly responsive to the Research Agenda and critical issues identified by the ADA Council on Scientific Affairs. Abstracts of PRC research presentations and publications, as well as reprints of published articles and manuscripts presented at scientific meetings, are available from the PRC by request.

The Strategic Plan of the American Dental Association: The activities of the PRC support the mission of the American Dental Association Health Foundation by advancing the oral health of the public through basic and applied research and development of improved dental materials and treatment technologies. The program also provides support for the ADA Council on Scientific Affairs by supplying scientific advice, responding to critical issues and providing basic research on product testing methodology.

Activities

Clinical Research: Under the auspices of the Center of Excellence for Materials Science Research, which is funded by the National Institute for Dental and Craniofacial Research (NIDCR), the development of a metallic direct-filling material is near completion. Current studies are being finalized on biocompatibility and condensation instruments. A decision will be made in 1999 on how to proceed with technology transfer.

The Center of Excellence project to develop glass-ceramic restorative materials has been completed, and the remaining project support has been transferred to a pilot project developing new measurement methods for fluoride releasing materials. A new NIDCR-funded project, which focused on using single crystal ceramic whiskers as high-strength reinforcement for composite resins and other directly placed materials, resulted in a patent. Technology transfer efforts are underway.

Dental Chemistry: Progress continues on desensitizing, remineralizing and bone repair systems based on amorphous calcium phosphate. The ADAHF funded a grant in 1999 for developing remineralizing dental composites based upon amorphous calcium phosphate.

PRC-developed calcium phosphate cements have been licensed to an orthopedic implant company that markets a product called BoneSource7® for cranioplasty and certain maxillofacial repairs. Clinical studies on periodontal, root socket filling, implant grouting and orthopedic applications of this remarkable new material continue while laboratory studies are conducted to broaden the applications and range of handling characteristics for this material.

Other continuing projects within the Dental Chemistry program include the development of phosphate selective electrodes, the study of cardiovascular calcifications and methods to inhibit calcification and microanalytical methods for measuring plaque and plaque fluid chemistry.

Polymer Chemistry: PRC researchers continue to make progress toward improving the Bowen adhesive bonding system, with two new patent applications and a patent issued in 1999. The adhesion patent portfolio is currently licensed to seven dental manufacturers. The ADAHF has rights to a NIST patent for an adhesion system coinvented by a PRC research associate and a NIST scientist. This technology has been sublicensed to industry.

Progress also is being made in other polymer chemistry projects, including three that are funded by the Center of Excellence grant: the development of polymers for preventive

coatings and margin repairs; reducing polymerization shrinkage and stress in resin restorations; and developing novel adhesive cariostatic cements that contain both a calcium phosphate cement and resin phase. A method and instrumentation developed at PRC for measuring shrinkage of dental composites during polymerization currently is being used by manufacturers and laboratories worldwide. PRC molecular modeling facilities have successfully developed the only known model of dentin collagen and are using this model in a recently funded NIDCR grant to further improve the design of adhesive and coating materials.

Dental Crystallography: This program continues to be critically involved in characterizing the crystal compositions of components in PRC-developed materials, including glass-ceramics, metals and calcium phosphates.

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

ADA Holding Company, Inc.

Notes

ADA Holding Company, Inc.

For-Profit Subsidiaries' Annual Report and Financial Affairs

ADA HOLDING COMPANY, INC.
Zapp, John S., chairman and chief executive officer*
Uchin, Robert A., president (at-large member dentist)
Johnson, Brian M., treasurer
Sfikas, Peter M., secretary
Thorne, Michele H., assistant secretary
Rose, S. Timothy (ADA President)*
Anderton, Robert M. (ADA Board member)
Campbell, Matthew J. (at-large member dentist)
DeNicola, Ross J., Jr. (ADA Board member)
Fine, Howard B. (ADA Board member)
Finger, Henry (ADA Board member)
Hunt, Donald S. (outside director)
Miller, Jerome (at-large member dentist)
Rosas, Rene M. (ADA Treasurer)*
Wilcox, R. David (outside director)
Yohanan, Robert R. (outside director)

ADA PUBLISHING CO., INC.
Zapp, John S., chairman
McFadden, Judith, president (at-large member dentist)
Kosden, Laura A., chief executive officer and publisher
Johnson, Brian M., treasurer*
Sfikas, Peter M., secretary
Thorne, Michele H., assistant secretary
DeNicola, Ross J., Jr. (ADA Board member)
McKaig, Bettie R. (ADA Board member)
Metro, Patrick S. (ADA Board member)
Pudwill, Myron L. (ADA Board member)
Rosas, Rene M. (ADA Treasurer)
Schechter, Daniel (outside director)
Stratton, Debra (outside director)

ADA FINANCIAL SERVICES CO.
Zapp, John S., chairman*
Hunt, Donald S., president (outside director)
Sweeney, James H., chief executive officer
Johnson, Brian M., treasurer
Sfikas, Peter M., secretary
Thorne, Michele H., assistant secretary
Finger, Henry (ADAHC and ADA Board member)
Hardymon, Stephen A. (outside director)
Mascola, Richard F. (ADA President-elect)
Rosas, Rene M. (ADA Treasurer)
Singer, Alan H. (at-large member dentist)
Watson, Terry (at-large member dentist)
Yohanan, Robert R. (outside director)

ADA ELECTRONIC COMMERCE CO.
Zapp, John S., chairman*
Hall, James B., president (at-large member dentist)
Owens, Robert L., chief executive officer
Johnson, Brian M., treasurer
Sfikas, Peter M., secretary
Thorne, Michele H., assistant secretary
Anderton, Robert M. (ADA Board member)
Bentley, Geoffrey D. (at-large member dentist)
Boyett, Joseph, Jr. (outside director)
Caudle, Sam N. (outside director)
Mascola, Richard F. (ADA President-elect)
Rosas, Rene M. (ADA Treasurer)
Sekiguchi, Eugene (ADA Board member)

ADA Holding Company, Inc.

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 three subsidiaries, ADA Publishing Co., Inc., ADA Financial Services Co. and ADA Electronic Commerce Co. This annual report outlines the business and financial affairs of these three subsidiaries for the year-end 1998 and the first four months of 1999.

Direction and Finance: Incorporated in late 1989, ADAHC began operations on January 1, 1990. The ADAHC Board provides guidelines and leadership to its for-profit subsidiaries. The Board consists of 13 directors—four ADA trustees; three at-large member dentists; three outside directors; the ADA Executive Director as chairman; the ADA President; and the ADA Treasurer.

During 1998 ADAHC received $550,000 in dividends from ADA Publishing Co., Inc. and ADA Financial Services Co. $540,000 of which ADAHC subsequently declared and paid in dividends to the ADA.

ADA Publishing Co., Inc.

Introduction: ADA Publishing Co., Inc. (ADAPCO) was incorporated in October 1989 when the former ADA Division of Editor and Publications was restructured as an independent full-service publishing company. ADAPCO's mission is to produce and distribute, at a profit, credible high-quality publications that inform the dental profession about the latest scientific, socioeconomic and political issues affecting oral health care. Its most important publications are *The Journal of the American Dental Association (JADA)* and the *ADA News*.

*nonvoting member

Governance: The Board of Directors includes 11 members, with the ADA Executive Director serving as chairman and the publisher as chief executive officer. Among the directors are: four members from the ADA Board of Trustees; one ADA member-at-large with publishing experience who is currently serving as president of the company; two outside publishing directors; and the ADA Treasurer. The chief financial officer of the ADA also serves on the Board as a nonvoting, *ex officio* member. Regular meetings of the Board of Directors are generally held in May and November of each year.

Financials: This past year was a banner year for ADAPCO. For the first time in its history, ADA Publishing Co., Inc. surpassed $10 million in total revenues for 1998, a one-year increase exceeding $750,000. Net pretax profits nearly doubled over 1997 levels, from $611,000 to $1.1 million.

Two major factors contributed to ADAPCO's success: significant growth in advertising sales; and the successful launch of the *ADA Guide to Dental Therapeutics.* In advertising, there was a record increase of 53 advertising pages in the *ADA News* compared with 1997, record sales of 27 advertising pages in the convention daily and a 32-page increase in *JADA*'s classified advertising. In contrast, there was a general downward trend in the marketplace in display advertising affecting professional journals and magazines, although *JADA* was able to maintain the same levels as 1997. Three primary reasons contributed to record sales in the *ADA News*: high direct response rates received by advertisers from their ads; growth in new and existing business sold by ADAPCO's sales force combined with greater flexibility in the advertising review process; and its number one position in readership among all dental periodicals. The growth is even more remarkable considering ADA periodicals are the only publications that do not discount rates and "offer deals."

Sales of the first edition of the *ADA Guide to Dental Therapeutics* exceeded expectations, approaching $400,000 in less than one year. These sales also included distribution of the book to all senior U.S. dental students, courtesy of Colgate-Palmolive.

***JADA* Reorganization:** *The Journal of the American Dental Association* recruited a team of volunteer Associate Editors to assist in developing important clinical content for specific topic areas: Dr. Karl Leinfelder, biomaterials and restorative care; Dr. Paul Moore, pharmacology; Dr. Jeffrey Morley, cosmetic/esthetic dentistry; Dr. Michael Glick, dentistry and medicine; Dr. Leslie Seldin, practice management; and Dr. Titus Schleyer, informatics and technology. Chosen for their expertise in their respective areas, the Associate Editors have been working with Editor Lawrence Meskin to identify suitable subject matter and to recruit authors.

Dr. Meskin also recruited three new Editorial Board members to help enhance *The Journal*'s appeal, especially with newer dentists: Dr. Daniel M. Castagna, a former Hillenbrand fellow, now with the University of the Pacific; Dr. Michael T. Rainwater, former editor of the *Journal of the Georgia Dental Association*; and Dr. Cherilyn G. Sheets, a clinical professor with the University of Southern California and founder of the Newport Coast Oral-Facial Institute, Newport Beach, CA.

In the first two issues of 1999, *The Journal* unveiled a number of changes and new sections aimed at boosting *JADA*'s appeal to its readers. The new sections correspond to the topic areas assigned to the Associate Editors. Still to be introduced is the section on cosmetic/esthetic dentistry, expected to begin appearing in the second quarter of 1999. *JADA* also has introduced an expanded, more structured abstract for clinical practice and research articles, offering readers a quick-take review of an article's contents. A new section, Advances in Dental Products, was added to offer clinical research on new products conducted by industry.

At present, *The Journal* is exploring certain changes in its graphic design and topography to make *JADA* more readable and accessible.

Continuing Dental Education: In February, ADAPCO began posting the question and answer form for *JADA*'s monthly CE program online as a prelude to electronic commerce. At this point, *JADA* CE participants are required to print out the answer form and mail it to the University of Colorado for grading and credit along with their payment ($10 for members, $15 for nonmembers). In time, it will be possible to handle these transactions over the Internet, giving participants the option of either online or print CE.

***JADA* Supplements:** In 1998, *JADA* produced two successful supplements. A highly regarded special supplement on periodontology was packaged with the September issue of *JADA*. It presented consensus reports from the 1996 World Workshop in Periodontics and was produced as a cooperative venture with The American Academy of Periodontology. Procter & Gamble's Oral Care Division provided an educational grant to fund the project along with the Academy. In addition, ADAPCO assisted the ADA in the development of a supplement on dental management service organizations that was mailed with the February 1999 issue of *JADA*. The supplement reviews the inception of DMSOs, their impact on dentistry, legal and financial issues and the ADA's role and resources available in helping members make informed choices.

***JADA* CD-ROM:** The annual update continues to be popular and produces a profit for the subsidiary. ADAPCO launched its first electronic version of *JADA* in CD-ROM format in 1996. The disk provides a full-text archive of all editorial content published from 1990 through 1998 and also includes 15 landmark articles in dentistry published by *JADA* dating back to the 1940s.

***ADA News*:** To help ADA members gain a better understanding of the Association's role in the legislative process, the *ADA News* introduced a new column in 1998 called "Inside the Beltway." Written in cooperation with the Washington Office, the new column provides an insider's view of how the ADA's lobbying efforts influence government decision making for the benefit of dentistry and its patients.

The News also explored certain design and content changes. A reorganized and streamlined *ADA News* will be unveiled in June 1999. New or improved sections will include: Government, Health & Science, Marketplace, Dental Practice, Materials and Technology, People, Viewpoint and a column of brief, late-breaking news items. The Starting Out section targeted to newer dentists and students will be expanded.

***ADA Guide to Dental Therapeutics*:** Under the direction of its editor, Dr. Sebastian Ciancio, work is under way for the second edition that is due out in October 2000 during the ADA annual session. The first edition was sent to 11 independent reviewers who are experts in their respective fields. Their reviews are being used by the authors to revise the content for the second edition. All chapters are being updated to ensure that the second edition is even more complete and user-friendly than the first.

***ADA Legal Adviser*:** The *ADA Legal Adviser*'s subscription base dropped by year end, although it continues to operate at a profit. A vigorous promotional campaign aimed at attracting new nonmember subscribers is in progress.

***JADA* Foreign Editions:** Working with publishing houses in Europe and South America, ADAPCO continues to publish three foreign editions—two in Spanish and one in Portuguese. All three foreign editions are published six times a year. ADAPCO also is exploring foreign-language editions of *JADA* in other countries in Europe and Asia (focusing on Japan, China, Italy, Germany, France and the Middle East).

International Visibility: To help enhance *JADA*'s international prestige, ADAPCO has begun to exhibit at the yearly FDI World Dental Congress, starting with last year's Congress in Barcelona and continuing with this year's meeting in Mexico City. Through these meetings, both *JADA* and the *ADA Guide to Dental Therapeutics* gain valuable international exposure.

ADA ONLINE: ADAPCO in 1997 introduced its own portion of the Association's Web site, ADA ONLINE. The centerpiece is the *ADA News Daily*, a news section that offers daily reports on events and developments affecting the dental profession. In 1999, new stories were added from Reuters Health News Service to enhance the value of the news. Also offered online are: previews of the upcoming issues of *ADA News* and *ADA Legal Adviser*; the full text of *JADA*'s monthly cover story; abstracts of other *JADA* articles; full text of the monthly column by the *Legal Adviser*'s editor; indexes and archives of all periodicals; classified advertising; and ordering information.

Excel Awards: ADAPCO won two Silver Excel Awards from the Society of National Association Publications. The *ADA News* (print) was acknowledged for excellence in news writing and the *ADA News Daily* (ONLINE) was given the award for content.

ADA Financial Services Co.

Introduction: The ADA Financial Services Co. (FINCO) was incorporated in 1994 to provide a complete line of financial services and products to members of the American Dental Association. These products and services have been provided through an arrangement between FINCO and Mellon Bank under the ADA® 1 PLAN℠ brand name.

Governance: The FINCO Board is comprised of ten members. The ten members consist of two members-at-large, three outside business directors, one of whom has been elected President of the company, one ADA trustee from ADA Holding Company, the ADA President-elect, the ADA Treasurer, the ADA Executive Director and the Chief Executive Officer. The ADA Executive Director serves as chairman and *ex officio* member.

Financials: FINCO is reporting net income for 1998 of $293,473 after taxes. Total assets of the company as of December 1998 are $844,228 with liabilities of $833,058 and a total stockholder's equity of $11,170. Operational expenses for 1999 are projected to be $405,000, with tax liabilities projected to be $4 million. In 1998, FINCO began to repay principal on the $700,000 Mellon note that was first drawn upon in 1995. Through December 31, 1998, three principal installments of $87,500 have been paid. An arrangement to forgive the remaining balance including interest became effective in 1999.

ADA 1 PLAN Update: The goal of the ADA 1 PLAN is to become the principal provider of financial services to ADA members. Members can obtain information on ADA 1 PLAN products by calling one toll-free number. An automated menu of services directs callers to the appropriate division of the bank to inquire about or to apply for financial services products.

An early offer of the ADA 1 PLAN, residential mortgages were available to ADA members through the Mellon Mortgage Company in Denver. Jumbo mortgages, or those over $250,000 were available through The Boston Co., a subsidiary of Mellon Bank. Due to service problems, conventional loans to ADA members were discontinued in 1998 until a new mortgage provider could be found. Jumbo mortgages remain available through the Boston Co.

In 1998, the ADA 1 PLAN began upgrading the ADA Gold MasterCard to a Platinum Visa and selling the Platinum Visa to prospective cardholders. The upgrade was done automatically unless the cardholder notified the bank not to upgrade the card. Cardholders were notified several times of this enhancement. The most common concern was the change in account number, since many dentists have dental supplies automatically charged to their credit cards. A new number meant that each vendor they work with would have to be notified of the change.

Another enhancement to the program involved changes to the TravelReturns Program. Members were now given the option to travel anywhere in the world, on any class of airline

service with no monthly or yearly limits on points earned. To accommodate these changes without negatively impacting program finances, changes to redemption levels were made. Members with 25,000 points could obtain a ticket up to a $250 value; 35,000 points were needed to acquire a ticket worth $500. Existing cardholders who had opted for TravelReturns were notified of these changes and given the option of changing immediately to the new program, or waiting until November 1, 1998 when they would be automatically enrolled in the new program.

The change proved positive for the Program. Mellon and FINCO staff attending state and regional dental meetings reported that the new product was more attractive to dentists, specifically because of TravelReturns. At the annual session in San Francisco, 1,000 applications for credit cards were received at the ADA 1 PLAN booth, far more than in previous years.

In late 1998, Mellon informed FINCO of its intention to sell its credit card processing accounts to an outside company. Mellon sold its portfolio to Paymentech, the third largest provider of credit card processing services in the United States. FINCO earned $25,000 from the sale and stood to earn an additional $52,700 if certain other conditions were met. These issues are discussed in more detail in the following section.

Also in 1998, the ADA 1 PLAN began to realize significant profits from all products in the program, but especially from the credit card portfolio. Royalty to the ADA and profit-sharing to FINCO totaled over $1.5 million, up $500,000 from 1997. Member recognition of the ADA 1 PLAN brand name has increased and more members than ever use ADA 1 PLAN products.

The Practice Financing Program provided by The Matsco Companies had its most successful year, loaning over $98 million to ADA members. In 1998 Matsco added commercial real estate financing and equipment leasing products to its already successful program. Members who obtain other types of financing from Matsco can now include commercial real estate as part of the transaction.

Support of ADA programs and services was increased in 1998. The ADA 1 PLAN provided financial support to the SUCCESS Program, the ADA Management Conference, the Dentistry as a Business Conference, the ADA Health Foundation, the ADA membership card and, as a cosponsor, the ADA services directory, *Connections*.

The ADA Health Foundation Benefit, an Evening at the Symphony, was held on Sunday evening during annual session and was a resounding success. A sold-out audience enjoyed the San Francisco Symphony Orchestra and attended a reception following the concert. The benefit donated over $41,000 to the Health Foundation.

In midyear, Mellon and FINCO began to address the issues surrounding the expiration of the current Mellon/FINCO Financial Services Agreement which was due to expire in December 2000. Both parties believed that it was necessary to begin planning for the retention of the 22 endorsing constituent dental societies and the recruitment of new constituents. To do that, Mellon offered a plan that would provide signing bonuses and new account bonuses to states that endorsed the program. Mellon sought the ADA's and FINCO's reaffirmation of the ADA 1 PLAN concept and their commitment to Mellon as the provider of the PLAN. Additionally, Mellon offered to forgive the remaining $437,500 on the line of credit that FINCO had drawn upon early on in the program if FINCO would agree to extend the Financial Services Agreement for five years. Mellon also offered to pay FINCO an additional $52,700 for the sale of credit card processing if FINCO agreed to extend the contract.

In October, the ADA Board reaffirmed its commitment to the idea and the FINCO Board reaffirmed their commitment as well at its December 1998 meeting. A letter of intent to renew was signed by FINCO in December. At the same meeting, the FINCO Board directed staff to present, at its February 1999 meeting, the implications of increasing the amount of profit sharing to endorsing states.

In January 1999, FINCO was notified that Mellon's entire credit card portfolio and unsecured lines of credit were being offered for sale. This portfolio included the ADA 1 PLAN accounts. Mellon disbanded its Affinity Financial Services Team when the sale took place, which terminated the agreements among the ADA, FINCO and Mellon regarding the offering of financial services to American Dental Association members.

Mellon asked FINCO to participate in the evaluation and selection of a buyer for the entire portfolio once the finalists were selected, which occurred at the end of March 1999. Out of a field of 12 bidders and six finalists, Citibank was chosen by Mellon to purchase the Mellon credit card and unsecured credit line portfolios. FINCO also selected Citibank to purchase its ADA member portfolio and to become the provider for ongoing ADA 1 PLAN business. Citibank through its affiliate the Travelers Bank will provide the ADA 1 PLAN credit card and unsecured lines of credit, and will submit proposals for other financial products and services to be offered through the ADA 1 PLAN. The ADA and FINCO benefited financially from the sale as the Mellon/FINCO contract provided FINCO an interest in the credit card portfolio.

The Matsco Companies is expected to continue to offer practice financing products through the ADA 1 PLAN under a direct relationship with FINCO. Additionally, Paymentech is expected to continue its relationship with FINCO to offer credit card processing to ADA members.

ADA Electronic Commerce Co.

Introduction: ADA Electronic Commerce Co. was formed on September 20, 1996, to serve as the for-profit resource to members, nonmembers, the American Dental Association and its subsidiaries by providing:

1. electronic claims processing of a higher quality while reducing costs.
2. data collection services to ensure organized dentistry remains the source of information to promote oral health to the public and improve the practice of dentistry.

3. discounted products and services by contracting with vendors at a national level through electronic commerce initiatives.

To accomplish its founding goals, ECCo has established a base vision of core competencies that will serve as the foundation for its future initiatives. The ECCo vision and mission statements are as follows.

Vision Statement

ADA ECCo is the resource to members, the American Dental Association and its subsidiaries for products and services designed to decreasing the costs, improving the operational efficiencies and promoting the use of electronic commerce within the dental profession.

Mission Statement

ADA ECCo is the for-profit subsidiary dedicated to providing products and services by contracting on behalf of the dental profession at a national level. These products and services are developed to provide participating members benefits beyond what is generally available in the marketplace.

ADA ECCo promotes the use of electronic technology in the dental practice through its educational programs.

ADA ECCo facilitates the collection of administrative data made available through ADA ECCo relationships. This data is collected on behalf of the profession in order to provide information that promotes the public's oral health and improves the practice of dentistry.

Governance: The ECCo Board is comprised of ten members. These are the ADA President-elect, the ADA Treasurer, two ADA trustees, two members at-large, one of whom currently serves as the president, two outside business directors, ECCo's Chief Executive Officer, and the ADA Executive Director serving as chairman. Regular meetings of the Board of Directors are generally held in April and September of each year.

Financial Operations: In 1998, ECCo collected $176,672 in total revenues to offset expenses of $145,468. ECCo's total assets in December 1998 were $209,612 with liabilities of $97,252 and a total stockholder's equity of $112,360.

Current Marketplace: ECCo's vision and mission provide ECCo with an unlimited electronic commerce market in which to develop and flourish. The entire American Dental Association membership is its marketplace. This marketplace is divided into three areas in terms of ECCo's current product offerings. These areas include:

1. members that have acquired a practice management software system and have implemented electronic claims capabilities;
2. members who have computer hardware capable of participating in electronic claims but have chosen not to purchase a practice management software system; and
3. members who do not have a computer.

The members in the first two categories are all candidates for participating in all ECCo current initiatives. Those in the third category will be able to participate in future initiatives that allow noncomputer participation in discounted vendor contracts and services. It is envisioned that over time those members in category three will diminish.

Business Operations: In 1998 ECCo continued to promote its contracted vendors. The vendors are Trojan Professional Services, Inc. and Envoy Corporation.

Trojan provides two endorsed product offerings. The first product is an electronic claims processing software. This software is called Dr. Direct. During 1997 this software was enhanced to improve its level of functionality in the Microsoft Windows environment. This change made it easier to implement in both stand-alone and integrated practice management software environment.

The other product is software that allows dental offices to determine their patients' dental benefits. The benefit program is updated monthly with information offered on an as needed basis between regular updates.

Envoy provides electronic claims clearinghouse services. Envoy maintains a network of over 200 practice management and other software vendors that have committed exclusive submission of claims through Envoy. Envoy adds value to the process by providing payer specific claim editing and payer communications. This allows software vendors to expend their available resources in improving operational functionality for the dental office in lieu of maintaining over 600 sets of payer specific edits. In 1998 Envoy processed more than 30 million dental claims, which is an increase from the 26 million claims processed in 1997. In 1998, 31% of members submitted their claims electronically.

In 1998, ECCo and Envoy continued the state endorsement initiative to provide state associations with a method to receive revenues from their members' participation in the ECCo-Envoy program. At year-end 1998, a total of 12 states endorsed the ECCo-Envoy program. The majority of these states realized incentive bonuses as high as $15,000. ECCo is making nonindividually identifiable data from the Envoy transactions available to the ADA and endorsing states for their own use.

New Product Development: The electronic commerce environment offers ECCo its largest development opportunity. Many initiatives throughout the American Dental Association and the dental community such as ADA ONLINE, electronic catalogs and electronic publishing, offer ECCo a market base. ECCo plans to establish a dental market of the future that promotes the use of information technology in dental practice.

ECCo will remain neutral in its electronic commerce initiatives by providing an environment in which all vendors are allowed to participate. This will allow ECCo to expand

services and programs offered on electronic commerce more rapidly and without the complexity of selecting one vendor over another. This approach should drive additional competition that will benefit members through discounted pricing and greater access.

In support of the electronic commerce marketplace of the future, ECCo will develop national contracts for appropriate products and services. The 1994 Survey of Constituent and Component Dental Societies shows that the second largest nondues revenue source for the state was office supplies. ECCo would avoid interference with states' local relationships while establishing ECCo as the national contract program for dental electronic commerce services. Members would be offered national contract discounts in the following areas:

1. supplies;
2. equipment;
3. financial services; and
4. consumer services.

ECCo plans to work with its sister companies, ADA Publishing, Inc. and ADA Financial Services Co., to provide dentists with complementary products and services that will enhance ECCo's success. Another key to ECCo's success will include working with tripartite organizations to develop product and service offerings that would as much as possible complement existing tripartite vendor relationships. ECCo's future success depends on its ability to achieve the objectives in this plan, encourage member participation in product and service offerings and raise awareness of the member benefits derived from the use of technology in the dental practice.

Future Projects: ECCo has planned three areas to be its core competencies over the next three to five years: These areas include:

1. electronic claims processing;
2. administrative data collection; and
3. a trusted and unbiased information technology resource for the ADA member practitioner to obtain information about technology.

Electronic Claims Processing: Recent legislative activity in administrative simplification has spawned several perceived issues in implementing EDI. The uncertainty is a result of the many legacy systems still supported in the payer community. In the future, payers and providers will be required to implement one standard per transaction. For dentistry, the past focused on submitting only one of the transactions necessary for reimbursement, the claim form. As a result, member benefits have been somewhat limited to reduce turnaround time in the adjudication process. To increase the benefits in the future and comply with the law, automating all reimbursement transactions will be required. Nine transactions are named in the administrative simplification law. ECCo plans to continue its unique position of facilitating their implementation on a national level by maintaining a portfolio of contract resources. Five of the nine transactions should be ECCo's priority. These transactions are:

1. benefit enrollment;
2. eligibility;
3. claim payment/remittance advice;
4. attachments; and
5. oral health records.

Benefit Enrollment. This transaction would allow electronic identification of insurance plan participants. This information could be used to populate databases for claims processing entities enabling real-time patient benefit inquiries. An example might be for an employer to send direct reimbursement information to its processing agent to establish the terms of dental benefits.

Eligibility. ECCo currently endorses Trojan Professional Services, Inc. to provide a program that allows patient benefit information to be stored in the dental office using CD-ROM technology. The system is updated on a monthly basis, with additions identified by dental offices. In the future, this transaction will become electronic and over time, interactive. This will allow the dental office to obtain the latest benefit information and to minimize the risk associated with benefit plan changes.

Claim Payments/Remittance Advice. This transaction has two different opportunities for ECCo. The first is to provide the dental office an automated method to reconcile the electronic claim and payment information. The second is an opportunity to work with ADA Financial Services Co. in establishing a cash management program for reimbursement. The benefits would be enormous for dentistry as a whole if dental practices have access to their funds in a more timely manner.

Attachments. The American Dental Association has supported the elimination of the claim attachment requirement. However, until the ADA's position has gained acceptance in the insurance industry, the attachment requirement from payers will continue. ECCo should influence health care industry leaders to use the appropriate electronic communications to facilitate the transaction while reinforcing the ADA's position. This will encourage the insurance or third-party community to evaluate in earnest the purpose of requiring information that typically cannot be processed by computers.

Oral Health Records. Currently dentistry is limited to communicating operational information such as a specific procedure performed on a patient. In the future, as the ADA disseminates a new coding structure that includes diagnosis, procedures and various modifiers, ECCo's EDI environment will continue to grow in value. For example, the necessary clinical information for a patient who moves or is referred to another dentist or specialist could be sent through EDI real-time instead of fax, mail or courier. This could be especially useful in emergency situations. Over time, the exchange of

clinical information may become as prevalent as sending a claim form is today.

Data Collection: ECCo has been given the responsibility for stewardship of dental data made available through the claims process. The initial opportunity for collecting dental information is limited to dental claim transactions. As the dental EDI market matures and embraces ECCo's offerings, additional data may become available. ECCo will continue to look for ways to use the data to offer organized dentistry products and services that support the ADA membership and improve the practice of dentistry. When diagnostic codes are completed and implemented, the oral health record will offer many new opportunities in this area. Clear data strategies for developing informational products would need to become commonplace for those that acquire the data from ECCo.

Looking toward 1999, ECCo will continue to develop these programs and services that assist members in taking advantage of the efficiencies and economies afforded by national contract programs and the use of electronic technology.

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

Notes

Resolutions

Notes

Resolutions

Delegate Emanuel W. Michaels, Virginia

Dental Care for the Underserved Needy

The following resolution was submitted on December 1, 1998 by Dr. Emanuel W. Michaels, delegate, Virginia.

Background: November 1998 provided an unusual opportunity for dentistry that may not come again. The Tobacco Industry has settled the suit brought by the States Attorneys General. They have agreed to pay to the respective states $206 billion over the next 25 years. To place this sum on a more earthly level, the state of Georgia, for instance, will receive almost $5 billion overall. This translates to about $175 million a year until 2024. This year has also been a boon to the states as well as the federal government in terms of revenue collected through normal channels. The economy has been on a wonderful upward run. This blessing, however, has not been shared by all Americans.

The news has it that a good portion of the tobacco money will be used for public health programs. The American Dental Association would be remiss in its duty if it does not see that a portion of this bonanza is allocated to dentistry. A few years ago, a related resolution was presented to this House to no effect. At that time, a survey of the 50 state health departments, with two-thirds replying, indicated a very uneven level of dental service for those below the poverty level. Almost all states provided dental care for children through their Medicaid Programs. Adult care ran from basic to none, and most states provided none.

The American Dental Association is the advocate for dentistry in this country. It is the Association's mission to help to improve the dental health of America. If not us—who then? And if not now—then when? This great country is very prosperous, and its people are the most generous in the world. It is unconscionable that, among some other things, Americans should go in pain and with acute infection. At the very least, they must be relieved of these problems. Hopefully, there will be more care for them.

We have seen to it that dentistry is recognized as an essential part of the health service. Now we must see to it that it is provided on the same level through state government, as other health care to the needy is provided. In most states dental care is not a mandated health service in their programs so it is most easily cut. Over the hard budget years it has been reduced relative to other health services.

The art of dentistry implies a certain sensitivity, and in practicing this art we must look out for those who have no other place to turn. It is our professional duty. It is our dues.

Therefore, be it

19. Resolved, that the American Dental Association discover the level of dental care given to the needy population through the respective state programs, with the term *needy* being defined as at poverty level or below for social service purposes, and be it further

Resolved, that the ADA then offer to help evaluate these programs, and that with its expertise, and that of its constituents, offer to help the states construct meaningful programs where such do not exist in order to provide such dental services as may be appropriate, and be it further

Resolved, that the Association should accept from the states no less a commitment than relief of pain and acute infection through state programs for the dentally involved needy population, and be it further

Resolved, that failing to receive such a commitment, the ADA, with the help of the constituent societies, regularly lobby the respective state administrative and legislative branches until they provide such services, and be it further

Resolved, that a report on these activities and dental care provided to the indigent by state programs be submitted annually to the House of Delegates.

Delegate Emanuel W. Michaels, Virginia

Need of Dental Public Health Education and Oral Health Services in Underserved Countries

The following resolution was submitted on May 10, 1999 by Dr. Emanuel W. Michaels, delegate, Virginia.

Background: Historians tell us that this has been the American Century. As you read the business news and the story of scientific progress, you can see how favored we in the developed world have been. It is a marvel to enter a contemporary American dental office with its stunning array of equipment and the ability to deliver high quality dentistry in volume to educated patients. Our standard of living overflows with a marvelous bounty. Walk into any American supermarket with its bright picture of plenty and you cannot imagine a world without. That world does exist. Ask any of your friends who have spent time as a volunteer in a dental clinic in some far away, or not so far away place. If you have been that volunteer yourself, you know how hard life can be for those people.

We have been blessed. This blessing comes with an obligation. It is the obligation to in some way share the ability to improve oral health with places that are hard put to take on the burden of improvement by themselves. An old Chinese proverb tells us that to give a man a fish feeds him for a day but to teach him to fish feeds him for a lifetime.

The futurists warn us that we cannot long remain an island of prosperity in a troubled sea. They tell us that the pressure of the newly developing parts of the world to have what they see is a better life, will create a source of world conflict. In our limited way, we can try to blunt this conflict and fulfill our obligation to

humanity at the same time. This would be a wonderful gift for us to take into the new millennium.

Therefore, be it

20. Resolved, that the American Dental Association seek to determine the places and depth of need with respect to the provision of dental public education and oral health services in the underserved parts of the world, and be it further

Resolved, that the American Dental Association then explore what, if anything, it or some other organization that it can influence might in some practical way do to help these countries help themselves through education in public health and of providers of oral health care, and be it further

Resolved, that a report of these findings be presented to the next House of Delegates for its consideration and possible action.

1998 Resolution Referred to 1999 House of Delegates for Action

Third Trustee District

Election, Term and Tenure of the ADA Treasurer

The following resolution was submitted by the Third Trustee District and transmitted on October 13, 1998 by Dr. Raymond R. Lancione, secretary, Pennsylvania Dental Association.

Background: Prior to 1992, the ADA Treasurer was a member of the Board of Trustees who served as Treasurer for a one-year term. (From 1984 through 1992, the President-elect was the Board member annually appointed to serve as Treasurer.)

In 1992 a *Constitution and Bylaws* change regarding the position of the ADA Treasurer was approved. That change is currently in effect and is found in Article V of the *Constitution*. It states:

> ARTICLE V. OFFICERS
> Section 20. APPOINTIVE OFFICERS: The appointive officers of this Association shall be an Executive Director, and a Treasurer, each of whom shall be appointed by the Board of Trustees as provided in Chapter IX of the *Bylaws*.

All other officers of the Board of Trustees are elected as per Article V also. It states:

> Section 10. ELECTIVE OFFICERS: The elective officers of this Association shall be a President, President-elect, a First Vice President, a Second Vice President and a Speaker of the House of Delegates, each of whom shall be elected by the House of Delegates as provided in Chapter VIII of the *Bylaws*.

Each trustee is elected by the House of Delegates as provided in the *Bylaws* under Chapter VII. BOARD OF TRUSTEES:

> Section 60. ELECTION: The trustee shall be elected by the House of Delegates ...

Council members are nominated by the Board of Trustees and also elected by the House of Delegates. This is provided for in Chapter X, Section 20B which describes the process.

As the budget and budgetary process of the Association expand in scope and complexity it becomes increasingly necessary that a candidate for Treasurer demonstrates a clear understanding of Association finances and be well versed and experienced in financial matters. The election of one who shoulders such considerable responsibility and accountability properly belongs to the House of Delegates just as they elect other officers of the Board, trustees and council members.

Accordingly, the following resolution is offered for the consideration of the House of Delegates.

97-1998. Resolved, that the Treasurer of the American Dental Association be elected by the House of Delegates, and be it further

Resolved, that the term of office of Treasurer be for three (3) years and the tenure shall be limited to two (2) consecutive terms, and be it further

Resolved, that all appropriate *Constitution and Bylaws* amendments be made to allow for the election of a Treasurer by the House of Delegates, and be it further

Resolved, that these resolutions become effective at the completion of the term of the next appointed Treasurer.

Notes

ADA Audit

Notes

Association Finances
A Joint Letter From the Treasurer and the Executive Director

Introduction

On a consolidated basis, the financial position of the American Dental Association was strengthened in calendar year 1998. The Association's Operating Division generated net income as did the Restricted Reserve Account. Additionally, the American Dental Association Health Foundation and the consolidated for-profit subsidiaries produced net income while the American Dental Real Estate Corporation experienced a net after-tax loss.

A consolidated audited financial report is prepared for the Association inclusive of its subsidiary operations. Additionally, for purposes of disclosing the financial activities of these subsidiary companies, and in recognition that these corporations function independently on a daily basis, separate audits were conducted for each entity.

Audit reports are also prepared for the American Dental Association Relief Fund and the ADA Endowment and Assistance Fund, Inc. although their results are not consolidated with the Association. The ADA Emergency Fund Board of Directors chose not to retain an independent firm to audit its financial statements given the level of revenue in fiscal 1998.

The accounting firm of Grant Thornton conducted each annual audit and in all cases expressed an unqualified opinion on the 1998 financial statements.

ADA and Subsidiary Operations

The comments that follow relate to the audit reports of the Association and its subsidiaries.

General Overview of Financial Statements: The financial statements reflect revenues and expenses separated into natural account categories. Certain reports also include disclosure of expenses in functional classifications as prescribed by the Financial Accounting Standards Board. In addition to the basic consolidated statements of financial position, activities and cash flows, the 1998 audit report includes supplementary "consolidating" statements for the ADA and all of its subsidiary companies.

The purpose of these additional statements is to provide further detail regarding the components of the ADA General Fund and to depict the financial results of each subsidiary. The Operating Division is displayed in total and by its Operating, Investment, Capital Improvement Account, Building Fund and ADA Online 2000 (information technology project) elements. The Reserve Division is separated into its Capital Formation and Restricted accounts.

In addition, the American Dental Association Health Foundation; the American Dental Real Estate Corporation; and the ADA Holding Company, Inc. consolidated with its subsidiaries, ADA Publishing Co., Inc., ADA Financial Services Co. and ADA Electronic Commerce Co. are also displayed. The format of the report includes a column entitled "Eliminations," which is used to remove the double-counting that invariably develops from transactions between a parent company and its subsidiaries.

Consolidated Association Statement of Financial Position: Favorable financial results for 1998 enabled the Association to increase its equity position, on a consolidated basis, by $6 million.

Total assets increased primarily due to higher cash balances as well as additional building improvements offset by a reduction in marketable securities. The carrying value of property and equipment increased primarily due to construction activity and capital acquisitions within the Capital Improvement Account and Building Fund. Marketable securities declined mainly due to spending in the Capital Improvement and Reserve Restricted Accounts in excess of investment earnings, which was partially offset by higher short-term investments in the Operating Account and Foundation.

On the liability side, notes payable decreased due to the continued paydown of debt on the Washington building.

Consolidated Association Revenues and Expenses: Revenues of $80,914,495 represent an increase of approximately $7 million from the previous year mainly due to higher membership dues, as well as annual session registration fees and exhibit booth rentals offset by lower investment income. The increase in membership dues resulted from the $49 dues raise approved at the 1997 House. The increase in annual session registration fees and exhibit space rental was caused by the larger venue and relative popularity of San Francisco versus Washington, DC. Expenses rose approximately $2.8 million or 4% from the previous year to $74,288,795 resulting primarily from staff compensation expense, professional services and meeting expenses. After consideration of $651,823 in income tax expense, consolidated net revenues in excess of expenses totaled $5,973,877.

Investment Account Analysis: The investment accounts of the Association are segregated into three categories: Capital Formation, which holds long-term investments that are not easily liquidated such as the Washington Office Building and the for-profit subsidiaries; the Operating Division Investment

Account, which consists of investments readily convertible to cash; and the Reserve Division Restricted Investment Account, which is primarily comprised of investments in mutual funds including an index fund.

Below is a recap of year-end balances for the five-year period ended December 31, 1998. These balances represent the total equity in each account including capital stock.

Recap of Year-End Balances
Investment Accounts

Year Ended	Operating Division	Capital Formation	Reserve Restricted	Total Investment
1994	$3,964,247	4,973,952	14,569,169	23,507,368
1995	4,169,398	4,328,051	18,879,689	27,377,138
1996	4,377,661	5,197,980	19,986,700	29,562,341
1997	4,609,355	7,372,149	21,880,320	33,861,824
1998	4,851,105	9,872,756	17,781,010	32,504,871

The following table illustrates the portion of the Reserve Account balances invested in marketable securities that could be liquidated to satisfy future contingencies of the Association. Therefore, it excludes the Capital Formation account balances that are illiquid and the Reserve Restricted Account's loan receivable from the Capital Improvement Account of $3.5 million plus accrued interest extended in 1992 and repaid in 1995.

Recap of Marketable Security Balances
Investment Accounts

Year Ended	Operating Division	Capital Formation	Reserve Restricted	Total Investment
1994	$3,964,247	-	10,804,169	14,768,416
1995	4,169,398	-	18,879,689	23,049,087
1996	4,377,661	-	19,986,700	24,364,361
1997	4,609,355	-	21,880,320	26,489,675
1998	4,851,105	-	17,781,010	22,632,115

Capital Improvement Account Analysis: Continuing work on the Capital Improvement Program during 1998 resulted in remodeling and asbestos abatement improvements to the Headquarters Building totaling $4,241,275. The completed work was supported by previously collected membership dues restricted by House resolution as the primary funding source for this program. This four-year $55 dues increase was effective from 1993 to 1996.

The program, which affects primarily tenant space, extends beyond the year 2000. Through December 31, 1998, improvements with the following costs, net of depreciation, have been completed:

Asbestos abatement	$4,672,008
Remodeling	12,068,764
	16,740,772
Less accumulated depreciation	3,917,021
	$12,823,751

Monies collected for this activity, but still unspent, are maintained in a separate short-term investment account to generate interest earnings, which had a balance of $9,318,714 at December 31,1998.

Building Fund Account: Beginning in 1993, monies are budgeted annually for transfer to a separate account from which major capital expenditures to improve and repair the Headquarters Building are made. In years where the annual appropriation exceeds planned expenditures, a base is provided for future replacements as well as a cushion to absorb the shock of any unanticipated expenses. Unspent monies are maintained in a separate short-term investment account to generate interest earnings which had a balance of $3,380,918 at December 31,1998.

Subsidiary Operations: In 1998, the for-profit subsidiaries generated consolidated net after-tax income of $948,466, compared with $590,236 in 1997. This increase of $358,230 reflects higher earnings of ADA Publishing Co., Inc. and ADA Financial Services Co. coupled with earnings of ADA Electronic Commerce Co. where the prior year had been a loss.

American Dental Real Estate Corporation (ADREC) experienced an after-tax loss of $661,685 for 1998 versus $811,157 in 1997. This improvement is mainly due to lower interest expense as the debt principal is paid down. While representing a significant shortfall, this deficit should be considered in light of the fact that the Association occupies its Washington premises rent-free, an imputed value of almost $250,000. This partially compensates for the economic losses of ADREC.

After adjusting this loss for such items as depreciation, debt reduction and capital expenditures, ADREC's cash flow loss totals $2,155,044. Of this amount $1,717,678 represents the principal paydown and prepayment penalty. Recognizing that income generated from building rentals is insufficient to support future interest and principal payments, the Association has committed to fund ADREC's cash flow losses up to $1.7 million annually. In addition to this commitment, principal prepayments began in 1997 to repay ADREC's debt by 2001 instead of the remaining scheduled term ending in 2004 as approved by the 1996 House of Delegates Resolution 127H (*Trans.*1996:666) and the Board of Trustees Resolution B-180-1996 (*Trans.*1996:652).

In 1998, the American Dental Association Health Foundation (ADAHF) exhibited net income of $907,206 compared with earnings of $347,701 in 1997. This increase is largely attributable to a reallocation of staff resources from ADAHF to the Association, thereby lessening ADAHF's costs. ADAHF received a grant from the Association of $1,978,205 in 1998 as compared with $2,613,659 in 1997.

ADA General Fund Operating Account

ADA Operating Results: The 1998 budget approved by the House of Delegates projected a funding surplus of $37,750. Annual financial results stated in a manner consistent with budgetary guidelines amounted to an available surplus of $3,780,712. The 1998 financial statements, however, show net income of $5,497,320 due to the differing treatment of certain items that are considered as revenues and expenses for budgetary but not for accounting purposes. Included among these reconciling items are certain budget allocations carried forward into the next fiscal year. The Board of Trustees approved this mechanism in 1996, decided on a case-by-case basis, for significant unexpended funds from authorized programs that could not be completed in the year authorized.

These financial results from 1998 operations resulted in a transfer of $3,717,644 from the ADA General Fund to the Reserve Division Restricted Investment Account in accordance with Board Resolution B-71-1999 composed of the $3,780,712 available surplus offset by $63,068 of net spending on activities authorized by the Board to come from reserves, which is net of monies already transferred during the year. That resolution also authorized the transfer of $437,366 from the Reserve Division Restricted Investment Account to ADREC for funding of its cash flow loss, which represents the $2,155,044 mentioned earlier less $1,717,678 already transferred during the year. A reconciliation of surplus funds to the amount transferred to reserves is shown below.

Net Income Per 1998 Financial Statements	$5,497,320
Decreases to net income:	
1997 Spending on National Public Awareness Campaign	(308,847)
Pension Funding Adjustment	(383,218)
Carryforwards from 1998 Operations	(316,700)
Funded Depreciation	(1,454,600)
Increases to net income:	
Dividend Received from ADAHC	540,000
1997-1998 Carryforwards Expended	206,757
Funds to be Transferred to Reserves from ADA Operations	$3,780,712

Monies Due from Reserves to ADA Related to 1998 Activity:

Provision for 1998 Spending on ADA ONLINE 2000	$(663,577)
Purchase of Lab Equipment	(426,608)
Dental Handpieces for Annual Session (expenses net of revenue)	(4,363)
Board Room Voting System	(3,698)
Data Collection from ECCo	(22,500)
Retiree Medical to Reserves	525,985
Unspent Carryforwards from 1997	531,693
Funds to be Transferred from Reserves to Fund Board Authorized Activities	$ (63,068)
Funds to be Transferred from Reserves to Fund ADREC's Cash Flow Loss	$(437,366)
Total Transfer to Reserves	$3,280,278

It is relevant to note that present and prospective commitments exist for the use of reserve funds. Specifically, it is anticipated that such monies will continue to be required to absorb expected cash flow shortfalls and debt prepayment relating to the Washington, DC property and to support an investment for upgrading computer capabilities to increase productivity and enhance member services, as well as development of tripartite association management software.

Variance to Budget: The $3,780,712 available surplus from 1998 represents a favorable variance of $3,742,962 from the budgeted surplus of $37,750. This difference is explained by the following items.

Revenues: Major variances in the sources of revenues compared to budget are described in the following table.

Dividends received below budgeted levels	($310,000)
Annual session registration fees and ticket sales below projections from programs in San Francisco	(617,219)
Annual Session Corporate Grants in excess of budget	248,279
Registration fee shortfall from programs in Dental Practice	(175,905)
Increase in membership dues, exclusive of Capital Improvement Program	506,301
All other revenue variances, net favorable	1,199
Total	($347,345)

Expenses and Other Items: Major variances between actual and budgeted amounts are shown in the following table.

Compensation savings	$1,695,627
Underspending in travel expense	394,187
Property tax savings	536,615
Underspending in consulting	427,506
Savings in printing, publication and marketing costs	773,750
Underspending in office expenses (such as postage, telephone, photocopy, etc.)	643,961
Savings in general insurance	109,288
Unused contingent fund	109,800
Carryforwards from 1998 to 1999	(316,700)
1997 Spending on National Public Awareness Campaign	(308,847)
Remaining expense and other item variances, net favorable	25,120
Total	$4,090,307

Conclusion

The financial results discussed above supported a multitude of activities to address the varied needs of the profession, the membership and the public.

Patient protection legislation remained the Association's major legislative priority in 1998. Momentum was growing to pass legislation that would assure patient choice, plan accountability and nondiscrimination by degree of provider. Unfortunately, as Congress and the media became obsessed with the political scandals in Washington, all efforts to pass meaningful legislation in this area as well as others came to an abrupt halt. However, the efforts of the Association and its coalition members on this issue yielded some positive benefits: the Labor Department determined that it could make some of the changes envisioned in the legislation via the regulatory process (a position the Association has long held and brought to the attention of the Labor Department back in 1995); health plans made several changes in their policies; and the coalition of health organizations advocating for patient protections was well-positioned to carry on the fight into the 106th Congress.

The ADA successfully lobbied for increased funding for several federal programs of importance to dentistry including the Centers for Disease Control and Prevention's (CDC) Oral Health Division, the National Institute of Dental and Craniofacial Research (a $25.3 million increase—the largest increase in the Institute's history), and other education, research and health delivery programs. The Association, with the help of several key members of Congress, restored the chief of the Air Force Dental Corps to the rank of Brigadier General and worked successfully, following Camp Pendleton, to prevent any new commercial on-base dental facilities from being established by the military.

On the tax front, at the request of the Association, the Accounting Fairness for Dentists and Physicians Act was introduced, which would exempt dentists and physicians from being required to use the accrual method of accounting. Efforts were also undertaken to increase the income and deduction limits allowed for interest on student loans and to provide a tax credit for dentists and physicians serving in underserved areas. The ADA and others also worked successfully for a small business exemption that would free dentists from the requirement to pay licensing fees for radio and television used in their offices.

The ADA grassroots network continued to develop, and dentists and their spouses hosted over 100 home fund-raisers for the 1998 elections. The American Dental Political Action Committee had a successful record in the elections by supporting winning candidates in 95% of the House races entered and 90% of the Senate races.

The Association testified on many issues before the Congress and the Administration and has been successful in raising the profile of organized dentistry and the importance of oral health care.

At the state level, the ADA continued its very successful LEAD program, thereby reaching 2000 dental students; helped Kansas obtain "free media" in its battle with the hygienists over expanded duty dental assistants; coordinated dentistry's involvement in the Health Care Administration's first-ever dental Medicaid Conference; and created several important resource packets, including one on the corporate practice of dentistry.

Beyond legislation, the Association pursued important legal issues for dentistry with various federal agencies, including the Federal Trade Commission, the Department of Justice, the Occupational Safety & Health Administration, the Department of Labor and CDC. The Association assisted the California Dental Association in having the United States Supreme Court review the lawsuit which was brought by the Federal Trade Commission against the California Dental Association. This case presents important issues involving the application of the antitrust laws to professional associations. The Association also supported cases to maintain the profession's ethical standards on professional advertising and to protect the Association's copyright of the *Current Dental Terminology—Second Edition (CDT-2)*. To help the profession avoid legal difficulties, the Association has provided written materials on managed care and has helped constituent societies plan their efforts on Direct Reimbursement (DR). In addition, the Association is also reviewing Dental Management Service Organizations' (DMSO) contracts, which are used for the acquisition of dental practices, and has worked with the Board of Trustees' Task Force to heighten the issue of DMSO's within the Association. The Association has continued to file friend-of-the-court briefs in appropriate cases that have a substantial impact on the dental

professional nationally, including the case of *Abbott v. Bragdon* in the First Circuit Court of Appeals. The Legal Division has also been assisting the Association to avoid legal exposure in the era of electronic communications.

The dental care marketplace continues to evolve, presenting new challenges to private dental practitioners. The Association has responded in several ways: increasing its efforts to provide information to members about these challenges and their possible responses; confirming its information gathering activities to better understand the dental care marketplace; aggressively promoting Direct Reimbursement to dental benefit plan purchasers; and providing analytical and design assistance to those purchasers who indicate an interest in DR. During the past year special emphasis was placed on gathering information and developing resources for members concerning DMSO's, a relatively new entry into the dental care marketplace.

The Association continues to advance the oral health of the public through activities in tobacco cessation, early oro-pharyngeal cancer detection, child abuse recognition, access to dental care and publications concerning oral health care for medically compromised patients. Dentist well-being activities have been enhanced and expanded to address the broad spectrum of wellness issues currently being faced by the dental team. Association activities in the area of ergonomics in the dental office were initiated.

The Association intends to be the premier source of information on oral health. The Health Policy Resources Center (HPRC) is the central repository for information relating to the health policy of the Association. The Association, through the HPRC, will develop a data repository of recent and historical data on a variety of topics to conduct analysis, will develop policy positions and will support advocacy enabling the Association to quickly respond to rapidly emerging issues. Continued development of the data repository will place the Association in a strong position for debate and advocacy relative to the interested participants in policy development.

The HPRC works to strengthen and contribute to policy and advocacy on economic and technical issues by identifying critical policy-position development needs in economic and technical areas for use by ADA councils, commissions and the Board of Trustees. The HPRC continues to provide unbiased, scientifically valid information and analysis on priority economic issues of the Association needed to effectively position the Association for the future. The HPRC provides oversight of activities of the Dental Economics Advisory Group as well as management and interpretation of survey results published by the Survey Center.

The Survey Center is responsible for the conduct of Association survey research and continues to support survey research mandated by the House of Delegates. The ongoing *Distribution of Dentists* census survey assists in maintaining a comprehensive registry of all U.S. dentists. Recent dental graduates are included in this census as part of the *Survey of Dental Graduates*. The annual *Survey of Dental Practice* tracks trends in the private dental office. Three individual specialties were over-sampled in the 1999 *Survey of Dental Practice*, which will yield data on specialty practices, updating the 1993 information. The 1998 House of Delegates funded two survey research projects on a one-time basis only. Resolution 73H requested the Survey Center to conduct a 1999 *Workforce Needs Assessment Survey* to assess both current and projected auxiliary needs. Resolution 81H requested the Commission on Accreditation to conduct a study of predoctoral pain and anxiety control—1999 *Dental School Anesthesiology Survey*.

In addition to House-mandated survey research, the department has expanded its survey research services to the entire Association. Over 35 different survey research projects were underway in 1998. Some examples of this research were: the Commission on Dental Accreditation's *Survey of Predoctoral Dental Institutions*, *Survey of Advanced Dental Institutions* and *Survey of Allied Dental Institutions*; the Division of Education's *Survey of Dental School Satellite Clinics*, *Survey of Clinical Testing Agencies*, and *Licensure by Credentials Survey*; the Division of Dental Practice's *Survey of State Medicaid Programs*, and *National Peer Review Reporting System Survey*; the Division of Membership and Dental Society Services' *Field Service Program Evaluation*; the House-directed Committee on the New Dentist's *Survey of New Dentists on the Impact of Student Debt*; the Division of Science's *Health Screening Program Surveys*; the Division of Government Affairs' *Continuing Education Survey*; and the Division of Communications' *National Public Awareness Campaign Member Survey*.

The Association through the Division of Communications continued to deliver positive oral health messages to the public in a variety of media, manage issues critical to the profession and provide communications support to dental societies and ADA members. Ongoing programs such as National Children's Dental Health Month, award-winning public service announcements and quarterly video news releases on important oral health issues are refined and reshaped on an ongoing basis to build on their success. In addition, relatively new initiatives such as the weekly radio series and the ADA Dental Minute on television already are reaching millions of households. Media relations outreach continued to yield hundreds of high-profile placements each year, including frequent appearances by the ADA spokespersons on prominent television news programs and in major news dailies.

ADA ONLINE, the Association's Web site, developed at a rapid pace, with the addition of more sophisticated and dynamic applications such as search engines, databases, directories, a discussion group and, soon, electronic commerce. An Intranet to improve the efficiency of employee communications also was launched. Registrations to access member-only content on ADA ONLINE passed 10,000 and were increasing rapidly. More than 5,000 visitors view the site daily.

Communications was the lead agency on public awareness activities for the second consecutive year. Under the terms of the program approved by the House of Delegates in 1998, five state dental societies were in various stages of campaign development, with new television advertisements for production in mid-1999.

The Association is at the forefront of science as it relates to the practice of dentistry and patient care. Through the Council on Scientific Affairs, the Association provides guidance to the profession by identifying and addressing critical/emerging

issues such as patient and provider safety, latex hypersensitivity, dental restorative materials, bloodborne pathogens, dental treatment water quality, infection control and other issues that impact dentistry. Through the Association's Seal of Acceptance Program, the Council also provides guidance on the safety and effectiveness of professional and consumer products.

To better respond to scientific issues of importance to the practicing dentist, capital improvements have been made to the Association's laboratory. These enhancements will facilitate the implementation of relevant research initiatives as identified in the Association's Research Agenda. Equipped with state-of-the-art instrumentation to conduct chemical, mechanical and biological research, the laboratory also evaluates dental products according to the safety and efficacy criteria established by the Association's Seal of Acceptance Program, the American National Standards Institute and the International Organization for Standardization. This facility and its staff, coupled with the work of the Council, help to enhance the Association's working relationship with member dentists, research institutions, professional organizations, dental schools, government agencies, industry and the public.

With regard to education the Association assumes primary responsibility for the operating costs of the Commission on Dental Accreditation. The Commission is responsible for the accreditation of over 1,325 educational programs in 14 dental and dental-related disciplines. To ensure the quality of dental and dental-related education, the Commission conducts accreditation site visits to approximately 180 programs each year.

In support of initiatives associated with the Association's Agenda for Change in the Clinical Licensure Process, *Guidelines for Examiner Standardization* have been developed and distributed to state and regional testing agencies. Also, in response to directives from the 1997 House of Delegates, activities were undertaken that would assist the membership recruiting qualified allied personnel. Specifically, updated allied career brochures have been developed and are available for distribution to members, constituents and component societies. Additionally, a resource packet for establishing an accredited dental hygiene program was developed to provide guidance to those interested in pursuing this activity. This document has been sent to constituent dental societies and will be available to the membership upon request.

Other major activities involved support for licensure initiatives, including the invitational licensure conferences that bring the licensure community together with Association leadership to ensure continued progress in implementing objectives contained in the Agenda for Change. Finally, support was provided for education activities related to a study of the cost of dental education and development of a proposal for recruiting and retaining underrepresented minorities in the dental profession.

During the past year, the Association continued to harness new technologies to enhance member service. The development of the Tripartite Association Management System (TAMS) will allow increased information flow across all three levels of the tripartite, reinforcing the value of membership. TAMS enables ADA and state and local dental society staff to keep effective membership records and dues payments, to make dentist referrals, to track legislative contacts, to produce reports and transmit data throughout the tripartite. Increased information about individual dentists and their needs will be available to all societies linked with TAMS resulting in enhanced membership service opportunities long-term.

In this software development project, the Association has demonstrated its commitment to the long-standing tripartite tradition that has made organized dentistry strong and responsive to our members' needs. State and local dental societies have worked together on this project for over three years, identifying needs, gathering input, assessing feedback, conducting pilot testing and launching the first deployment sites. The Association is a recognized leader among professional membership societies in pioneering uses of new information technology for society management, in order to better serve its members and promote the value of organized dentistry.

Other major activities of the Association involved continued focus on the Health Foundation's expanded mission and the operations of the for-profit subsidiaries.

Throughout 1998, the Association's limited resources were allocated on a priority basis to provide quality service to the profession, members and the public.

Treasurer

Executive Director

Report of Independent Certified Public Accountants

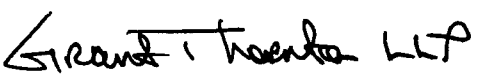
The Board of Trustees
American Dental Association

We have audited the accompanying consolidated statements of financial position of American Dental Association and subsidiaries as of December 31, 1998 and 1997, and the related consolidated statements of activities and cash flows for the years then ended. These financial statements are the responsibility of the Association'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 consolidated financial position of American Dental Association and subsidiaries as of December 31, 1998 and 1997, and the consolidated results of their operations and their consolidated cash flows for the years then ended in conformity with generally accepted accounting principles.

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole of the American Dental Association and subsidiaries. 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. Such information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the 1998 consolidated financial statements taken as a whole.



GRANT THORNTON LLP

Chicago, Illinois
April 2, 1999

American Dental Association and Subsidiaries

Consolidated Statements of Financial Position

December 31, 1998 and 1997

	1998	1997
ASSETS		
Cash and cash equivalents	$ 7,653,152	5,893,868
Receivables, net of allowance for doubtful accounts of $166,605 in 1998 and $120,402 in 1997	2,802,239	2,306,128
Deferred taxes and income taxes receivable (Note 7)	995,670	1,098,493
Inventories, net of reserves of $216,393 in 1998 and $168,253 in 1997	1,329,278	1,262,677
Marketable securities, at market (Note 2)	45,194,064	46,844,858
Property and equipment, net (Notes 3 and 4)	39,837,813	36,100,313
Funds held for deferred compensation (Note 5)	4,125,201	3,828,507
Prepaid expenses and other assets (Note 8)	1,883,692	2,184,187
TOTAL ASSETS	$103,821,109	99,519,031
LIABILITIES AND NET ASSETS		
Liabilities:		
Accounts payable and accrued liabilities	$ 10,442,886	10,746,208
Accrued pension liability (Note 8)	555,947	939,165
Notes payable (Note 6)	5,405,500	7,324,000
Deferred revenues	7,346,796	6,710,249
Liability for deferred compensation (Note 5)	4,125,201	3,828,507
TOTAL LIABILITIES	27,876,330	29,548,129
Net assets (Note 9):		
Unrestricted	74,832,505	69,246,276
Temporarily restricted	1,112,274	724,626
TOTAL NET ASSETS	75,944,779	69,970,902
TOTAL LIABILITIES AND NET ASSETS	$103,821,109	99,519,031

See accompanying notes to consolidated financial statements.

American Dental Association and Subsidiaries

Consolidated Statements of Activities

Years Ended December 31, 1998 and 1997

	1998	1997
REVENUES		
Membership dues	$ 38,954,500	33,878,438
Advertising	8,097,879	7,587,690
Rental income	2,906,573	2,892,149
Publication and product sales	5,585,417	4,983,366
Subscriptions	664,473	884,243
Testing and accreditation fees	5,204,808	4,876,340
Meeting and seminar income	7,461,646	5,738,764
Grants and contributions (including temporarily restricted contributions of $488,980 in 1998 and $229,459 in 1997)	3,370,938	3,012,933
Royalties	3,220,665	2,368,871
Investment income (including temporarily restricted income of $36,562 in 1998 and $32,341 in 1997)	3,927,421	6,117,684
Other income	1,520,175	1,590,224
Net assets released from restrictions (Note 9)	-	-
TOTAL REVENUES	80,914,495	73,930,702
EXPENSES		
Staff compensation, taxes and benefits (Note 8)	31,208,184	30,360,792
Printing, publication and marketing	12,951,570	13,229,561
Meeting expenses	3,202,833	2,365,337
Travel expenses	4,678,039	4,194,729
Professional services	7,993,404	6,786,762
Office expenses	4,659,772	4,158,028
Facility and utility expenses	3,189,232	3,621,215
Grants and awards	483,746	735,013
Endorsement expenses	259,368	199,467
Depreciation and amortization	4,037,409	3,736,100
Interest expense	510,627	627,969
Other expenses	1,114,611	1,430,471
TOTAL EXPENSES	74,288,795	71,445,444
Increase in net assets before income taxes	6,625,700	2,485,258
Income tax expense (Note 7)	(651,823)	(333,063)
Increase in net assets (Note 9)	5,973,877	2,152,195
Net assets at beginning of year	69,970,902	67,818,707
Net assets at end of year	$ 75,944,779	69,970,902

See accompanying notes to consolidated financial statements.

American Dental Association and Subsidiaries

Consolidated Statements of Cash Flows

Years Ended December 31, 1998 and 1997

	1998	1997
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase in net assets	$ 5,973,877	2,152,195
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	4,037,409	3,736,100
Deferred income taxes	46,883	14,510
Unrealized depreciation (appreciation) in market value of marketable securities	380,554	(882,917)
Gain on sale of marketable securities	(2,033,013)	(2,965,321)
Changes in assets and liabilities:		
Receivables, net	(464,719)	(57,280)
Income taxes receivable	55,940	76,553
Inventories, net	(66,601)	(15,150)
Prepaid expenses and other assets	294,718	(651,879)
Accounts payable and accrued liabilities	(334,714)	3,646,923
Accrued pension liability	(383,218)	(41,952)
Deferred revenues	636,547	415,722
Net cash provided by operating activities	8,143,663	5,427,504
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of marketable securities	(47,020,758)	(36,886,389)
Sale and maturity of marketable securities	50,324,011	39,516,202
Acquisitions of property and equipment	(7,769,132)	(5,622,383)
Net cash used by investing activities	(4,465,879)	(2,992,570)
NET CASH USED IN FINANCING ACTIVITIES		
Principal repayment on notes payable	(1,918,500)	(1,656,000)
Net increase in cash and cash equivalents	1,759,284	778,934
Cash and cash equivalents at beginning of year	5,893,868	5,114,934
Cash and cash equivalents at end of year	$ 7,653,152	5,893,868
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid during the year for:		
Interest	$ 510,627	606,619
Income taxes	$ 549,000	242,000

See accompanying notes to consolidated financial statements.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1998 and 1997

1. Significant Accounting Policies

Basis of Presentation: The American Dental Association (Association) is organized as an association of members of the dental profession, residing primarily in the United States 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 Publishing Co., Inc. (ADAPCO) , ADA Financial Services Co. (FINCO), and ADA Electronic Commerce Co. (ECCO).

ADAHF was organized to operate exclusively for charitable, scientific and educational purposes.

ADREC was organized for the exclusive purpose of holding title to the Association's Washington, D.C. Office building, collecting rental income thereon, and remitting the net income to the Association. ADREC intends to hold the property for continued use.

ADAHC was organized for the purpose of holding equity positions in, and managing, the for-profit corporations organized by the Association. ADAPCO performs certain publishing functions for the publications of the Association, including *JADA* and *ADA News*. FINCO offers a range of financial services to Association members in conjunction with Mellon Bank, N.A. under the title of ADA1 PLAN. ECCO offers a range of electronic data transmission services to Association members.

All significant intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates: In preparing financial statements in conformity with generally accepted accounting principles, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Fair Value of Financial Instruments: The Association's financial instruments include cash and cash equivalents, marketable securities and notes payable. The carrying value of cash and notes payable approximates their estimated fair values based upon quoted market prices. The fair value of investments in marketable securities and cash equivalents is estimated based on quotes from brokers or current rates offered for instruments with similar characteristics.

Cash Equivalents: Cash equivalents at December 31, 1998 and 1997 consist primarily of interest bearing deposits under overnight repurchase agreements, which are carried at fair value. The Association, ADAHF, FINCO and ADAPCO each maintain their cash balances in financial institutions which at times may exceed federally insured limits. The Association, ADAHF, FINCO and ADAPCO have not experienced any losses in such accounts and believe they are not exposed to any significant credit risk on cash.

Marketable Securities: Investments in marketable securities are carried at fair value. Realized and unrealized investment gains and losses are included within investment income in the accompanying consolidated financial statements. Net realized capital gains or losses on sales are calculated based on the first-in, first-out cost of securities sold.

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 for operations upon approval of the Board of Trustees, with subsequent reporting to the Association's House of Delegates. Investment expenses of $44,246 and $60,949 in 1998 and 1997, respectively, are included in professional services in the accompanying consolidated financial statements.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1998 and 1997 (continued)

Inventories: Inventories, consisting principally of salable educational materials and supplies, are carried at the lower of cost or market (net realizable value). Cost is primarily determined using the first-in, first-out method.

Property and Equipment: Property, equipment and leasehold improvements are stated at cost, less accumulated depreciation and amortization. Depreciation is computed on the straight-line method once assets are put into service over the estimated useful lives of the assets, which are as follows:

Buildings	30-55 years
Building improvements	7-20 years
Furniture, equipment and libraries	3-20 years

Tenant leasehold improvements are amortized over the shorter of their estimated useful lives 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 $5,537,000 and $5,106,000 at December 31, 1998 and 1997, respectively.

Subscriptions to periodicals are recognized as income over the terms of the subscriptions. Subscriptions paid in advance are recorded as deferred revenue. Advertising revenue and direct publication costs are recognized in the period the related periodical is issued.

Rental income from the Association's Headquarters Building and Washington, D.C. Office building is recorded as revenue when earned.

Testing fees are recognized as income when the related examinations are administered.

Contributions, which are defined as non-reciprocal transfers, are recognized as revenues in the period pledged and classified according to the existence or absence of donor-imposed restrictions. When a donor restriction has been satisfied by incurring expenses consistent with the designated purpose, temporarily restricted net assets are reclassified to unrestricted net assets for reporting of related expenses.

Corporate grants that do not constitute contributions are recognized as income when costs of the related programs or projects are incurred. Corporate grants received but not yet expended are reported as deferred revenues. 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: Deferred taxes are established for temporary differences between the financial reporting basis and the tax basis of assets and liabilities. Deferred taxes are based upon enacted tax rates, which would apply during the period in which taxes become payable or recoverable, and the adjustment of cumulative deferred taxes for any changes in the tax rate.

Net Assets: Net assets subject to donor-imposed stipulations are classified as temporarily or permanently restricted net assets while net assets not subject to such restrictions are classified as unrestricted net assets.

Reclassifications: Certain 1997 amounts have been reclassified to conform to the 1998 presentation.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1998 and 1997 (continued)

2. Marketable Securities

Marketable securities at December 31, 1998 and 1997 consisted of the following:

	1998		1997	
	Cost	Market	Cost	Market
Money market funds	$ 21,042,101	21,042,101	21,058,658	21,058,658
Certificates of deposit	4,809,540	4,809,540	3,357,164	3,357,164
U.S. government obligations	597,253	603,283	1,203,255	1,236,785
Corporate bonds	2,093,427	2,123,204	2,000,462	2,013,004
Mutual funds	14,174,957	16,615,936	16,367,979	19,179,247
	$ 42,717,278	45,194,064	43,987,518	46,844,858

The fair value of marketable securities held in the Reserve Division amounted to $19,478,894 and $22,958,231 at December 31, 1998 and 1997 respectively.

Investment income at December 31, 1998 and 1997 consisted of the following:

	1998	1997
Interest and dividends	$ 2,274,962	2,269,446
Net realized and unrealized appreciation in market value of marketable securities	1,652,459	3,848,238
	$3,927,421	6,117,684

3. Property and Equipment

Property and equipment at December 31, 1998 and 1997 consisted of the following:

	1998			1997		
	Chicago, IL	Washington, DC	Total	Chicago, IL	Washington, DC	Total
Land	$ 712,113	3,030,000	3,742,113	712,113	3,030,000	3,742,113
Building	12,381,169	9,602,195	21,983,364	12,381,169	9,602,195	21,983,364
Building improvements	27,630,851	385,786	28,016,637	21,931,080	385,786	22,316,866
Furniture and equipment	17,204,035	1,040,868	18,244,903	15,536,286	723,088	16,259,374
Film and book libraries	653,479	-	653,479	653,479	-	653,479
Tenant leasehold improvements	636,399	425,122	1,061,521	638,319	342,290	980,609
	59,218,046	14,483,971	73,702,017	51,852,446	14,083,359	65,935,805
Less accumulated depreciation and amortization	30,164,007	3,700,197	33,864,204	26,701,557	3,133,935	29,835,492
	$29,054,039	10,783,774	39,837,813	25,150,889	10,949,424	36,100,313

Depreciation and amortization expense related to property, equipment and tenant leasehold improvements for the years ended December 31, 1998 and 1997 amounted to $4,028,335 and $3,727,208, respectively.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1998 and 1997 (continued)

Building improvements at December 31, 1998 and 1997, include the following costs related to a renovation and asbestos abatement program for the Association's Headquarters building:

	1998	1997
Asbestos abatement	$4,672,008	4,251,802
Remodeling	12,068,764	8,247,694
	16,740,772	12,499,496
Less accumulated depreciation	3,917,021	3,153,634
	$12,823,751	9,345,862

This program, which affects primarily tenant space, will extend beyond the year 2000, having estimated total capital expenditures of $21.5 million, plus interest on borrowings used to finance the project. In 1992, the House of Delegates approved a four year $55 dues increase for Association members, effective from 1993 to 1996, relating to this program. These revenues are restricted for the specific purpose of financing remodeling and asbestos abatement activities and as such are classified, along with related assets, liabilities and expenses in the Capital Improvement Account within the Operating Division.

The Association leases portions of both the Headquarters Building and the Washington, D.C. 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:

1999	$ 2,776,129
2000	2,862,933
2001	2,793,700
2002	2,685,366
2003	2,164,928
Thereafter	9,883,306
	$ 23,166,362

Building expenses include the cost of facilities occupied by the Association, as well as those costs related to other tenants.

4. ADA Online 2000 Project

The Association has initiated a project to upgrade its information technology systems by replacing the mainframe and related software supporting core applications, with an anticipated cost of $5.6 million. This project has expanded to include development of a tripartite association management system at an expected cost of $778,000, additional purchase and implementation costs for a financial systems package estimated at $1.9 million and membership system enhancements of $444,050. These projects, collectively referred to here as ADA Online 2000, anticipate capital purchases of software and hardware as well as expense items such as consulting and training.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1998 and 1997 (continued)

At December 31, 1998 and 1997 property and equipment includes the following costs related to this project:

	1998	1997
Computer software, hardware and wiring	$ 3,849,863	3,374,926
Less accumulated depreciation	1,562,798	893,379
	$ 2,287,065	2,481,547

Additionally, during 1998 and 1997 expenses were incurred in the following categories for this activity:

	1998	1997
Travel expenses	$ 6,500	45,944
Meeting expenses	-	694
Professional services	1,361,107	192,860
Office expenses	220	260
Depreciation	669,419	587,532
Other expenses	45,900	-
	$ 2,083,146	827,290

5. Deferred Compensation

Pursuant to agreements between the Association and certain officers and employees, portions of their compensation have been retained by the Association and invested as directed by those participants. The assets are owned by the Association until distributed to the participants after termination of employment or services.

6. Notes Payable

In February 1989, ADREC purchased the building constructed on land in Washington, D.C. owned by the Association for $9,500,000. The mortgage loan existing at December 31, 1992 was refinanced during 1993 by issuing notes of ADREC.

On June 24, 1996, FINCO entered into a revolving line of credit agreement with Mellon Bank, N.A. Advances under the agreement are evidenced by promissory notes and collateralized by ADA1 PLAN revenues. Draw privileges under the agreement expired June 24, 1997.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1998 and 1997 (continued)

Notes payable at December 31, 1998 and 1997 consisted of the following:

	1998	1997
7.79% Guaranteed Senior Notes, due February 1, 2005, with monthly interest payments on unpaid principal balance. Annual principal payments of $920,000 commencing February 1, 1996 through maturity. Guaranteed by the Association.	$ 4,968,000	6,624,000
$1,750,000 Revolving Credit Agreement dated June 24, 1996, due December 31, 1999; interest free through December 31, 1996, with interest thereafter at an average daily prime rate plus ½% payable quarterly on outstanding balances; principal payable from program revenues in eight equal quarterly installments commencing March 31, 1998 through maturity.	437,500	700,000
	$ 5,405,500	7,324,000

The ADREC note agreement requires, among other things, that the combined ADA group (excluding the American Dental Association Health Foundation) maintain a cash flow to debt factor of at least .30 and a cash flow to debt-service factor of at least 1.5. The agreement also contains certain other restrictions related to corporate structure, insurance, building condition, assumption of additional debt, and transactions with affiliates. The Company has complied with restrictions and limitations included in the provisions of the loan agreement.

On February 1, 1999, 1998 and 1997, through additional investments by the Association, the annual principal payments on the ADREC loan were made in the amount of $1,656,000, consisting of the scheduled payment of $920,000, plus an additional payment of $736,000 for each year. These additional payments evidence ADREC's intent to retire the notes payable on an accelerated basis by 2001 instead of the remaining scheduled term ending in 2004. Prepayment penalties of $82,308, $61,678 and $38,644 in 1999, 1998 and 1997, respectively, were assessed on these additional payments.

The fourth quarterly installment of $87,500 on the balance under the $1,750,000 Revolving Credit Agreement was unpaid at December 31, 1998 pending negotiation for forgiveness of the entire outstanding balance, as described in Note 12.

7. Income Taxes

The Association, ADAHF and ADREC have received favorable determination letters from the Internal Revenue Service stating that they 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. The income of the Association's for-profit subsidiaries, determined separately, is also subject to federal and state income taxes.

The Association files consolidated income tax returns with ADREC. ADAHC files consolidated income tax returns with ADAPCO, FINCO and ECCO. ADAHF files its own tax return.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1998 and 1997 (continued)

Income tax expense for the years ended December 31, 1998 and 1997 is as follows:

	1998	1997
Current:		
Federal	$ (494,274)	(256,913)
State	(110,666)	(61,640)
Current income tax expense	(604,940)	(318,553)
Deferred:		
Federal	(42,652)	(11,946)
State	(4,231)	(2,564)
Deferred income tax expense	(46,883)	(14,510)
Income tax expense	$ (651,823)	(333,063)

Income tax expense differs from the amount computed by applying the statutory federal income tax rate of 34% to income before income tax expense primarily because the majority of consolidated income is exempt from income tax.

Deferred taxes and income taxes receivable at December 31, 1998 and 1997 consisted of:

	1998	1997
Deferred tax assets resulting from:		
Start-up expenses	$ 43,421	78,159
Alternative minimum tax credits	-	22,944
Excess of the tax basis over book basis of receivables, net	27,735	29,381
Excess of tax basis over book basis of postretirement health benefits	43,121	29,921
	114,277	160,405
Deferred tax liability resulting from excess of book basis over tax basis of furniture and equipment, net	(88,180)	(87,425)
Deferred tax assets, net	26,097	72,980
Federal and state income taxes receivable resulting from net operating loss carrybacks, amended tax returns and current refunds	969,573	1,025,513
	$ 995,670	1,098,493

ADREC's non-exempt operating results are included in the income tax returns 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 income tax returns. ADREC recorded an income tax benefit of $4,487 in 1998 under this arrangement. ADREC recorded no payment under this arrangement for 1997 due to the Association's inability to use the tax benefits generated to offset current income taxes.

As of December 31, 1998, ADREC had net operating loss carryforwards totaling approximately $2,324,300 available to offset future unrelated business taxable income, expiring as follows: $136,300 in 2007, $194,700 in 2008, $277,200 in 2009, $356,900 in 2010, $479,900 in 2011, $590,900 in 2012, and $288,400 in 2013. Because of uncertainty of realization, management has established a valuation allowance to fully offset the related deferred tax assets of approximately $790,300 and $695,400 at December 31, 1998 and 1997, respectively.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1998 and 1997 (continued)

8. Employee Benefit Plans

The Association sponsors a noncontributory defined benefit pension plan which covers substantially all employees of the Association and its subsidiaries meeting certain eligibility requirements. Generally, the Association's funding policy is to contribute annually to the pension plan such amounts that may be deducted for Federal income tax purposes. Retirement benefit payments are based on years of credited service, average compensation during the five years of employment that produce the highest average, and the average Social Security limit at employment termination date.

Pursuant to agreements between the Association and a certain prior employee, the Association also maintains a frozen unfunded supplemental retirement income plan. Investments designated for the supplemental plan of $919,239 and $790,947 at December 31, 1998 and 1997, respectively, are carried at fair value and included in prepaid expenses and other assets.

The following table sets forth the plans' funded status and amounts recognized in the Association's consolidated financial statements:

	1998			
	Employees' Retirement Trust	Employees' Supplemental Trust	Total	1997 Total
Benefit obligation at December 31	$ 38,719,751	965,666	39,685,417	36,027,069
Plan assets at fair value, primarily bonds, stocks and insurance guarantee contracts	31,809,302	-	31,809,302	28,611,222
Funded status	$ (6,910,449)	(965,666)	(7,876,115)	(7,415,847)
Accrued pension expense included in accrued pension payable	$ 85,315	(641,262)	(555,947)	(939,165)
Weighted average assumptions as of December 31:				
Discount rate	7.0%	7.0%	7.0%	7.5%
Expected return on plan assets	10.0%	10.0%	10.0%	10.0%
Rate of compensation increase	4.5%	4.5%	4.5%	5.0%
Benefit cost	$2,157,059	74,613	2,231,672	2,471,818
Employer Contribution	2,522,094	92,796	2,614,890	2,513,770
Benefits paid	1,675,642	92,796	1,768,438	1,633,079

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1998 and 1997 (continued)

The Association has a savings and retirement plan for all eligible employees. The Association matches 50% of contributed amounts up to a maximum of $500 per participant each year. The Association's contributions under this plan were $156,805 in 1998 and $158,276 in 1997.

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, the related trusts are exempt from federal income taxes. The Employees' Supplemental Trust is a non-qualified plan and as such is not exempt from federal income taxes.

The Association has established the Executive Parity Plan which compensates Association executives who suffered restrictions in their pension benefits beginning in 1994 as a result of the Omnibus Budget Reconciliation Act. This is a deferred compensation arrangement which allows the Compensation Committee of the Board of Trustees to set aside, on an annual basis, a specified cash amount for those individuals who suffered a benefit loss during the year, to be paid upon vesting. Awards totaling $340,614 and $295,444 (reflected in accrued liabilities) at December 31, 1998 and 1997, respectively, were granted, after payments totaling $88,926 were made to participants.

The Association sponsors a contributory defined benefit postretirement health plan which covers substantially all employees of the Association and its subsidiaries. The plan provides both medical and dental benefits.

The following table sets forth the plan's funded status:

	1998	1997
Benefit obligation at December 31	$(5,128,591)	(4,695,164)
Plan assets at fair value	-	-
Funded status	$(5,128,591)	(4,695,164)
Accrued postretirement benefit cost	$(1,913,008)	(1,387,023)
Weighted average assumptions as of December 31:		
Discount rate	7.0%	7.5%
Health care cost trend rate	6.0%	6.0%
Benefit Cost	$ 709,839	705,239
Employer Contribution	183,854	169,848
Benefits paid	183,854	169,848

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1998 and 1997 (continued)

9. Net Assets

The following activity impacted unrestricted and temporarily restricted net assets during 1998 and 1997:

	1998			1997		
	Unrestricted	Temporarily Restricted	Total	Unrestricted	Temporarily Restricted	Total
Revenues	$ 80,388,953	525,542	80,914,495	73,668,902	261,800	73,930,702
Net assets released from restrictions	137,894	(137,894)	-	179,155	(179,155)	-
Total revenues	80,526,847	387,648	80,914,495	73,848,057	82,645	73,930,702
Expenses Including income taxes	74,940,618	-	74,940,618	71,778,507	-	71,778,507
Change in net assets	5,586,229	387,648	5,973,877	2,069,550	82,645	2,152,195
Net assets at beginning of year	69,246,276	724,626	69,970,902	67,176,726	641,981	67,818,707
Net assets at end of year	$ 74,832,505	1,112,274	75,944,779	69,246,276	724,626	69,970,902

Temporarily restricted net assets are available for the following purposes:

	1998	1997
Trusts and endowments	$ 785,033	600,485
Awards	250,511	70,423
Education	62,736	42,423
Research	11,918	6,418
Access	2,076	4,877
	$ 1,112,274	724,626

Trusts and endowments include funds restricted by donors for periodontal research, public education in dental health and memorial commemoration.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1998 and 1997 (continued)

Net assets were released from donor restrictions by incurring expenses satisfying the restricted purposes as follows:

	1998	1997
Trusts and endowments	$ 6,000	-
Awards	100,831	126,655
Education	25,063	34,500
Research	-	18,000
Access	6,000	-
	$ 137,894	179,155

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1998 and 1997 (continued)

10. Expenses by Functional Classification

The following table summarizes the costs of providing various programs and activities on a functional basis:

	1998	1997
Administration and Policy	$ 8,240,354	7,171,725
Legal Affairs	2,114,928	2,081,944
Government Affairs	2,754,916	2,661,680
Communications	2,207,234	2,179,222
Membership and Dental Society Services	3,298,985	3,275,230
Conference and Meeting Services	5,567,567	4,809,407
Finance and Operations	2,588,734	2,365,596
Headquarters Building	3,290,419	3,488,415
Salable Materials	2,998,771	3,225,959
Central Administration	7,021,325	8,866,616
Information Technology	3,027,397	2,191,491
Dental Practice	3,424,827	3,278,187
Health Policy Resource Center	1,419,447	1,469,007
Education	5,665,302	5,082,605
Science	2,235,217	1,485,980
Grant to ADAHF from ADA	1,978,205	2,613,659
1997-1998 Carryforwards Expended	206,757	405,481
	58,040,385	56,652,204
Investment Account	2,000	980
Capital Improvement Account	765,386	744,833
Building Fund	915,162	796,872
ADA Online 2000 Project	2,083,146	827,290
Reserve Division Restricted Account	36,246	58,011
Eliminations of intercompany activity -		
Grant to ADAHF from ADA	(1,978,205)	(2,613,659)
Production Services Fee	(98,426)	(74,879)
ECCO miscellaneous sales	(22,500)	-
Interest expense – Operating Account	-	(35,931)
Overhead recovery	509,657	472,218
	60,252,851	56,827,939
ADAHF	4,743,482	5,509,951
ADREC	1,586,080	1,676,105
ADAHC (for-profit activities)	10,673,890	9,945,831
Eliminations of intercompany activity -		
Interest expense-FINCO	(21,350)	(21,350)
Legal expenses	(21,044)	(11,563)
Compass rent expense	(31,392)	(31,392)
ADAPCO, FINCO and ADREC rental charges	(272,270)	(238,418)
Overhead recovery and ADAPCO royalty	(1,209,629)	(1,118,596)
ADAPCO contract fee	(760,000)	(760,000)
	$ 74,940,618	71,778,507

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1998 and 1997 (continued)

11. Commitments and Contingencies

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.

12. Subsequent event

Effective on March 31, 1999, FINCO entered into agreements to terminate its relationship with Mellon Bank and approve the sale of its credit card portfolio to The Travelers Bank, USA, a Citigroup affiliate (The Travelers). These actions resulted from Mellon Bank's decision to sell its overall credit card business to The Travelers. In connection with the sale, FINCO received $7 million due to its ownership interest in the credit card portfolio and $1 million due to its acceptance of the new vendor. Additionally, the outstanding unpaid balance under the revolving credit agreement of $437,500 plus all unpaid accrued interest thereon was forgiven.

Effective on April 1, 1999, FINCO contracted with The Travelers to continue the credit card business under the ADA1PLAN. FINCO received an upfront payment of $2 million in connection with this action. In addition, the Association received a royalty payment of $1 million.

Use of these funds will include certain distributions to participating state dental societies or their related financial service subsidiaries that elect to continue participation in the ADA1PLAN. Additional uses of the proceeds are being considered by the FINCO Board of Directors.

The net revenue generated from the above transactions will be recognized in 1999 less related income taxes estimated at $3.2 million.

American Dental Association and Subsidiaries
Consolidating Statement of Financial Position
December 31, 1998

	General Fund													
	Operating Division						Reserve Division							
	Operating Account	Investment Account	Capital Improvement Account	Building Fund	ADA On-Line 2000	Total	Capital Formation Account	Restricted Account	Total General Fund	ADAHF	ADREC	ADAHC	Eliminations	Total
ASSETS														
Cash and cash equivalents	$ 5,561,322	-	-	-	-	5,561,322	-	-	5,561,322	514,640	121,774	1,455,416	-	7,653,152
Receivables, net	939,458	-	-	-	-	939,458	-	41,329	980,787	390,035	54,797	1,376,620	-	2,802,239
Due from (to) affiliates	(393,362)	-	521,420	(1,188,162)	(500,640)	(1,560,744)	2,504,598	525,985	1,469,839	(759,527)	(522,198)	(188,114)	-	-
Deferred taxes and income taxes receivable	828,698	-	-	-	-	828,698	-	-	828,698	-	-	166,972	-	995,670
Inventories, net	1,253,940	-	-	-	-	1,253,940	-	-	1,253,940	-	-	75,338	-	1,329,278
Marketable securities, at market	3,377,279	4,851,105	9,318,714	3,380,918	-	20,928,016	-	19,478,894	40,406,910	4,787,154	-	-	-	45,194,064
Investment in subsidiaries	-	-	-	-	-	-	4,338,158	-	4,338,158	-	-	-	(4,338,158)	-
Property and equipment, net	3,133,759	-	12,823,751	10,002,071	2,287,065	28,246,646	3,030,000	-	31,276,646	448,516	7,753,774	358,877	-	39,837,813
Funds held for deferred compensation	4,125,201	-	-	-	-	4,125,201	-	-	4,125,201	-	-	-	-	4,125,201
Prepaid expenses and other assets	1,621,282	-	-	-	-	1,621,282	-	-	1,621,282	-	184,481	86,998	(9,069)	1,883,692
Notes receivable	305,000	-	-	-	-	305,000	-	-	305,000	-	-	-	(305,000)	-
Total assets	$ 20,752,577	4,851,105	22,663,885	12,194,827	1,786,425	62,248,819	9,872,756	20,046,208	92,167,783	5,380,818	7,592,628	3,332,107	(4,652,227)	103,821,109
LIABILITIES AND NET ASSETS														
Liabilities:														
Accounts payable and accrued liabilities	$ 6,419,905	-	854,700	-	162,937	7,437,542	-	2,265,198	9,702,740	144,419	133,405	462,322	-	10,442,886
Accrued pension liability	555,947	-	-	-	-	555,947	-	-	555,947	-	-	-	-	555,947
Notes payable	-	-	-	-	-	-	-	-	-	-	4,968,000	742,500	(305,000)	5,405,500
Deferred revenues	6,214,228	-	-	-	-	6,214,228	-	-	6,214,228	852,219	-	280,349	-	7,346,796
Liability for deferred compensation	4,125,201	-	-	-	-	4,125,201	-	-	4,125,201	-	-	-	-	4,125,201
Total liabilities	17,315,281	-	854,700	-	162,937	18,332,918	-	2,265,198	20,598,116	996,638	5,101,405	1,485,171	(305,000)	27,876,330
Net Assets:														
Common stock	-	-	-	-	-	-	-	-	-	-	100	100,100	(100,200)	-
Additional paid-in capital	-	-	-	-	-	-	-	-	-	-	8,853,867	500,000	(9,353,867)	-
Unrestricted	3,437,296	4,851,105	21,809,185	12,194,827	1,623,488	43,915,901	9,872,756	17,781,010	71,569,667	3,271,906	(6,362,744)	1,246,836	5,106,840	74,832,505
Temporarily restricted	-	-	-	-	-	-	-	-	-	1,112,274	-	-	-	1,112,274
Total net assets	3,437,296	4,851,105	21,809,185	12,194,827	1,623,488	43,915,901	9,872,756	17,781,010	71,569,667	4,384,180	2,491,223	1,846,936	(4,347,227)	75,944,779
Total liabilities and net assets	$ 20,752,577	4,851,105	22,663,885	12,194,827	1,786,425	62,248,819	9,872,756	20,046,208	92,167,783	5,380,818	7,592,628	3,332,107	(4,652,227)	103,821,109

See accompanying report of independent certified public accountants.

American Dental Association and Subsidiaries
Consolidating Statement of Activities
Year Ended December 31, 1998

	General Fund													
	Operating Division						Reserve Division							
	Operating Account	Investment Account	Capital Improvement Account	Building Fund	ADA On-Line 2000	Total	Capital Formation Account	Restricted Account	Total General Fund	ADAHF	ADREC	ADAHC	Eliminations	Total
Revenues:														
Membership dues	$ 38,953,700	-	800	-	-	38,954,500	-	-	38,954,500	-	-	-	-	38,954,500
Advertising	126,400	-	-	-	-	126,400	-	-	126,400	-	-	7,971,479	-	8,097,879
Rental income	2,300,738	-	-	-	-	2,300,738	-	-	2,300,738	-	909,495	-	(303,660)	2,906,573
Publication and product sales	4,764,728	-	-	-	-	4,764,728	-	-	4,764,728	39,361	-	902,254	(120,926)	5,585,417
Subscriptions	184,477	-	-	-	-	184,477	-	-	184,477	-	-	479,996	-	664,473
Testing and accreditation fees	5,204,808	-	-	-	-	5,204,808	-	-	5,204,808	-	-	-	-	5,204,808
Meeting and seminar income	7,440,046	-	-	-	-	7,440,046	-	-	7,440,046	21,600	-	-	-	7,461,646
Grants and contributions	945,188	-	-	-	-	945,188	-	-	945,188	4,403,955	-	-	(1,978,205)	3,370,938
Royalties	813,367	-	-	-	-	813,367	-	-	813,367	980,376	-	1,449,696	(22,774)	3,220,665
Investment income	642,016	243,750	623,466	170,429	-	1,679,661	286,780	2,042,766	4,009,207	194,878	-	31,466	(308,130)	3,927,421
Other income	2,162,237	-	-	-	-	2,162,237	1	-	2,162,238	10,518	14,900	787,465	(1,454,946)	1,520,175
Total revenues	63,537,705	243,750	624,266	170,429	-	64,576,150	286,781	2,042,766	66,905,697	5,650,688	924,395	11,622,356	(4,188,641)	80,914,495
Expenses:														
Staff compensation, taxes and benefits	25,968,633	-	-	-	-	25,968,633	-	-	25,968,633	2,990,175	10,246	2,438,482	(199,332)	31,208,184
Printing, publication and marketing	7,140,756	-	-	-	-	7,140,756	-	-	7,140,756	48,725	100	5,825,262	(63,273)	12,951,570
Meeting expenses	3,081,015	-	-	-	-	3,081,015	-	-	3,081,015	75,442	-	46,376	-	3,202,833
Travel expenses	4,479,613	-	-	-	6,500	4,486,113	-	-	4,486,113	85,614	-	106,312	-	4,678,039
Professional services	6,153,635	2,000	2,000	2,000	1,361,107	7,520,742	-	36,246	7,556,988	262,401	53,333	160,928	(40,246)	7,993,404
Office expenses	4,188,064	-	-	-	220	4,188,284	-	-	4,188,284	210,655	4,829	271,004	(15,000)	4,659,772
Facility and utility expenses	2,735,232	-	-	-	-	2,735,232	-	-	2,735,232	-	473,078	269,584	(288,682)	3,189,232
Grants and awards	225,756	-	-	-	-	225,756	-	-	225,756	257,990	-	-	-	483,746
Grants to health related groups	1,978,205	-	-	-	-	1,978,205	-	-	1,978,205	-	-	-	(1,978,205)	-
Endorsement expenses	69,592	-	-	-	-	69,592	-	-	69,592	-	-	189,776	-	259,368
Depreciation and amortization	861,846	-	763,386	913,162	669,419	3,207,813	-	-	3,207,813	177,954	567,262	87,678	(3,298)	4,037,409
Interest expense	-	-	-	-	-	-	-	-	-	-	459,440	72,537	(21,350)	510,627
Other expenses	1,153,551	-	-	-	45,900	1,199,451	-	-	1,199,451	634,526	22,279	554,148	(1,295,793)	1,114,611
Total expenses	58,035,898	2,000	765,386	915,162	2,083,146	61,801,592	-	36,246	61,837,838	4,743,482	1,590,567	10,022,067	(3,905,159)	74,288,795
Increase (decrease) in net assets before income taxes	5,501,807	241,750	(141,120)	(744,733)	(2,083,146)	2,774,558	286,781	2,006,520	5,067,859	907,206	(666,172)	1,600,289	(283,482)	6,625,700
Income tax (expense) benefit	(4,487)	-	-	-	-	(4,487)	-	-	(4,487)	-	4,487	(651,823)	-	(651,823)
Increase (decrease) in net assets	5,497,320	241,750	(141,120)	(744,733)	(2,083,146)	2,770,071	286,781	2,006,520	5,063,372	907,206	(661,685)	948,466	(283,482)	5,973,877
Net assets at beginning of year	(2,945,891)	4,609,355	21,950,305	11,484,960	2,155,097	37,253,826	7,372,149	21,880,320	66,506,295	3,476,974	(5,701,059)	838,370	4,850,322	69,970,902
Equity transfer	885,867	-	-	1,454,600	1,551,537	3,892,004	2,213,826	(6,105,830)	-	-	-	-	-	-
Dividends	-	-	-	-	-	-	-	-	-	-	-	(540,000)	540,000	-
Net assets at end of year	$ 3,437,296	4,851,105	21,809,185	12,194,827	1,623,488	43,915,901	9,872,756	17,781,010	71,569,667	4,384,180	(6,362,744)	1,246,836	5,106,840	75,944,779

See accompanying report of independent certified public accountants.

Schedule 2

American Dental Association and Subsidiaries
Consolidating Statement of Cash Flows
Year Ended December 31, 1998

	General Fund													
	Operating Division						Reserve Division							
	Operating Account	Investment Account	Capital Improvement Account	Building Fund	ADA On-Line 2000	Total	Capital Formation Account	Restricted Account	Total General Fund	ADAHF	ADREC	ADAHC	Eliminations	Total
Cash flows from operating activities:														
Increase (decrease) in net assets	$ 5,497,320	241,750	(141,120)	(744,733)	(2,083,146)	2,770,071	286,781	2,006,520	5,063,372	907,206	(661,685)	948,466	(283,482)	5,973,877
Adjustments to reconcile increase (decrease) in net assets to net cash provided (used) by operating activities:														
Depreciation and amortization	861,846	-	763,386	913,162	669,419	3,207,813	-	-	3,207,813	177,954	567,262	87,678	(3,298)	4,037,409
Deferred income taxes	-	-	-	-	-	-	-	-	-	-	-	46,883	-	46,883
Unrealized depreciation (appreciation) in market value of marketable securities	-	-	-	-	-	-	-	380,554	380,554	-	-	-	-	380,554
Gain on sale of marketable securities	-	-	-	-	-	-	-	(2,033,013)	(2,033,013)	-	-	-	-	(2,033,013)
Equity in earnings of subsidiaries	-	-	-	-	-	-	(286,780)	-	(286,780)	-	-	-	286,780	-
Changes in assets and liabilities:														
Receivables, net	(161,326)	-	-	-	-	(161,326)	-	32,796	(128,530)	(269,976)	(1,389)	(64,824)	-	(464,719)
Income taxes receivable	-	-	-	-	-	-	-	-	-	-	-	55,940	-	55,940
Inventories, net	(98,491)	-	-	-	-	(98,491)	-	-	(98,491)	-	-	31,890	-	(66,601)
Prepaid expenses and other assets	216,310	-	-	-	-	216,310	-	-	216,310	61,730	(24,949)	41,627	-	294,718
Accounts payable and accrued liabilities	(1,168,351)	-	350,056	-	162,937	(655,358)	-	577,771	(77,587)	(1,499)	23,329	(278,957)	-	(334,714)
Accrued pension liability	(383,218)	-	-	-	-	(383,218)	-	-	(383,218)	-	-	-	-	(383,218)
Deferred revenues	280,181	-	-	-	-	280,181	-	-	280,181	303,398	-	52,968	-	636,547
Net cash provided (used) by operating activities	5,044,271	241,750	972,322	168,429	(1,250,790)	5,175,982	1	964,628	6,140,611	1,178,813	(97,432)	921,671	-	8,143,663
Cash flows from investing activities:														
Purchase of marketable securities	(5,139,330)	(241,750)	(624,299)	(1,623,030)	-	(7,628,409)	-	(13,420,787)	(21,049,196)	(25,971,562)	-	-	-	(47,020,758)
Sale and maturity of marketable securities	2,002,000	-	4,414,381	834,747	-	7,251,128	-	18,552,583	25,803,711	24,520,300	-	-	-	50,324,011
Investment in subsidiary	-	-	-	-	-	-	(2,213,826)	-	(2,213,826)	-	-	-	2,213,826	-
Due from/to affiliated organizations	-	-	(521,129)	-	-	(521,129)	(540,001)	9,406	(1,051,724)	-	-	-	1,051,724	-
Acquisitions of property, equipment	(1,078,163)	-	(4,241,275)	(1,458,495)	(474,937)	(7,252,870)	-	-	(7,252,870)	(61,789)	(401,612)	(52,861)	-	(7,769,132)
Net cash provided (used) by investing activities	(4,215,493)	(241,750)	(972,322)	(2,246,778)	(474,937)	(8,151,280)	(2,753,827)	5,141,202	(5,763,905)	(1,513,051)	(401,612)	(52,861)	3,265,550	(4,465,879)
Cash flows from financing activities:														
Due from/to affiliated organizations	(300,955)	-	-	623,749	174,190	496,984	-	-	496,984	650,414	(6,475)	(89,199)	(1,051,724)	-
Principal repayment on notes payable	-	-	-	-	-	-	-	-	-	-	(1,656,000)	(262,500)	-	(1,918,500)
Additional investment from ADA	-	-	-	-	-	-	-	-	-	-	2,213,826	-	(2,213,826)	-
Receipt (payment) of dividends	-	-	-	-	-	-	540,000	-	540,000	-	-	(540,000)	-	-
Net cash provided (used) by financing activities	(300,955)	-	-	623,749	174,190	496,984	540,000	-	1,036,984	650,414	551,351	(891,699)	(3,265,550)	(1,918,500)
Net increase (decrease) in cash and cash equivalents	527,823	-	-	(1,454,600)	(1,551,537)	(2,478,314)	(2,213,826)	6,105,830	1,413,690	316,176	52,307	(22,889)	-	1,759,284
Cash and cash equivalents at beginning of year	4,147,632	-	-	-	-	4,147,632	-	-	4,147,632	198,464	69,467	1,478,305	-	5,893,868
Equity transfers	885,867	-	-	1,454,600	1,551,537	3,892,004	2,213,826	(6,105,830)	-	-	-	-	-	-
Cash and cash equivalents at end of year	$ 5,561,322	-	-	-	-	5,561,322	-	-	5,561,322	514,640	121,774	1,455,416	-	7,653,152

See accompanying report of independent certified public accountants.

Schedule 3

Report of Independent Certified Public Accountants

The Board of Directors
American Dental Association Health Foundation

We have audited the accompanying statements of financial position of American Dental Association Health Foundation as of December 31, 1998 and 1997, and the related statements of activities, 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 and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States. 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, 1998 and 1997 and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

In accordance with *Government Auditing Standards*, we have also issued our report dated April 2, 1999 on our consideration of American Dental Association Health Foundation's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts and grants.

Our audit was conducted for the purpose of forming an opinion on the basic financial statements taken as a whole of American Dental Association Health Foundation as of and for the years ended December 31, 1998 and 1997. The Statement of Activities by Fund is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

Grant Thornton LLP

GRANT THORNTON LLP

Chicago, Illinois
April 2, 1999

American Dental Association Health Foundation

Statements of Financial Position

December 31, 1998 and 1997

	1998	1997
ASSETS		
Cash	$ 514,640	198,464
Unbilled contract revenues and reimbursable grant expenses	390,035	120,059
Prepaid expenses	-	61,730
Marketable securities, at market (Note 2)	4,787,154	3,335,892
Furniture and equipment, net (Note 3)	448,516	564,681
TOTAL ASSETS	$ 6,140,345	4,280,826
LIABILITIES AND NET ASSETS		
Liabilities:		
Accounts payable and accrued liabilities	$ 144,419	145,918
Due to American Dental Association (Note 9)	759,527	109,113
Deferred revenues (Note 4)	852,219	548,821
TOTAL LIABILITIES	1,756,165	803,852
Net assets:		
Unrestricted	3,271,906	2,752,348
Temporarily restricted (Note 6)	1,112,274	724,626
TOTAL NET ASSETS	4,384,180	3,476,974
TOTAL LIABILITIES AND NET ASSETS	$ 6,140,345	4,280,826

See accompanying notes to financial statements.

American Dental Association Health Foundation

Statements of Activities

Years Ended December 31, 1998 and 1997

	1998			1997		
	Unrestricted	Temporarily Restricted	Total	Unrestricted	Temporarily Restricted	Total
REVENUE						
Government contracts and grants	$1,532,543	-	1,532,543	1,620,955	-	1,620,955
Royalties	980,376	-	980,376	636,065	-	636,065
Other grants and contributions	404,227	488,980	893,207	529,087	229,459	758,546
American Dental Association grant (Note 9)	1,978,205	-	1,978,205	2,613,659	-	2,613,659
Investment income, net	158,316	36,562	194,878	141,813	32,341	174,154
Other income	10,518	-	10,518	-	-	-
Publication and product sales	39,361	-	39,361	14,000	-	14,000
Meeting and seminar income	21,600	-	21,600	40,273	-	40,273
Net assets released from restrictions (Note 7)	137,894	(137,894)	-	179,155	(179,155)	-
TOTAL REVENUE	5,263,040	387,648	5,650,688	5,775,007	82,645	5,857,652
EXPENSES (Note 8)						
Staff compensation, taxes and benefits (Note 9)	2,990,175	-	2,990,175	3,469,277	-	3,469,277
Printing, publication & marketing	48,725	-	48,725	55,088	-	55,088
Meeting expenses	75,442	-	75,442	42,912	-	42,912
Travel expenses	85,614	-	85,614	114,447	-	114,447
Professional services	262,401	-	262,401	349,365	-	349,365
Laboratory and office expenses	210,655	-	210,655	244,389	-	244,389
Grants and awards	257,990	-	257,990	309,542	-	309,542
Depreciation	177,954	-	177,954	152,469	-	152,469
Other expenses, including indirect costs (Note 9)	634,526	-	634,526	772,462	-	772,462
TOTAL EXPENSES	4,743,482	-	4,743,482	5,509,951	-	5,509,951
Increase in net assets	519,558	387,648	907,206	265,056	82,645	347,701
Net assets at beginning of year	2,752,348	724,626	3,476,974	2,487,292	641,981	3,129,273
Net assets at end of year	$3,271,906	1,112,274	4,384,180	2,752,348	724,626	3,476,974

See accompanying notes to financial statements.

American Dental Association Health Foundation

Statements of Cash Flows

Years Ended December 31, 1998 and 1997

	1998	1997
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase in net assets	$ 907,206	347,701
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation	177,954	152,469
Changes in assets and liabilities:		
Unbilled contract revenues and reimbursable grant expenses	(269,976)	23,731
Prepaid expenses	61,730	(54,780)
Accounts payable and accrued liabilities	(1,499)	(20,214)
Deferred revenues	303,398	(94,278)
Net cash provided by operating activities	1,178,813	354,629
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of marketable securities	(25,971,562)	(26,080,840)
Sale and maturity of marketable securities	24,520,300	25,907,800
Acquisition of equipment	(61,789)	(239,256)
Net cash used in investing activities	(1,513,051)	(412,296)
NET CASH PROVIDED (USED) BY FINANCING ACTIVITIES		
Net increase (decrease) in due to American Dental Association	650,414	(125,420)
Net increase (decrease) in cash	316,176	(183,087)
Cash at beginning of year	198,464	381,551
Cash at end of year	$ 514,640	198,464

See accompanying notes to financial statements.

American Dental Association Health Foundation

Notes to Financial Statements, December 31, 1998 and 1997

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 is an Illinois not-for-profit corporation.

Use of Estimates: In preparing financial statements in conformity with generally accepted accounting principles, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Cash: The Foundation maintains its cash balance in two financial institutions which at times may exceed federally insured limits. The Foundation has not experienced any losses in such account and believes it is not exposed to any significant credit risk on cash.

Marketable Securities: Marketable securities are carried at fair value and are available for current use. The fair values of the marketable securities are estimated based on quotes from brokers or current rates offered for instruments with similar characteristics.

Revenue Recognition: Contributions, which are defined as nonreciprocal transfers, are recognized as revenues in the period pledged and classified according to the existence or absence of donor-imposed restrictions. When a donor restriction has been satisfied by incurring expenses consistent with the designated purpose, temporarily restricted net assets are reclassified to unrestricted net assets for reporting of related expenses.

Corporate grants that do not constitute contributions are recognized as income when costs of the related programs or projects are incurred. Corporate grants received but not yet expended are reported as deferred revenues.

Contributed Facilities: The Foundation occupies without charge certain premises located in government-owned research facilities. No amounts have been reflected in the financial statements for their use as no objective basis is available to measure the value of such facilities.

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 five to ten years.

Net Assets: Net assets subject to donor-imposed stipulations are classified as temporarily or permanently restricted net assets while net assets not subject to such restrictions are classified as unrestricted net assets.

Reclassifications: Certain 1997 amounts have been reclassified to conform to the 1998 presentation.

2. Marketable Securities

Marketable securities at December 31, 1998 and 1997 consisted of the following:

	1998		1997	
	Cost	Market	Cost	Market
Certificates of deposit	$ 4,787,154	4,787,154	3,335,892	3,335,892

American Dental Association Health Foundation

Notes to Financial Statements, December 31, 1998 and 1997 (continued)

3. Furniture and Equipment

Furniture and equipment at December 31, 1998 and 1997 consisted of the following:

	1998	1997
Furniture and equipment	$ 1,229,743	1,167,954
Less accumulated depreciation	781,227	603,273
	$ 448,516	564,681

4. Changes in Deferred Revenues

The following represents changes in deferred revenues:

	1998	1997
Balances at beginning of year	$ 548,821	643,099
Additions – grants	680,958	334,271
Deductions - funds expended during the year	(377,560)	(428,549)
Balances at end of year	$ 852,219	548,821

5. Income Taxes

The Foundation has received a favorable determination letter from the Internal Revenue Service stating that it 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 1998 or 1997 and therefore a provision for income taxes was not required.

6. Temporarily Restricted Net Assets

Temporarily restricted net assets at December 31, 1998 and 1997 are available for the following purposes:

	1998	1997
Trusts and endowments	$ 785,033	600,485
Awards	250,511	70,423
Education	62,736	42,423
Research	11,918	6,418
Access	2,076	4,877
	$ 1,112,274	724,626

Trusts and endowments include funds restricted by donors for periodontal research, public education in dental health and memorial commemoration.

American Dental Association Health Foundation

Notes to Financial Statements, December 31, 1998 and 1997 (continued)

7. Net Assets Released from Donor Restrictions

Net assets were released from donor restrictions by incurring expenses satisfying the restricted purposes as follows:

	1998	1997
Trusts and endowments	$ 6,000	-
Awards	100,831	126,655
Education	25,063	34,500
Research	-	18,000
Access	6,000	-
	$ 137,894	179,155

8. Expenses by Functional Classification

The following table summarizes the costs of providing various programs or activities on a functional basis:

	1998	1997
Association sponsored research	$ 1,624,676	2,087,273
Federal government sponsored research	1,520,957	1,599,213
Corporate and donor sponsored programs relating to research, education, access and awards	941,364	1,019,610
Fundraising	189,477	283,394
Administrative and general	467,008	520,461
	$ 4,743,482	5,509,951

9. 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 $1,978,205 and $2,613,659 in 1998 and 1997, respectively. The Foundation receives financial and administrative services from the Association as may be required. In 1998 and 1997, the Foundation paid $677,198 and $633,905, respectively, for such services.

The Association sponsors a noncontributory defined benefit pension plan and a savings and retirement plan which cover substantially all employees of the Association and its subsidiaries meeting certain eligibility requirements. Pension expense charges are allocated to the Foundation in connection with its employees' participation in the Association's retirement plans. These expenses, which amounted to approximately $315,000 and $240,000 for 1998 and 1997, respectively, are based upon the actual cash contributions made by the Association to the plans for the benefit of Foundation employees.

Additionally, the Association sponsors a contributory defined benefit postretirement health plan, which covers substantially all employees of the Association and its subsidiaries. The Foundation expensed postretirement benefit charges of $68,679 and $74,690 for 1998 and 1997, respectively, associated with participating Foundation employees.

Periodically, expenses of one organization may be paid by an affiliated organization and subsequently reimbursed.

American Dental Association Health Foundation

Statement of Activities by Fund

Year Ended December 31, 1998

	ADA Sponsored	Federal Government Sponsored	Corporate and Donor Sponsored	Eliminations	Total
REVENUE					
Government contracts and grants	$ -	1,532,543	-	-	1,532,543
Royalties	-	-	980,376	-	980,376
Other grants and contributions	-	-	893,207	-	893,207
American Dental Association grant	1,978,205	-	-	-	1,978,205
Investment Income	2,254	-	192,624	-	194,878
Publication and product sales	-	-	39,361	-	39,361
Meeting and seminar income	-	-	21,600	-	21,600
Other Income	125,000	-	10,518	(125,000)	10,518
TOTAL REVENUE	$ 2,105,459	1,532,543	2,137,686	(125,000)	5,650,688
EXPENSES					
Staff compensation, taxes and benefits	$ 1,842,340	903,685	244,150	-	2,990,175
Printing, publication and marketing	33,203	3,424	12,098	-	48,725
Meeting expenses	10,751	4,085	60,606	-	75,442
Travel expenses	27,607	17,684	40,323	-	85,614
Professional services	145,799	59,868	181,734	(125,000)	262,401
Laboratory and office expenses	40,889	53,056	116,710	-	210,655
Grants and awards	-	-	257,990	-	257,990
Depreciation	7,486	34,879	135,589	-	177,954
Other expenses including indirect costs	2,616	479,156	152,754	-	634,526
	2,110,691	1,555,837	1,201,954	(125,000)	4,743,482
Increase (decrease) in net assets	(5,232)	(23,294)	935,732	-	907,206
Net assets at beginning of year	126,692	85,114	3,265,168	-	3,476,974
Net assets at end of year	$121,460	61,820	4,200,900	-	4,384,180

See accompanying notes to financial statements.

SCHEDULE 1

Report of Independent Certified Public Accountants

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, 1998 and 1997 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, 1998 and 1997 and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

Grant Thornton LLP

GRANT THORNTON LLP

Chicago, Illinois
April 2, 1999

American Dental Real Estate Corporation

(A wholly-owned subsidiary of American Dental Association)

Balance Sheets

December 31, 1998 and 1997

	1998	1997
ASSETS		
Cash and cash equivalents	$ 121,774	69,467
Receivables	54,797	53,408
Prepaid expenses and other assets	184,481	159,532
Building, equipment and tenant leasehold improvements, net (Note 2)	7,753,774	7,919,424
TOTAL ASSETS	$ 8,114,826	8,201,831
LIABILITIES AND STOCKHOLDER'S EQUITY		
Liabilities:		
Accounts payable and accrued liabilities	$ 133,405	110,076
Due to American Dental Association	522,198	528,673
Notes payable (Note 4)	4,968,000	6,624,000
TOTAL LIABILITIES	5,623,603	7,262,749
Stockholder's equity:		
Common stock, $1 par value; authorized 1,000 shares; issued and outstanding 100 shares	100	100
Additional paid-in capital (Note 5)	8,853,867	6,640,041
Accumulated deficit	(6,362,744)	(5,701,059)
TOTAL STOCKHOLDER'S EQUITY	2,491,223	939,082
TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY	$ 8,114,826	8,201,831

See accompanying notes to financial statements.

American Dental Real Estate Corporation

(A wholly-owned subsidiary of American Dental Association)

Statements of Revenues, Expenses and Accumulated Deficit

Years Ended December 31, 1998 and 1997

	1998	1997
REVENUES		
Rental income	$ 909,495	847,798
Other income	14,900	17,150
TOTAL REVENUES	924,395	864,948
EXPENSES		
Staff compensation, taxes and benefits	10,246	12,769
Facility costs, including utilities	473,078	509,323
Professional services	53,333	50,004
Office expenses	4,829	6,928
Printing, publications and marketing	100	-
Depreciation and amortization	567,262	491,287
Interest expense	459,440	565,406
Other expenses	22,279	40,388
TOTAL EXPENSES	1,590,567	1,676,105
Excess of expenses over revenues before income tax benefit	(666,172)	(811,157)
Income tax benefit (Note 3)	4,487	-
Excess of expenses over revenues	(661,685)	(811,157)
Accumulated deficit at beginning of year	(5,701,059)	(4,889,902)
Accumulated deficit at end of year	$ (6,362,744)	(5,701,059)

See accompanying notes to financial statements.

American Dental Real Estate Corporation

(A wholly-owned subsidiary of American Dental Association)

Statements of Cash Flows

Years Ended December 31, 1998 and 1997

	1998	1997
CASH FLOWS FROM OPERATING ACTIVITIES:		
Excess of expenses over revenues	$ (661,685)	(811,157)
Adjustments to reconcile excess of expenses over revenues to net cash used by operating activities:		
Depreciation and amortization	567,262	491,287
Changes in assets and liabilities:		
Receivables	(1,389)	(19,228)
Prepaid expenses and other assets	(24,949)	16,706
Accounts payable and accrued liabilities	23,329	(14,939)
Net cash used by operating activities	(97,432)	(337,331)
NET CASH USED BY INVESTING ACTIVITIES:		
Acquisition of building, equipment and tenant leasehold improvements	(401,612)	(197,461)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Principal repayment on notes payable (Note 4)	(1,656,000)	(1,656,000)
Additional investment from American Dental Association (Note 5)	2,213,826	2,395,089
Net change in due to American Dental Association	(6,475)	(311,290)
Net cash provided by financing activities	551,351	427,799
Net increase (decrease) in cash and cash equivalents	52,307	(106,993)
Cash and cash equivalents at beginning of year	69,467	176,460
Cash and cash equivalents at end of year	$ 121,774	69,467
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION:		
Cash paid during the year for interest	$ 459,440	565,406

See accompanying notes to financial statements.

American Dental Real Estate Corporation

(A wholly-owned subsidiary of American Dental Association)

Notes to Financial Statements, December 31, 1998 and 1997

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 the Association's Washington, DC Office building, collecting rental income thereon, and remitting the net income to the Association. ADREC intends to hold the property for continued use.

Use of Estimates: In preparing financial statements in conformity with generally accepted accounting principles, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Cash Equivalents: Cash equivalents at December 31, 1998 and 1997 consist of deposits under overnight repurchase agreements which are carried at their fair value.

Building, Equipment and Tenant Leasehold Improvements: Building, equipment and tenant 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. Tenant 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 1997 amounts have been reclassified to conform to the 1998 presentation.

2. Building, Equipment, and Tenant Leasehold Improvements

Building, equipment and tenant leasehold improvements at December 31, 1998 and 1997 consisted of the following:

	1998	1997
Building	$ 9,602,195	9,602,195
Building improvements	385,786	385,786
Building equipment	1,040,868	723,088
Tenant leasehold improvements	425,122	342,290
	11,453,971	11,053,359
Less accumulated depreciation and amortization	3,700,197	3,133,935
	$ 7,753,774	7,919,424

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 $773,510 in 1999, $668,944 in 2000, $555,767 in 2001, $434,756 in 2002, $340,208 in 2003 and $138,841 thereafter. These amounts may change upon renewal of the leases.

American Dental Real Estate Corporation

(A wholly-owned subsidiary of American Dental Association)

Notes to Financial Statements, December 31, 1998 and 1997 (continued)

3. Income Taxes

ADREC has received a favorable determination letter from the Internal Revenue Service stating that it is exempt from taxation on income related to its exempt purpose under Section 501(c)(2) of the Internal Revenue Code. No federal or state income taxes were owed on unrelated business activities in 1998 or 1997 as such operations generated losses.

ADREC's non-exempt operating results are included in the income tax returns 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 income tax returns. ADREC recorded an income tax benefit of $4,487 in 1998 under this arrangement. ADREC recorded no payment under this agreement for 1997 due to the Association's inability to use the tax benefits generated to offset current income taxes.

As of December 31, 1998, ADREC had net operating loss carryforwards totaling approximately $2,324,300 available to offset future unrelated business taxable income, expiring as follows: $136,300 in 2007, $194,700 in 2008, $277,200 in 2009, $356,900 in 2010, $479,900 in 2011, $590,900 in 2012, and $288,400 in 2013. Because of uncertainty of realization, management has established a valuation allowance to fully offset the related deferred tax assets of approximately $790,300 and $695,400 at December 31, 1998 and 1997, respectively.

4. Notes Payable

In February 1989, ADREC purchased the building constructed on land owned by the Association for $9,500,000. The mortgage loan was refinanced during 1993 by issuing notes of ADREC.

The notes payable at December 31, 1998 and 1997 consisted of the following:

	1998	1997
LONG-TERM NOTES PAYABLE		
7.79% Guaranteed Senior Notes, due February 1, 2005, with monthly interest payments on the unpaid principal balance. Annual principal payments of $920,000 commencing February 1, 1996 through maturity. Guaranteed by the Association.	$4,968,000	$ 6,624,000

The note agreement requires, among other things, that the combined ADA group (excluding the American Dental Association Health Foundation) maintain a cash flow to debt factor of at least .30 and a cash flow to debt-service factor of at least 1.5. The agreement also contains certain other restrictions related to corporate structure, insurance, building condition, assumption of additional debt, and transactions with affiliates. The Company has complied with restrictions and limitations included in the provisions of the loan agreement.

On February 1, 1999, 1998 and 1997, through additional investments by the Association, the annual principal payments were made in the amount of $1,656,000, consisting of the scheduled payment of $920,000, plus an additional payment of $736,000 for each year. These additional payments evidence ADREC's intent to retire the notes payable on an accelerated basis by 2001 instead of the remaining scheduled term ending in 2004. Prepayment penalties of $82,308, $61,678 and $38,644 in 1999, 1998 and 1997, respectively, were assessed on these additional payments.

American Dental Real Estate Corporation

(A wholly-owned subsidiary of American Dental Association)

Notes to Financial Statements, December 31, 1998 and 1997 (continued)

5. Additional Paid-In Capital

During 1998, the Association made an additional investment of $2,213,826 in ADREC. This investment satisfied the Association's commitments to fund ADREC's 1997 cash flow losses of $496,148 and its 1998 scheduled and additional note principal repayments (plus prepayment penalty) totaling $1,717,678.

During 1997, the Association made an additional investment of $2,395,089 in ADREC. This investment satisfied the Association's commitments to fund ADREC's 1996 cash flow losses of $700,445 and its 1997 scheduled and additional note principal repayments (plus prepayment penalty) totaling $1,694,644.

6. Transactions With Related Parties

The Association occupies approximately 17% of space in the building owned by ADREC. The building owned by ADREC is situated on land owned by the Association. A nominal rental is exchanged in connection with these arrangements.

Periodically, expenses of one organization may be paid by an affiliated organization and subsequently reimbursed.

7. Liquidity

During 1998 and 1997, ADREC sustained significant operating deficits. The ability of ADREC to continue operating the rental property is dependent upon receipt of additional advances and capital investment from the Association, to cover working capital requirements, capital improvements and debt service as necessary. The Association intends to provide funds to allow ADREC to meet its 1999 funding and operational needs.

Report of Independent Certified Public Accountants

The Board of Directors and Stockholder
ADA Holding Company, Inc.

We have audited the accompanying consolidated balance sheets of ADA Holding Company, Inc. (a wholly-owned subsidiary of American Dental Association) and subsidiaries as of December 31, 1998 and 1997, and the related consolidated statements of operations 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 consolidated financial position of ADA Holding Company, Inc. and subsidiaries as of December 31, 1998 and 1997, and the consolidated results of their operations and their consolidated cash flows for the years then ended in conformity with generally accepted accounting principles.

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole of the ADA Holding Company, Inc. and subsidiaries. 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. Such information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the 1998 consolidated financial statements taken as a whole.

Grant Thornton LLP

GRANT THORNTON LLP

Chicago, Illinois
April 2, 1999

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Consolidated Balance Sheets

December 31, 1998 and 1997

	1998	1997
ASSETS		
Cash and cash equivalents	$ 1,455,416	1,478,305
Receivables, net of allowance for doubtful accounts of $76,432 in 1998 and $73,170 in 1997	1,376,620	1,311,796
Deferred taxes and income taxes receivable (Note 3)	166,972	269,795
Inventory	75,338	107,228
Furniture and equipment, net (Note 2)	358,877	384,619
Other assets, net	86,998	137,700
TOTAL ASSETS	$ 3,520,221	3,689,443
LIABILITIES AND STOCKHOLDER'S EQUITY		
Liabilities:		
Accounts payable and accrued liabilities	$ 462,322	741,279
Notes payable, Mellon Bank (Notes 4 and 7)	437,500	700,000
Note payable, affiliate (Note 5)	305,000	305,000
Due to American Dental Association (Note 5)	188,114	277,313
Deferred revenues	280,349	227,381
TOTAL LIABILITIES	1,673,285	2,250,973
Stockholder's Equity:		
Common stock, $1 par value; Authorized 101,000 shares; issued and outstanding 100,100 shares	100,100	100,100
Additional paid-in capital	500,000	500,000
Retained earnings	1,246,836	838,370
TOTAL STOCKHOLDER'S EQUITY	1,846,936	1,438,470
TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY	$ 3,520,221	3,689,443

See accompanying notes to consolidated financial statements.

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Consolidated Statements of Operations and Retained Earnings

Years Ended December 31, 1998 and 1997

	1998	1997
REVENUES		
Advertising, including classified ads	$ 7,971,479	7,587,690
Subscriptions	479,996	619,566
Publishing fees (Note 5)	760,000	760,000
Publication and product sales	902,254	388,813
Royalties and service fees	1,449,696	1,147,842
Investment income	31,466	17,887
Other income	27,465	14,269
TOTAL REVENUES	11,622,356	10,536,067
EXPENSES		
Staff compensation, taxes and benefits (Note 5)	2,438,462	2,266,875
Printing, publication and marketing expenses	5,825,262	5,773,714
Endorsement costs (Note 6)	189,776	173,427
Professional services	160,928	143,386
Facility and utility costs	269,584	237,431
Office expense	271,004	217,470
Meeting expenses	46,376	30,052
Travel expenses	106,312	88,702
Depreciation and amortization	87,678	82,218
Interest expense (Note 5)	72,537	83,913
Other expenses, including allocated general and administrative expenses (Note 5)	554,148	515,580
TOTAL EXPENSES	10,022,067	9,612,768
Income before income tax expense	1,600,289	923,299
Income tax expense (Note 3)	(651,823)	(333,063)
Net income	948,466	590,236
Retained earnings at beginning of year	838,370	248,134
Dividends paid	(540,000)	-
Retained earnings at end of year	$ 1,246,836	838,370

See accompanying notes to consolidated financial statements.

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Consolidated Statements of Cash Flows

Years Ended December 31, 1998 and 1997

	1998	1997
CASH FLOWS FROM OPERATING ACTIVITIES		
Net income	$ 948,466	590,236
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	87,678	82,218
Deferred income taxes	46,883	14,510
Changes in assets and liabilities:		
Receivables, net	(64,824)	20,575
Income taxes receivable	55,940	76,553
Inventory	31,890	(36,569)
Other assets, net	41,627	(27,823)
Accounts payable and accrued liabilities	(278,957)	278,748
Deferred revenues	52,968	(19,218)
Net cash provided by operating activities	921,671	979,230
CASH FLOWS USED BY INVESTING ACTIVITIES		
Acquisitions of furniture and equipment	(52,861)	(81,993)
CASH FLOWS FROM FINANCING ACTIVITIES		
Principal repayment on notes payable, Mellon Bank	(262,500)	-
Net change in due to American Dental Association	(89,199)	(432,013)
Payment of dividends	(540,000)	-
Net cash used by financing activities	(891,699)	(432,013)
Net (decrease) increase in cash and cash equivalents	(22,889)	465,224
Cash and cash equivalents at beginning of year	1,478,305	1,013,081
Cash and cash equivalents at end of year	$ 1,455,416	1,478,305
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid during the year for		
Income taxes	$ 549,000	242,000
Interest	$ 51,187	62,563

See accompanying notes to consolidated financial statements.

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Notes to Consolidated Financial Statements, December 31, 1998 and 1997

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.

The accompanying consolidated financial statements include the accounts of ADAHC and its wholly-owned subsidiaries, ADA Publishing Co., Inc. (ADAPCO), ADA Financial Services Co., (FINCO), and ADA Electronic Commerce Co. (ECCO). ADAPCO performs certain publishing functions for the publications of the Association, including *JADA* and *ADA News*. FINCO offers a range of financial services to Association members in conjunction with Mellon Bank, N.A. under the title of ADA1 PLAN. ECCO offers a range of electronic data transmission services to Association members. All significant intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates: In preparing financial statements in conformity with generally accepted accounting principles, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Cash Equivalents: Cash equivalents at December 31, 1998 and 1997 consist of interest bearing deposits under overnight repurchase agreements, which are carried at their fair value. FINCO and ADAPCO each maintain their cash balances in financial institutions which at time may exceed federally insured limits. FINCO and ADAPCO have not experienced any losses in such accounts and believe they are not exposed to any significant credit risk on cash.

Inventory: Inventory, consisting of CD-ROM products, books and accumulated book production costs, is carried at the lower of cost or market (net realizable value). Cost is determined using the average unit cost method.

Furniture and Equipment: Furniture and equipment are stated at cost less accumulated depreciation. Depreciation is computed on the straight-line method over five to ten years, the estimated useful lives of the assets.

Other Assets: Postage deposits established in connection with ADAPCO's publishing operations are expensed as publications are mailed. Costs incurred in the establishment of FINCO and ECCO have been capitalized and are being amortized on the straight-line method over respective 60-month periods.

Revenue and Expense Recognition: Subscriptions to periodicals are recognized as revenue over the terms of the subscriptions. Subscriptions paid in advance are recorded as deferred revenue. Advertising revenue and direct publication costs are recognized in the period the related publication is issued. Endorsement costs are recognized when conditions for their accrual under the agreements with participating state societies or their subsidiaries are satisfied.

Income Taxes: Deferred taxes are established for temporary differences between the financial reporting basis and the tax basis of assets and liabilities, based upon enacted tax rates which would apply during the period in which taxes became payable or recoverable, and the adjustment of cumulative deferred taxes for any changes in the tax rate.

Reclassifications: Certain 1997 amounts have been reclassified to conform to the 1998 presentation.

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Notes to Consolidated Financial Statements, December 31, 1998 and 1997 (continued)

2. Furniture and Equipment

Furniture and equipment at December 31, 1998 and 1997 consisted of the following:

	1998	1997
Furniture and equipment	$ 809,392	756,531
Less accumulated depreciation	450,515	371,912
	$ 358,877	384,619

3. Income Taxes

ADAHC files consolidated income tax returns with its wholly-owned subsidiaries.

Income tax expense for the years ended December 31, 1998 and 1997, is as follows:

	1998	1997
Current:		
Federal	$ (494,274)	(256,913)
State	(110,666)	(61,640)
Current income tax expense	(604,940)	(318,553)
Deferred:		
Federal	(42,652)	(11,946)
State	(4,231)	(2,564)
Deferred income tax expense	(46,883)	(14,510)
Total income tax expense	$ (651,823)	(333,063)

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, 1998 and 1997, as follows:

	1998	1997
Statutory federal income tax	$ (544,098)	(313,922)
State income taxes	(77,102)	(44,485)
Other, net	(30,623)	25,344
Income tax expense	$ (651,823)	(333,063)

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Notes to Consolidated Financial Statements, December 31, 1998 and 1997 (continued)

Deferred taxes and income taxes receivable at December 31, 1998 and 1997 consisted of:

	1998	1997
Deferred tax assets resulting from:		
Start-up expenses	$ 43,421	78,159
Alternative minimum tax credits	-	22,944
Excess of tax basis over book basis of receivables, net	27,735	29,381
Excess of tax basis over book basis of post-retirement health benefits	43,121	29,921
	114,277	160,405
Deferred tax liability resulting from excess of book basis over tax basis of furniture and equipment, net	(88,180)	(87,425)
Deferred tax assets, net	26,097	72,980
Federal and state income taxes receivable	140,875	196,815
	$ 166,972	269,795

4. Notes Payable, Mellon Bank

On June 24, 1996, FINCO entered into a revolving line of credit agreement with Mellon Bank, N.A. Advances under the agreement are evidenced by promissory notes and collateralized by ADA1 Plan revenues. Draw privileges under the agreement expired June 24, 1997.

The notes payable at December 31, 1998 and 1997 consisted of the following:

	1998	1997
$1,750,000 Revolving Credit Agreement dated June 24, 1996, due December 31, 1999; interest free through December 31, 1996, with interest thereafter at an average daily prime rate plus ½% payable quarterly on outstanding balances; principal payable from program revenues in eight equal quarterly installments commencing March 31, 1998 through maturity.	$ 437,500	700,000

The fourth quarterly installment of $87,500 was unpaid at December 31,1998 pending negotiation for forgiveness of the entire balance, as described in Note 7.

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 $474,521 and $438,339 during the years ended December 31, 1998 and 1997, respectively.

The Association sponsors a noncontributory defined benefit pension plan and a savings and retirement plan which cover substantially all employees of the Association and its subsidiaries meeting certain eligibility requirements. In addition to the allocated expenses described above are pension expense charges associated with ADAHC and its subsidiaries' employees who are participants in the Association's retirement plans. These expenses, which amounted to $198,552 and $165,000 in 1998 and 1997, 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.

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Notes to Consolidated Financial Statements, December 31, 1998 and 1997 (continued)

Additionally, the Association sponsors a contributory defined postretirement health plan which covers substantially all employees of the Association and its subsidiaries. ADAHC expensed postretirement benefit charges of $35,061 and $37,780 for the years ended December 31, 1998 and 1997, respectively, associated with participating employees .

The Association also leases equipment and office space to ADAPCO and office space to FINCO. Rent expense under these leases amounted to $272,268 and $238,418 during 1998 and 1997, respectively. The office space leases total $21,033 a month. The ADAPCO lease is on a month-to-month basis. The FINCO lease expires September 30, 2006. Minimum future rentals to be paid for equipment leased under non-cancelable operating leases currently in effect are $15,000 for each year through 1999.

Periodically, expenses of one organization may be paid by an affiliated organization and subsequently reimbursed.

Effective January 1, 1990, the Association and ADA Publishers, Inc., a predecessor corporation to ADAPCO, entered into a publishing agreement which has been assigned to ADAPCO. 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, ADAPCO performs all publishing and distribution functions related to the Association's two major publications and may include new publications 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 ADAPCO. Under the terms of the agreement, the Association paid publishing fees in the amount of $760,000 during the years ended December 31, 1998 and 1997. Also under the terms of the agreement, a royalty fee was paid 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 ADAPCO's pre-tax income. Royalties paid were approximately $22,800 in 1998 and $12,500 in 1997.

On July 1, 1995 the Association loaned FINCO $305,000 in exchange for an unsecured promissory note bearing simple interest at 7% per annum. The note is due July 1, 2000 and can be prepaid, in whole or in part, at any time without penalty. Interest expense amounted to $21,350 for each of the years ended December 31, 1998 and 1997.

In 1996 the Association authorized a $300,000 revolving line of credit to ECCO. Under the agreement, ECCO may draw funds once each quarter beginning after January 24, 1997 through December 31, 1998. Amounts borrowed can be repaid at any time without penalty. Mandatory repayment of principal begins March 31, 1999, with final payment due December 31, 1999. Interest accrues on outstanding balances at 2% over the average published daily prime rate, compounded quarterly. No amounts have been drawn under this agreement at December 31, 1998.

6. Endorsement Costs

On July 1, 1995 the Association ceased endorsing affinity cards and other financial products offered by Maryland Bank N.A. (MBNA) in favor of products offered by Mellon Bank and FINCO. During 1995 participating state dental societies or their related financial service subsidiaries entered into agreements with FINCO and the Association. These agreements require the state organizations to endorse FINCO's ADA1PLAN products to its members, in exchange for a share in the revenues generated by the program. The agreements also provide for different service fees or royalties depending upon the specific products involved. In addition, through December 31, 1996, the agreements guaranteed participating organizations will receive, at a minimum, what they would have earned in the comparable period of the previous year under the affinity card program with MBNA. This minimum payment guarantee was extended by FINCO Board action through 1997.

Additionally, a new card fee of $40 and $15 is paid for each new affinity card opened in a participating state by dentists and dental team members, respectively, through December 31, 1996. The payment of new card fees was subsequently extended on a limited basis to include cards opened by dentists as a result of a specific promotional mailing in the first quarter of 1997.

Endorsement costs for 1998 and 1997 are comprised of these royalties and new card fees.

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Notes to Consolidated Financial Statements, December 31, 1998 and 1997 (continued)

7. Subsequent event

Effective on March 31, 1999, FINCO entered into agreements to terminate its relationship with Mellon Bank and approve the sale of its credit card portfolio to The Travelers Bank, USA, a Citigroup affiliate (The Travelers). These actions resulted from Mellon Bank's decision to sell its overall credit card business to The Travelers. In connection with the sale, FINCO received $7 million due to its ownership interest in the credit card portfolio and $1 million due to its acceptance of the new vendor. Additionally, the outstanding unpaid balance under the revolving credit agreement of $437,500 plus all unpaid accrued interest thereon was forgiven.

Effective on April 1, 1999, FINCO contracted with The Travelers to continue the credit card business under the ADA1 PLAN. FINCO received an upfront payment of $2 million in connection with this action. In addition, the Association received a royalty payment of $1 million.

Use of these funds will include certain distributions to participating state dental societies or their related financial service subsidiaries that elect to continue participation in the ADA1 PLAN. Additional uses of the proceeds are being considered by the FINCO Board of Directors.

The net revenue generated from the above transactions will be recognized in 1999 less related income taxes estimated at $3.2 million.

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Consolidating Balance Sheet

December 31, 1998

	ADAHC	ADAPCO	FINCO	ECCO	Eliminations	Consolidated ADAHC
ASSETS						
Cash and cash equivalents	$ 26,334	1,210,391	67,384	151,307	-	1,455,416
Receivables, net	-	1,005,738	333,034	37,848	-	1,376,620
Deferred taxes and income taxes receivable	166,972	-	-	-	-	166,972
Inventory	-	75,338	-	-	-	75,338
Investment in ADAPCO	1,512,433	-	-	-	(1,512,433)	-
Investment in FINCO	11,170	-	-	-	(11,170)	-
Investment in ECCO	112,360	-	-	-	(112,360)	-
Furniture and equipment, net	-	295,525	63,352	-	-	358,877
Other assets, net	-	59,959	6,582	20,457	-	86,998
TOTAL ASSETS	$ 1,829,269	2,646,951	470,352	209,612	(1,635,963)	3,520,221
LIABILITIES AND STOCKHOLDER'S EQUITY						
Liabilities:						
Accounts payable and accrued liabilities	$ 6,187	365,498	90,558	79	-	462,322
Notes payable, Mellon Bank	-	-	437,500	-	-	437,500
Note payable, affiliate	-	-	305,000	-	-	305,000
Due to affiliated organizations, net	(23,854)	488,671	(373,876)	97,173	-	188,114
Deferred revenues	-	280,349	-	-	-	280,349
TOTAL LIABILITIES	(17,667)	1,134,518	459,182	97,252	-	1,673,285
Stockholder's equity :						
Common stock	100,100	1,000,000	1,000	100,000	(1,101,000)	100,100
Additional paid-in capital	500,000	501,000	500,000	-	(1,001,000)	500,000
Retained earnings (deficit)	1,246,836	11,433	(489,830)	12,360	466,037	1,246,836
TOTAL STOCKHOLDER'S EQUITY	1,846,936	1,512,433	11,170	112,360	(1,635,963)	1,846,936
TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY	$ 1,829,269	2,646,951	470,352	209,612	(1,635,963)	3,520,221

See accompanying report of independent certified public accountants.

Schedule 1

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Consolidating Statement of Operations and Retained Earnings

Year Ended December 31, 1998

	ADAHC	ADAPCO	FINCO	ECCO	Eliminations	Consolidated ADAHC
REVENUES						
Advertising, including classified ads	$	7,971,479	-	-	-	7,971,479
Subscriptions	-	479,996	-	-	-	479,996
Publishing fees	-	760,000	-	-	-	760,000
Publication and product sales	-	879,754	-	22,500	-	902,254
Royalties and service fees	-	91,008	1,204,516	154,172	-	1,449,696
Investment income	-	31,466	-	-	-	31,466
Other income, net	-	2,465	25,000	-	-	27,465
TOTAL REVENUES	-	10,216,168	1,229,516	176,672	-	11,622,356
EXPENSES						
Staff compensation, taxes and benefits	-	2,081,442	305,601	51,419	-	2,438,462
Printing, publication and marketing expenses	61	5,778,734	667	45,800	-	5,825,262
Endorsement costs	-	-	189,776	-	-	189,776
Professional services	23,290	100,811	23,682	13,145	-	160,928
Facility and utility costs	-	214,777	54,807	-	-	269,584
Office expense	689	258,217	10,424	1,674	-	271,004
Meeting expenses	1,435	40,840	2,540	1,561	-	46,376
Travel expenses	10,541	49,584	33,963	12,224	-	106,312
Depreciation and amortization	-	70,646	10,151	6,881	-	87,678
Interest expense	-	-	72,537	-	-	72,537
Other expenses, including allocated general and administrative expenses	4,689	505,178	31,517	12,764	-	554,148
TOTAL EXPENSES	40,705	9,100,229	735,665	145,468	-	10,022,067
Income (loss) before income taxes	(40,705)	1,115,939	493,851	31,204	-	1,600,289
Income tax benefit (expense)	11,779	(456,689)	(200,378)	(6,535)	-	(651,823)
Income (loss) before equity in earnings of subsidiaries	(28,926)	659,250	293,473	24,669	-	948,466
Equity in income of subsidiaries	977,392	-	-	-	(977,392)	-
Net income	948,466	659,250	293,473	24,669	(977,392)	948,466
Retained earnings (deficit) at beginning of year	838,370	(147,817)	(733,303)	(12,309)	893,429	838,370
Dividends paid	(540,000)	(500,000)	(50,000)	-	550,000	(540,000)
Retained earnings (deficit) at end of year	$ 1,246,836	11,433	(489,830)	12,360	466,037	1,246,836

See accompanying report of independent certified public accountants.

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Consolidating Statement of Cash Flows

Year Ended December 31, 1998

	ADAHC	ADAPCO	FINCO	ECCO	Eliminations	Consolidated ADAHC
CASH FLOWS FROM OPERATING ACTIVITIES						
Net income	$ 948,466	659,250	293,473	24,669	(977,392)	948,466
Adjustments to reconcile net income to net cash provided by operating activities:						
Depreciation and amortization	-	70,646	10,151	6,881	-	87,678
Deferred income taxes	-	8,576	38,307	-	-	46,883
Equity in income of subsidiaries, less dividends	(427,392)	-	-	-	427,392	-
Changes in assets and liabilities:						
Receivables, net	-	(4,358)	(59,671)	(795)	-	(64,824)
Income taxes receivable	102,823	-	-	-	(46,883)	55,940
Inventory	-	31,890	-	-	-	31,890
Other assets, net	-	48,283	(5,120)	(1,536)	-	41,627
Accounts payable and accrued liabilities	1,977	(309,927)	39,088	(10,095)	-	(278,957)
Deferred revenues	-	52,968	-	-	-	52,968
Net cash provided (used) by operating activities	625,874	557,328	316,228	19,124	(596,883)	921,671
CASH FLOWS USED BY INVESTING ACTIVITIES						
Acquisitions of furniture and equipment	-	(35,514)	(17,347)	-	-	(52,861)
CASH FLOWS FROM FINANCING ACTIVITIES						
Principal repayment on notes payable, Mellon Bank	-	-	(262,500)	-	-	(262,500)
Net change in due to affiliated organizations, net	(96,138)	15,237	(122,729)	67,548	46,883	(89,199)
Payment of dividends	(540,000)	(500,000)	(50,000)	-	550,000	(540,000)
Net cash provided (used) by financing activities	(636,138)	(484,763)	(435,229)	67,548	596,883	(891,699)
Net increase (decrease) in cash and cash equivalents	(10,264)	37,051	(136,348)	86,672	-	(22,889)
Cash and cash equivalents at beginning of year	36,598	1,173,340	203,732	64,635	-	1,478,305
Cash and cash equivalents at end of year	$ 26,334	1,210,391	67,384	151,307	-	1,455,416

See accompanying report of independent certified public accountants.

Schedule 3

Report of Independent Certified Public Accountants

The Board of Directors and Stockholder
ADA Financial Services Co.

We have audited the accompanying balance sheets of ADA Financial Services Co. (a wholly-owned subsidiary of ADA Holding Company, Inc.) as of December 31, 1998 and 1997 and the related statements of operations 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 Financial Services Co. as of December 31, 1998 and 1997 and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

Grant Thornton LLP

GRANT THORNTON LLP

Chicago, Illinois
April 2, 1999

ADA Financial Services Co.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Balance Sheets

December 31, 1998 and 1997

	1998	1997
ASSETS		
Cash	$ 67,384	203,732
Receivables	333,034	273,363
Due from affiliated organizations, net (Note 5)	373,876	289,454
Furniture and equipment, net (Note 2)	63,352	53,962
Other assets, net	6,582	3,656
TOTAL ASSETS	$ 844,228	824,167
LIABILITIES AND STOCKHOLDER'S EQUITY (DEFICIT)		
Liabilities:		
Accounts payable and accrued liabilities	$ 90,558	51,470
Notes payable, Mellon Bank (Notes 4 and 7)	437,500	700,000
Note payable, affiliate (Note 5)	305,000	305,000
TOTAL LIABILITIES	833,058	1,056,470
Stockholder's Equity (Deficit):		
Common stock, $1.00 par value; authorized, issued and outstanding 1,000 shares	1,000	1,000
Additional paid-in capital	500,000	500,000
Accumulated deficit	(489,830)	(733,303)
TOTAL STOCKHOLDER'S EQUITY (DEFICIT)	11,170	(232,303)
TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY	$ 844,228	824,167

See accompanying notes to financial statements.

ADA Financial Services Co.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Statements of Operations and Accumulated Deficit

Years Ended December 31, 1998 and 1997

	1998	1997
REVENUES		
Royalties and service fees	$ 1,204,516	934,704
Other income	25,000	-
TOTAL REVENUES	1,229,516	934,704
EXPENSES		
Staff compensation, taxes and benefits (Note 5)	305,601	239,834
Endorsement costs (Note 6)	189,776	173,427
Professional services	23,682	18,345
Facility and utility costs (Note 5)	54,807	22,699
Office expense	10,424	12,623
Printing, publication and marketing	667	72
Meeting expenses	2,540	3,775
Travel expenses	33,963	17,513
Depreciation and amortization	10,151	5,787
Interest expense	72,537	83,913
Other expenses, including allocated general and administrative expenses (Note 5)	31,517	24,314
TOTAL EXPENSES	735,665	602,302
Income before income taxes	493,851	332,402
Income tax expense (Note 3)	(200,378)	(192,095)
Net income	293,473	140,307
Accumulated deficit at beginning of year	(733,303)	(873,610)
Dividends paid	(50,000)	-
Accumulated deficit at end of year	$ (489,830)	(733,303)

See accompanying notes to financial statements.

ADA Financial Services Co.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Statements of Cash Flows

Years Ended December 31, 1998 and 1997

	1998	1997
CASH FLOWS FROM OPERATING ACTIVITIES		
Net income	$ 293,473	140,307
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	10,151	5,787
Deferred income taxes	38,307	36,703
Changes in assets and liabilities:		
Receivables	(59,671)	28,367
Other assets	(5,120)	-
Accounts payable and accrued liabilities	39,088	(58,428)
Net cash provided by operating activities	316,228	152,736
NET CASH USED BY INVESTING ACTIVITIES		
Acquisitions of furniture and equipment	(17,347)	(49,550)
CASH FLOWS FROM FINANCING ACTIVITIES		
Principle repayment on notes payable, Mellon Bank	(262,500)	-
Change in due to affiliated organizations, net	(122,729)	(367,775)
Payment of dividends	(50,000)	-
Net cash used by financing activities	(435,229)	(367,775)
Net decrease in cash	(136,348)	(264,589)
Cash at beginning of year	203,732	468,321
Cash at end of year	$ 67,384	203,732
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid during the year for:		
Interest	$ 51,187	62,563
Income taxes	$ 167,000	154,000

See accompanying notes to financial statements.

ADA Financial Services Co.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Notes to Financial Statements, December 31, 1998 and 1997

1. Significant Accounting Policies

Basis of Presentation: ADA Financial Services Co. (FINCO) 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). FINCO offers a range of financial services to Association members in conjunction with Mellon Bank, N.A. under the title of ADA1 PLAN. FINCO's sole sources of revenue are royalties and service fees received under agreements with Mellon Bank, N.A. Revenues are based on activity levels of the services offered to Association members who reside primarily in the United States. Receivables are comprised of royalties and service fees earned from Mellon Bank, N.A.

Use of Estimates: In preparing financial statements in conformity with generally accepted accounting principles, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Cash: FINCO maintains its cash balance in one financial institution which at times may exceed federally insured limits. FINCO has not experienced any losses in this account and believes it is not exposed to any significant credit risk on cash.

Furniture and Equipment: Furniture and equipment are stated at cost less accumulated depreciation. Depreciation is computed on the straight-line method over five to ten years, the estimated useful lives of the assets.

Organization Costs: Organization costs incurred in the establishment of the corporation have been capitalized and are included in other assets. These costs are being amortized on the straight-line method over a 60-month period.

Endorsement Costs: Endorsement costs are recognized when conditions for their accrual under the agreements with participating state societies or their subsidiaries are satisfied.

Income Taxes: Deferred taxes are provided for temporary differences between the financial reporting basis and the tax basis of assets and liabilities. Deferred taxes are based upon enacted tax rates which would apply during the period in which taxes become payable or recoverable, and the adjustment of cumulative deferred taxes for any changes in the tax rate.

Reclassifications: Certain 1997 amounts have been reclassified to conform to the 1998 presentation.

2. Furniture and Equipment

Furniture and equipment at December 31, 1998 and 1997 consisted of the following:

	1998	1997
Furniture and equipment	$ 78,471	61,124
Less accumulated depreciation	15,119	7,162
	$ 63,352	53,962

ADA Financial Services Co.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Notes to Financial Statements, December 31, 1998 and 1997 (continued)

3. Income Taxes

FINCO operating results are included in the consolidated income tax returns of ADAHC. Income taxes for financial reporting purposes are calculated in accordance with a tax sharing agreement that generally reflects expense or benefit based on separate entity filings. Included in total income tax expense/benefit are $38,307 and $36,703 of deferred income tax expense for 1998 and 1997, respectively. Income tax expense differs from the amount computed by applying the federal and state statutory income tax rates to income before income tax expense due to state income taxes and the effect of the federal surtax exemption.

Deferred tax liabilities of approximately $9,700 and $4,300 and deferred tax assets of approximately $47,400 and $80,300 at December 31, 1998 and 1997, respectively, are included in due from affiliated organizations. Net current deferred taxes result primarily from the difference in book and tax basis of start up costs, accrued liabilities and furniture and equipment.

4. Notes Payable, Mellon Bank

On June 24, 1996 FINCO entered into a revolving line of credit agreement with Mellon Bank, N.A. Advances under the agreement are evidenced by promissory notes and collateralized by ADA1 Plan revenues. Draw privileges under the credit agreements expired June 24, 1997.

The notes payable at December 31, 1998 and 1997 consisted of the following:

	1998	1997
$1,750,000 Revolving Credit Agreement dated June 24, 1996, due December 31, 1999; interest free through December 31, 1996, with interest thereafter at an average daily prime rate plus ½% payable quarterly on outstanding balances; principal payable from program revenues in eight equal quarterly installments commencing March 31, 1998 through maturity.	$ 437,500	700,000

The fourth quarterly installment of $87,500 was unpaid at December 31, 1998 pending negotiation for forgiveness of the entire balance, as described in Note 7.

ADA Financial Services Co.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Notes to Financial Statements, December 31, 1998 and 1997 (continued)

5. Transactions With Related Parties

The Association and ADAHC provide FINCO with administrative services as may be required. The allocated cost of such services amounted to $31,400 and $24,900 for the years ended December 31, 1998 and 1997, respectively.

The Association sponsors a noncontributory defined benefit pension plan and a savings and retirement plan which cover substantially all employees of the Association and its subsidiaries meeting certain eligibility requirements. In addition to the allocated expenses described above are pension expense charges associated with FINCO's employees who are participants in the Association's retirement plans. These expenses, which amounted to $21,805 in 1998 and $12,000 in 1997, are based upon the actual cash contributions made by the Association to the plans for the benefit of employees of FINCO.

Additionally, the Association sponsors a contributory defined benefit postretirement health plan which covers substantially all employees of the Association and its subsidiaries. FINCO expensed postretirement benefit charges of $4,369 and $4,040 for the years ended December 31, 1998 and 1997, respectively, associated with participating FINCO employees.

The Association also leases office space to FINCO. Rent expense under this lease amounted to $54,415 in 1998 and $21,694 in 1997. The office space lease amounts to $4,421 a month. This lease expires September 30, 2006.

Periodically, expenses of one organization may be paid by an affiliated organization and subsequently reimbursed.

At December 31, 1998 and 1997, amounts due from (to) affiliated organizations were as follows:

	1998	1997
Association	$ (122,568)	(224,084)
ADAHC (includes net deferred tax assets - Note 3)	481,217	514,595
ADA Publishing Co., Inc.	(1,057)	(1,057)
ADA Electronic Commerce Co.	16,284	-
	$ 373,876	289,454

On July 1, 1995 the Association loaned FINCO $305,000 in exchange for an unsecured promissory note bearing simple interest at 7% per annum. The note is due July 1, 2000 and can be prepaid, in whole or in part, at any time without penalty. Interest expense amounted to $21,350 for each of the years ended December 31, 1998 and 1997.

6. Endorsement Costs

On July 1, 1995 the Association ceased endorsing affinity cards and other financial products offered by Maryland Bank N.A. ("MBNA") in favor of products offered by Mellon Bank and FINCO. During 1995 participating state dental societies or their related financial service subsidiaries entered into agreements with FINCO and the Association. These agreements require the state organizations to endorse FINCO's ADA1PLAN products to its members, in exchange for a share in the revenues generated by the program. The agreements also provide for different service fees or royalties depending upon the specific products involved. In addition, through December 31, 1996, the agreements guaranteed participating organizations would receive, at a minimum, what they would have earned in the comparable period of the previous year under the affinity card program with MBNA. This minimum payment guarantee was extended by Board action through 1997.

Additionally, a new card fee of $40 and $15 is paid for each new affinity card opened in a participating state by dentists and dental team members, respectively, through December 31, 1996. The payment of new card fees was subsequently extended on a limited basis to include cards opened by dentists as a result of a specific promotional mailing in the first quarter of 1997.

Endorsement costs for 1998 and 1997 are comprised of these royalties and new card fees.

ADA Financial Services Co.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Notes to Financial Statements, December 31, 1998 and 1997 (continued)

7. Subsequent Events

Effective March 31, 1999, FINCO entered into agreements to terminate its relationship with Mellon Bank and approve the sale of its credit card portfolio to The Travelers Bank USA, a Citigroup affiliate (The Travelers). These actions resulted from Mellon Bank's decision to sell its overall credit card business to The Travelers. In connection with the sale, FINCO received $7 million due to its ownership interest in the credit card portfolio and $1 million due to its acceptance of the new vendor. Additionally, the outstanding unpaid balance under the revolving credit agreement of $437,500 plus all unpaid accrued interest thereon was forgiven.

Effective April 1, 1999 FINCO contracted with The Travelers to continue the credit card business under the ADA1 PLAN. FINCO received an upfront payment of $2 million in connection with this action. In addition, the Association received a royalty payment of $1 million.

Use of these funds will include certain distributions to participating state dental societies or their related financial service subsidiaries that elect to continue participation in the ADA1 PLAN. Additional uses of the proceeds are being considered by the FINCO Board of Directors.

The net revenue generated from the above transactions will be recognized in 1999 less related income taxes estimated at $3.2 million.

Report of Independent Certified Public Accountants

The Board of Directors and Stockholder
ADA Publishing Co., Inc.

We have audited the accompanying balance sheets of ADA Publishing Co., Inc. (a wholly-owned subsidiary of ADA Holding Company, Inc.) as of December 31, 1998 and 1997, and the related statements of operations, 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 Publishing Co., Inc. as of December 31, 1998 and 1997 and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

Grant Thornton LLP

GRANT THORNTON LLP

Chicago, Illinois
April 2, 1999

ADA Publishing Co., Inc.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Balance Sheets

December 31, 1998 and 1997

	1998	1997
ASSETS		
Cash and cash equivalents	$ 1,210,391	1,173,340
Receivables, net of allowance for doubtful accounts of $76,432 in 1998 and $73,170 in 1997	1,005,738	1,001,380
Inventory	75,338	107,228
Prepaid expenses and other assets	59,959	108,242
Furniture and equipment, net (Note 2)	295,525	330,657
TOTAL ASSETS	$ 2,646,951	2,720,847
LIABILITIES AND STOCKHOLDER'S EQUITY		
Liabilities:		
Accounts payable and accrued liabilities	$ 365,498	675,425
Due to affiliated organizations, net (Note 4)	488,671	464,858
Deferred revenues	280,349	227,381
TOTAL LIABILITIES	1,134,518	1,367,664
Stockholder's Equity:		
Common stock, $10 par value; authorized, issued and outstanding 100,000 shares	1,000,000	1,000,000
Additional paid-in capital	501,000	501,000
Retained earnings (deficit)	11,433	(147,817)
TOTAL STOCKHOLDER'S EQUITY	1,512,433	1,353,183
TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY	$ 2,646,951	2,720,847

See accompanying notes to financial statements.

ADA Publishing Co., Inc.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Statements of Operations

Years Ended December 31, 1998 and 1997

	1998	1997
REVENUES		
Advertising, including classified ads	$ 7,971,479	7,587,690
Subscriptions	479,996	619,566
Publishing fees (Note 4)	760,000	760,000
Publication and product sales	879,754	388,813
Royalties	91,008	70,667
Investment income	31,466	17,887
Other income	2,465	14,269
TOTAL REVENUES	10,216,168	9,458,892
EXPENSES		
Staff compensation, taxes and benefits (Note 4)	2,081,442	1,993,161
Printing, publication and marketing	5,778,734	5,727,289
Professional services	100,811	105,556
Facility and utility costs (Note 4)	214,777	214,732
Office expense	258,217	193,269
Meeting expenses	40,840	24,403
Travel expenses	49,584	49,328
Depreciation	70,646	69,550
Other expenses, including allocated general and administrative expenses (Note 4)	505,178	470,482
TOTAL EXPENSES	9,100,229	8,847,770
Income before income tax expense	1,115,939	611,122
Income tax expense (Note 3)	(456,689)	(144,796)
Net income	659,250	466,326
Accumulated deficit at beginning of year	(147,817)	(614,143)
Dividends paid	(500,000)	-
Retained earnings (deficit) at end of year	$ 11,433	(147,817)

See accompanying notes to financial statements.

ADA Publishing Co., Inc.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Statements of Cash Flows

Years Ended December 31, 1998 and 1997

	1998	1997
CASH FLOWS FROM OPERATING ACTIVITIES		
Net income	$ 659,250	466,326
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation	70,646	69,550
Deferred income taxes	8,576	(22,193)
Changes in assets and liabilities:		
Receivables, net	(4,358)	23,786
Inventory	31,890	(36,569)
Prepaid expenses and other assets	48,283	(27,823)
Accounts payable and accrued liabilities	(309,927)	327,228
Deferred revenues	52,968	(19,218)
Net cash provided by operating activities	557,328	781,087
NET CASH USED BY INVESTING ACTIVITIES:		
Acquisitions of furniture and equipment	(35,514)	(32,443)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Net change in due to/from affiliated organizations, net	15,237	49,419
Payment of dividends	(500,000)	-
Net cash (used) provided by financing activities	(484,763)	49,419
Net increase in cash and cash equivalents	37,051	798,063
Cash and cash equivalents at beginning of year	1,173,340	375,277
Cash and cash equivalents at end of year	$ 1,210,391	1,173,340
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid during the year for income taxes	$ 382,000	80,000

See accompanying notes to financial statements.

ADA Publishing Co., Inc.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Notes to Financial Statements, December 31, 1998 and 1997

1. Significant Accounting Policies

Basis of Presentation: ADA Publishing Co., Inc. (ADAPCO) 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). ADAPCO is a for-profit corporation whose current business is to perform certain publishing functions for the publications of the Association, including *JADA* and *ADA News*.

Use of Estimates: In preparing financial statements in conformity with generally accepted accounting principles, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Cash Equivalents: Cash equivalents at December 31, 1998 and 1997 consist of interest bearing deposits under overnight repurchase agreements, which are carried at their fair value. ADAPCO maintains its cash balance in one financial institution which at times may exceed federally insured limits. ADAPCO has not experienced any losses in such account and believes it is not exposed to any significant credit risk on cash and cash equivalents.

Inventory: Inventory, consisting of CD-ROM products, books and accumulated book production costs, is carried at the lower of cost or market (net realizable value). Cost is determined using the average unit cost method.

Furniture and Equipment: Furniture and equipment are stated at cost less accumulated depreciation. Depreciation is computed on the straight-line method over five to ten 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. Subscriptions paid in advance are recorded as deferred revenue. Advertising revenue and direct publication costs are recognized in the period the related publication is issued.

Income Taxes: Deferred taxes are established for temporary differences between the financial reporting basis and the tax basis of assets and liabilities, based upon enacted tax rates which would apply during the period in which taxes become payable or recoverable, and the adjustment of cumulative deferred taxes for any changes in the tax rate.

Reclassifications: Certain 1997 amounts have been reclassified to conform to the 1998 presentation.

2. Furniture and Equipment

Furniture and equipment at December 31, 1998 and 1997 consisted of the following:

	1998	1997
Furniture and equipment	$ 730,921	695,407
Less accumulated depreciation	435,396	364,750
	$ 295,525	330,657

ADA Publishing Co., Inc.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Notes to Financial Statements, December 31, 1998 and 1997 (continued)

3. Income Taxes

ADAPCO operating results are included in the consolidated income tax returns of ADAHC. Income taxes for financial reporting purposes are calculated in accordance with a tax sharing agreement that generally reflects expense or benefit based on separate entity filings. Included in total income tax expense are $8,576 of deferred income tax expense for 1998 and $22,193 of deferred income tax benefit for 1997. Income tax expense differs from the amount computed by applying the federal and state statutory income tax rates to income before income tax expense due to variances in historical estimates of book and tax income differences.

Deferred tax liabilities of approximately $78,500 and $83,100 and deferred tax assets of approximately $66,900 and $80,100 at December 31, 1998 and 1997, respectively, are included in due to affiliated organizations. Net current deferred taxes result primarily from the difference in book and tax basis of accrued liabilities and furniture and equipment.

4. Transactions With Related Parties

The Association and ADAHC provide ADAPCO with administrative services as may be required. The allocated cost of such services amounted to $425,668 and $393,814 during the years ended December 31, 1998 and 1997, respectively.

The Association sponsors a noncontributory defined benefit pension plan and a savings and retirement plan which cover substantially all employees of the Association and its subsidiaries meeting certain eligibility requirements. In addition to the allocated expenses described above are pension expense charges associated with ADAPCO's employees who are participants in the Association's retirement plans. These expenses, which amounted to $175,947 and $153,000 in 1998 and 1997, respectively, are based upon the actual cash contributions made by the Association to the plans for the benefit of employees of ADAPCO.

Additionally, the Association sponsors a contributory defined benefit postretirement health plan which covers substantially all employees of the Association and its subsidiaries. ADAPCO expensed postretirement benefit charges of $30,692 and $33,740 for the years ended December 31, 1998 and 1997 respectively, associated with participating ADAPCO employees.

The Association also leases equipment and office space to ADAPCO. Rent expense under these leases amounted to $217,853 during 1998 and $216,724 during 1997. The office space lease amounts to $16,612 a month. This lease is on a month-to-month basis. Minimum future rentals to be paid for equipment leased under non-cancelable operating leases currently in effect are $15,000 for each year through 1999.

Periodically, expenses of one organization may be paid by an affiliated organization and subsequently reimbursed.

ADA Publishing Co., Inc.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Notes to Financial Statements, December 31, 1998 and 1997 (continued)

At December 31, 1998 and 1997, amounts due from (to) affiliated organizations were as follows:

	1998	1997
Association	$ 41,205	(9,671)
ADAHC (includes deferred tax liabilities, net - Note 3)	(530,933)	(456,244)
ADA Financial Services Co.	1,057	1,057
	$ (488,671)	(464,858)

Effective January 1, 1990, the Association and ADA Publishers, Inc., a predecessor corporation to ADAPCO, entered into a publishing agreement which has been assigned to ADAPCO. 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, ADAPCO performs all publishing and distribution functions related to the Association's two major publications, and may include new publications developed in the future. In connection with the agreement, the Association assigned all relevant production and advertising contracts, together with all nonmember subscriptions and the revenue from single copy sales, to ADAPCO. Under the terms of the agreement, the Association paid publishing fees to ADAPCO in the amount of $760,000 during the years ended December 31, 1998 and 1997. Also under the terms of the agreement, ADAPCO 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 ADAPCO's pre-tax income. Royalties paid were approximately $22,800 and $12,500 for 1998 and 1997, respectively.

Report of Independent Certified Public Accountants

The Board of Directors and Stockholder
ADA Electronic Commerce Co.

We have audited the accompanying balance sheets of ADA Electronic Commerce Co. (a wholly-owned subsidiary of ADA Holding Company, Inc.) as of December 31, 1998 and 1997, and the related statements of operations 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 Electronic Commerce Co. as of December 31, 1998 and 1997 and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

GRANT THORNTON LLP

Chicago, Illinois
April 2, 1999

ADA Electronic Commerce Co.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Balance Sheets

December 31, 1998 and 1997

	1998	1997
ASSETS		
Cash	$ 151,307	64,635
Receivables	37,848	37,053
Other assets, net	20,457	25,802
TOTAL ASSETS	$ 209,612	127,490
LIABILITIES AND STOCKHOLDER'S EQUITY		
Liabilities:		
Accounts payable	$ 79	10,174
Due to affiliated organizations, net (Note 3)	97,173	29,625
TOTAL LIABILITIES	97,252	39,799
Stockholder's Equity:		
Common stock, $1.00 par value; authorized, issued and outstanding 100,000 shares	100,000	100,000
Retained earnings (deficit)	12,360	(12,309)
TOTAL STOCKHOLDER'S EQUITY	112,360	87,691
TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY	$ 209,612	127,490

See accompanying notes to financial statements.

ADA Electronic Commerce Co.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Statements of Operations

Years Ended December 31, 1998 and 1997

	1998	1997
REVENUES		
Royalties	$ 154,172	142,471
Miscellaneous sales	22,500	-
TOTAL REVENUES	176,672	142,471
EXPENSES		
Staff compensation	51,419	33,880
Professional services	13,145	6,905
Office expense	1,674	10,697
Printing, publication and marketing	45,800	46,353
Meeting expenses	1,561	1,208
Travel expenses	12,224	19,824
Amortization	6,881	6,881
Other expenses, including allocated general and administrative expenses (Note 3)	12,764	18,679
TOTAL EXPENSES	145,468	144,427
Net income (loss) before income taxes	31,204	(1,956)
Income tax (expense) benefit (Note 2)	(6,535)	157
Net income (loss)	24,669	(1,799)
Accumulated deficit at beginning of year	(12,309)	(10,510)
Retained earnings (deficit) at end of year	$ 12,360	(12,309)

See accompanying notes to financial statements.

ADA Electronic Commerce Co.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Statements of Cash Flows

Year Ended December 31, 1998 and 1997

	1998	1997
CASH FLOWS FROM OPERATING ACTIVITIES		
Net income (loss)	$ 24,669	(1,799)
Adjustments to reconcile net income (loss)		
to net cash provided (used) by operating activities:		
Amortization	6,881	6,881
Changes in assets and liabilities:		
Receivables	(795)	(31,578)
Accounts payable	(10,095)	10,174
Other assets	(1,536)	-
Net cash provided (used) by operating activities	19,124	(16,322)
NET CASH PROVIDED (USED) BY FINANCING ACTIVITIES		
Net change in due to affiliated organizations	67,548	(19,043)
Net increase (decrease) in cash	86,672	(35,365)
Cash at beginning of year	64,635	100,000
Cash at end of year	$ 151,307	64,635
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid during the year for income taxes	$ -	8,000

See accompanying notes to financial statements.

ADA Electronic Commerce Co.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Notes to Financial Statements, December 31, 1998 and 1997

1. Significant Accounting Policies

Basis of Presentation: ADA Electronic Commerce Co. (ECCO) 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). ECCO was established on September 20, 1996 as a for-profit corporation to offer a range of electronic data transmission services to Association members residing primarily in the United States. ECCO's main source of revenue is royalties received under agreements with two electronic data service providers. Receivables are comprised of royalties earned from these service providers.

Use of Estimates: In preparing financial statements in conformity with generally accepted accounting principles, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Organization costs: Organization costs incurred in the establishment of the corporation have been capitalized and are included in other assets. These costs are being amortized on the straight-line method over a 60-month period. Effective January 1, 1999, in accordance with SOP 98-5, Reporting on the Costs of Start-up Activities, ECCO will expense $18,921 of remaining unamortized organization costs as a cumulative effect of a change in accounting principle.

Reclassifications: Certain 1997 amounts have been reclassified to conform to the 1998 presentation.

2. Income Taxes

ECCO operating results are included in the consolidated income tax returns of ADAHC. Income taxes for financial reporting purposes are calculated in accordance with a tax sharing agreement that generally reflects expense or benefit based on separate entity filings. ECCO does not have any deferred income taxes at December 31, 1998 or 1997. Income tax expense differs from the amount computed by applying the federal and state statutory income tax rates to income before income tax expense due to state income taxes and the effect of the federal surtax exemption.

3. Transactions With Related Parties

The Association and ADAHC provide ECCO with administrative services as may be required. The allocated cost of such services amounted to $12,764 and $17,520 during the years ended December 31, 1998 and 1997, respectively.

The Association sponsors a noncontributory defined benefit pension plan and a savings and retirement plan which cover substantially all employees of the Association and its subsidiaries meeting certain eligibility requirements. In addition to the allocated expenses described above are pension expense charges associated with ECCO's employees who are participants in the Association's retirement plans. These expenses, which amounted to $800 in 1998 and $0 in 1997, are based upon the actual cash contributions made by the Association to the plans for the benefit of employees of ECCO.

Periodically, expenses of one organization are paid by an affiliated organization and subsequently reimbursed.

At December 31 amounts due from (to) affiliated organizations were as follows:

	1998	1997
Association	$ (85,347)	(40,617)
ADA Financial Services Co.	(16,283)	-
ADAHC (includes current tax receivable — Note 2)	4,457	10,992
	$ (97,173)	(29,625)

ADA Electronic Commerce Co.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Notes to Financial Statements, December 31, 1998 and 1997

In 1996 the Association authorized a $300,000 revolving line of credit to ECCO. Under the agreement, ECCO may draw funds once each quarter beginning after January 24, 1997 through December 31, 1998. Amounts borrowed can be repaid at any time without penalty. Mandatory repayment of principal begins March 31, 1999, with final payment due December 31, 1999. Interest accrues on outstanding balances at 2% over the average published daily prime rate, compounded quarterly. No amounts have been drawn under this agreement at December 31, 1998.

Report of Independent Certified Public Accountants

Commission on Relief Fund Activities
American Dental Association

We have audited the accompanying statements of financial position of American Dental Association Relief Fund (Relief Fund) as of December 31, 1998 and 1997, and the related statements of activities, functional expenses and cash flows for the years 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 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 Relief Fund as of December 31, 1998 and 1997, and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

Grant Thornton LLP

GRANT THORNTON LLP

Chicago, Illinois
April 2, 1999

American Dental Association Relief Fund

Statements of Financial Position

December 31, 1998 and 1997

	1998	1997
ASSETS		
Cash	$ 67,441	42,521
Interest receivable	27,486	24,796
Prepaid expenses	26,524	31,870
Grants due from constituent societies	19,016	17,132
Due from affiliated organizations (Note 4)	30,128	-
Marketable securities, at market (Note 2)	7,113,524	7,334,877
Furniture and equipment, net (Note 3)	2,261	3,079
TOTAL ASSETS	$ 7,286,380	7,454,275
LIABILITIES AND NET ASSETS		
Accounts payable and accrued liabilities	$ 15,024	5,625
Due to constituent societies	466,595	508,168
Due to affiliated organizations (Note 4)	-	321,259
TOTAL LIABILITIES	481,619	835,052
Net assets (Note 1)	6,804,761	6,619,223
TOTAL LIABILITIES AND NET ASSETS	$ 7,286,380	7,454,275

See accompanying notes to financial statements.

American Dental Association Relief Fund

Statements of Activities

Years ended December 31, 1998 and 1997

	1998	1997
REVENUES		
Contributions	$ 336,026	378,532
Allocation of contributions to constituent societies	(247,341)	(298,584)
Net contributions	88,685	79,948
Earnings on investments:		
Interest and dividends	240,861	200,380
Net realized capital gains	386,281	856,742
Net unrealized (depreciation) appreciation of marketable securities	(4,516)	104,013
Investment management fees and expenses	(57,289)	(57,410)
Net earnings on investments	565,337	1,103,725
Miscellaneous income	-	5,000
TOTAL REVENUES	654,022	1,188,673
EXPENSES		
Program services	207,027	196,715
General and administrative	188,553	177,496
Fundraising	72,904	75,243
TOTAL EXPENSES	468,484	449,454
Increase in net assets	185,538	739,219
Net assets at beginning of year	6,619,223	5,880,004
Net assets at end of year	$ 6,804,761	6,619,223

See accompanying notes to financial statements.

American Dental Association Relief Fund

Statements of Functional Expenses

Years Ended December 31, 1998 and 1997

	1998				1997			
	Program Services	Supporting Services			Program Services	Supporting Services		
	Grants	General and Administrative	Fundraising	Total	Grants	General and Administrative	Fundraising	Total
EXPENSES								
Relief Grants	$ 207,027	-	-	207,027	196,715	-	-	196,715
Staff compensation, taxes and benefits	-	127,721	-	127,721	-	121,070	-	121,070
Meeting	-	2,463	-	2,463		2,277		2,277
Travel	-	19,263	-	19,263	-	13,105	-	13,105
Telephone	-	5,795	-	5,795	-	5,327	-	5,327
Stationery and supplies	-	4,636	-	4,636	-	3,207	-	3,207
Postage and mailing	-	666	28,359	29,025	-	1,890	32,476	34,366
Printing and publication	-	-	36,968	36,968	-	23	30,584	30,607
Photocopy	-	1,397	-	1,397	-	1,438	-	1,438
Professional services	-	23,059	7,577	30,636	-	23,890	12,183	36,073
Miscellaneous	-	470	-	470	-	-	-	-
Depreciation	-	3,083	-	3,083	-	5,269	-	5,269
TOTAL EXPENSES	$ 207,027	188,553	72,904	468,484	196,715	177,496	75,243	449,454

See accompanying notes to financial statements.

American Dental Association Relief Fund

Statements of Cash Flows

Years ended December 31, 1998 and 1997

	1998	1997
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase in net assets	$ 185,538	739,219
Adjustments to reconcile increase in net assets to net cash used by operating activities:		
Depreciation	3,083	5,269
Net realized capital gains	(386,281)	(856,742)
Net unrealized depreciation (appreciation) of marketable securities	4,516	(104,013)
Changes in assets and liabilities:		
Interest receivable	(2,690)	(15,381)
Prepaid expenses	5,346	(31,870)
Grants due from constituent societies	(1,884)	(5,102)
Accounts payable and accrued liabilities	9,399	1,306
Due to constituent societies	(41,573)	(57,034)
Net cash used by operating activities	(224,546)	(324,348)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of marketable securities	(8,960,668)	(10,584,483)
Sale and maturity of marketable securities	9,563,786	10,467,894
Acquisition of equipment	(2,265)	
Net cash provided (used) by investing activities	600,853	(116,589)
CASH FLOWS FROM FINANCING ACTIVITIES		
Net change in due (from) to affiliated organizations	(351,387)	391,260
Net increase (decrease) in cash	24,920	(49,677)
Cash at beginning of year	42,521	92,198
Cash at end of year	$ 67,441	42,521

See accompanying notes to financial statements.

American Dental Association Relief Fund

Notes to Financial Statements, December 31, 1998 and 1997

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.

Use of Estimates: In preparing financial statements in conformity with generally accepted accounting principles, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Marketable Securities: Investments in marketable securities are carried at fair value. The fair value of the marketable securities is estimated based on quotes from brokers or current rates offered for instruments with similar characteristics. Net realized capital gains or losses on sales are calculated based on the first in-first out (FIFO) cost of securities sold.

Furniture and Equipment: Furniture and equipment are stated at cost, less accumulated depreciation. Depreciation is computed on the straight-line method once assets are put into service over the five-year estimated useful life of the assets.

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 unconditionally pledged or 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. Refunds in the amount of $337,723 and $356,790 at December 31, 1998 and 1997, respectively (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. As of December 31, 1998 and 1997, $128,872 and $151,378, respectively, are reflected as due to constituent societies for the fiscal year campaigns which end June 30, 1999 and 1998, respectively.

Grant Expense: Grants to relief recipients are recorded when the grant is paid. Conditional commitments for future grant payments previously authorized by the Commission amounted to $63,538 and $81,582 at December 31, 1998 and 1997, respectively. The Relief Fund retains the right to discontinue future payments to grant recipients at any time. Grants paid are usually shared equally by the Relief Fund and the recipient's constituent society.

Functional Expenses: The statement of functional expenses reflects direct costs related to general and administrative and fundraising activities.

Net Assets: Net assets subject to donor-imposed stipulations are classified as either temporarily or permanently restricted net assets, while net assets not subject to such restrictions are classified as unrestricted net assets. For the years ended December 31, 1998 and 1997 there were no donor-restricted contributions to the Relief Fund. All net assets are unrestricted as of December 31, 1998 and 1997.

Reclassifications: Certain 1997 amounts have been reclassified to conform to the 1998 presentation.

American Dental Association Relief Fund

Notes to Financial Statements, December 31, 1998 and 1997 (continued)

2. Marketable Securities

Marketable securities as of December 31, 1998 and 1997 consisted of the following:

	1998		1997	
	Cost	Market	Cost	Market
Commercial paper	$ 187,182	187,182	950,148	950,148
Corporate bonds	330,642	352,198	141,714	150,325
U.S. government obligations	2,180,312	2,209,878	1,923,821	1,933,022
Common stocks	3,444,171	4,364,266	3,343,461	4,301,382
Total	$ 6,142,307	7,113,524	6,359,144	7,334,877

3. Furniture and Equipment

Furniture and equipment at December 31, 1998 and 1997 consisted of the following:

	1998	1997
Furniture and equipment	$ 32,211	29,946
Less accumulated depreciation	29,950	26,867
	$ 2,261	3,079

4. Related Party Transactions

The ADA provides administrative and financial support to the Relief Fund. General and administrative expenses include allocations from the ADA. The allocated cost of such services amounted to $16,800 and $15,600 during the years ended December 31, 1998 and 1997, respectively.

The Association sponsors a noncontributory defined benefit pension plan and a savings and retirement plan which cover substantially all employees of the Association and its subsidiaries meeting certain eligibility requirements. Pension expense charges are allocated to the Relief Fund in connection with its employees' participation in the Association's retirement plans. These expenses, which amounted to $17,113 and $0 for 1998 and 1997, respectively, are based upon the actual cash contributions made by the Association to the plans for the benefit of Relief Fund employees.

Additionally, the Association sponsors a contributory defined benefit postretirement health plan which covers substantially all employees of the Association and its subsidiaries. The Relief Fund expensed postretirement benefit charges of $3,014 and $3,990 for 1998 and 1997, respectively, associated with participating Relief Fund employees.

Periodically, expenses of one organization may be paid by an affiliated organization and subsequently reimbursed.

At December 31, 1998 and 1997, amounts due from (to) affiliated organizations were as follows:

	1998	1997
American Dental Association	$ 20,483	(316,359)
The ADA Endowment and Assistance Fund, Inc.	9,645	(5,000)
American Dental Association Health Foundation	-	100
	$ 30,128	(321,259)

American Dental Association Relief Fund

Notes to Financial Statements, December 31, 1998 and 1997 (continued)

5. Income Taxes

The Relief Fund has received a favorable determination letter from the Internal Revenue Service stating that it qualifies under section 501(c)(3) of the Internal Revenue Code (Code) and, therefore, is exempt from Federal income taxes on income related to its exempt purpose under section 501(a) of the Code. The Relief Fund had no significant unrelated business income during 1998 and 1997.

Report of Independent Certified Public Accountants

Board of Directors
The ADA Endowment and Assistance Fund, Inc.

We have audited the accompanying statements of financial position of the ADA Endowment and Assistance Fund, Inc. (Endowment Fund) as of December 31, 1998 and 1997, and the related statements of activities 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, 1998 and 1997 and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

Grant Thornton LLP

GRANT THORNTON LLP

Chicago, Illinois
April 2, 1999

The ADA Endowment and Assistance Fund, Inc.

Statements of Financial Position

December 31, 1998 and 1997

	1998	1997
ASSETS		
Cash	$ -	7,185
Accounts Receivable	-	2,043
Interest receivable	9,068	6,450
Loans receivable, net (Note 5)	141,770	157,754
Marketable securities, at market (Note 2)	1,705,909	1,681,115
Furniture and equipment, net (Note 3)	223	668
TOTAL ASSETS	$ 1,856,970	1,855,215
LIABILITIES AND NET ASSETS		
Accounts payable	$ 4,614	3,620
Due to affiliated organizations (Note 4)	91,742	75,405
TOTAL LIABILITIES	96,356	79,025
Net Assets (Note 1)	1,760,614	1,776,190
TOTAL LIABILITIES AND NET ASSETS	$ 1,856,970	1,855,215

See accompanying notes to financial statements.

The ADA Endowment and Assistance Fund, Inc.

Statements of Activities

Years ended December 31, 1998 and 1997

	1998	1997
REVENUES		
Earnings on investments:		
Interest and dividends	$ 74,217	72,829
Net realized capital gains	84,305	83,018
Net unrealized (depreciation) appreciation of marketable securities	(8,288)	55,181
Investment management fees and expenses	(22,823)	(22,747)
Net earnings on investments	127,411	188,281
Scholarship contributions	35,336	34,000
Contribution income	16,300	5,500
Interest on loans	5,492	6,438
TOTAL REVENUES	184,539	234,219
EXPENSES		
Dental Student Scholarship Awards	53,750	45,000
Dental Hygienist Scholarship Awards	10,000	9,997
Laboratory Technical Scholarship Awards	5,000	4,500
Dental Assistant Scholarship Awards	8,500	10,500
Minority Dental Student Scholarship Awards	36,000	33,000
General and administrative	76,920	74,849
Uncollectible loans expense	9,500	30,500
Depreciation	445	445
TOTAL EXPENSES	200,115	208,791
(Decrease) increase in net assets	(15,576)	25,428
Net assets at beginning of year	1,776,190	1,750,762
Net assets at end of year	$ 1,760,614	1,776,190

See accompanying notes to financial statements.

The ADA Endowment and Assistance Fund, Inc.

Statements of Cash Flows

Years ended December 31, 1998 and 1997

	1998	1997
CASH FLOWS FROM OPERATING ACTIVITIES		
(Decrease) increase in net assets	$ (15,576)	25,428
Adjustments to reconcile (decrease) increase in net assets to net cash used by operating activities:		
Provision for uncollectible loans receivable	9,500	30,500
Depreciation	445	445
Net realized capital gains	(84,305)	(83,018)
Net unrealized depreciation (appreciation) of marketable securities	8,288	(55,181)
Changes in assets and liabilities:		
Accounts receivable	2,043	(2,043)
Interest receivable	(2,618)	(480)
Accounts payable	994	1,412
Net cash used by operating activities	(81,229)	(82,937)
CASH FLOWS FROM INVESTING ACTIVITIES		
Disbursements of loans receivable	(48,500)	(44,700)
Proceeds from loans receivable	54,984	78,494
Purchase of marketable securities	(2,099,846)	(1,601,978)
Sale and maturity of marketable securities	2,151,069	1,650,376
Net cash provided by investing activities	57,707	82,192
CASH FLOWS FROM FINANCING ACTIVITIES		
Net change in due to affiliated organizations	16,337	4,256
Net (decrease) increase in cash	(7,185)	3,511
Cash at beginning of year	7,185	3,674
Cash at end of year	$ -	7,185

See accompanying notes to financial statements.

The ADA Endowment and Assistance Fund, Inc.

Notes to Financial Statements

December 31, 1998 and 1997

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.

Use of Estimates: In preparing financial statements in conformity with generally accepted accounting principles, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Marketable Securities: Investments in marketable securities are carried at fair value. The fair value of investments in marketable securities is estimated based on quotes from brokers or current rates offered for instruments with similar characteristics. Net realized capital gains or losses on sales are calculated based on the first in-first out (FIFO) cost of securities sold.

Furniture and Equipment: Furniture and equipment is stated at cost, less accumulated depreciation. Depreciation is computed on the straight line method once assets are put into service over the five-year estimated useful life of the assets.

Net Assets: Net assets subject to donor-imposed stipulations are classified as either temporarily or permanently restricted net assets, while net assets not subject to such restrictions are classified as unrestricted net assets. For the years ended December 31, 1998 and 1997, there were no donor-restricted contributions to the Endowment Fund. All net assets are unrestricted as of December 31, 1998 and 1997.

Reclassifications: Certain 1997 amounts have been reclassified to conform to the 1998 presentation.

2. Marketable Securities

Marketable securities at December 31, 1998 and 1997 consisted of the following:

	1998		1997	
	Cost	Market	Cost	Market
Commercial paper	$ 63,746	63,746	73,443	73,443
U.S. government obligations	822,912	836,233	840,076	849,422
Corporate bonds	41,983	46,063	41,551	43,718
Common stocks	621,126	759,867	561,615	714,532
	$ 1,549,767	1,705,909	1,516,685	1,681,115

The ADA Endowment and Assistance Fund, Inc.

Notes to Financial Statements (Continued)

December 31, 1998 and 1997

3. Furniture and Equipment

Furniture and equipment at December 31, 1998 and 1997 consisted of the following:

	1998	1997
Furniture and equipment	$ 2,226	2,226
Less accumulated depreciation	2,003	1,558
	$ 223	668

4. Related Party Transactions

The ADA provides administrative and financial support to the Endowment Fund. General and administrative expenses include allocations from the ADA. The allocated cost of such services amounted to $10,200 and $9,400 during the years ended December 31, 1998 and 1997, respectively.

Periodically, expenses of one organization may be paid by an affiliated organization and subsequently reimbursed.

At December 31, 1998 and 1997, amounts due from (to) affiliated organizations were as follows:

	1998	1997
American Dental Association	$ (82,097)	(80,405)
American Dental Association Relief Fund	(9,645)	5,000
	$ (91,742)	(75,405)

5. Loans Receivable

Loans receivable consist of loans to disaster victims, loans to assist in the treatment of chemically dependent dentists and loans for educational retraining, which are non-interest bearing until maturity. After maturing, annual interest rates are 12% on loans granted between April 1, 1981 and December 31, 1991, and 1% over the prime rate on loans granted after December 31, 1991. During 1998 and 1997, $4,500 and $9,000, respectively, of loans were determined to be impaired and were written off.

Loans receivable at December 31, 1998 and 1997 consisted of the following:

	1998	1997
Disaster loans	$ 71,062	106,369
Chemical dependency loans	88,011	61,487
Educational retraining loans	31,697	33,898
	190,770	201,754
Less allowance for uncollectible loans	49,000	44,000
	$ 141,770	157,754

The ADA Endowment and Assistance Fund, Inc.

Notes to Financial Statements (Continued)

December 31, 1998 and 1997

The repayment status of loans receivable was as follows:

	1998	1997
Loans in repayment	$ 109,820	119,984
Loans maturing in the future		
1998	-	49,070
1999	32,700	32,700
2001	48,250	-
	$ 190,770	201,754

6. Income Taxes

The Endowment Fund has received a favorable determination letter from the Internal Revenue Service stating that it qualifies under Section 501(c)(3) of the Internal Revenue Code (Code) and, therefore, is exempt from Federal income taxes on income related to its exempt purpose under Section 501(a) of the Code. The Endowment Fund had no significant unrelated business income during 1998 and 1997.

American Dental Association

Supplemental Financial Information for the Year Ended December 31, 1998
(Unaudited)

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
REVENUES		
Membership Dues	$ 38,953,700	38,447,400
Advertising	126,400	-
Rental Income	2,300,738	2,466,050
Publication and Product Sales	4,764,728	5,046,450
Subscriptions	184,477	145,000
Testing and Accreditation Fees	5,204,808	4,798,100
Meeting and Seminar Income	7,440,046	8,182,300
Grants and Contributions	945,188	895,500
Royalties	813,367	902,000
Investment Income	642,016	560,000
Other Income	2,162,237	2,257,250
TOTAL REVENUES	63,537,705	63,700,050
EXPENSES (Note A)		
Staff Compensation, Taxes and Benefits	25,968,633	27,815,050
Printing, Publication and Marketing	7,140,756	7,893,558
Meeting Expenses	3,081,015	3,226,750
Travel Expenses	4,479,613	5,005,072
Professional Services	6,153,635	6,964,570
Office Expenses	4,188,064	4,847,100
Facility and Utility Expenses	2,735,232	3,429,800
Grants and Awards	225,756	257,550
Grant—ADA Health Foundation	1,978,205	2,032,200
Endorsement Expenses	69,592	72,000
Depreciation and Amortization	861,846	815,000
Other Expenses	1,153,551	1,417,500
TOTAL EXPENSES	58,035,898	63,776,150
NET REVENUE/(EXPENSE) BEFORE INCOME TAXES	5,501,807	(76,100)
Income Taxes	(4,487)	(20,000)
NET REVENUE/(EXPENSE) AFTER INCOME TAXES	5,497,320	(96,100)

	1998 ACTUAL	1998 BUDGET
Pension Funding Adjustment	(383,218)	-
1997 Spending on National Public Awareness Campaign	(308,847)	-
Carryforwards from 1998 Operations	(316,700)	-
Funded Depreciation	(1,454,600)	(1,454,600)
1997 to 1998 Carryforwards Expended	206,757	738,450
Dividends	540,000	850,000
NET REVENUE/(EXPENSE)	$3,780,712	37,750
Monies Due From Reserves:		
ADA Online 2000 and TAMS	$(663,577)	-
Purchase of Lab Equipment	(426,608)	-
Dental Handpieces for Annual Session (Expenses Net of Revenue)	(4,363)	-
Retiree Medical to Reserves	525,985	-
Unspent Carryforwards from 1997	531,693	-
Board Room Voting System	(3,698)	-
Data Collection from ECCo	(22,500)	-
	$(63,068)	-
ADREC Cash Flow Loss	$(437,366)	-
Total Funds to be Transferred to Reserves	$3,280,278	(Note B)

Notes:

(A) Actual and budgeted expenses by natural accounts include activity related to projects carried forward from 1997 to 1998. Alternatively, the grant to the ADA Health Foundation is displayed as one line item.

(B) It was anticipated that a 1998 cash flow loss from ADREC of $395,800 plus a principal payment of $1,656,000 would be funded from reserves. In addition to the $437,366 pending transfer shown above, $1,717,678 was distributed from reserves to ADREC during 1998 to support the February 1 principal payment and prepayment penalty for a total amount of $2,155,044.

Divisional Summary Worksheets

Division of Administration and Policy

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
REVENUES		
Grants and Contributions	$ 2,662	-
Other Income	53,102	33,500
TOTAL REVENUES	55,764	33,500
EXPENSES		
Staff Compensation	2,025,339	2,170,350
Printing, Publication and Marketing	2,755,928	2,785,600
Meeting Expenses	66,536	110,000
Travel Expenses	1,060,116	1,136,000
Professional Services	1,315,143	1,557,200
Office Expenses	566,077	696,800
Facility and Utility Expenses	150	400
Other Expenses	451,065	462,300
TOTAL EXPENSES	8,240,354	8,918,650
NET REVENUE/(EXPENSE)	$ (8,184,590)	(8,885,150)

Division of Legal Affairs

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
REVENUES		
Publication and Product Sales	$ -	1,500
Meeting and Seminar Income	(280)	-
Other Income	38,127	30,200
TOTAL REVENUES	37,847	31,700
EXPENSES		
Staff Compensation	1,164,767	1,227,350
Printing, Publication and Marketing	57,873	57,208
Meeting Expenses	7,282	10,950
Travel Expenses	69,634	75,672
Professional Services	760,296	788,720
Office Expenses	54,836	76,050
Other Expenses	240	2,600
TOTAL EXPENSES	2,114,928	2,238,550
NET REVENUE/(EXPENSE)	$ (2,077,081)	(2,206,850)

Division of Government Affairs

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
REVENUES		
Meeting and Seminar Income	$ 9,110	10,000
TOTAL REVENUES	9,110	10,000
EXPENSES		
Staff Compensation	1,689,622	1,836,850
Printing, Publication and Marketing	43,132	74,000
Meeting Expenses	212,532	138,600
Travel Expenses	402,297	635,000
Professional Services	102,092	164,100
Office Expenses	262,702	369,050
Facility and Utility Expenses	8,740	15,000
Grants and Awards	25,000	50,000
Other Expenses	8,799	11,500
TOTAL EXPENSES	2,754,916	3,294,100
NET REVENUE/(EXPENSE)	$ (2,745,806)	(3,284,100)

Division of Communications

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
REVENUES		
Publication and Product Sales	$ 98,426	125,000
Meeting and Seminar Income	10,000	10,000
TOTAL REVENUES	108,426	135,000
EXPENSES		
Staff Compensation	1,308,785	1,323,250
Printing, Publication and Marketing	621,290	708,250
Meeting Expenses	22,324	27,000
Travel Expenses	91,121	127,900
Professional Services	55,724	68,700
Office Expenses	106,836	171,700
Facility and Utility Expenses	112	-
Other Expenses	1,042	5,300
TOTAL EXPENSES	2,207,234	2,432,100
NET REVENUE/(EXPENSE)	$ (2,098,808)	(2,297,100)

Division of Membership and Dental Society Services

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
REVENUES		
Publication and Product Sales	$ 513	11,900
Meeting and Seminar Income	64,097	95,200
Grants and Contributions	260,390	386,700
Other Income	1,134	-
TOTAL REVENUES	326,134	493,800
EXPENSES		
Staff Compensation	1,946,814	2,033,450
Printing, Publication and Marketing	328,895	346,450
Meeting Expenses	177,652	178,150
Travel Expenses	292,816	362,750
Professional Services	220,185	368,450
Office Expenses	323,792	400,600
Facility and Utility Expenses	58	600
Other Expenses	8,773	9,900
TOTAL EXPENSES	3,298,985	3,700,350
NET REVENUE/(EXPENSE)	$ (2,972,851)	(3,206,550)

Division of Conference and Meeting Services

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
REVENUES		
Advertising	$ 126,400	-
Rental Income	49,355	35,000
Publication and Product Sales	214,007	243,500
Meeting and Seminar Income	6,658,334	7,259,100
Grants and Contributions	488,079	239,800
Other income	39,690	127,500
TOTAL REVENUES	7,575,865	7,904,900

Division of Conference and Meeting Services (continued)

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
EXPENSES		
Staff Compensation	1,091,056	1,176,950
Printing, Publication and Marketing	683,807	627,900
Meeting Expenses	2,045,006	2,109,200
Travel Expenses	448,547	483,550
Professional Services	849,074	772,500
Office Expenses	398,031	299,400
Facility and Utility Expenses	42,547	48,700
Other Expenses	9,499	18,300
TOTAL EXPENSES	5,567,567	5,536,500
NET REVENUE/(EXPENSE)	$ 2,008,298	2,368,400

Division of Finance and Operations

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
REVENUES		
Investment Income	$ 620,830	560,000
Other Income	551,199	488,150
TOTAL REVENUES	1,172,029	1,048,150
EXPENSES		
Staff Compensation	1,894,199	2,120,100
Printing, Publication and Marketing	68,788	63,100
Meeting Expenses	5,992	6,500
Travel Expenses	51,178	73,800
Professional Services	291,766	121,100
Office Expenses	103,215	149,050
Other Expenses	173,596	126,400
TOTAL EXPENSES	2,588,734	2,660,050
NET REVENUE/(EXPENSE)	$ (1,416,705)	(1,611,900)

Headquarters Building

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
REVENUES		
Rental Income	$ 2,236,383	2,416,050
Other Income	61,090	24,000
TOTAL REVENUES	2,297,473	2,440,050
EXPENSES		
Staff Compensation	376,320	376,300
Printing, Publication and Marketing	23,355	23,000
Professional Services	127,915	105,600
Office Expenses	22,998	20,550
Facility and Utility Expenses	2,665,138	3,355,900
Other Expenses	74,693	99,200
TOTAL EXPENSES	3,290,419	3,980,550
NET REVENUE/(EXPENSE)	$ (992,946)	(1,540,500)

Salable Materials

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
REVENUES		
Publication and Product Sales	$ 4,389,962	4,590,550
Subscription Income	184,477	145,000
Other Income	499	2,000
TOTAL REVENUES	4,574,938	4,737,550
EXPENSES		
Staff Compensation	415,252	437,550
Printing, Publication and Marketing	1,659,967	1,923,200
Meeting Expenses	48,653	47,250
Travel Expenses	23,461	30,700
Professional Services	759,457	768,250
Office Expenses	65,187	70,100
Facility and Utility Expenses	6,467	2,500
Other Expenses	20,327	12,000
TOTAL EXPENSES	2,998,771	3,291,550
NET REVENUE/(EXPENSE)	$ 1,576,167	1,446,000

Central Administration

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
REVENUES		
Membership Dues	$ 38,953,700	38,447,400
Rental Income	15,000	15,000
Royalties	557,744	670,000
Investment Income	21,186	-
Other Income	722,076	700,000
TOTAL REVENUES	40,269,706	39,832,400
EXPENSES		
Staff Compensation	5,354,025	5,381,400
Printing, Publication and Marketing	12,337	52,850
Meeting Expenses	3,166	35,300
Travel Expenses	64,956	(357,300)
Professional Services	58,133	229,400
Office Expenses	118,826	174,050
Facility and Utility Expenses	4,082	2,500
Grants and Awards	110,044	112,550
Endorsement Expenses	69,592	72,000
Depreciation and Amortization	861,846	815,000
Other Expenses	359,831	653,400
EXPENSES SUBTOTAL	7,016,838	7,171,150
Income Taxes	4,487	20,000
TOTAL EXPENSES	7,021,325	7,191,150
NET REVENUE/(EXPENSE)	$ 33,248,381	32,641,250

Division of Information Technology

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
REVENUES		
Publication and Product Sales	$ 61,892	70,000
Royalties	255,473	225,000
Other Income	-	1,000
TOTAL REVENUES	317,365	296,000
EXPENSES		
Staff Compensation	1,506,647	1,891,200
Printing, Publication and Marketing	(63)	-
Meeting Expenses	3,300	-
Travel Expenses	76,239	46,450
Professional Services	383,790	247,000
Office Expenses	1,027,346	1,009,650
Other Expenses	30,138	-
TOTAL EXPENSES	3,027,397	3,194,300
NET REVENUE/(EXPENSE)	$ (2,710,032)	(2,898,300)

Division of Dental Practice

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
REVENUES		
Publication and Product Sales	$ (72)	-
Meeting and Seminar Income	609,705	684,000
Grants and Contributions	194,057	219,000
Royalties	150	7,000
Other Income	1,384	12,500
TOTAL REVENUES	805,224	922,500
EXPENSES		
Staff Compensation	1,743,019	2,002,550
Printing, Publication and Marketing	278,381	594,300
Meeting Expenses	132,536	141,200
Travel Expenses	685,268	888,000
Professional Services	378,492	505,250
Office Expenses	197,968	268,050
Facility and Utility Expenses	3,348	200
Other Expenses	5,815	1,500
TOTAL EXPENSES	3,424,827	4,401,050
NET REVENUE/(EXPENSE)	$ (2,619,603)	(3,378,550)

Health Policy Resources Center

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
REVENUES		
Other Income	$ 128,378	93,400
TOTAL REVENUES	128,378	93,400
EXPENSES		
Staff Compensation	835,118	926,600
Printing, Publication and Marketing	6,054	35,050
Meeting Expenses	4,587	10,500
Travel Expenses	26,844	28,400
Professional Services	294,704	427,500
Office Expenses	251,381	245,500
Other Expenses	759	-
TOTAL EXPENSES	1,419,447	1,673,550
NET REVENUE/(EXPENSE)	$ (1,291,069)	(1,580,150)

Division of Education

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
REVENUES		
Publication and Product Sales	$ -	3,000
Testing and Accreditation Fees	5,204,808	4,798,100
Meeting and Seminar Income	89,080	124,000
Other Income	82,118	113,500
TOTAL REVENUES	5,376,006	5,038,600
EXPENSES		
Staff Compensation	2,807,088	2,955,550
Printing, Publication and Marketing	526,648	498,050
Meeting Expenses	268,695	314,900
Travel Expenses	1,064,728	1,172,400
Professional Services	453,556	395,600
Office Expenses	471,449	578,100
Facility and Utility Expenses	4,590	4,000
Grants and Awards	59,712	64,000
Other Expenses	8,836	15,100
TOTAL EXPENSES	5,665,302	5,997,700
NET REVENUE/(EXPENSE)	$ (289,296)	(959,100)

Division of Science

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
REVENUES		
Publication and Product Sales	$ -	1,000
Grants and Contributions	-	50,000
Other Income	483,440	506,500
TOTAL REVENUES	483,440	557,500
EXPENSES		
Staff Compensation	1,810,582	1,945,450
Printing, Publication and Marketing	74,364	73,500
Meeting Expenses	17,560	31,200
Travel Expenses	117,973	155,050
Professional Services	6,395	21,800
Office Expenses	202,205	282,350
Grants and Awards	6,000	6,000
Other Expenses	138	-
TOTAL EXPENSES	2,235,217	2,515,350
NET REVENUE/(EXPENSE)	$ (1,751,777)	(1,957,850)

ADA Health Foundation

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
REVENUES		
Miscellaneous Income	$ -	125,000
TOTAL REVENUES	-	125,000
EXPENSES		
Grant—ADA Health Foundation	1,978,205	2,032,200
TOTAL EXPENSES	1,978,205	2,032,200
NET REVENUE/(EXPENSE)	$ (1,978,205)	(1,907,200)

Carryforwards

NATURAL ACCOUNTS	1998 ACTUAL	1998 BUDGET
EXPENSES		
Staff Compensation	-	10,150
Printing, Publication and Marketing	-	31,100
Meeting Expenses	65,194	66,000
Travel Expenses	4,435	146,700
Professional Services	96,913	423,400
Office Expenses	15,215	36,100
Grants and Awards	25,000	25,000
TOTAL EXPENSES	206,757	738,450
NET REVENUE/(EXPENSE)	$ (206,757)	(738,450)

1998 Contingent Fund

Board-Approved Allocations Compared with Actual

	Actual Expenses Net	Board Approved Allocations
House, Board, Executive Director, Administration and Policy, Quality and Strategic Planning		
FDI Mid-Year Meeting	$ 12,193	11,600
1998 Council Chairs Meeting	11,217	15,550
Alternative Public Awareness Campaign	14,310	44,050
Legal Affairs		
CEBJA Subcommittee to Study Credentials	0	2,300
DMSO Supplement to *JADA*	0	81,000
Government Affairs		
Additional Funds for Third National Grassroots Conference	0	40,000
Funds to Support PARCA	10,000	24,000
Contribution to PARCA for Consulting	34,132	65,000
Grant to Mississippi Dental Association	5,044	5,050
Grant to Texas	0	2,500
Communications		
National Telephone Hotline Day	9,825	12,650
Response to "60 Minutes"	1,785	41,700
Membership and Dental Society Services		
Getting Off to a Smart Start Program	0	18,200
Dental Practice		
Study of DMSOs	2,739	7,300

	Actual Expenses Net	Board Approved Allocations
Education		
Joint ADA/AADS Steering Committee	8,650	9,700
Completion of Data Dictionary Project	16,508	27,500
Committee on Examiner Calibration	4,451	23,950
Science		
Interagency Task Force on Bloodborne Pathogens	7,441	10,750
ADA Health Foundation		
ADAHF Planned Giving Program	0	9,900
Total Expense Allocation for 1998 Contingent Fund	$ 138,295	452,700

Supplemental requests funded from reserves: The Board also authorized the following supplemental requests for funding from reserves, rather than the contingent fund, because their actions cross fiscal years. Through December 31, 1998 the following has been expended:

Tripartite Association Management System	$ 691,996	(B)	691,000
Subscription Module for TAMS	41,600	(B)	87,000
Dental Handpieces for Annual Session (A)	4,363	(B)	2,450
Board Room Voting System Upgrade	3,698	(B)	15,500
Electronic Claims Data Collection	22,500		108,000
Member/Nonmember Differentiation System	61,727	(B)	60,000
Continuation of Library Automation Project	0		18,500
	$ 825,884		982,450

Notes: (A) The authorized amount of $2,450 represents the net approved costs. Actual expenses of $48,663 were offset by revenues, through ticket sales at annual session, in the amount of $44,300.
(B) Funds spent include both expense items as well as capital items.

Notes

Appendix

Notes

Index to Resolutions

1998 Resolutions

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