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ADA American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611
Pages 1-245

2002

Annual Reports and Resolutions

143rd Annual Session

New Orleans, Louisiana

October 19-23, 2002

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Annual Reports and Resolutions

143rd Annual Session

New Orleans, Louisiana

October 19-23, 2002

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Special Note

Copies of *2002 Annual Reports and Resolutions* have been mailed to 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

Schwartz, Stephen F., Texas, 2002, chairman
Daly, Nelson P., Louisiana, 2002, *ex officio*[*]
Gamba, Thomas W., Pennsylvania, 2003
Hadlock, William A., Louisiana, 2005
Hewett, Sally, Washington, 2002
Hite, D. Stanley, Missouri, 2005
Kattner, Paul F., Illinois, 2005
Kent, Ronald J., Minnesota, 2003
LoMonaco, Carmine J., New Jersey, 2005
Mueller, Carl M., Michigan, 2004
Olmsted, John S., North Carolina, 2004
Parnes, Edmund I., Florida, 2003
Schachner, Joseph, New York, 2002
Schott, Kenneth, Louisiana, 2002, *ex officio*
Sessa, Kevin D., Colorado, 2004
Shinbori, Dennis D., California, 2003, *ex officio*
Tonelli, J. Steven, Massachusetts, 2002
Williams, Frank C., Ohio, 2003
Williamson, James R., Georgia, 2004
Yarborough, Craig S., California, 2004
Guinta, Vicki, director
Cherrett, Helen McK., manager
Donovan, James, manager
Johnson, Patricia, manager

Meetings: The Council met February 7-9, 2002 at the Headquarters Building in Chicago, and May 29-June 1, 2002 in New Orleans.

Activities: During the past year, the Council on ADA Sessions and International Programs (CASIP) continued to serve as the planning body for the annual scientific session and technical exhibition. At its February meeting, the Council continued planning for the 2002 annual scientific session and exhibition in New Orleans. 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 its progress. At the June meeting, the Council finalized plans for the 2002 annual session and continued its planning for the 2003 and 2004 meetings.

American Dental Association Strategic Plan: The Association's annual scientific program provides a full schedule of the highest quality and comprehensive continuing dental education courses to the membership, and provides documentation of members' attendance at courses for continuing education purposes. The scientific program supports Member and Support Services: achieve the highest possible membership market share; Practice Support: enhance the effectiveness of dentists and their staff; Image, Ethics and Professionalism: communicate dentistry's message to the public and ADA's value to dentists; and Information: analyze, interpret, synthesize and disseminate information on oral health care. At the same time, the meeting generates significant non-dues revenues for the Association and therefore also provides resources that support membership development and retention: operations, infrastructure and resource management.

The Council has continued to identify action plans to support various goals and objectives of the ADA Strategic Plan, has established criteria for measuring success in meeting those and has evaluated the effectiveness of its activities using those criteria. Activities that no longer strongly support the Plan are being eliminated and new activities that support the Plan have been identified for implementation at the earliest possible date. At its February 2002 meeting, the Council drafted a comprehensive strategic plan that itemizes objectives that support the goals of the ADA Strategic Plan.

Future of Dentistry Report: The Council reviewed and discussed the Future of Dentistry Report at its February 2002 Council meeting held at the ADA Headquarters building. Below is a summary of items that the Council addressed during its meeting.

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

Research Recommendations—The ADA annual session could be a significant venue for the reporting and dissemination of information relative to craniofacial research emanating from NIDCR.

Recommendations for Global Oral Health—Many of the current activities of the International Subcommittee support these recommendations.

Technological Advances in Clinical Practice Management—The ADA annual session will need to continue to monitor changes in the formats of continuing education in order to remain relevant to its members.

Competency—CE courses presented at the annual session may need to employ pre- and post-test questions to help in the assessment of competency.

Life-Long Learning—The ADA annual session has been established by survey results as a major source of continuing dental education. The focus of the scientific program should be biased in helping ADA members fulfill their commitment to life-long learning and satisfying the mandatory CE for re-licensure.

Life-Long Learning Formats—The ADA annual session will need to be ever vigilant in the challenge by for-profit entities, both dental and non-dental in nature. The ADA annual session currently employs two of the three delivery formats for continuing education: the standard, traditional lecture and hands-on participation courses. The annual session will need to understand and take advantage of the third format—interactive self-instruction, along with automated real-time testing, both via the Internet. The utilization of ADA.org along with the library of digitally recorded annual session courses positions CASIP and the ADA in a leadership role in providing CE utilizing the Internet.

Background to the Change of the Annual Session Schedule: The ADA House of Delegates encouraged the Council on ADA Sessions and International Programs to review and enhance the ADA annual session. After extensive research, consultation and discussion, the Council recommended to the ADA Board of Trustees, at their February 2002 meeting, that the scientific sessions schedule change to now take place on Thursday, Friday, Saturday and Sunday; and the technical exhibits to now be scheduled on Friday, Saturday and Sunday at the ADA annual session beginning in October 2003 in San Francisco. The Board subsequently adopted the Council's recommendation.

A supplemental report will be forwarded to the 2002 House of Delegates to address Resolution 128H-2001 (*Trans*.2001:427), which called for the Council to study all aspects of the annual session and report its recommendations to the 2002 House of Delegates.

142nd Annual Session, Kansas City, Missouri, October 13-17, 2001

Kansas City, Missouri was the site of the Association's 142nd Annual Scientific Session and Technical Exhibition. This was the first time since 1981 that the ADA held its annual meeting in the heartland of the United States. The Kansas City Convention Center was the location for the exhibition, most of the scientific program, and meetings of the House of Delegates. The ADA/Dentsply Student Clinician Program and the ADAHF Health Screening Program were located at the Convention Center as well. Some programs were presented at the Kansas City Marriott Hotel. The Council wishes to express its appreciation to the University of Missouri - Kansas City School of Dentistry for their assistance, and for helping to make their laboratories available for annual session workshops.

Total registration was 18,619 including 5,406 dentists. A total of 1,058 standard booths were occupied in the exhibit hall including 989 booths rented to 489 companies and organizations, and 28 complimentary booths provided to related dental organizations. In addition, the ADA Membership Services Pavilion was comprised of 31 booths (13 ADA Member Advantage providers and 18 ADA agencies and councils).

Opening Ceremony: The Opening Ceremony was convened in the Municipal Arena of the Kansas City Convention Center. The event included a presentation by veteran journalist Walter Cronkite, a Missouri native.

Scientific Program: In 2001, over 190 courses on a wide selection of dental topics were offered in Kansas City. Over 4,500 participants attended at least one course during annual session. Two courses were captured for DVD production and most of the other courses were audiotaped. These tapes were available for purchase at the meeting and following the meeting.

A full schedule of registered clinics, lectures and participation workshops were offered during the annual session in Kansas City. In addition to the open attendance courses, 19 registered clinics and 33 participation workshops were offered. The registered clinics addressed a variety of topics including technology, practice management, endodontics and esthetics. Attendance at the clinics was 1,590. Workshops had more than 630 participants. In addition to the regular schedule of courses, "Technology Day IV: a technology odyssey" was attended by over 400 attendees and "Team Building Conference VI: a wizard's guide to team building" was held with 210 participants for this two-day course. Due to the travel situation, several clinicians provided programs to replace speakers who could not attend the meeting. The speakers who substituted were: Dr. Paul C. Belvedere, Dr. Nolen Levine, Dr. K. William "Bud" Mopper, Dr. L. Stephen Buchanan, Dr. Stephen Schwartz, Dr. Roger Levin and Dr. Steven Jeffries.

Post-Session Seminars: The post-session seminars were canceled due to an insufficient number of registrants.

Table Clinics: The table clinic program was held on Saturday, October 13. Twelve clinics were presented on Saturday. Attendees at the table clinics received two hours of continuing education credit.

ADA/DENTSPLY Student Clinician Program: The student program, which celebrated its 42nd anniversary at the 2001 annual session, is conducted annually by the Council and is financially supported by DENTSPLY International, Inc., York, Pennsylvania.

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 15 and to the general attendance on Monday afternoon at the Kansas City Convention Center. On Tuesday morning the winning students presented their clinics.

Winning students in Category I, Clinical Application and Technique, were: Dana Gamblin, Southern Illinois University School of Dental Medicine, first place; Demotrios Syrpes, University of Colorado Health Sciences Center School of Dentistry, second place; and Thomas Faber, University of California at Los Angeles School of Dentistry, third place.

Winning students in Category II, Basic Science and Research, were: Ginger P. Glayzer, University of California at San Francisco School of Dentistry, first place; Sherri Lyn W.J. Chong, University of Pittsburgh School of Dental Medicine, second place; and Daniel H. Chen, University of Pennsylvania 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 2002 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. Jack Penhall, Greensburg, PA, chairman; Dr. Shirley Austin, Dearborn, MI; Dr. Stephen B. Corbin, Rockville, MD; Dr. Peter Guevara, Pittsburgh, PA; Dr. Arthur Hunger, Jr., York, PA; Dr. Keith Krell, West Des Moines, IA; Dr. Dan Middaugh, Seattle, WA; and Dr. John S. Rutkauskas, Hinsdale, IL.

Judges for Category II were: Dr. Richard Tatum, Columbia, MD, chairman; Dr. Robert Augsburger, Tulsa, OK; Dr. Thomas Emmering, Bloomingdale, IL; Dr. Mirdza E. Neiders, Amherst, NY; Dr. Rahele Rezai, Washington, D.C.; Dr. Jon B. Suzuki, Pittsburgh, PA; Dr. Joel White, San Francisco, CA; and Dr. Hans J. Wenz, Germany.

143rd Annual Session, New Orleans, Louisiana, October 19-22, 2002

New Orleans, Louisiana is the site of the Association's 2002 annual session. The Morial Convention Center will house all scientific and general audience programs, table clinics, the ADAHF Health Screening Program, the exhibition as well as meetings of the House of Delegates.

Distinguished Speakers Series: General sessions will be convened at the Morial Convention Center on Saturday, October 19, Sunday, October 20 and Monday, October 21. Featured speakers will be former U.S. President, George Bush, former U.S. Secretary of State, Madeleine Albright and former Senate Majority Leader, Bob Dole.

Scientific Program: The 2002 scientific program offers courses on a wide range of topics, including esthetics, prosthodontics, periodontics, anesthesia, operative dentistry, financial management and practice management. New topics included in the scientific program are HIPAA: Health Insurance Portability and Accountability Act; bioterrorism; and personal digital assistants. New programs for the 2002 annual session include: the ADA Aging and Oral Health Conference, "Oral cancer: I think I found it…now what do I do?"; ADA Women's Leadership Conference: the business of dentistry (participation workshop); and the participation workshop "The cutting edge of esthetics: where form meets function." The ADA Aging and Oral Health Conference presents an overview of aspects of caring for the aging population including using age defying esthetics, treating nursing home residents, treating patients with medical risk factors and treating difficult denture patients. Featured speakers are: Dr. Paul C. Belvedere, Dr. Gregory J. Folse, Dr. Gretchen Gibson, Dr. Randy Huffines, Dr. Linda Niessen and Dr. Barbara J. Steinberg. The participation workshop, "The cutting edge of esthetics" is a 2-day didactic and workshop with featured speakers Dr. Loyle "Buzz" Raymond, Dr. Jay Anderson, Dr. David Latz and Dr. Gloria McNeil. The Women's Conference features world recognized speakers presenting an overview of the business of dentistry highlighting specific areas that are unique to women in practice including women's health, finance, developing a practice, leadership and staff management issues. Featured speakers are Dr. Linda Niessen, Dr. Jacinthe Paquette, Dr. Bette Robin, Dr. Cherilyn Sheets, Dr. Barbara J. Steinberg, Dr. Cynthia Brattesani and Terry Savage. Keynote speaker for the all-day program is Dame Margaret Seward, chief dental officer at the Department of Health for England, who, in 2002, held three top jobs in dentistry—chief dental officer, president of the General Dental Council and president of the British Dental Association.

Post-Session Seminars: Post session seminars have been suspended for 2002.

Table Clinics: Table clinics are scheduled for Saturday, October 19, 11:00 a.m. -2:00 p.m. Attendees at the table clinics can receive two hours of continuing education credit.

ADA/DENTSPLY Student Clinician Program: This year's student clinician program marks the 43rd year it has been an important feature of the annual session. Presentation of the student clinics is Monday, October 21, from 2:00 - 4:00 p.m. in the table clinic area on the exhibit floor at the Morial Convention Center. Each accredited dental school in the United States including Puerto Rico sends the winner of its table clinic competition to participate in the annual session. The winners of this competition present their clinics for the general registration on Tuesday, October 22, from 9:30 a.m. - 12:00 p.m. Winners of the DENTSPLY-sponsored

competitions in Australia, Canada, France, Germany, India, Japan, Korea, Scandinavia, South Africa, Sweden, Taiwan, Thailand and the United Kingdom will also present their clinics during the open presentations on Monday and with the winners of the U.S. competition on Tuesday.

International Activities

Certificate of Recognition for Volunteer Service in a Foreign Country: At its May meeting, the Council reviewed the nominations for the Certificate of Recognition for Volunteer Service in a Foreign Country. There were 94 nominations that completely fulfilled the criteria and were awarded Certificates and 27 incomplete applications. It is believed that the number of applications decreased this year due to the resulting travel restrictions and concerns that followed the national tragedy in September 2001.

This year two articles about the program appeared in the *ADA News,* March 4 and April 15, a news release appeared on the ADA Web page, and two notices appeared in the Executive Director's Update. In addition, a mailing was sent to constituent and component dental societies and deans of dental schools as well as to the 69 volunteer organizations listed in the publication *International Dental Volunteer Organizations: A Guide to Service and a Directory of Programs.*

Since the program was initiated in 1975, 2,324 Certificates have been awarded to individuals in 50 states and the District of Columbia. 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.

Global Health Council (GHC): Four years ago 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 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 given a rare opportunity to reinvent itself. This reorganization followed the recommendations by Dr. C. Everett Koop's NCIH Strategic Consultative Group. The ADA, through its former Council member representative played a prominent role in this transition to the Global Health Council, which better reflects the focus on the need for improving global health and making health one of the cornerstones of globalization.

The new mission of the organization is to promote better health around the world by assisting all who work for improvement and equity in global health to secure the information and resources they need to work effectively. To this end the GHC serves its members through work in advocacy, building alliances, and community experiences and best practices.

In order to enhance the voice of the members in setting the Council's technical and policy agenda, the Board of Directors endorsed the establishment of an Advisory Council and a series of advisory committees. The Advisory Council was incorporated into the GHC's new bylaws to complement the role of the Board of Directors. It also serves to advise the president and board on priority policy issues, and the chair of the Advisory Council sits on the GHC's Board of Directors. The Advisory Council is made up of representatives from each of the advisory committees. Each advisory committee is made up of Council members with strong interest and expertise in the specific committee's theme. Since the themes are established according to the members' priorities and commitments, in light of current membership interest they have started with issues such as: Child Nutrition Survival, HIV/AIDS, and Infectious Diseases. It is through the establishment of an advisory committee on oral health that the Association hopes to play a role within the Global Health Council.

An ADA representative, Dr. Kathryn Kell, a consultant to the Council, no longer has a seat on the Board of GHC, but 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 29th annual conference was held May 28-31 and the theme was "Global Health in Times of Crisis." Internationally acclaimed leaders joined frontline health workers in assessing progress made, lessons learned and challenges still to be met in addressing the health needs of families and communities in the face of war, political strife, natural disasters and environmental catastrophes. Two members of the ADA/HVO Dentistry Overseas program had their programs accepted for presentation at the conference: Dr. Peter Berthold, Abstract—Actions Against Noma in sub-Saharan Africa, Presentation format—Roundtable; and Dr. Valerie Robison, Abstract—Improving the KAP of Thai dentists regarding HIV/AIDS, Presentation format—Poster. At this conference Dr. Kell continued to support the efforts to develop an oral health committee as part of the Advisory Council.

Health Volunteers Overseas (HVO): HVO is a nonprofit organization established in 1986 to improve health care in developing countries through education and training. HVO currently has over 2,100 members and has ten active divisions in anesthesia, dentistry, hand surgery, medicine, nurse anesthesia, nursing, oral and maxillofacial surgery, orthopedics, pediatrics, and physical therapy. Programs operate in 25 countries around the world. Since 1986, HVO has sent more than 3,400 health professionals abroad. Between 1986 and 2000, HVO has delivered educational materials valued at more than $13 million to over 45 program sites (2000 figures). While each program varies according to the needs of the host country, certain elements remain constant, including an emphasis on the transfer of skills rather than the performance of clinical work. In addition, training focuses on pathologies

and problems that are common locally; it makes use of local supplies and equipment as well as encourages trainees to teach their colleagues what they have learned. HVO recruits highly qualified volunteers (dentists, nurses, physicians, physical therapists, and other professionals) and places them overseas to teach. HVO volunteers work side-by-side with local counterparts giving lectures, conducting ward rounds, and demonstrating procedures and techniques in classrooms, clinics and operating rooms.

Dentistry Overseas: In 1989, the Board of Trustees adopted a proposal (*Trans*.1989:471) that established an ADA Voluntary Service Program, under the auspices of HVO. The program is managed by a special steering committee, composed of seven consultants and a Council member who acts as the liaison. Dr. Sally Hewett is the liaison, and Dr. Peter Berthold, Dr. Kevin S. Harwick, Dr. Martin H. Hobdell, Dr. C. Neil Kay, Dr. Gary S. Leff (chairperson), Dr. Stephen B. Mackler and Dr. Valerie Anne Robison were appointed to serve on the committee for terms ending with the 2002 annual session. This experienced committee is sensitive to the oral health needs of the developing world and selects programs and activities that are realistic and practical.

As of March 2002, there were 220 members in the Dentistry Overseas Division of HVO. During 2001, 43 dental volunteers in this program served as follows: nine in Brazil; three in Haiti; four in Jamaica; 12 in St. Lucia; nine in Vietnam; and four in Moldova including the site assessment. In addition, a site assessment was conducted in Nepal (two). For the first quarter of 2002, 12 volunteers have served with Dentistry Overseas.

In 2002, the committee met on January 26-27 in Miami Beach, Florida and appointed Dr. Leff as chair. At this meeting, the committee reviewed the annual reports from the current programs in Dhaka—Bangladesh, Santarem—Brazil, Haiti, Chisneau—Moldova, Jamaica, St. Lucia, and Ho Chi Minh City—Vietnam. The program in Zimbabwe was put on hold in January 2001 due to political instability in the country but has since been canceled due to the violent and unstable outcome of the national election. The program in India was re-established for a trial period of one year. The committee discussed the possibility of a potential program in Dharan in Eastern Nepal but a final agreement is on hold until the U.S. Department of State Public Announcement Travel Advisory to Nepal has been softened.

For the second time, at the annual session in New Orleans, the ADA/HVO Dentistry Overseas Steering Committee is presenting an International Volunteer Symposium (one and one-half day program) just before the annual session. Limited to 40 dentists, the symposium has been subsidized by grants to HVO from the Pierre Fauchard Academy and the Academy of Dentistry International. The symposium will be held at the Hilton New Orleans Riverside Hotel beginning with a reception and a multicultural training exercise Thursday evening, October 17 and continuing all day on Friday, October 18. Topics include: the role of volunteers in developing countries; effective cross-cultural communication; appropriate interventions within dentistry, techniques for transferring appropriate skills and knowledge to local health care practitioners; and a cookbook approach to organizing international volunteer service programs. The program includes lectures and interactive sessions. The International Volunteer Symposium is designed primarily for those who are interested in volunteering overseas for the first time but veteran international dental volunteers will also find this program helpful. Speakers include Dr. Gary Leff, Dr. Stephen Mackler, Ms. Susan Moher Berryman and Dr. Frank Serio, and of particular note is the agreed participation of Dr. Murray Dickson who is the author of *Where There is No Dentist.* This program will give an exciting and fresh visibility to the Association's international commitment to global oral health.

As repercussions from the horrific events of September 11 continue to shape the international landscape, the Council believes that the ADA/HVO Dentistry Overseas Program is more important than ever before. The humanitarianism expressed by the healthcare community is a powerful person-to-person interface and ADA dentists are extremely important ambassadors for the profession and the country to the world. Though the immediate consequences meant that a third of the volunteers scheduled for the end of the year 2001 had to postpone their commitments, the renewed interest and activity as people feel and believe they have to do something is now noticeable. As people realize that health care is taking on an increasingly global nature, HVO's volunteers find their impact is at least two-fold: while working to improve health care (and thereby increase the stability) in developing countries, their presence serves to decrease the sense of professional isolation and foster cross-cultural understanding.

***Bylaws* Amendment Regarding the Name and Duties of the Council on ADA Sessions and International Programs:** At the April 2002 meeting of the Board of Trustees, the Board established an Oversight Committee on International Activities, which consolidates the international activities of the ADA under one auspices, and clearly defined the composition and duties of this new committee. These changes included incorporating the international programs and activities that belonged to the Council. In order to finalize the creation of the Oversight Committee on International Activities independent of the Council, as was intended by the Board of Trustees, the Council supports the consolidation of all international activities and believes it necessary to amend the ADA *Bylaws.* Therefore, the Council presents the following resolution for consideration.

10. Resolved, that the ADA *Bylaws*, Chapter X. COUNCILS, Section 10. NAME (line 1805) be amended by striking the words "and International Programs" from the name of the Council on ADA Sessions and International Programs, so the new name of the Council is the Council on ADA Sessions, and be it further

Resolved, that the ADA *Bylaws*, Chapter X. COUNCILS, Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS (line 1827), and the first line of the footnote pertaining to the Council on ADA Sessions and International Programs, be amended by striking the words "and International Programs" where they appear, and be it further

Resolved, that the ADA *Bylaws*, Chapter X. COUNCILS, Section 110. DUTIES, Subsection B. COUNCIL ON ADA SESSIONS AND INTERNATIONAL PROGRAMS (lines 2063-64) be amended by striking the words “AND INTERNATIONAL PROGRAMS” from the name of the Council, and be it further

Resolved, that the ADA *Bylaws*, Chapter X. COUNCILS, Section 110. DUTIES, Subsection B. COUNCIL ON ADA SESSIONS AND INTERNATIONAL PROGRAMS be amended by striking subparagraph “c” in its entirety (lines 2070-73), so the amended duties of the Council read as follows:

a. To have responsibility for conducting the annual session of this Association, except the House of Delegates, subject to approval by the Board of Trustees as provided in these *Bylaws*.
b. To plan and coordinate other Association sessions or regional meetings.

and be it further

Resolved, that any other reference in the ADA *Bylaws* to the Council on ADA Sessions and International Programs be amended by striking the words “and International Programs” from the name of the Council.

Acknowledgments: The Council wishes to express its heartfelt appreciation to Dr. Kenneth Schott, general chairman of the 2002 Committee on Local Arrangements, who leaves the Council after this year’s session, for his assistance in the planning and production of this year’s meeting and for his useful contributions to all the Council’s deliberations during his tenure. The Council also wishes to thank those who so capably assisted the Committee’s activities related to the 2002 annual session: Dr. Terry F. Fugetta, vice-chairman, Committee on Local Arrangements; Dr. Melanie J. Andrews, co-chair, Program Coordinating Committee; Dr. Debra C. Arnold, co-chair, Program Coordinating Committee; Dr. Gabriel F. Daroca, III, co-chair, Registration and Special Services Committee; Dr. Glenn C. Dubroc, Jr., co-chair, Registration and Special Services Committee; Dr. Joseph M. Campo, co-chair, Hospitality Committee; Dr. Ronald A. Mancuso, Jr., co-chair, Hospitality Committee. The Council also wishes to express its sincere appreciation to the entire membership of the Committee on Local Arrangements for their valuable assistance in the production of the annual session and to the Louisiana Dental Association and New Orleans Dental Association for their support of this year’s ADA annual session. Without the assistance and cooperation of these individuals and organizations, the 2002 annual session would not have been 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 2002 annual session: Dr. Sally Hewett who contributed tirelessly to the Council’s international activities, Dr. Joseph Schachner who served as 2002 Program Director, Dr. Stephen F. Schwartz who served as Council chair for 2002, and Dr. J. Steven Tonelli who served as 2001 Program Director. The Council also would like to recognize the contributions made by Dr. Richard Haught, Board of Trustees’ liaison, and Dr. Nelson P. Daly, Committee on the New Dentist member, who served on the Council during 2002. The Council will miss them and wishes them all the best in their future endeavors.

The Council also wishes to express special gratitude to Dr. Stephen B. Mackler, Greensboro, North Carolina, who completes his term at the end of 2002 after six years of service on the ADA/HVO Steering Committee—Dentistry Overseas. Dr. Mackler’s dedication was exceptional and it was because of his commitment and enthusiasm that three volunteer program sites were established: at the Pioneer Dental College in Dhaka—Bangladesh; at the State University of Medicine and Pharmacy; and in Chisinau Moldova; and at the School of Dental Therapy and Technology in Harare—Zimbabwe.

Summary of Resolutions

10. Resolved, that the ADA *Bylaws*, Chapter X. COUNCILS, Section 10. NAME (line 1805) be amended by striking the words “and International Programs” from the name of the Council on ADA Sessions and International Programs, so the new name of the Council is the Council on ADA Sessions, and be it further

Resolved, that the ADA *Bylaws*, Chapter X. COUNCILS, Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS (line 1827), and the first line of the footnote pertaining to the Council on ADA Sessions and International Programs, be amended by striking the words “and International Programs” where they appear, and be it further

Resolved, that the ADA *Bylaws*, Chapter X. COUNCILS, Section 110. DUTIES, Subsection B. COUNCIL ON ADA SESSIONS AND INTERNATIONAL PROGRAMS (lines 2063-64) be amended by striking the words “AND INTERNATIONAL PROGRAMS” from the name of the Council, and be it further

Resolved, that the ADA *Bylaws*, Chapter X. COUNCILS, Section 110. DUTIES, Subsection B. COUNCIL ON ADA SESSIONS AND INTERNATIONAL PROGRAMS be amended by striking subparagraph “c” in its entirety (lines 2070-73), so the amended duties of the Council read as follows:

a. To have responsibility for conducting the annual session of this Association, except the House of Delegates, subject to approval by the Board of Trustees as provided in these *Bylaws*.
b. To plan and coordinate other Association sessions or regional meetings.

and be it further

Resolved, that any other reference in the ADA *Bylaws* to the Council on ADA Sessions and International Programs be amended by striking the words “and International Programs” from the name of the Council.

Council on Communications

Harms, Kimberly A., Minnesota, 2002, chairman
Seidberg, Bruce H., New York, 2003, vice chairman
Anderson, David C., Virginia, 2004
Egan, Michael R., Connecticut, 2005
Fiddler, Terry L., Arkansas, 2005
Garlitz, Jay H., Florida, 2004
Habjan, Denise, California, 2004
Lubar, Larry B., New Mexico, 2004
Lutes, Don A., Texas, 2004
Marx, Alan, District of Columbia, 2003
O'Brien, Michael, Alabama, 2002
Ogata, Randy, Washington, 2002, *ex officio**
Ross, Sylvia, Michigan, 2003
Shaver, Samantha, Kentucky, 2005
Stefanowicz, Elaine, Pennsylvania, 2005
Strickland, Daniel J., Ohio, 2002
Sullivan, Thomas E., Illinois, 2003
Wilson, D. Richard, Oregon, 2002
Mickel, Clayton B., director
O'Donnell, Kathleen, manager

Organization and Procedures: The Council on Communications continued to channel and maximize its members' talents and energy through subcommittees corresponding to the departments of the Division of Communications. Subcommittee chairmen were: Dr. Jay H. Garlitz, Electronic Communications and Editorial Support; Dr. Daniel J. Strickland, Media and Creative Services; and Dr. Thomas E. Sullivan, Public Information and Education.

Dr. William D. Powell, Sixth District trustee, served as the Board of Trustees' liaison to the Council.

Meetings: The Council met in the Association's Headquarters Building on January 18-19, 2002, with a second meeting scheduled for June 14-15.

Personnel: The Council expresses appreciation to retiring members Dr. Kimberly A. Harms, Dr. Michael O. O'Brien, Dr. Daniel J. Strickland and Dr. D. Richard Wilson. The Council is grateful to Dr. Harms for her leadership and direction as chairman.

The Strategic Plan of the American Dental Association: Using metrics developed in cooperation with the Office of Strategic Planning and Consulting, the Council noted continuing progress in fulfilling goals of the Association's Strategic Plan. Highlights include:

Goal: Image, Ethics and Professionalism. State participation in National Children's Dental Health Month (NCDHM) exceeded the Council's goal of having at least 85% of the states request campaign materials. In 2001, all states requested the materials, resulting in $132,000 in non-dues revenue, as well as $36,900 in children's video sales. Dental society evaluations of the materials, which averaged 3.8 (on a 4-point scale), exceeded the Council's goal of 3.5. Use of the Association's NCDHM public service announcements (PSAs) also exceeded the Council's goals, with 25,000 airings of the television PSA in both English and Spanish markets and only .003% of stations that responded declining to use the radio PSA.

The Council particularly wishes to call attention to strong progress in meeting its goals of significant print, broadcast and Internet media placements of Association messages. The Association's media relations efforts, including monthly media packets mailed to more than 750 key contacts, generated multiple appearances by ADA consumer advisors on the top-rated *Today* show and other major network broadcasts, articles in major newspapers and national magazines, wire-service coverage and appearances on the growing number of respected and frequently consulted Internet health news sites. The Association's electronic news release distribution programs now reaches more than 100 journalists nationwide.

Goals: Information, Member and Support Services, Practice Support. At its January 2002 meeting, the Council established goals of increasing daily user sessions on ADA.org, the Association's Web site, by 20% in 2002, as well as increasing the number of registrants for members-only site content by 20%. During the first quarter of 2002, member visits were up over 48% compared to first quarter 2001.

The Council also set a goal of increasing the Association's database of e-mail addresses for dentists by 100% in 2002,

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

with an ultimate goal of having the Association's ADA Updates and ADA E-Grams reach as broad an audience as possible. A test mailing soliciting e-mail addresses from 1,200 dentists for whom the Association does not currently have addresses was launched in May and will take about a month to complete. A full direct mail campaign to all members will follow.

Response to Assignments from the 2001 House of Delegates:

National Access Month. A supplemental report will be submitted to the House detailing the Council's response to Resolution 125H-2001 (*Trans*.2001:432), which called for feasibility and cost studies for establishing a nationwide dental access month or similar activity, utilizing ideas and concepts developed from various volunteer programs.

Dental Issues Briefcase Media Program. In response to Resolution 126H-2001 (*Trans*.2001:417), the Council developed this program to build on a heightened media awareness of oral health issues that grew from the Association's 2000 National Media Conference. This initiative was especially appropriate at this time, as several emerging critical issues posed difficult challenges for the Association's media relations efforts and strategies.

At its January 2002 meeting, the Council focused on three critical issues for the Dental Issues Briefcase: dental amalgam, fluoridation and access to care. At that time, the Association contracted the services of Ketchum Inc. Issues and Crisis Network staff in New York City to provide recommendations.

At its February 2002 meeting, the Board of Trustees supported focusing the funds and activities of the Dental Issues Briefcase on the critical issues surrounding dental amalgam. The Board's decision was precipitated by mounting negative publicity involving anti-amalgam groups, the increasing number of amalgam-related bills in state legislatures and threatened legislation in Congress, pending litigation, and the need for clarification of the Association's policy with regard to amalgam and bolstering the position of the ADA as the preeminent resource for oral health information.

After a thorough researching of the amalgam issue, it was decided that the Association would launch a media outreach program to selected major outlets, along with the training and placement of spokespersons, development and distribution of press materials, and placement of information supporting these efforts on ADA.org.

While the emphasis is currently focused on dental amalgam, the Dental Issues Briefcase provides an effective tool for reaching the media and continues to evolve with emerging critical issues facing the profession and the Association.

Future of Dentistry Report: Council chairman Dr. Kimberly A. Harms served on the Future of Dentistry Oversight Committee. At its June 2002 meeting, the Council will discuss recommendations in the Future of Dentistry Report for which the Council might be able to provide valuable input and suggestions. The Council notes that the Association's 2001 Oral Cancer Awareness Campaign in cooperation with OralScan is an outstanding example of the initiatives called for in Clinical Practice Recommendation 13 in the Report.

National Children's Dental Health Month/Adult Oral Health Awareness Promotion: The Council approved continuance of the theme "Don't Let Your Smile Become Extinct" for the 2003 NCDHM print materials and outdoor billboards.

In order to enhance recognition of the Association's Adult Oral Health Awareness Program, the Council approved permanent continuance of the theme "Keeping Your Smile Young With Good Oral Care." Topics approved by the Council for the 2002 planning kit for the program include periodontal disease; side effects of medications, including xerostomia; and issues affecting older adults.

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

Council on Membership

Hoffman, Charles W., Florida, 2002, chairman
Brattesani, Cynthia K., California, 2003, vice chairman
Bell, David J., Arkansas, 2002
Bickley, Catherine W., North Carolina, 2003
Dishler, Bernard P., Pennsylvania, 2004
Epel, Lidia M., New York, 2005
Forcucci, Richard F., Massachusetts, 2004
Hehr, Nathan J., Iowa, 2004
Lee, William E., Kentucky, 2004
Masak, John G., Wisconsin, 2003
Matanzo, Thomas, Ohio, 2002
Pendergrast, Phyllis, Alaska, 2002
Rounds, Norman K., Utah, 2005
Sadler, Charles A., Jr., Indiana, 2002, *ex officio*[*]
Sauer, Edward H., Texas, 2005
Schwartz, Howard A., New Jersey, 2003
Shapiro, Elizabeth A., Illinois, 2005
Stevens, Alvin W., Jr., Alabama, 2004
Hoffmann, Rita M., director
Yancy, Phyllis A., manager

Meetings: The Council met at the Headquarters Building on January 25-26, 2002 and will meet again on June 21-22, 2002. Dr. T. Carroll Player, trustee, Sixteenth District, serves as the Board of Trustees' liaison to the Council.

Personnel: At its June 2001 meeting, the Council nominated Dr. Charles W. Hoffman, chairman and elected Dr. Cynthia Brattesani, vice chairman for 2001-2002. At the close of the 2002 annual session, the terms of four highly regarded members of the Council will end: Dr. David Bell, member 1998-2002; Dr. Charles Hoffman, member 1998-2002, who also served as chairman of the Council for two terms; Dr. Thomas Matanzo, member 1998-2002, who also served as vice-chairman of the Council 2000-2001 and as chairman of the Subcommittee on Member Benefits/Communication Issues; and Dr. Phyllis Pendergrast, member 1998-2002. Dr. Richard Forcucci, member 2001-2002 resigned during his second term. 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 January 2002 meeting, the Council conducted a strategic planning session and discussed its current activities and the need to eliminate programs found to be unnecessary. It developed criteria for measuring the effectiveness of its programs and identified activities that can be tied to the Strategic Plan. The Council will continue to provide metrics and any new action items with the appropriate link to the current 2002-2005 Strategic Plan goals/objectives to the Board and submit to the ADA Office of Strategic Planning and Consulting as appropriate.

Council Bylaws Duties: Resolution 5H-2001 (*Trans.*2001:422) amended the duties of the Council to be:

a. To formulate and recommend policies related to membership recruitment and retention and other related issues.
b. To identify and monitor trends and issues that affect membership recruitment and retention, particularly among under-represented segments, and to encourage membership involvement throughout organized dentistry.
c. To support, monitor and encourage membership activities of constituent and component dental societies and to enhance cooperation and communication on tripartite recruitment and retention efforts.
d. To recommend, monitor and support the development of membership benefits and services that respond to identified needs of members.
e. To act as an advocate for membership benefits.

Future of Dentistry Report: The Council received the report at its January meeting and will provide comments on sections relating to potential membership issues following a discussion at its June meeting.

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

Response to Assignments from the 2001 House of Delegates

ADA Block Grants to States for Dental Student Activities: To facilitate constituent society outreach to dental students and conversion of student members to active membership after graduation, the 2001 ADA House of Delegates adopted Resolution 3H-2001 (*Trans.*2001:419) which makes available annual block grants to constituent societies, up to $3,000 per dental school located within participating states, for the purpose of enhancing student recruitment activities and the sharing of successful ideas throughout the tripartite. The program was implemented in 2002 and will be evaluated in January 2003.

Definition of Membership Diversity: Resolution 4H-2001 (*Trans.*2001:421) defined diversity as differences related to personal characteristics, demographics, and professional choices. This definition will be incorporated into all appropriate ADA materials.

Amendment of the ADA *Bylaws* Regarding the Duties of the Council on Membership: As mentioned above, Resolution 5H-2001 (*Trans.*2001:422) amended the *Bylaws* to acknowledge the Council's proactive membership role. The ADA *Constitution and Bylaws,* revised to January 1, 2002, incorporates the amendment.

Administrative Process for Transferring Members: Resolution 6H-2001 (*Trans.*2001:422) directed the Council to develop guidance for states regarding charging dues to transferring members who change the location of his/her residence or practice. The Council communicated its support of Resolution 6H-2001 and encouraged state dental societies to accept the dentist as a member without imposing additional dues for the balance of that membership year.

Processing of New Member Application by ADA, Constituent and Component Societies: Resolution 42H-2001 (*Trans.*2001:417) directed the appropriate agencies to explore mechanisms to begin services to members once the state or local dental society informs the ADA that any member has paid dues. In response to this resolution, a request has been made to the constituent dental societies to e-mail a list of new members as soon as they have begun dues payments. In turn, a protocol has been developed in which ADA Publishing, a division of ADA Business Enterprises, Inc., ADA.org and Great-West Life are all informed of new members so that ADA publications, access to the members-only side of ADA.org, and ADA life insurance benefits are available, prior to the Association actually receiving and posting dues at the national level. Work is now underway to increase constituent compliance by simplifying the reporting mechanism.

Amendment of ADA *Bylaws* Regarding Requirements for Associate Membership: Resolution 43H-2001 (*Trans.*2001:417) amended the *Bylaws* to broaden the eligibility requirements for associate membership to encourage membership in this category. The *Bylaws* change eliminates the requirement that the individual be employed by an accredited institution as well as the requirement that the individual not be educationally qualified to be a dentist. The ADA *Constitution and Bylaws,* revised to January 1, 2002, incorporates the amendment.

Streamlining Membership Category Transfers: Resolution 44H-2001 (*Trans.*2001:426) directed the Council to ensure the smooth transition of dental students to active tripartite membership upon graduation from dental school by encouraging constituent and component dental societies to implement steps to streamline membership processing. These steps were outlined in the ADA Membership Manual that was distributed to the tripartite in 2002. In addition, the Council has taken action to help identify the state in which fourth-year dental students who plan to practice, and to inform the respective constituent dental society of this information on a monthly basis.

Tripartite Grassroots Membership Initiative: Resolution 79H-2001 (*Trans.*2001:427) directed the Association to undertake a Tripartite Grassroots Membership Initiative to convey the value of membership to all active licensed dentists in order to increase market share to at least 75% by 2005. Details on Initiative activities to date are included in this report under council activities. The Council will outline activities for the future during its June meeting and recommendations will be reported to the 2002 House of Delegates in its supplemental report.

Establishment of Student Dental Societies with the Component or Constituent Dental Societies: Recognizing that early involvement in organized dentistry is the key to higher student involvement and conversion to active membership, the 2001 ADA House of Delegates adopted Resolution 80H-2001 (*Trans.*2001:417). In response, the *Student Society Resource Book* was developed to provide constituent and component dental societies with information to assist in the creation of dental student societies. It was distributed to constituent and component staff in May 2002.

Review of Financial Hardship Dues Waiver Policy: Resolution 81H-2001 (*Trans.*2001:427) directed the appropriate agency to study the issue of financial hardship dues waivers, including an evaluation of the appropriateness of dues waivers for family leave, maternity leave or other disruptive life or practice circumstances. The Council considered this resolution at its January 2002 meeting and will study policy to offer more directive guidance for the constituents and report at the June 2002 Council meeting. The Council's report and recommendations will be reported to the 2002 House of Delegates in its supplemental report.

Life Member Pins: The 2001 House of Delegates approved a recommendation to add $12,000 to the 2002 budget for life member pins. Beginning in June 2002, the newly designed membership pins will be mailed to all new life members.

Other Council Activities

Tripartite Grassroots Membership Initiative: The theme for this effort is "Your Profession, Your Association, Your Future." This theme, along with a graphic logo identity, was selected after several focus groups of nonmembers were impaneled across the country to research potential membership value messages and graphic presentations that resonated with them in a positive, professional and inviting manner.

The Initiative was launched at the March 22-23 ADA Annual Conference on Membership Recruitment and Retention where approximately 200 attendees discussed nonmember recruitment and member retention. Immediately following the Conference, an invitation for states to join the Initiative was issued. More than half of the constituent societies made the commitment to participate and designated a state "team leader" within a month of receiving the invitation.

The Initiative encourages members to contact nonmembers in their areas to inform them of the value intrinsic to ADA membership. This person-to-person approach encourages networking at a grassroots level, thereby giving nonmembers the chance to hear and see firsthand the benefits of ADA membership as part of their local professional network. The Initiative depends on a unified tripartite effort, with ADA resources and support, constituent coordination and component implementation of the nonmember contacts. With a comprehensive communications strategy that includes a resource manual, recruitment and retention brochures, as well as a manual of style standards, volunteers and staff at every level of the tripartite are positioned to succeed. A CD-Rom and corresponding style manual featuring the logo, stationery templates, and ad slicks that can be used by state and local societies in their publications, facilitates the consistent use of the graphic identity and Initiative message at all levels.

Technology is aiding tripartite communication for the Initiative. Most notably, this has taken the form of a section on ADA.org for the Initiative. The Web site provides a vehicle to keep volunteer leaders and staff informed of the activities and progress of constituent societies setting up membership grassroots action teams. Volunteer members are able to communicate electronically with other grassroots membership action teams.

The ADA also has established a special toll-free telephone number for nonmembers who wish to call the Association for a tripartite membership application or additional membership information. Tripartite applications for membership are sent from the ADA to the interested doctor with instructions to return them to the appropriate constituent dental society. In addition, constituent dental societies using a membership application other than the ADA tripartite application have been asked to provide the ADA with these to respond to nonmember inquiries from those states. ADA informs constituent societies about nonmembers' requests in their state. This enables the Association to work with state and local dental societies in strengthening tripartite recruitment efforts.

ADA Membership Services Outreach Program (MSOP): The Council has had oversight of the general activities of the Membership Services Outreach Program since the Council's inception in 1993. MSOP continues to demonstrate its effectiveness by providing membership marketing and organizational support to constituent and component dental societies to increase the number of new members and to decrease nonrenewal rates. MSOP works with state and local membership committees to: review membership patterns, trends, organizations strengths and weaknesses; examine geographic and political considerations that may affect membership; assess organizational strengths and weaknesses; determine training needs; and provide statistical and demographic data.

The following dental societies are currently participating in the traditional 2001-2002 Membership Services Outreach Program:

- Rhode Island Dental Association
- New Mexico Dental Association
- Indiana Dental Association, with focus on Indianapolis District Dental Society
- Detroit District Dental Society
- Greater Cleveland Dental Society
- Greater Milwaukee Dental Association
- Ninth District (PA) Dental Society

At the Council's request, the ADA Survey Center conducted the 2000-2001 ADA Membership Services Outreach Program Survey. This survey was mailed to 136 participants of membership committees from the 12 constituent and component dental societies that participated in MSOP from mid-2000 to the end of 2001. Almost 99% of the respondents expressed satisfaction with the MSOP experience in their dental society. Most respondents (89.5%) indicated that their dental society would continue to make member recruitment and retention a priority. "Knowledge and helpfulness of the ADA Outreach Manager" gathered the highest percentage of excellent ratings on the ratings of favorable experiences.

ADA Annual Conference on Membership Recruitment and Retention: The Association's ninth Annual Conference on Membership Recruitment and Retention was held March 22-23, 2002, at ADA Headquarters in Chicago. The main purpose of this year's conference was to launch the Tripartite Grassroots Membership Initiative. The agenda was designed to debut new resources for dental societies and grassroots recruiting, as well as provide the opportunity for participants to interact extensively with other conference attendees and presenters.

This year's kick-off reflected a tripartite commitment to increase national marketshare to 75% by 2005 through personal, grassroots member-to-nonmember contacts. Speakers provided insight to the Tripartite Grassroots Membership Initiative, the research conducted by ADA, the resources available to the tripartite and motivational expertise on member-to-member communication and recruitment.

The conference attracted a record 194 attendees, including 110 member dentists, 54 dental society staff (34 constituent, 20 components), 13 council members, 26 ADA staff, two outside speakers, four Alliance of the American Dental Association members and at least one representative from the:

Indian Dental Association, Canadian Dental Association, America Association of Oral & Maxillofacial Surgeons, Department of Veterans Affairs, U.S. Navy, U.S. Public Health Service and U.S. Air Force.

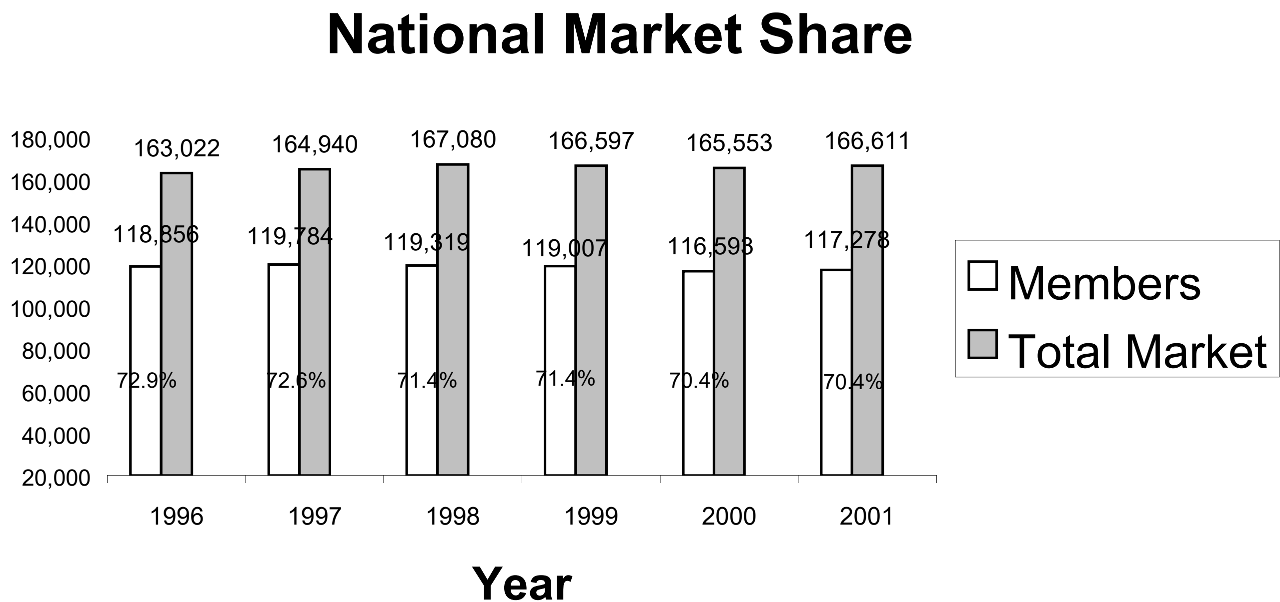
The overall evaluation for the conference was a 4.6 on a scale of 1.0 to 5.0, with 5.0 being "excellent." Conference organization was rated 4.8, speakers was rated 4.6, and resources was rated 4.6. Twenty-four states signed on to participate in the Initiative within the first month following the conference.

Processing of New Member Applications by ADA, Constituent and Component Societies: Resolution 77H-2000 (*Trans.*2000:453), directed the ADA, through the Council, to implement a new member tracking system and report annually to the House of Delegates to include an accounting of the new member applications received by state, the date of the dues receipt by the constituent society, the date of the dues receipt by the ADA and the date of the first communication by the ADA with the new member. Due to the difficulty encountered in gathering the data needed to comply with this report and the different criteria throughout the tripartite to define "new members," the Council will reconsider its new member tracking system and protocols during its June meeting. This report will be provided to the 2002 House of Delegates in the Council's supplemental report.

End-of-Year 2001 Membership Statistics: According to the ADA National Recruitment & Retention Report End of Year 2001 For Active Licensed Dentists, in 2001, the total number of Association members, both licensed and unlicensed, was 144,877. Traditionally, when computing market share, the Association only uses the number of dentists who are not retired and are licensed to practice dentistry in the United States.

Table 1 illustrates the six-year membership trend. From 1996-2001 there was an increase of 3,589 active licensed dentists in the market. For the first time in four years, the aggregate number of active, licensed members has increased by 685 from 116,593 at the end of 2000, to 117, 278 at the end of 2001.

Table 1



The following table (Table 2) highlights the changes in the market share for key target markets, when comparing year-end 2001 with year-end 2000. The results on the membership market share for specific target markets is mixed. The new dentist and women market shares are up slightly (64.6% and 63.1% respectively), but the market share for minority dentists is down slightly at 55.4%. (New dentists are defined as those who graduated from dental school less than ten years previously.) The market share is also down for general practitioners (67.7%) and up for specialists (81.1%). The federal dental service market share (Air Force, Army, Civil Service, Navy, Public Health and Veterans Affairs is up significantly (9.8 percentage points to 46.9%).

It should also be noted that the timing of information updates (such as the in-service and out-service records for military/public health dentists or creation of records for foreign-trained dentists practicing in the U.S.) may have a tendency to misrepresent the membership market share, particularly in smaller target market categories.

Table 2

Target Markets
Comparison 2000 vs. 2001 Market Share Summary
Active Licensed U.S. Dentists

Target Market	Increase/ Decrease in 2001 Members	2001 Market Share Percentage	2000 Market Share Percentage	Increase/ Decrease in Market 2000/2001
Women Dentists	+624	63.1%	62.9%	+877
Full-time Faculty	-102	67.7%	67.7%	-153
General Practitioners	-614	67.7%	67.9%	-397
Specialists	+1,299	81.1%	80.8%	+1,455
Federal Dental Service (FDS)	+497	46.9%	37.1%	+120
Foreign Trained Dentists	+204	58.7%	56.8%	+172
Minority Dentists	+327	55.4%	55.6%	+670
New Dentists	-385	64.6%	63.5%	-1,218

Target Marketing: In support of tripartite efforts to recruit and retain under-represented segments such as recent dental school graduates, women dentists, new dentists and minority dentists, the Department of Membership Marketing conducts targeted communications campaigns. In 2001-02, new dentists (defined as those out of dental school less than ten years) were identified for recruitment.

In order to facilitate the conversion of new graduates to active membership, the Class of 2001 received a "Where are you going" postcard mailing, allowing them to update their addresses and let the Association know about their post-graduation plans. Over 50% of the new graduates provided this information. Subsequently, each member of the graduating class received a personalized letter specific to their individual practice plans (private practice, graduate student/resident, federal dentist or not currently practicing). In an effort to streamline the transition from dental student membership to the appropriate post-graduation membership categories, new graduates were urged to take advantage of the $0 dues for the six months of Association membership following dental school graduation and make a prompt transition. By so doing, the members ensure the continuity of membership benefits and are included when members are invoiced for dues renewal.

In addition, the December *Journal of the American Dental Association* (*JADA*) featured a special cover for the class of 2001, reminding recipients that their ASDA/ADA membership would expire on December 31 and offering information about how to join in 2002.

As of May 15, a total of 1,752 of the class of 2001 graduates had paid 2002 dues, for a conversion rate to date of 42.1%. Recruitment of these new graduates will continue throughout 2002 and the final conversion rate established at the end of the year. The "Where are you going" postcard mailing was expanded for the Class of 2002 to incorporate additional channels of communication, including e-mail, on-line, through the American Student Dental Association and the constituent dental societies. Targeted communication as above is planned.

Nonmember new dentists in private practice were identified to receive recruitment communications in the fall of 2001; this was expanded to include all nonmembers in private practice. These dentists received three letters. Each letter included a tripartite application and highlighted a different issue: the Association's 2001 lawsuit against Aetna, the ADA Seal Program, and ways in which the Association makes dentistry better. Membership applications were returned directly to the constituent dental societies, which reported a positive impact on membership recruitment as a result of the campaign.

Nonmember new dentists also received the March 2002 issue of *ADA New Dentist News* (formerly *ADA Lifeline)* as an insert in the *ADA News,* which incorporated a membership message. The quarterly publication is sent to members three times per year, and includes nonmembers every spring. Nonmember new dentists also received a special cover on the May 2002 bonus issue of the *ADA News* featuring news and information about the Association as well as an invitation to membership. The cover incorporated a membership application.

Direct Member Recruitment: The Department of Membership Marketing also conducted recruitment initiatives directed toward dentists eligible for direct membership in the American Dental Association, including graduate student membership, affiliate membership and federal dental service membership.

Nonmember dentists eligible for graduate student membership were identified to receive recruitment mailings in October 2001, and February and May 2002. Messages emphasized the benefits of membership. Distribution of graduate student membership brochures to postdoctoral program directors was completed in May 2002.

Potential affiliate members were targeted for recruitment at the American Dental Association booth at the FDI World Dental Federation meeting in Malaysia (September 2001), the ADA annual session (October 2001), and at the Brazilian Dental Association annual meeting (January 2002). Material featuring membership benefits and an application was distributed at the two latter meetings: Association participation in the FDI World Dental Federation meeting was cancelled due to post-September 11 travel restrictions. Through May 2002, a total of 65 new affiliate membership applications were received for the 2002 membership year. An affiliate membership brochure and magazine ads for placement in non-U.S. editions of *JADA* and other appropriate publications were developed in English, Spanish and Portuguese.

Federal Dental Services (FDS): In order to enhance membership recruitment and retention of federally employed dentists, several member service and communications

initiatives have been undertaken. These include the implementation of a dues installment payment program; the development of a member service office with dedicated staff offering "one-stop shopping" for FDS members with a special toll-free number and e-mail address; a special section on ADA.org for federal dentists; the enhancement and expanded distribution of *Federal Dental News*; and participation with a membership booth at the annual Association of Military Surgeons of the United States (AMSUS) conference. Recruitment initiatives included recruitment mailings in October 2001, March 2002 and June 2002. A membership advisory committee, comprised of one individual from each branch of the federal dental services, was established in November 2001 and has met by conference call and in person to address issues related to data reconciliation, recruitment, retention and member services. These initiatives have had a positive impact on membership. At the end of 2001, the Association had gained an additional 497 members compared to the end of year 2000. Through May 15, an additional 131 federal dentists have joined the ADA in 2002.

In addition, a new process was put in place at the end of the 2001 membership year in order to streamline the membership transfer process for federal dentists who completed advanced dental education programs as a part of their federal service. All federal dentists who paid graduate student dues in 2001 and had completed their programs that year were identified and invoiced for the appropriate rate as an active member. Previously, these dentists would have been required to complete an application. The retention rate for these members and for members overall will be evaluated in July 2002.

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. Students join the American Dental Association as student members through the American Student Dental Association (ASDA). The ultimate goal of the Association 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 Council 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 and market share conversion. Student market share is up from 67% in 1995 to 82.3% in 2001.

In order to achieve the overall student membership goals identified by the Association, the Council developed several strategies that direct the Association's student marketing activities. These strategies are interactive and interdependent.

- Increase direct communications with all predoctoral students to increase their awareness and understanding of ADA membership benefits.
- Coordinate membership marketing activities with ASDA.
- Educate students to the tripartite structure and how to join organized dentistry.
- Increase the ADA's understanding of the needs and interests of dental students at each stage of their education.
- Implement strategies to establish a lifelong commitment to organized dentistry among students and recent graduates.
- 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 is responsible for managing the Student Marketing Plan. The overall goal of the Office of Student Affairs is to improve communications and strengthen relationships with dental students and to obtain a better understanding of the students' needs, concerns and interests. The Office serves as the primary American Dental 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 Office of Student Affairs:

1. establish relationships with ASDA chapter representatives to ensure that all students are aware of the importance and value of American Dental Association membership;
2. establish a presence in the dental schools and develop a positive relationship with the dental school administration, particularly the Dean of Student Affairs; and
3. 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 Office of Student Affairs relies upon the support and collaborative efforts of ASDA. The Office of Student Affairs is responsible for over 40 initiatives outlined in the Student Marketing Plan. One part of the Student Marketing Plan is implemented by the Committee on the New Dentist—dental school visits through the $mart $tart and Transition Programs. Each program is offered to half the dental schools each year—$mart $tart targeting first year students, Transition Program to dental school seniors. Each features a strong membership message. $mart $tart also focuses on managing student debt while the Transition Program features information to assist students in making transition to dental practice. The Office of Student Affairs coordinates the programs. Below are several of the newest and/or ever-evolving initiatives.

Student Awareness Program. The Student Awareness Program was first implemented in 1989 to introduce students to the Association, its programs and services. As a primary component of the Student Marketing Plan, this communications activity is evaluated and updated yearly. The 2001-02 program featured:

- a personalized welcome letter to first-year students from the presidents of both ASDA and the ADA (Office of Student Affairs magnet also included);
- a “Welcome to the profession” card distributed to first-year students in the fall with a response mechanism enabling freshmen to communicate with the Office of Student Affairs;
- a first through third place monetary award was rewarded to the ASDA chapters that were the first to submit 100% of its first year dental students;
- a customized student appointment book, sponsored by Pfizer, sent to second- and third-year members;
- a graduation card from President D. Gregory Chadwick mailed to all senior dental students in the spring;
- an address change mailer sent to all senior dental students to gather necessary future contact information; and
- the ASDA and ADA dual awareness poster which was distributed to ASDA delegates for display on their schools’ ASDA bulletin boards for fall recruitment.

In addition, with support from the American Student Dental Association, a regular e-communication is sent to ASDA national leaders notifying them of recent American Dental Association accomplishments and/or key topics in the dental profession. The leaders can then share this information with their peers as an incentive to become involved with organized dentistry. In preparation to expand the e-communication to dental student members, e-mail addresses are being gathered for all dental students.

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, described in this report, response rates to the mailings vary from to 7 to 20%, depending upon the mailing topic. The fall 2001 mailer highlighted access to care issues; the spring 2002 communication featured resources available for dental students at the local, state and national level.

ADA InfoPaks. 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, the Office of Student Affairs initiated this service in 1997 to respond to students’ information requests. Thirteen ADA InfoPaks are available on: Practice Management, Managing Finances, Managed Care and Marketplace Issues, Licensure, Alternative Careers in Dentistry, OSHA, Insurance Programs, Locating a Practice, Legislative Issues, Advanced Dental Education, DMSOs, Associateships and Access to Care, which was introduced in 2002. These InfoPaks are updated on an as-needed basis. Approximately 10,000 ADA InfoPaks are distributed yearly upon request through the student communications campaign and evaluations from the Transition and $mart $tart Programs. Portions of the InfoPaks are also available on ADA.org.

Student Resources on ADA.org. Enhancements have been made to ADA.org to target dental student needs and concerns. A section devoted to dental student resources features ADA InfoPaks, the publication *Dental Boards and Licensure Information for the New Graduate*, *ADA Resources for the Dental Student Member*, Careers and Classifieds, FAQs for dental students/recent graduates, *Financial Planning Issues for Dental Students*, information for non-U.S. dental students, membership information, links to ASDA and other Web sites of interests, as well as an e-mail to Office of Student Affairs and American Student Dental Association.

Transition Mailing. To convey the membership message to senior dental students at schools not hosting a Transition Program during the 2001-2002 academic year, a special Transition Mailing was sent in April 2002. This mailing’s objective, which includes a letter, and *ADA Resources for the New Dentist Member* booklet, is to inform the students of the many benefits and services the Association offers to assist in their transition from dental school to practice or graduate training. *ADA Resources for the New Dentist Member* booklet highlights many of the ADA resources that can play an integral role in a new dentist’s success. The mailing also reminds the students of the reduced dues that are available to them as new dentists and to contact their state/local dental societies to transfer to active membership status.

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

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

Nelson, Robert L., Missouri, 2002, chairman
Keenan, Allen C., Oklahoma, 2002, vice chairman
Biermann, Michael E., Oregon, 2003
Cerveris, Michael D., Pennsylvania, 2003
Fick, H. Sam, Ohio, 2004
Gall, Teran J., California, 2005
Goodman, Susan B., Maryland, 2004
Haering, Harold J., Florida, 2004, *ad interim*
Hankin, Errol P., New York, 2002, American Hospital Association
Hooker, William J., Arizona, 2005, *ad interim*
Lander, William W., Pennsylvania, 2002, American Medical Association
Landman, Paul, Illinois, 2004
Lauf, Robert C., North Dakota, 2005
McLellan, Thomas S., Michigan, 2005
Meador, Robert C., Texas, 2002
Parker, Melanie S., California, 2002, *ex officio* [*]
Parker, S. Edward, Jr., South Carolina, 2002
Seminara, Robert Anthony, New York, 2003
Swartz, Michael S., Massachusetts, 2003
Young, Joseph S., Mississippi, 2004
Klyop, John S., director
Jasek, Jane F., manager
McGinley, Jane S., manager
Muraoka, Sharon G., 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 held a conference call meeting on September 21, 2001 and met in the ADA Headquarters Building on March 15-16, 2002. The Council is scheduled to meet again September 13-14, 2002. Three subcommittees – Access to Dental Care, Preventive Dentistry and Interprofessional Relations – meet in conjunction with regularly scheduled Council meetings.

Personnel: The close of the 2002 annual session brings to an end the terms of four valued members of the Council: Dr. Allen C. Keenan; Dr. Robert C. Meador; Dr. Robert L. Nelson and Dr. S. Edward Parker, Jr. These members have given unselfishly of their time and energy on behalf of the profession. The Council acknowledges their efforts with great appreciation.

The Strategic Plan of the American Dental Association: In 1998 the Council adopted a mission statement, 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 2000 the Council determined criteria for measuring the effectiveness of its activities. The Council used these criteria in 2001 to evaluate the success of its program activities and the direction of future activities. Only a few program activities did not achieve the goals set in 2000; these activities were evaluated and either the criteria were adjusted for the 2001 implementation evaluation or the program activity was discontinued, as appropriate. In 2002, the action plan has been keyed to the goals and objectives of the new *ADA Strategic Plan: 2002-2005* and criteria and program activity adjusted or eliminated based on achievement of 2001 goals.

In response to Board of Trustees Resolution B-67-1998 (*Trans.*1998:592), which directed ADA councils to utilize Goal V., Objective v (Continue to optimize ADA processes

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

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 program 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.

The Future of Dentistry Report: At its March meeting, the Council approved a list of 21 of the 114 recommendations as being pertinent to CAPIR. The Council is now proceeding with an in-depth review of the implications of these 21 recommendations regarding ADA policies and programs of the Council.

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; 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 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; Coalition on Smoking OR Health; FDI World Dental Federation; International Academy for Sports 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 Medical Staff Services; National Cancer Institute; National Center for Tobacco-Free Kids; 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; Special Care Dentistry; Special Olympics Special Smiles; U.S. Olympic Committee; U.S. Public Health Service; U.S. Surgeon General's Office; and Volunteers in Health Care.

Alternative Dental Career Information: Initiated in 1995, the Council provides 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* 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 the ADA.org Web page through the Education and Career Resources area, as well as through the New Dentists content area. The packet is also featured as part of the "ADA Infopaks" from the Office of Student Affairs. The *Alternative Dental Careers Packet* is available from the Council office. Since the initiation of this service, nearly 2,900 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 2001, the Council sponsored programs on: systemic factors of treatment of periodontal disease, and fluorides and enamel fluorosis. The Council will sponsor three scientific programs at the 2002 Scientific Session. The programs include: oral cancer and precancer, reporting suspected abuse and neglect, and bioterrorism.

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 dental/medical 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. Additionally, the Council recommends policy and reviews legislation relating to dental/medical interrelationships and develops professional informational resource material regarding hospital medical staff issues and dental management of patients with complex medical conditions.

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. David A. Whiston (Virginia) serves 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. He routinely attends the Council's meetings and reports on JCAHO activities of interest.

Although JCAHO accreditation surveys are voluntary, both state and federal government agencies have been paying closer attention to office based surgery outcomes and are considering accreditation as a base line for quality of care. The Association was actively engaged as the Joint Commission developed a new program, Office Based Surgery. In addition, JCAHO's Ambulatory Care Professional and Technical Advisory Committee and other key stakeholders provided input. These standards generally apply to smaller (less than four practitioners) surgical offices. The first office accredited under these standards was an oral and maxillofacial surgery office.

The Association is well represented on numerous Joint Commission committees and task forces. The Corporate Members of the JCAHO (American College of Physicians-American Society of Internal Medicine, American College of Surgeons, American Dental Association, American Hospital Association and American Medical Association) formed a Corporate Member Planning Group on Patient Safety. The Group expressed strong support for a project to create a common patient safety taxonomy whose broad adoption could be leveraged by the leadership influence of the six participating partners. The Group supported the development of a business case for patient safety, but agreed that it would be an extremely challenging project. The Association is represented by Dr. Jeanne Altieri (Connecticut) and Dr. David Whiston, along with Association staff. A 20-member task force was formed to review the hospital standards and determine which standards are most relevant to the safety and quality of patient care, while targeting for elimination or modification those standards that do not contribute to good patient outcomes. Led by Mr. Ken Shull of the South Carolina Hospital Association, the task force includes representatives from quality improvement, medical records, nursing, physicians, engineers, risk managers and other hospital leaders who have first-hand experience with Joint Commission accreditation standards and surveys. There is a medical staff standards task force to specifically review the medical staff chapter. Dr. Steven Nelson (Colorado, former CAPIR vice chair) and Dr. Paul Casamassimo (Ohio) have been appointed to represent the ADA on this task force.

Dr. Thomas W. Braun (Pennsylvania) is a member of the Hospital Professional and Technical Advisory Committee (PTAC) with Dr. Paul Casamassimo serving as alternate; Dr. Douglas B. Berkey (North Carolina) serves on the Long Term Care and Assisted Living PTAC with Dr. William Milner (North Carolina) serving as alternate; Dr. Jeffry E. Persons (California) serves on the Ambulatory Care PTAC with Dr. David E. Frost (North Carolina) serving as alternate; and Dr. Michael S. Strayer (Ohio) serves on the Home Care PTAC with Dr. Robert Henry (Kentucky) serving as alternate. Serving on the Behavioral Health Care PTAC is Dr. Sanford J. Fenton (Tennessee) with Dr. Jerome Kleponis (Pennsylvania) as alternate. And finally, serving on the Network PTAC is Dr. Benjamin Schechter (Ohio) with Dr. Richard Tempero (Nebraska) as alternate.

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 Association was invited to comment on several Joint Commission field reviews regarding standards, accreditation and the survey process. The Association responded to requests regarding resident safety and credentialing of licensed independent practitioners in long term care facilities; practitioner panels in networks; and medication use standards.

The Council continued to promote the availability of an improved version of *Guide to Joint Commission Hospital Accreditation Resources for Dentists*, jointly published with the Joint Commission. 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 guides 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. The Council routinely provides technical assistance to members with concerns regarding Joint Commission activities.

***Oral Health Care Series* Development:** The Council is continuing to develop new manuals and to revise existing *Oral Health Care Series* manuals for patients with complex medical conditions. There is a need to revisit many of the existing manuals to assure that they are kept up to date, as well as considering possible new topics for manuals. The Council thanks the Committee members for their continuing work on behalf of the Association: Dr. William Carpenter (California); Dr. Michael Glick (New Jersey); Dr. Steven Nelson (Colorado); Dr. Lauren L. Patton (North Carolina); and Dr. Steven Roser (New York). 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. As it has done for several years, the Council sponsored a scientific program at the 2001 annual session regarding complex medical conditions.

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 provides an information packet regarding loan repayment through the National Health Service Corps upon request.

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. Staff continues as a member of the Association of Professionals in Infection Control and Epidemiology, American Society of Association Executives, Association Forum of Chicagoland, Special Care Dentistry-American Association of Hospital Dentists and the National Association Medical Staff Services that will enable future liaison activities. Staff monitors several organization listservs and Web sites in this capacity.

Additionally, staff has been invited to attend the Committee on Hospital and Interprofessional Affairs of the American Association of Oral and Maxillofacial Surgeons. Staff re-initiated a relationship with the Accreditation Association for Ambulatory Health Care (AAAHC) and has been invited to attend its Board meetings as an observer. The Council invited AAAHC to submit a report on its activities to the Council and Dr. John Burke, executive director, AAAHC, was pleased to participate.

American Medical Association. Dr. David A. Whiston served as the Association's Official Observer to the American Medical Association (AMA) in 2001 and attended the AMA Annual, Interim and Organized Medical Staff Section meetings, as well as the Surgical Caucus and subsequently reported to the Board of Trustees on his experience at these meetings. Council staff 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. D. Gregory Chadwick re-appointed Dr. David Whiston as the Association's Official Observer to the 2002 AMA House of Delegates. The Council is grateful to Dr. Whiston for his extra service on behalf of the Association.

The AMA House of Delegates tackled issues across the spectrum of health as well as issues related to the AMA's structure and governance, including, but not limited to, medical preparedness for terrorism and other disasters, membership concerns, governance and association management, patient safety, tort reform, expanding health insurance coverage, patient protection legislation, cadavaric organ donation, genetic based biotechnology and the future of medicine. The AMA devoted a major portion of its Interim Meeting to discussions related to bioterrorism. The issue of non-physician scope of practice continues to surface, but has not posed a major threat to dentistry largely due to the efforts of Dr. Whiston and assistance from Dr. William Lander, Council member, AMA delegate from Pennsylvania and honorary ADA member. The Council will continue to track this issue closely.

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. Chadwick, is Dr. Robert Nelson. The Council wishes to express its appreciation to Dr. Nelson 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.

Patient Safety: The Council continues to address the issue of patient safety in response to Resolution 9H-2000 (*Trans.*2000:456). There was substantial discussion regarding the importance of the issue of patient safety and medical errors. It was noted that, although the issue may not affect Association members to the extent that it may affect other members of the health care community, anyone can be a patient. The issue was recognized as one of importance to Association members who are members of medical and dental staffs of hospitals. Therefore, the Council recommended adoption of Resolution 50-2001, which was forwarded to the House of Delegates. The House adopted substitute Resolution 50RC-2001. Resolution 50H-2001 (*Trans.*2001:429) directed the appropriate Association agencies to communicate the Association's commitment to improve patient safety, work in cooperation with others on behalf of patient safety and to disseminate information on patient safety to the membership. The Council was assigned as the lead agency to respond to this resolution (see page 35 for an update).

Access and Community Health

Access to Oral Health Care: The Council's primary goal regarding access to care is to help special population groups receive the oral health care they need and want. In addition, the Council promotes several community health activities that complement clinical dental care services. To meet its goals, the Council identifies and promotes innovative programs to make care more accessible to individuals who are economically disadvantaged, disabled, medically compromised, homebound and/or institutionalized. Recognizing that the Association itself does not deliver care, the Council serves to identify oral health needs and to facilitate state and local level outreach programs to meet those needs consistent with the Association's policies.

In addition to promoting public awareness of the oral health needs of underserved populations, the Council provides technical assistance and counseling to dental societies, dental schools, individuals and organizations interested in developing, implementing or maintaining a dental access initiative. Further, the Council recommends policy and reviews legislation aimed at promoting community health and improving the availability of oral health care services for special needs patients, develops and distributes professional and patient resource materials and sponsors continuing education activities for the dental team.

Exclusive School Soft Drink Contracts: The Council has carried out the intent of the Association's policy opposing exclusive school soft drink contracts (*Trans.*2000:457). The Council assisted in and funded development of a pamphlet titled *Sipping, Snacking and Oral Health: Facts for Parents and Educators* (Item W273 sold via the *ADA Catalog*). Council staff responded to 157 requests for technical assistance and copies of the report received by the 2001 ADA House of Delegates. Council staff worked with the American Association of Public Health Dentistry in developing their draft policy statement on exclusive soft drink contracts in schools.

Family Violence Prevention: The Council works to educate members 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. Approximately 44 P.A.N.D.A. coalitions have been developed in the United Sates since 1993.

At the invitation of the Family Violence Prevention Fund, the Association is a co-sponsor of the biennial National Conference on Health Care and Domestic Violence to be held on September 26-28, 2002. Dr. Lynn Mouden, Council consultant in abuse prevention issues, participated in planning the agenda and reviewing abstracts. Dr. Mouden and Council staff are assembling a panel of speakers from dentistry to make presentations to the interdisciplinary audience.

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

Two Association trustees sit on the 13-member NFDH Board of Directors. They are: Dr. Richard Haught (term expires June 30, 2003) and Dr. William D. Powell (term expires June 30, 2004).

The Foundation develops and implements three major programs providing care for low-income and uninsured persons who are disabled, elderly, and/or medically compromised: Donated Dental Services (DDS), Dental HouseCalls, and BRIDGE (a preventive dental health outreach project).

Donated Dental Services (DDS). DDS programs have been established in 32 states. Additionally, the "national" Donated Dental Services project identified dentists in 11 other states where DDS programs have not yet been established. During fiscal year 2000-2001, approximately 27,000 people received $7.9 million in total services through DDS.

Efforts are also underway, with secured consent of dental associations, to organize DDS in two additional states. Further, the NFDH is working to expand the DDS program nationally in response to increasing oral health need. The Association and other dental honorary and specialty organizations have supported the effort and offered to assist with promoting the need for dentist volunteers.

The Council is working to promote the fact that the cumulative value of dental care provided to individuals via the DDS program will reach $50 million sometime in the summer of 2002. That represents humanitarian efforts of over 10,000 dentists and 2,000 dental laboratories on behalf of over 44,000 vulnerable individuals since DDS began as a small pilot program in Colorado in 1986.

DentaCheques. Since 1990, the Foundation has successfully marketed the sale of a dental product coupon book called DentaCheques as a fund-raising activity. Various Association agencies help to promote this ongoing activity. The Council helps update the content of a DentaCheques promotional page on ADA.org.

Development of Dental Access Resources: The Council continues to develop resources to assist the members in their efforts to provide dental care to those less fortunate. The *Manual on Dental Care Access Programs* provides resources and program ideas for developing oral health care access programs. The *Manual* is available to members from the Council office.

Two new monographs were produced this year and are available from the Council office. *Obtaining Funding for Dental Access Programs: An Overview* guides dental access program staff to possible funding sources. *Dental Access Program Marketing: How to Build Public Image and Participation* is a resource for getting the word out about the availability of dental access programs and encouraging volunteer participation.

Council staff continue to enter information into the Council's centralized, electronic database of information on state and local dental access program activity. These programs include public education activities as well as charitable oral health care programs.

Nationwide Dental Access Activity: The Council was asked to assist the Council on Communications with its response to Resolution 125H-2001 (*Trans.*2001:432), which directed that a report be provided to the 2002 House of Delegates on the feasibility and cost of establishing a nationwide dental access month or similar activity using concepts from various volunteer programs. The Council agreed with the Council on Communications that a dental access month was not financially feasible and would be administratively difficult for constituents. The Council on Communications will present a report on alternative ideas. Also, in April 2002, the ADA Board of Trustees approved sponsorship of an annual nationwide event during National Children's Dental Health Month, beginning in 2003, to promote access to care for underserved children.

Cooperative Efforts with the Council on Government Affairs: The Council worked in conjunction with the Council on Government Affairs on several dental access activities in

2001 and 2002. Council representatives attended the Surgeon General's Conference on Health Disparities and Mental Retardation in December 2001. Representatives also collaborated on information for the Centers for Medicare and Medicaid Services to assist with improved oral health survey and quality improvement mechanisms for skilled nursing facilities. The Councils work together to educate state and local officials about oral health needs for underserved groups and also to increase awareness about the charitable efforts of dentists.

Oral Health Access for Persons with Mental Retardation: Following the 2001 Surgeon General's Conference on Health Disparities and Mental Retardation, the Council moved to enhance Association support regarding access to oral health care for persons with mental retardation and other developmental disabilities. The Council is working with the Council on Government Affairs to draft a policy statement to be included in a supplemental report to be forwarded to the 2002 House of Delegates. The Council wrote two letters to the Commission on Dental Accreditation encouraging changes in accreditation standards so that students have educational experiences in providing dental care for persons with mental retardation. The Commission has taken action to review its standards. The Council requested that Special Olympics Special Smiles be added to its list of formal liaison organizations. The Council also agreed to work with the National Oral Health Information Clearinghouse to provide comments on its draft document "Making a Difference: Practical Care for People with Developmental Disabilities" and to promote the resource when it is completed. Council staff attended the annual National Conference on Special Care Issues in Dentistry to discuss issues with members of Special Care Dentistry and the American Academy of Persons with Disabilities.

Dr. Sanford Fenton, chair of pediatric dentistry at the University of Tennessee College of Dentistry, is the Council's consultant for these issues and attended the Surgeon General's Conference as the Association representative.

Oral Health Access for Persons in Nursing Facilities: The Council took action this year to augment its liaison with Special Care Dentistry and the American Society for Geriatric Dentistry regarding oral health needs for persons in nursing facilities. This coincides with the Association's work with the Centers for Medicare and Medicaid Services to improve survey and quality improvement mechanisms in skilled nursing facilities. Council members recognized that dentists would be increasingly called on by skilled nursing facilities to train staff and to provide clinical dental services for residents. Thus, the Council included in its 2003 budget a request for a meeting in early 2003 between Council and Special Care Dentistry representatives. Preliminary plans for the meeting include reviewing available written resources and continuing education for dentists, followed by planning development of new resources.

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

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 2002, 181 individuals from 38 states and Puerto Rico have received recognition.

Recipients in 2001 were: Dr. William J. Comport, California; Dr. Clifford A. Brown, Illinois; Dr. Robert F. Frost, Illinois; Dr. Curzio Paesani, Illinois; Dr. Katherine Elsner, Iowa; Dr. Kimberly K. Salow, Iowa; Dr. Nevin K. Waters, Kansas; Dr. Andrew L. Allen, Maine; Dr. Jeffrey D. Dow, Maine; Dr. Karl P. Woods, Maine; Dr. Lee R. Johnson, Masachusetts; Dr. Melvin A. White, Michigan; Dr. Ralph MacDonald, Montana; Dr. John Snively, Montana; Dr. David Tawney, Montana; Dr. Junius Harris Rose, Jr., North Carolina; Dr. Armand J. Gareau, Rhode Island; Dr. George V. Picard, Rhode Island; Dr. Jean A. Picard, Rhode Island; Dr. Joel F. Picard, Rhode Island; and Ms. Diane Bouknight, South Carolina.

This program assists the Council in identifying the increasing number of individuals who work to ensure that oral health services are provided to underserved individuals. The Council continues to aggressively promote this program to constituent dental societies and appreciates the societies' thoughtful nominations.

Community Preventive Dentistry Award. The Community Preventive Dentistry Award recognizes significant preventive dentistry programs and is administered by the Council. This award is sponsored through the ADA Health Foundation with generous funding support from Johnson & Johnson Oral Health Products. Four programs were recognized during 2001, the 29th year of the program. The highest award of $2,500 was presented to the Assistance League of Portland Children's Dental Center of Portland, Oregon. Meritorious awards were granted to three programs: "Happiness is a Healthy Smile," New York; Dallas County Sealant Initiative, Texas; and Anderson Center for Dental Care: Project Adopt-A-Home, San Diego, California.

Geriatric Oral Health Care Award. The Geriatric Oral Health Care Award program, administered by the Council since 1984, recognizes those individuals and organizations that have improved the oral health of older adults through innovative community outreach projects. This award is sponsored through the ADA Health Foundation with the support of a generous grant from the Pfizer Consumer Healthcare Group. In 2001, the highest award of $2,500 was presented to Carolinas Mobile Dentistry, Charlotte, North Carolina.

Collaboration with the ADA Health Foundation (ADAHF): This year the Council provided technical assistance to the Foundation for judging the Harris Fund for Children's Dental Health Grant Program. Council members Dr. Michael

Biermann and Dr. Joseph Young serve on the ADAHF grants administration committee as a first level of review for general dental access grant proposals. In addition, the ADAHF oversees the funding for the Council's two competitive award programs, the Community Preventive Dentistry Award and the Geriatric Oral Health Care Award, which were previously described in this report. Also this year, the Council encouraged the ADAHF to investigate the feasibility of establishing an education, research or access-related grant program targeted to improving the oral health of elderly persons.

National Commission on Correctional Health Care (NCCHC): The Association, through the Council, maintains liaison with the 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 also fields technical assistance calls from members who are on staffs of correctional facilities.

National Oral Health Information Clearinghouse (NOHIC): 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 is also 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 in February 2002.

National Council on the Aging (NCOA): For many years, the Council has maintained liaison with the 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.

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. In 2001, the Council provided educational materials and assisted active campaigns to initiate or retain fluoridation in 22 states. Direct assistance contributed to positive fluoridation decisions in a number of communities including: Yuma, Arizona; Escondido and Santa Monica, California; and Erie, Pennsylvania.

Fluoridation Political Tools: The Council continues its development of fluoridation-related political resources for state/local dental societies and members, including a new "Introductory Community Water Fluoridation Resources Packet" which includes a listing of Association fluoridation resources available to members and community coalitions. Additionally, work continued on the Council's new community water fluoridation video, which is scheduled for release in 2002. These resources will help members approach community water fluoridation decisions as the political process that it is today; for example, guiding public opinion and lobbying decision-makers.

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 28, 2002. The following members are serving one-year terms on the NFAC: Dr. Michael S. Swartz; Ms. Diane Brunson; Dr. Robert (Pete) Crawford, Jr.; Dr. Herschel Horowitz; Dr. Jayanth (Jay) Kumar; Dr. Ernest Newbrun; and Mr. Thomas Reeves.

Early Childhood Caries: The Council is working toward objectives outlined in its three-year plan for early childhood caries prevention, including professional and public education activities. Of particular importance is keeping current with the public health science and collaborating with other Association agencies to use emerging early childhood caries science to shape public policy regarding community preventive activities, dental Medicaid and access to oral health care issues. In addition, the Council continues to work with the Council on Communications to update existing public education materials on early childhood caries as needed.

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 Dental Consulting Group.

Oral Cancer Prevention Grant: A grant proposal, "Behavior Modification, Dentists and Oral Cancer Control" was submitted to the National Cancer Institute (NCI) in January 2001. The project seeks to augment continuing education in oral cancer prevention. If funded, the Association would be the repository for the grant funds which total approximately $1.2 million dollars over the five-year grant period. While the Council anticipated that NCI would announce which grant proposals were approved and funded prior to the close of 2001, the delay in the approval of the federal government FY2002 budget caused a significant delay in the NCI process.

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. 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 remains involved with the national efforts noted above designed to increase the public's awareness about the hazards associated with smokeless tobacco use. Working with the Division of Communications, the Council updated two Association brochures on tobacco use this year, *Thinking About Quitting Smoking*? and *Think Before You Chew: Smokeless Doesn't Mean Harmless*. Because of duplication, the Council combined its two tobacco resource packets (Smokeless Tobacco and Tobacco Cessation) into one item which will better serve members' needs. The Council now distributes an expanded Tobacco Cessation Resource Packet which contains informational materials on the hazards associated with smoking and the use of smokeless tobacco as well as information on smoking cessation and tobacco intervention programs suitable for implementation in a dental office setting. This packet is available from the Council office.

Response to Assignments from the 2001 House of Delegates

Report on Patient Safety in Response to Resolution 9H-2000—Medical Errors: As noted earlier under the Interprofessional Relations section of this report, Resolution 50H-2001 (*Trans.*2001:429) directed appropriate agencies to communicate the Association's commitment to improve patient safety, work in cooperation with others on behalf of patient safety and to disseminate information on patient safety to the membership. In response to Resolution 50H-2001, the Council:

- participated on the JCAHO Corporate Member Planning Group on Patient Safety represented by Dr. Jeanne Altieri and Dr. David Whiston, along with ADA staff;
- worked with *ADA News* staff to develop a story on Patient Safety Week which was published on March 4, 2002 and also appeared on ADA.org as part of *Today's News* on March 4, 2002 (the extended article included ideas from the National Patient Safety Foundation on how to participate, along with its Web site and offered resources through the Department of Health and Human Services Agency for Health Care Research and Quality); and
- through Mr. Errol Hankin (Council member and senior vice president, New York Methodist Hospital), the Dental and Pharmacy team at New York Methodist Hospital and Dr. Don Nielsen at the American Hospital Association, drafted a Self-Survey on Safe Medication Practices in Dental Offices, which will undergo further development through appropriate agencies.

Comprehensive Dental Care to Include Topical Application of Fluoride Varnish: Resolutions 73-2001 and 73S-1-2001 (*Trans.*2001:430) discuss the use of fluoride varnish as part of comprehensive dental care which requires an examination and supervision by a dentist. Following extensive and mixed testimony at the Reference Committee and the House of Delegates, these resolutions were referred to the appropriate Association agencies for study and report to the 2002 House of Delegates. The resolutions were assigned to the Council on Access, Prevention and Interprofessional Relations (CAPIR) and the Council on Scientific Affairs with CAPIR designated as the lead agency. In order to prepare the report for the 2002 House of Delegates, CAPIR has asked for the assistance of a number of Association agencies including the Council on Scientific Affairs, the Council on Dental Practice and the Department of State Government Affairs. CAPIR will finalize the report to the House at its September meeting.

Women's Oral Health: Patient Education: Resolution 87H-2001 (*Trans.*2001:428), directed the Association to incorporate oral health education information into health care educational outreach efforts directed at low-income mothers and their children. In response to Resolution 87H-2001, the Council worked with Council on Government Affairs (CGA) staff on a request from the American College of Obstetricians and Gynecologists (ACOG) regarding oral health in pregnant women. CAPIR staff developed a response for the Executive Director that was sent to ACOG. CGA staff followed up with ACOG after the passage of the Women's Oral Health policies to facilitate the Association's involvement. The Council on Government Affairs approved a strategic plan regarding implementation of the women's oral health policies that addresses four perspectives: congressional, federal agencies, states and the private/scientific sector. Senator John R. Edwards (D-NC) and Senator Jeff Bingaman (D-NM) introduced legislation titled, "The Perinatal Dental Health Improvement Act of 2002" (S. 2202). The Association and Children's Dental Health Project worked on this together. The legislation would provide grant funding to dental schools, public entities and non-profit organizations to increase professional and public awareness of the link between periodontal disease in pregnant women and pre-term, low birth-weight babies.

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

Council on Dental Benefit Programs

Cuttino, Charles L., Virginia, 2002, chairman
Floyd, Thomas P., Florida, 2003, vice chairman
Ferlita, David, Florida, 2002, *ex officio*[*]
Greenblatt, Charles L., Jr., Tennessee, 2005
Grubb, Richard, Maryland, 2004
Hall, Glen D., Texas, 2005
Hedlund, Steven, Iowa, 2002
Jacobs, Thomas A., California, 2005
Jennings, Michael D., Michigan, 2003
Lipton, Lawrence I., Connecticut, 2004
Nicholas, Dean P., Illinois, 2005
Schweinebraten, Marie C., Georgia, 2004
Setterberg, James C., Colorado, 2003
Singer, Robert R., Pennsylvania, 2004
Stetzel, Mark R., Indiana, 2003
Thompson, R. Wayne, Kansas, 2002
Thurn, Steven, Oregon, 2004
Volland, Lawrence, New York, 2002
Marshall, James Y., director
Ellek, Donalda, manager
McHugh, Dennis, manager
Pokorny, Frank, manager

Meetings: The Council met in the Association's Headquarters Building on November 2-4, 2001 and April 19-21, 2002. It is scheduled to meet again November 8-10, 2002.

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

Subcommittee on the *Code*	January 26-27, 2002
Third-Party Issues Subcommittee	February 15-16, 2002
Dental Benefit Information Service Subcommittee	March 1-2, 2002
Quality Assessment and Improvement Subcommittee	March 8-9, 2002

The Dental Content Committee, housed within the Council, met on November 7, 2001, at the ADA's Headquarters Building. The Joint Council Committee on SNODENT met by conference call on February 26, 2002. In addition, the Dental Practice Parameters Committee, housed within the Council, met on February 8, 2002 at the ADA's Headquarters Building.

Chairman: Dr. Thomas P. Floyd was nominated as chairman of the Council for the 2002-2003 term at the April 2002 meeting.

Vice Chairman: Dr. Michael D. Jennings was elected vice chairman of the Council for the 2002-2003 term at the April 2002 meeting.

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

Board Liaison: Dr. Frank K. Eggleston served as the Board of Trustees' liaison to the Council.

Personnel: The close of the 2002 annual session brings to an end the terms of four valued members of the Council: Dr. Charles L. Cuttino, who has served as chairman of the Council during the 2001-02 term; Dr. Steven Hedlund; Dr. R. Wayne Thompson; and Dr. Lawrence Volland. 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. Also, in addition to his duties as director of the Council, Mr. James Y. Marshall has been appointed as director, Council on Dental Practice.

The Strategic Plan of the American Dental Association: The Council's activities continue to support the *ADA Strategic Plan: 2002-2005*, primarily Strategic Plan Goals Advocacy; Image, Ethics and Professionalism; Information; Member and Support Services; and Practice Support.

Each council of the Association was asked by the Board to Trustees to examine activities in relation to the Strategic Plan and eliminate those that did not support the Plan (Resolution B-67-1998), and to develop criteria for measuring the effectiveness of their activities (Resolution B-79-1998). All of the Council activities supported the Strategic Plan. Evaluation criteria were developed and forwarded to the Strategic Planning Committee. Eighteen criteria were developed.

Goals and Objectives. The Council interpreted the scope of the Strategic Plan's Goals and Objectives and identified connections with each of the Goals and several of the individual objectives. The following describes the relevant Council activities as related to the goals and objectives.

Goal: Advocacy

Objectives. Through its long-standing responsibility for management of third-party payment issues, the Council advocates for the membership and for the doctor/patient relationship by providing assistance with claims problems, advocating for improved claims processing procedures; preserving the content and the integrity of the ADA procedure codes and nomenclature, *CDT-3;* maintaining communication with national third-party payer organizations and state and federal dental programs; and by providing dental plan design consultation for purchasers. Also, dental practice parameters were designed with the primary objective of making the doctor rather than third-party payers in charge of treatment. This year the Council met with third-party payers who administer dental insurance for over 45 million people. National third-party payer organizations and associations were also contacted.

In addition, the Council protects patient rights and freedom of choice by promoting these issues in its dental benefit information and through its promotion of direct reimbursement (DR).

The Council further protects the doctor/patient relationship by working to eliminate inappropriate and misleading language in third-party payer communications with patients, particularly explanation of benefits statements. Overseeing quality assessment and improvement issues also protects the doctor/patient relationship because the quality of care is the very foundation of the doctor/patient relationship.

The Council also promotes peer review as a means of properly resolving conflicts between doctors and patients.

Finally, the Council's programs on dental benefits, procedure and diagnostic code development, and development of quality assessment tools and procedures benefit all members of the Association.

Goal: Image, Ethics and Professionalism

Objectives. The Council believes that the end product of its collective program activities serves to benefit the oral health of the public and thereby enhances the image of the profession. The Council's efforts to preserve the doctor/patient relationship, to improve and simplify claims processing, to promote peer review and quality assurance mechanisms and to promote quality dental plan designs, all contribute to the positive image of the profession in the public's view.

The Council's Dental Benefit Information Service promotes the oral health of the public and raises awareness of the association as a resource for dental benefits issues by working with employers, journalists and researchers.

In addition, the Council's management of the Direct Reimbursement marketing campaign, and promotion of DR in general, address the objective of communications on critical issues.

The Council's role in dealings with third-party payer organizations, its management of the procedure codes (*CDT-3)* and the new diagnostic dental codes and its leadership in developing quality assessment tools for dentistry, all serve to position the Association as a unifying voice of dentistry.

The Council's expertise on dental benefit management and quality assessment issues also helps to promote the Association as a credible source of information for outside entities.

Goal: Information

Objectives. Through sponsored conferences such as DR Days and the Mediation Workshops, the Council facilitates the development and dissemination of important new information about dental benefits, peer review processes and relevant clinical information that impacts both member dentists and the public. In addition, the Council manages the development and maintenance of the Dental Practice Parameters. The Council is also instrumental in providing input as to the appropriate content of emerging standards for electronic claims processing as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Finally, the Council's maintenance of *CDT-3* and the new diagnostic code, SNODENT, contributes to fulfilling the information needs of the profession.

In addition, the Council promotes direct research on benefit plan design and on quality assessment tools, both of which impact the practice of dentistry.

The Council develops print and audiovisual materials on dental benefit plan design, direct reimbursement and quality assessment tools to facilitate transfer of this information to the public and the profession.

Finally, the Council is coordinating the development of the diagnostic code and maintains the procedure codes and the uniform claim form, all of which need to be compatible with emerging information technology.

Goal: Member and Support Services

Objectives. The Council has shared responsibility for the Association's Contract Analysis Service. In addition, the Council provides personal follow-up on third-party payer problems, maintains the diagnostic and procedure codes and develops peer review resources and quality assessment tools.

The Council also maintains liaison with numerous outside and associated organizations, including third-party payer groups, dental benefits consulting organizations, code development agencies and quality assessment organizations.

Goal: Practice Support

Objectives. The Council's programs provide practice support through development and maintenance of *CDT-3,* the uniform dental claim form, the new diagnostic code, Systematized Nomenclature of Dentistry (SNODENT) and the dental practice parameters. The Council also develops and disseminates information for the membership and the public on various dental reimbursement mechanisms, particularly direct reimbursement.

Finally, the Council educates the members about various dental reimbursement mechanisms through national conferences, print materials and special reports in Association publications.

Federal Programs: The Council continues to promote improvements in the design and administration of the Medicaid Dental program.

Dental Benefit Information Service: The Dental Benefit Information Service (DBIS) within the Council on Dental Benefit Programs was established as the authority and primary resource at the Association for dental plan sponsors and patients in need of assistance in designing effective dental benefit plans. The goals of DBIS are to:

- promote dental benefit plan models in accordance with the policies of the American Dental Association including direct reimbursement (DR);
- communicate with constituent dental societies regarding local 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 Analysis Service. DBIS staff has been educating the public on dental benefits through the Association's dental benefit plan guidelines and the ADA's standards of dental benefits. In November 2001, staff re-created the plan analysis form, which will be distributed at tradeshows in 2002, as well as mailed to tradeshow attendees. Once a completed form is received along with the employer's current or proposed dental benefits plan, the employer will be mailed a detailed analysis using the Association's dental benefit guidelines to be compared to the employer's current or proposed dental benefits plan. There were 73 requests for information for this service in 2001.

Additional DBIS Resources. DBIS provides many resources regarding dental benefit issues for distribution to dental plan purchasers. These materials, brochures and kits are distributed to both the public and Association members at no charge. Several new resources were created in 2002. For example, a new brochure entitled *Understanding Your Dental Plan: ADA Plan Analysis Service* promotes the ADA's Plan Analysis Service, and *Direct Reimbursement Case Studies 2002* profiles eight companies, of various sizes, that have a direct reimbursement dental plan for their employees. In addition, an "envelope stuffer" for use by third parties that administer direct reimbursement plans was created and is available for use by this audience; the envelope stuffer, which is sent to patients with their dental bill or explanation of benefits statement, promotes the dental plan as a concept that is supported by the Association.

DBIS Media Relations. DBIS staff suggests story ideas on dental benefits topics to editors of publications and staff will author such stories whenever possible. DBIS staff also sends press releases and letters to editors in an effort to place positive DR stories in appropriate publications. In 2002, staff worked with writers at many publications, including *Crain's New York Business, Milwaukee Business Journal* and *Employee Benefit Plan Review.*

DBIS staff provided dental benefits articles for *Human Capital Strategies & News*. The publication, which has a circulation of 40,000 subscribers in the fields of benefits, compensation and human resources at the largest companies in the United States, contained an article entitled "Making Dental Benefits Count," promoting dental benefit plan utilization within companies. DBIS staff also wrote an article for *President & CEO* magazine, a new magazine targeted to small and medium sized companies published by Hughes Communications. The article—entitled "Is My Dental Plan a Good One?"—presents some of the criteria the Association uses in its Plan Analysis Service: freedom-of-choice, prioritization of benefits, UCR, EOB language, etc. *President & CEO* magazine has a circulation of 50,000.

In addition, a positive DR story appeared in the February 2002 issue of *HIU* (*Health Insurance Underwriter*); and the March 14, 2002 edition of *Career Journal from The Wall Street Journal* included a positive DR story that was originally printed in the January 2001 issue of *Employee Benefit News*. Regular "advertorials" in *Workforce* and *Fortune Small Business* have generated additional interest from employers.

DBIS staff will continue these efforts, with the goal of increasing the awareness of the Association as a resource for employers and also to promote fee-for-service, freedom of choice dentistry, including direct reimbursement.

Direct Reimbursement. DBIS staff continues to promote direct reimbursement along with 48 constituent societies that are formally participating in the ADA's DR direct-mail marketing campaign. DBIS 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.

The Council continues to offer assistance at annual sessions and other meetings of constituent dental societies in conducting workshops and forums for audiences of dentists and dental society staff. Usually moderated by DBIS staff, these forums are intended to educate interested members and their staff about the DR concept. Issues presented and discussed at these events include: 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. The current DR Cost Estimation System is based on Milliman, Inc.'s (formerly Milliman & Robertson, Inc.) Health Care Cost Guidelines of 1999, which have now been superseded by the Guidelines of 2001. The system is currently being reviewed for potential changes that it may undergo aside from the updated formula. Plans to update the cost estimation system will be planned accordingly. DBIS staff is currently researching all options of maintaining the system in some form. Possibilities include program changes that would update the current program making it more compatible with the latest Microsoft environment and technical changes that would enhance the program itself. The idea of transferring the program design to Association programmers and obtaining only the formula itself from Milliman, Inc. is also being explored. In addition, a training session for new users of the system was once again provided at ADA Headquarters in September 2001.

DR Days 2002. DR Days 2002 is scheduled for August 2-3, 2002 with a "first-time attendee" session on Thursday, August 1. It is expected that approximately 150 attendees will participate in this year's meeting. Those attendees will include brokers, consultants, third-party administrators (TPAs), constituent and component dental society staff, and dentists involved in the promotion of DR. This program will provide an opportunity for participants to learn about the Association's promotional campaign, network with fellow DR promoters and to share ideas to assist in the promotion of DR on a national level. The 2001 meeting was attended by almost 150 people. Also, there were six companies that exhibited DR-related products or services at the meeting.

Direct Reimbursement Campaign—Overview: By adopting Resolution 47H-1996 (*Trans*.1996:690), the House of Delegates called for the expenditure of $2.5 million in the years 1997-1999 for the promotion of direct reimbursement. These funds were used exclusively for the development and placement of DR ads and to conduct the direct mail portion of the campaign. By adopting Resolution 35H-1999 (*Trans*.1999:925), the House of Delegates again called for the expenditure of $2.5 million for each of the years 2000-2002, to be used exclusively for the promotion of direct reimbursement subject to annual approval by the House of Delegates.

Listed below, as of March 2002, are DR implementations that staff is aware of for the year 2001 as well as cumulative results:

2001 Results

479	new DR plans implemented
31,186	new covered employees
73,100	total new covered lives

Cumulative Results 1997-2001

1,954	new DR plans in force
236,941	new covered employees
555,390	total new covered lives

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

Direct Reimbursement Campaign—Print Advertising. The 2002 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 has again been selected for the ADA's media campaign. These publications include: *HR Magazine, HR Executive, Employee Benefit News, Workforce, Forbes, Fortune Small Business, Entrepreneur,* and *INC. Magazine*. There are a total of 55 placements of the Association's DR ads in these publications scheduled for 2002, reaching more than 16 million subscribers. The schedule created by FCB Direct, the business-to-business marketing agency that directs the campaign, reaches readers throughout the year with an emphasis in the late spring and early fall.

Due to the successful testing of bind-in-cards (BICs) and 1-1/3 page ad units in 2001, the 2002 media schedule includes 37 insertions with these direct response vehicles. The sole purpose of these unique response vehicles is to increase the number of responses. As of March 31, 2002, these response vehicles are performing quite well as DBIS has received 73% more leads from print advertising than during this same time period in 2001.

Direct Reimbursement Campaign—Direct Mail. The direct-mail phase of the DR promotional campaign continues to grow. During the spring 2002 campaign, a total of 48 constituent societies, including Iowa, New Jersey, North Dakota and South Dakota as the newest participating constituent dental societies, elected to participate in the direct-mail component of the promotion. The constituents participating in the direct-mail campaign include: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin and Wyoming. These

constituents chose to participate in the direct-mail campaign based on their ability to meet a number of criteria developed and monitored by the Council. The criteria include having adequate support in place and functioning to follow-up on the leads generated by the campaign, as well as reporting any successful DR plan implementations to the Association.

The direct mail package, “Set your own price for dental benefits,” was mailed for a final time in September 2001. This direct mail package was entered into the Chicago Association of Direct Marketing’s 2002 Tempo Awards competition, which awards advertising agencies for top direct marketing promotions. The Tempo Award is a prestigious award in the direct marketing industry. Some of last year’s winners included AT&T, *The Wall Street Journal*, Crate & Barrel and Cadillac. The ADA’s “Set your own price for dental benefits” package was awarded two Tempo Awards in the Business Direct Mail category on March 21, 2002: one award was for Creative and another award for Marketing Strategy & Results.

In January 2002, a company called Consumer Truth conducted focus group research with two new direct mail concepts developed by FCB. Of the two concepts, “Stage” and “Tooth Fairy,” the majority of the respondents preferred the clear benefit delivery and dental context of the “Tooth Fairy” concept. The key benefits that were extracted from the “Tooth Fairy” concept were freedom of choice, flexibility and cost control. Based on the research results, the “Tooth Fairy” direct mail package was introduced in the spring 2002 direct mail campaign to approximately 250,000 benefits decision-makers and C-level (CFOs and CEOs) management at companies nationwide.

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, including major human resource organizations. In addition, subscriber lists of several of the aforementioned publications are provided as “added-value,” or at no charge to the Association as a result of FCB’s negotiation skills with the publications.

The following related DR support activities are funded through the Council’s DBIS budget.

Non-participating Constituent Societies. There are presently four constituent societies that are not participating in the direct-mail portion of the ADA’s DR promotional campaign. Staff has been in contact with these constituents, has been educating them on the success of the campaign, and has been working with them to persuade them to join the campaign. DBIS 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 for the states that have no formal means of follow-up.

Communications with Constituent Dental Societies. To ensure consistency and ongoing communications with participating campaign states, DBIS is in regular contact with the DR staff of the constituent dental societies participating in the DR campaign. In addition to frequent phone conversations, faxes, emails and written communication, DBIS staff conducts telephone interviews with constituent society staff in order to evaluate and update information regarding the state marketing programs. Also, the DR NEWSLETTER continues to be distributed to constituent and component society executive directors, presidents, DR contacts, as well as to brokers who work with these agencies. In addition, monthly “Campaign Update” faxes are sent to all DR contacts in the participating constituent dental societies. Finally, constituent society staffs are encouraged to attend the DR Days program every summer to enhance communication among DBIS staff and constituent staff around the country.

DR Information Repository. DBIS has created the Information Repository, which is a database of employers with existing DR plans. This information is used to track the aggregate totals for DR plans nationwide. Various reports can be generated based on request. The database includes information such as implementation date, plan design, industry type, employee size and cost savings information. As of March 28, 2002 the DBIS is aware of the following DR plans:

DR Data Summary (1986-2002)[*]

3,427	total DR plans filed in DR Information Repository
660,544	total estimated employees covered
1,548,315	total estimated lives covered

DR Exhibiting Resources. DBIS continues to coordinate the use of the DR “traveling” displays that are available to constituent and component societies. These table top 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.

National Trade Show Activity. DBIS staff attended nine industry trade shows in 2001 including the ADA annual session and numerous leads were generated from these shows. Trade shows continue to be a significant opportunity for staff to market DR to the decision-makers of employers. DBIS staff has six trade shows scheduled for 2002 and will also be staffing an informational exhibit at the ADA’s annual session in New Orleans. Major shows include meetings of the National School Boards Association, Society for Human Resource Management, Self-Insurance Institute of America, Benefits Expo (sponsored by *Employee Benefits News)* and the Association of School Board Officials.

DR Broker Issues. DBIS staff actively works with brokers, consultants, and third-party administrators to help promote the implementation of direct reimbursement plans. Staff has met with several brokers to educate and provide information to them regarding direct reimbursement. In addition staff has gone on joint presentations with brokers to educate and inform employers about DR. Brokers play a key role in the

[*] The ADA started its original promotion of DR in 1986. These numbers include all known DR plan implementations through March 28, 2002.

implementation of DR plans and staff continues to seek their input and is looking to expand this relationship with brokers on a national level. In addition, brokers have indicated that they felt the ADA's DR marketing campaign is critical to the success of their DR sales efforts.

A group of DR brokers has been chartered as the National Direct Reimbursement Association (NDRA). The NDRA is open for membership to brokers, TPAs, consultants, dentists, dental organizations and even employers using DR.

Brokers and constituent dental societies have been given permission to place an ADA direct reimbursement ad, as is, in a local trade or business publication for optimal exposure and efficient lead generation. The ads will be placed in local trade and business publications allowing brokers to target businesses in their specific areas. One advantage to brokers would be that they would not incur the cost of producing a quality ad on their own. Another advantage would be the strength of the ADA's name versus that of a small brokerage firm, especially if that firm is new to the industry.

DBIS staff has gained feedback from brokers and TPAs regarding the information they would like to see in the ad. Staff found that the brokers had two viewpoints on the ad concepts. One concept was to reflect cost savings and incorporate how self-funding can save employers money. The second concept was to educate the public on direct reimbursement itself. Staff has been working to develop an ad that incorporates some of the feedback from the brokers. The ad should be available for use by brokers and constituents in the summer of 2002.

In order to recognize brokers who have been successful in selling DR plans, the broker incentive award program was created. The broker incentive program consists of two award categories: the greatest number of employees and the most DR plans sold. The 2001 winners were announced at the annual DR Days Conference in September 2001, and each winner received a plaque and a monetary award ranging from $500 – $2,500. Total expenditures were $5,000.

Applications for the ADA's third annual DR broker incentive program were mailed out early September 2001 to over 200 brokers. The winners will be announced at DR Days 2002 to be held August 2-3, 2002.

The Council will provide a supplemental report to the 2002 House of Delegates with updated results and a resolution for continuing the national campaign.

Contract Analysis Service (CAS): Since its inception in 1987, the Contract Analysis Service has received and analyzed approximately 3,430 dental provider contracts. The Service is operated out of the Association's Legal Department. In 2001, 87 contracts 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 offer information on dental provider contracting issues and responds frequently to telephone inquiries from members about such issues. The Service remains committed to the following goals: meeting the current demand in a timely manner; developing new informational material regarding dental provider contracts; and working closely with state and local societies to address member dental provider contracting concerns.

During the past year, the Service completed a yearlong trial period in which it analyzed direct Medicaid agreements between dentists and state agencies. At its November 2001 meeting, the Council approved a recommendation by the Service's director to permanently expand the criteria for contracts reviewed by the CAS to include contracts between dentists and government agencies administering government-sponsored dental benefit programs, along with contracts between group dental practices and dental plans. In 2001, the Service also participated in the drafting of the "ADA Model Software License and Support Agreement," which was prepared by the Division of Legal Affairs and posted on ada.org in August 2001.

In the coming year, the Service plans to update "What Every Dentist Should Know Before Signing a Dental Provider Contract," and to investigate ways in which it might provide more information on agreements involving reimbursement from Medicaid or other government programs.

Code and Third-Party Issues:

The Code on Dental Procedures and Nomenclature. The current version of the *Code* was effective on January 1, 2000. Litigation between the ADA and Delta Dental Plans Association was resolved in 2001, and the ADA put together a *Code* revision process that is consistent with the settlement agreement. These actions enabled review of requested changes and revision to the *Code* to proceed.

On January 28-29, 2002 the ADA's Code Revision Committee was convened and, in accordance with the structure provided by the settlement agreement with Delta Dental Plans Association, proceeded with deliberations on 84 requested changes to the *Code*. These deliberations resulted in 52 additions, 56 revisions and 26 deletions to this code set. The next version of the *Code* will be effective on January 1, 2003 and will be included in the new ADA publication titled "CDT-4," available from the Department of Salable Materials.

A process for ongoing review of change requests, leading to bi-annual publication of the revised *Code* is to be developed, approved by the Code Revision Committee, and administered by Council staff.

Code Workshop. A new workshop presentation has been prepared in order to address changes to the *Code* that are effective as of January 1, 2003. The sponsoring organization is responsible for covering the travel expenses of the Council volunteer who delivers the workshop. Also, at its April 2002 meeting, the Council approved the concept of having a fee assessed to the sponsoring group in order to help defray the ongoing development and maintenance costs of the *Code*.

Licensing the Code on Dental Procedures and Nomenclature. Licensing to third-party payers, software vendors, publishers and other parties continues in the Department of Salable Materials. The Division of Legal

Affairs has prepared a revised license agreement that reflects the annual fee to be charged to third-party payers, and other licensed users such as practice management system vendors.

The Systematized Nomenclature of Dentistry (SNODENT) Code Project. The Joint Council Committee on SNODENT, comprised of three members of the Council on Dental Benefit Programs and three members of the Council on Dental Practice, is overseeing an effort to field-test SNODENT in clinical situations. Attempts to identify and enter into an agreement with an educational or other outside organization to "field-test" SNODENT has resulted in a licensing agreement with the University of Iowa College of Dentistry. Some dental specialty groups have expressed interest in such licensing agreements as well.

Until the field-testing is completed and the membership is fully informed of the intent of SNODENT, there is no definite date for release of the SNODENT codes. SNODENT is not included among required code sets for electronic transactions specified by HIPAA.

Third-Party Liaison. The Council continues to meet regularly with individual third-party payers or their national organizations. During the first quarter 2002 the Subcommittee on Third-Party Issues met with representatives of three commercial carriers that administer dental insurance programs covering employer groups and individual insureds. Problematic EOB (Explanation of Benefit) language and dentist access to the payers' dental consultants were the two areas of major member and Council concern that were addressed. The Council chair and staff has also met with the Health Insurance Association's Dental Relations Committee where discussion of these issues continued with representatives of additional third-party payers.

Dental Claim Form. On January 1, 2003 the next version of the ADA's Dental Claim Form (paper) will become the current version for use by members of the profession. Changes to the data content and format have been made to address concerns with the 2000 version raised by the membership and the third-party payers. In addition the Council undertook revisions that harmonize the data content of the paper form and the HIPAA standard electronic claim format. This was done in accordance with Resolution 100H-2001 (see page 46 for an update).

The next version of the claim form will be incorporated into the ADA publication titled "CDT-4," which will be available from the Department of Salable Materials (DSM) beginning in September 2002. Revision to and publication of new versions of the claim form in concert with each edition of the *Current Dental Terminology (CDT)* manual is no longer an Association policy. Resolution 7H-2001 (*Trans.*2001:428) amended existing ADA policy on the ADA's Dental Claim Form (*Trans.*1991:631) on this matter. Concurrent release is not, however, precluded by the policy change and this year's events reflect simultaneous prompt Council action to address the needs of the membership (see page 45 for an update).

Dental Content Committee. In 2002 the Association's Dental Content Committee's (DeCC) entered its second full year of review and action on requested changes to HIPAA standard electronic transactions. The working relationships that have been built between representatives of the profession, third-party payer organizations and other data content organizations has enabled the DeCC to address most issues via conference call in lieu of periodic meetings at ADA Headquarters. There is an annual DeCC meeting scheduled for December 13, 2002.

There is a continuing flow of requested changes to the HIPAA standards, primarily from the payer sector, but including some originated by the Association to remedy potential ambiguity in instructions or to ensure harmony with ADA policy adopted by the House of Delegates (e.g., code sets used to designate tooth numbers and areas of the oral cavity). The DeCC addresses approximately 15 change requests each month, and over 480 requests have been addressed since the Committee's first meeting in September 2000.

ADA Policy Recommendations. The Council's Subcommittee on Third-Party Issues recommended that existing ADA policy on Definitions of Tooth Designation Systems (*Trans*.1994:652) be amended to provide a means for identifying supernumerary teeth within the Universal/National Tooth Designation System.

The Council therefore recommends that the following resolution be adopted, which supports ADA Strategic Plan Goals of Advocacy, Information and Practice Support.

5. Resolved, that the policy on Definitions of Tooth Designation Systems (*Trans*.1994:652) be amended by the addition of the following new language at the end of the section titled Permanent Dentition:

> Supernumerary teeth are identified by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar (e.g., supernumerary #51 is adjacent to the upper right molar #1; supernumerary #82 is adjacent to the lower right third molar #32).

and be it further

Resolved, that the section titled Primary Dentition be amended by the addition of the following new language at the end of the section:

> Supernumerary teeth are identified by the placement of the letter "S" following the letter identifying the adjacent primary tooth (e.g., supernumerary "AS" is adjacent to "A"; supernumerary "TS" is adjacent to "T").

Quality Assessment and Improvement: The Subcommittee on Quality Assessment and Improvement was established to monitor and analyze policy and initiatives that involve or affect the conceptualization, implementation or assessment of quality of health care and the Association's peer review system. The Subcommittee recommends, through the Council, Association policy and maintains resources for quality assessment and improvement and peer review. The Subcommittee includes members of the Council on Dental Benefit Programs and reports directly to the Council. However, because the subject of quality of care has ramifications for many agencies of the Association, the Subcommittee also includes representatives from the Council on Dental Practice, the Council on Dental Education and Licensure and the Council on Government Affairs.

Surveys. The Office of Quality Assessment and Improvement plans and implements two biennial surveys: one is the Dental Practice Parameters Survey; the other is the National Peer Review Reporting System Survey. Both of these surveys have been conducted in 2002 and results will be available from the Association's Survey Center in late 2002.

Credentialing. Dentists who participate in managed care and third-party reimbursement programs are often required to provide frequent and duplicative information on forms used by third-party payers for credentialing and recredentialing purposes. Although the intent of credentialing is to assure, at some level, the quality of care that enrollees of the benefit plans receive, the Council is exploring ways in which credentialing can be accomplished more efficiently through a uniform credentialing form. An initiative is underway in the health care system to develop uniform accreditation standards applied to the credentialing process and to develop a uniform credentialing database to which providers would submit data. The major accreditation bodies in the United States are negotiating the uniform accreditation standards and the Coalition of Affordable Quality Healthcare, a coalition composed primarily of third-party payers, is developing a uniform credentialing database.

Definition of Dental Enrollment Credentialing. The Subcommittee on Quality Assessment and Improvement also proposed that a definition of "dental enrollment credentialing" be adopted by the Association. The Subcommittee recommended to the Council on Dental Benefit Programs that the definition should highlight the distinction from credentialing for licensure and provide greater clarity on the use of the term "credentialing" as it is used for participating in third-party reimbursement plans. The Council, therefore, recommends the adoption of the following resolution. The resolution supports Strategic Plan Goals: Practice Support, Image, Ethics and Professionalism.

6. Resolved, that the term "dental enrollment credentialing" is a formal process that defines the standards and requirements for participation in a hospital or third-party programs and that verifies professional qualifications in order to allow licensed dentists to provide services to members of these groups.

Dental Practice Parameters. The Dental Practice Parameters Committee is composed of representatives from the Council on Dental Benefit Programs, the Council on Dental Practice and the Council on Dental Education and Licensure and is staffed by the Office of Quality Assessment and Improvement. The Dental Practice Parameters Committee meets annually to review and discuss policy and actions related to the development and use of guidelines, parameters and standards throughout the health care system. It identifies the implications for the quality and delivery of oral health care and recommends policy actions and revisions to the Association's Dental Practice Parameters to enhance the accessibility and usefulness of parameters to dentists. This year the Committee discussed the effectiveness of the online parameters' hyperlinks to related Association policy and positions on clinical oral health care and considered whether additional clinical literature should be added as a resource. The Committee concluded that further resources would not be added at this time. The Committee also recommended that staff study how guidelines and parameters are being used throughout the health care system, particularly in dentistry, and report the findings to the Committee.

The Committee also reviewed recently published parameters from the American Academy of Oral and Maxillofacial Radiology (AAOMR) and provided comment to the AAOMR.

Peer Review. The American Dental Association's peer review program is a means of efficiently settling disputes between a dentist and patient. In its recommendations on the structure and process of peer review programs, the Association has encouraged the use of peer review by third-party payers to settle disputes between a dentist and third-party payer. This year the Council clarified that the peer review process can be effective in settling such disputes about a single claim, but that each constituent society must independently judge whether it has the resources and structure to settle disputes between a dentist and third-party payer about multiple claims.

Peer Review Question and Answer Sheet. The Association's guidance on peer review programs requires that up-to-date information be communicated to constituents, components and peer review committees on an ongoing basis because the nature of information is affected by state and federal legislation, regulations and the resources available for the practice of dentistry. The peer review manual, *Peer Review in Focus*, and the peer review workshops are important avenues of communication between the American Dental Association and constituent and component dental societies to maintain an effective peer review system throughout the country.

The peer review manual contains general information and concepts that are applicable to all states. However, during peer review workshops, clarifications and interpretations are frequently discussed in the context of discussing a state's peer review system. Such clarification and interpretation would sometimes be of interest to all constituents and components and thus the Council is developing a collection of these questions and answers, which will be updated at least yearly and will be provided to constituents and components.

Peer Review Orientation Material. To further meet needs that have been expressed by constituent and component dental societies, the Council is developing materials that can be loaned to constituent and component dental societies to provide orientation to peer review for new members of the peer review committees. Although the materials cannot provide the benefits of the discussion and mediation training that occurs in peer review workshops and is not intended to supplant the workshops, they provide immediate access to peer review orientation.

Peer Review Workshops. Five peer review workshops have been scheduled, to date, for 2002. The purpose of the workshops is to explain the Association's recommendations on the structure and implementation of peer review programs and to assist constituents and components with issues specific to the management of their peer review programs.

Amendment to Peer Review Policy. The Council discussed current policy on peer review and recommended that current policy on Guidelines on the Structure, Functions and Limitations of the Peer Review Process (*Trans.*1992:603) be amended by the addition of the following statement to the list of recommendations contained in that policy. The statement reads, "Statistically-based utilization review should not be used to determine acceptable norms or clinical standards of dental practice."

The Council believes that it is important to include this statement which is already ADA policy (*Trans*.1989:542), to the Peer Review policy guidelines for reference in those instances when a peer review case involves a third-party payer.

This resolution supports the Strategic Plan Goal of Advocacy.

7. Resolved, that the Guidelines on the Structure, Functions and Limitations of the Peer Review Process (*Trans*.1992:603) be amended by the addition of the following statement to the list of recommendations:

> 15. Statistically-based utilization review should not be used to determine acceptable norms or clinical standards of dental practice.

Future of Dentistry Report: The Council reviewed the Future of Dentistry Report on a chapter by chapter basis at its April 2002 meeting. The Report will continue to be reviewed and consulted as the Council plans for its future projects and activities. No resolutions based on the Report are contained in this annual report.

Definition of Dental Necessity: The Council was asked to develop a definition of Dental Necessity in response to Resolution 112H-2001 (*Trans*.2001:429). Both the Council Subcommittee on Third-Party Issues and the Subcommittee on Quality Assessment and Improvement considered the issue and offered draft definitions to the full Council.

The Council recognized its duty to fulfill the request of the House of Delegates and a proposed definition is included in this report. However, the Council was concerned that the existence of such a definition may be confusing to the membership and others.

In response to Resolution 112H-2001 the Council recommends that the following resolution be adopted. The resolution supports ADA Strategic Plan Goals of Advocacy and Information.

8. Resolved, that the "dental necessity" for a dental service is based on whether a prudent dentist would provide the service to a patient to diagnose, prevent or treat orofacial pain, infection, disease, dysfunction or disfiguration.

Response to Assignments from the 2001 House of Delegates

ADA's Dental Claim Form: Resolution 7H-2001 (*Trans*.2001:428) amended the policy on ADA'S Dental Claim Form (*Trans.*1991:631) to no longer formally require that revisions of the uniform claim form be issued coincidentally with revisions to the *Code on Dental Procedures and Nomenclature*. The Council is now managing the claim form on a schedule that may not coincide with revisions to the *Code* but will be based primarily on the need for revision. The claim form will continue to be included in the *CDT* code manual as a matter of information for the members.

Amendment of the Guidelines on Professional Standards for Utilization Review Organizations: Resolution 8H-2001 (*Trans*.2001:433) amended policy on Guidelines on Professional Standards for Utilization Review (*Trans*.1992:33, 600, 601) by including a recommendation that when a utilization review process involves subjecting a patient to clinical evaluation, such evaluation should be undertaken through the constituent peer review process.

The Council conveys this amended policy position to third-party payers and local dental societies as appropriate.

Amendment of the Standards for Dental Benefit Plans: Resolution 9H-2001 (*Trans*.2001:428) amended policy on Standards for Dental Benefit Plans (*Trans*.1988:478; 1989:547; 1993:696; 2000:458) by stating that information on the possibility of post-payment utilization review, and any consequences of same, must be provided to both participating and non-participating dentists. This change has been incorporated into the Standards and is communicated to third-party payers as appropriate.

Amendment of the Definition of Claims Payment Fraud: Resolution 10H-2001 (*Trans*.2001:428) amended the following definition of Claims Payment Fraud (*Trans*.1998:701) by adding the words, "or procedure codes" after the word "facts" so that the amended definition reads:

> **Claims Payment Fraud:** The intentional manipulation or alteration of facts or procedure codes submitted by a treating dentist resulting in a lower payment to the beneficiary and/or treating dentist than would have been paid if the manipulation had not occurred.

This change has been made and the policy is to be conveyed to third-party payers as appropriate.

Dental Procedure Code Changes: Resolution 11H-2001 (*Trans*.2001:433) states that when a third-party payer or any other entity adjudicating a dental claim changes the submitted dental procedure code for internal processing purposes, all outgoing transactions, including EOBs, should show the originally submitted dental procedure code to avoid the dentist and the dental plan having inconsistent records of the treatment rendered.

The Council is using this policy to advocate for appropriate information on EOB forms used by third-party payers.

Amendment of the Protocol for Developing and Updating the Dental Practice Parameters: Resolution 12H-2001 (*Trans*.2001:434) amended the process for developing new parameters of care (*Supplement* 1996:502) by reducing the total number of conferees required to meet from 45 to 20.

Resolution 12H-2001 also amended the process for making revisions to existing parameters of care by no longer requiring a consensus conference and by requiring a review by mail by 35 practicing dentists.

Adoption of new parameters or adoption of revisions to existing parameters still requires approval by the House of Delegates.

Request for Insurance Companies to Retain Dentists' Social Security Numbers: Resolution 98H-2001 (*Trans*.2001:428) calls on the Council on Dental Benefit Programs to urge insurance companies to keep on file the Social Security numbers of those dentists who accept assignment of benefits, and cease requesting them on claim forms or walkout statements. This policy position is communicated to the third-party payer industry as appropriate.

Coordinate Modifications to Paper and Electronic Claim Forms: Resolution 100H-2001 (*Trans*.2001:434) calls on the Association to endeavor to coordinate modifications to both the ADA Dental Claim Form and the Health Insurance Portability Act of 1996 (HIPAA) electronic dental claim (837 Dental) for consistency and location of data content. The Council, in concert with the Department of Dental Informatics and the Dental Content Committee, has been pursuing the intent of Resolution 100H by proposing and considering modifications to the electronic dental claim format and the redesign of the paper claim form. The internal syntax of the HIPAA electronic dental claim is designed to be machine-readable and conform to X12 standards. As a Designated Standards Maintenance Organization, the Dental Content Committee of the ADA reviews all proposed modifications to HIPAA standard transactions, including the electronic dental claim. The next versions of the paper ADA Claim Form and the HIPAA electronic dental claim will have consistent data content. Moreover, practice management vendors are encouraged to display and print the ADA paper claim format for consistent data location.

Develop a Definition of Dental Necessity: Resolution 112H-2001 (*Trans*.2001:429) was referred to the appropriate Association agency. In response to this resolution, the Council developed a definition of "dental necessity" which is found in this report on page 45.

Summary of Resolutions

5. Resolved, that the policy on Definitions of Tooth Designation Systems (*Trans*.1994:652) be amended by the addition of the following new language at the end of the section titled Permanent Dentition:

> Supernumerary teeth are identified by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar (e.g., supernumerary #51 is adjacent to the upper right molar #1; supernumerary #82 is adjacent to the lower right third molar #32).

and be it further

Resolved, that the section titled Primary Dentition be amended by the addition of the following new language at the end of the section:

> Supernumerary teeth are identified by the placement of the letter "S" following the letter identifying the adjacent primary tooth (e.g., supernumerary "AS" is adjacent to "A"; supernumerary "TS" is adjacent to "T").

6. Resolved, that the term "dental enrollment credentialing" is a formal process that defines the standards and requirements for participation in a hospital or third-party programs and that verifies professional qualifications in order to allow licensed dentists to provide services to members of these groups.

7. Resolved, that the Guidelines on the Structure, Functions and Limitations of the Peer Review Process (*Trans*.1992:603) be amended by the addition of the following statement to the list of recommendations:

> 15. Statistically-based utilization review should not be used to determine acceptable norms or clinical standards of dental practice.

8. Resolved, that the "dental necessity" for a dental service is based on whether a prudent dentist would provide the service

to a patient to diagnose, prevent or treat orofacial pain, infection, disease, dysfunction or disfiguration.

Council on Dental Practice

Rainwater, Michael T., Georgia, 2002, chairman
Fair, Julian H., South Carolina, 2003, vice chairman
Bade, Daniel M., Indiana, 2003
Bell, Howard C., Florida, 2004
Berryman, Richard A., New Hampshire, 2005
Calnon, William R., New York, 2002
Drumm, John W., District of Columbia, 2005
Durr, Aubrey, Louisiana, 2003
Leslie, Thomas W., West Virginia, 2004
Martin, Max M., Jr., Nebraska, 2004
Okano, David K., Wyoming, 2002
Papapetros, Nicholas, Massachusetts, 2003*, ex officio**[*]
Proesel, Charles L., Jr., Illinois, 2003
Robson, James, Idaho, 2004
Stratigopoulos, George, California, 2004
Stuart, Michael L., Texas, 2005
Swanson, Loren C., Wisconsin, 2002
Tully, John J., Pennsylvania, 2005
Marshall, James Y., director
Block, Joan M., manager
Collins, Donald, manager
Collins, Susan E., manager
Kittelson, Linda E., manager

Meetings: The Council on Dental Practice met in the Association Headquarters Building on November 8-10, 2001 and May 9-11, 2002. Dr. Steven Bruce, Eleventh District trustee, serves as the Board of Trustees' liaison to the Council.

Organization: The Council is organized into two 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. There are three advisory committees serving the Council. One of these advisory committees, the Dentist Well-Being Advisory Committee (DWAC), met March 8-9, 2002. Two Council members serve on this Committee and the remaining members are consultants. A second advisory committee, the Ergonomics and Disability Support Advisory Committee (EDSAC), met April 5-6, 2002. Two Council members serve on this Committee and the remaining members are consultants to the Council. A third advisory committee, the Dental Team Advisory Panel, will meet on June 28, 2002.

Personnel: At the May 2002 meeting of the Council, Dr. Julian "Hal" Fair was unanimously nominated as chairman for 2002-2003. The 2002 ADA annual session will mark the retirement from the Council of Dr. Michael T. Rainwater, chairman, Dr. William R. Calnon, Dr. David K. Okano and Dr. Loren C. Swanson. The Council wishes to express its appreciation to these individuals for their thoughtful, determined leadership and for the many contributions during their tenure. Also, Mr. James Y. Marshall was appointed director of the Council in October 2001.

The Strategic Plan of the American Dental Association: The Council activities continue to support the ADA *Strategic Plan 2002-2005*, primarily Strategic Plan Goals Practice Support; Member and Support Services; Image, Ethics and Professionalism; and Information. The Strategic Plan metrics results for 2001 and the projections for 2002 were approved by the Council at its May 2002 meeting.

Future of Dentistry Report: The Council reviewed the Future of Dentistry Report on a chapter by chapter basis at its May 2002 meeting. The Report will continue to be reviewed and consulted as the Council plans for its future projects and activities. No resolutions based on the Report are contained in this annual report.

Response to Assignments from the 2001 House of Delegates

Dental Society Activities Against Illegal Dentistry: The Council on Dental Practice was assigned primary reporting responsibility on Resolution 14H-2001 (*Trans.*2001:435), which amended the Association policy on Dental Society

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

Activities Against Illegal Dentistry (*Trans.*1977:934) to include other forms of illegal dentistry and by naming the Council on Dental Practice as the contact agency, rather than the former Council on Dental Laboratory Relations.

This revised policy will be incorporated into the Council's materials and references to illegal dentistry.

Amendment of Policy on Opposition to "Denturist Movement": The Council on Dental Practice was assigned primary reporting responsibility on Resolution 15H-2001 (*Trans*.2001:436), which states that the Association vigorously opposes denturism, the denturism movement and all other similar activities, regardless of how they are designated, in this country and which rescinded Resolution 119H-1977 (*Trans*.1977:928), Opposition to "Denturist Movement." This revised policy will be incorporated into the Council's materials and references to illegal dentistry.

Amendment of Policy on "Denturist" and "Denturism": The Council on Dental Practice was assigned primary reporting responsibility on Resolution 16H-2001 (*Trans*.2001:436), which amended the Association policy on "Denturist" and "Denturism" (*Trans*.1976:868) to encompass the variety of terms used to describe the denturist movement, and to acknowledge that "denturists" are recognized in some states.

This revised policy will be incorporated into the Council's materials and references to illegal dentistry.

Sale of Dental Equipment to Illegal Practitioners: The Council was designated the lead agency in the implementation of Resolution 33H-2001 (*Trans*.2001:436), which directed that the Association urge dental equipment manufacturers and suppliers to develop and implement guidelines which preclude the sale, transfer or conveyance of new and used dental equipment and supplies (excluding "over the counter" consumer care products) to illegal practitioners of dentistry and that these guidelines require that the manufacturers or suppliers first verify that the purchaser is licensed to practice dentistry in the state the product(s) will be delivered; and also, that the contracts, purchases orders and invoices used in these transactions include the purchaser's dental license number. The Council believes that such guidelines should include the provision that allow for the sale, transfer or conveyance of dental equipment and supplies to as yet unlicensed dental students or recent graduates provided they provide verification of current attendance in or graduation from an accredited dental school. The Council has begun conveying this policy position to the dental equipment industry.

Council Activities

SUCCESS 2001-2002: Completing its 19th successful year of operation, the SUCCESS Program has continued to grow in both popularity and impact. Initially known as OPTIONS, the Program concentrates on the issues that a new graduate will face as he or she enters private practice. In 1991, the Program was retitled SUCCESS to more accurately reflect the current content of the Program. Responses from corporate sponsors, dental students, dental schools and organized dentistry continue to be extremely positive. Senior, junior and graduate dental students throughout the United States benefited from the efforts of SUCCESS 2001-2002. 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 2001-2002 continued to focus upon business training for junior, senior, and graduate dental students. The Program conveys this information to students in two ways. First, the Association's publication, *Starting Your Dental Practice: A Complete Guide*, was distributed to over 4,400 senior dental students during the year. The publication is a comprehensive 130-page manual that includes chapters on options for entering dental practice, 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 25 dental schools in 2001-2002. This concentrated seminar covers such topics as: life after dental school; options for entering practice, associateships; dental management service organizations; the office dental team; practice by the numbers (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.

The Council on Dental Practice cosponsored the SUCCESS/Ethics seminars for 2001-2002.

Corporate Sponsors. The following corporate sponsors made a financial contribution to the SUCCESS Program: A-dec, Inc.; The CNA Insurance Companies and Brown & Brown Insurance; DENTSPLY International; The Equitable Life Assurance Society of the United States, New York; Great-West Life & Annuity Insurance Company; John O. Butler Company; Sullivan-Schein Dental, A Henry Schein, Inc. Company; the Pankey Institute; Patterson Dental Supply, Inc.; Procter & Gamble Company; Ultradent Products, Inc.; and the Pfizer, Inc. 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.

Sponsor Recognition. Corporate sponsors received the following benefits and recognition: a feature article in the September 17, 2001 issue of the *ADA News* that was distributed to over 160,000 dentists and subscribers and was promoted by ADA.org; a feature article in the *American Student Dental Association News*, September 2001 issue; a feature article in *New Dentist Fall 2001* magazine; formal acknowledgment on the inside front and back covers of the publication, *Starting Your Dental Practice: A Complete Guide*,

which was distributed to senior dental students; acknowledgment on the inside front and back covers of the seminar manual, *Starting Your Dental Practice*; distribution of sponsors' literature to all seminar participants via a dossier in which interested corporate sponsors were able to place a promotional flyer; opportunities for sponsors to send representatives to student seminars; an excel address list of student attendees who filled in the practice management publication coupon and a formal recognition plaque.

Seminar Site Selection. SUCCESS 2001-2002 seminars were presented on the dates indicated below: September 11, University of Iowa; September 20, University of Missouri-Kansas City; September 28, University of Washington; October 5, University of Texas Health Science Center at San Antonio; October 23, University of Alabama; October 31, University of Illinois at Chicago; November 7, Meharry Medical College; November 8, University of Florida; December 6, University of Mississippi; December 13, State University of New York at Stony Brook; January 9, University of Tennessee; January 11, University of Texas-Houston Dental Branch; January 18, University of Nebraska; January 23, Ohio State University; January 26, University of Minnesota; January 28, Medical University of South Carolina; February 2, Yankee Dental Congress; February 8, West Virginia University; February 9, Columbia University; February 16, University of Michigan; February 22, Baylor College of Dentistry and Indiana University; February 28, Louisiana State University.

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. Two professionals selected from the Council's list of consultants presented each seminar.

SUCCESS 2001-2002 Program Revisions. Each year the SUCCESS Program is reviewed in light of the changing dental practice environment and student needs. The SUCCESS Manual was updated this past year and sent to speakers along with revised presentation slides on CD-ROM in the PowerPoint format.

As part of a coupon redemption program, a coupon was distributed to those students in attendance at the conclusion of each seminar. Coupons could be redeemed for a free copy of one of seven of the Council's practice management publications.

The dental student attendees rated the overall SUCCESS Program for 2001-2002 an average of above 4.5 on a 1.0 to 5.0 scale of excellence.

With continued corporate support, this Program will again be offered to dental schools throughout the United States and Puerto Rico. The overall goal remains the same—to make available quality information about starting a dental practice to junior, senior and graduate dental students who will be entering practice in the near future.

Seminar Series 2001-2002: The ADA Seminar Series is provided by the Council on Dental Practice. The Council cosponsors over 150 practice management and clinical seminars with state, local, national, international dental organizations and other dental related groups. Completing its 15th successful year of operation, the ADA Seminar Series has continued to grow in both popularity and impact. Seminar Series programs were sponsored in 48 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 2001. Seminar attendees continue to rate the overall program and speaker quality on an average of 4.5 on a 1.0 to 5.0 scale of excellence.

Objective. The Council's Seminar Series primary objective is to offer tripartite and other dental organizations nationally known speakers and Association-developed/Association-approved continuing education programs as a tangible member benefit at below-market rates to help local dental organizations provide high-quality continuing education programs and generate non-dues revenue**.** To date, the American Dental Association Seminar Series' speakers have also agreed to present a limited number of programs at a fee even below the discounted fee they presently charge the Association. This has served as a valuable membership benefit, especially for those societies with limited resources and difficult access to top quality programs.

Program Growth. In 2001, 164 seminar programs were arranged, 149 programs have been scheduled for 2002, 63 for 2003 and 11 for 2004. Because of increased demand, the Council added nine new seminars to the 2001-2002 *Seminar Series 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 their timeliness and the marketability of speakers and topics.

Corporate Sponsors. The 2001-2002 Seminar Series programs are sponsored by the American Dental Association with the support of Sullivan-Schein Dental, a Henry Schein company and 3M ESPE.

Sponsor Recognition. To publicly acknowledge the corporate sponsors, levels of recognition have been developed to identify the support given to the Seminar Series.

Seminar Presenters. Program speakers are recommended by the Council based upon their recognized expertise in the areas of clinical practice and practice management. A potential new speaker was selected at the November 2001 meeting of the Council and forwarded to the Association President, who approved one speaker consultant to the Council for the 2002-2003 *Catalog*. The Council recommended four additional new seminar speakers in May 2002.

ADVANTAGE Program. The ADVANTAGE Program, "Dentistry Is A Business: Practice Advice For New Dentists, Seasoned Practitioners, and Dentists in Transition," was added to the *Seminar Series Catalog* in 1998. Since the inclusion in the *Catalog*: two programs were held in 1998, in California

and Tennessee; two programs were held in 1999, in Louisiana and Tennessee; one program was held in 2000, in Oregon; one program was held in 2001, in Wisconsin; three programs were held in 2002, in New Hampshire, Florida and South Carolina; and one program is scheduled for 2003, in Texas. At the May 2002 meeting of the Council, it was that recommended that The ADVANTAGE Program be removed from the 2002-2003 Seminar Series due to low bookings and low program ratings. The Council further recommended the creation of a practice management seminar, targeted to the new dentist, with input from the Committee on the New Dentist and that it be added to the Seminar Series as a future catalog offering.

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, through internal and external agency publications, e.g., EDU, *Benefit Briefs*, ADA.org, *ADA News*, and various specialty newsletters and journals and through internal and external agency activities, e.g., President-Elect's Conference; President's Conference; Management Conference; Field Representative programs and the Association's annual session.

Attendance at Dental Meetings. Council staff attended the ADA annual session in October 2001; the Yankee Dental Congress in January 2002; and the Chicago Midwinter Meeting in February 2002. Staff continues to attend these meetings to evaluate and scout programs as potential new seminars for the benefit of the membership.

Council Publications: The Department of Salable Materials assisted the Council with the development and promotion of its publications.

Two publications targeted to dental office staff, *Basic Training for the New Dental Office Staff* and *Employee Office Manual: A Guide for the Dental Office*, are now available on CD-ROM as well as in printed copy. The CD-ROM versions were added at members' request so that they could customize the information for their particular office. Two additional books in the *Basic Training* series are being developed, based on member surveys indicating such members would like such resources. It is anticipated that *Basic Training II for New Clinical Personnel* will be available in fall 2002.

A new publication titled *Dental Office Design: A Guide to Building, Remodeling, and Relocating* was released in March of 2002. 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 2001. A new dentist-targeted publication, *Practice Options for the New Dentist: A Financial Guide,* concentrates on choosing advisors, different types of practice arrangements, developing business plans, evaluating assets and projecting growth, obtaining practice financing and insurance coverage. It will be updated in 2002 and a chapter on forms of business, (i.e. corporations, partnerships, etc.) will be added. The publication *Dentistry as a Business: A Financial Guide* is being updated in 2002.

Marketing Publications: Currently, six marketing publications developed through the Council are available for purchase through the Department of Salable Materials. The scope and content of the Council's most recent publications have reflected many current trends in practice marketing and the dental marketplace as a whole. The Department is dedicated to developing content that best reflects the current issues and trends faced in dental offices. Continued attention to the issues relevant to today's dentists will help ensure that members view the Association—as opposed to outside consultants—as the foremost resource for insightful practice marketing information. The sale of the Council's marketing publications continues to generate significant nondues revenue for the Association. The Council on Dental Practice marketing also provides marketing materials that members may request free of charge. The *Marketing Resource Guide*, *Marketing Tactics* brochure and *Communicating Infection Control* materials are among the complimentary resources offered through the Department. Over 1,000 copies of these materials are distributed to dentists each year. The newest addition to the compilation of free marketing materials is the brochure entitled *Surveys for the Dental Practice*. In the coming year, the Department will focus its attention on promotion of its current publications to help ensure the continued success of the product line. As directed by the Board of Trustees, the Association and the American Academy of Periodontology updated the Periodontal Screening & Recording (PSR) program. The new PSR brochure is currently available for purchase through the *ADA Catalog*.

Directory of Dental Practice Appraisers and Brokers: Now in its fifth edition, this publication (formerly entitled the *Directory of Dental Practice Appraisers and Valuators*) of the Council on Dental Practice continues to be in great demand as a resource for information concerning valuing a dental practice. The *Directory of Dental Practice Appraisers and Brokers* lists individuals and companies across the country that can help dentists value a practice as part of estate planning, returning to school, insurance purchase, or for establishing a baseline valuation prior to establishing an associateship or partnership arrangement. The 2001 *Directory* indicates which regions in the United States are served by the listed consultants, their education, the number of valuations they performed the previous year, the valuation method they use, fee range, their professional affiliations and more.

Directory of Dental Placement Services in the United States 2000: The *Directory of Dental Placement Services in the United States* 2000 continues to be a resource for locating dental practices for sale, for finding dental associateships and placing dental office staff.

The *Directory* contains information about individual placement services, such as who can receive job-counseling assistance (dentist only, dental hygienists and dental assistants, etc.); whether the service offers help with resumes, has a Web site, and how frequently postings for jobs are updated. Always popular, the *Directory* has been revised and republished biennially since 1989.

Directory of Dental Practice Consultants: The Council approved a directory of dental practice management consultants at its May 2002 meeting. The individuals listed will be consultants who can offer a variety of customized services to dentists that could improve their efficiency and productivity. Practice management consultants, for example, can provide training to staff, streamline scheduling and supply purchasing, create comprehensive marketing strategies or assist with understanding regulatory compliance matters. The listed practice management consultants pay a fee to be included. No endorsement is implied by their appearance in the publication.

HIPAA Privacy Activities: The HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule applies to health plans, health care clearinghouses, and health care providers who conduct standard transactions in electronic form. As of this writing, most covered entities must comply with the Privacy Rule by April 14, 2003. The Privacy Rule establishes national standards to protect the privacy of individually identifiable health information.

The Department of Health and Human Services (HHS) issued Guidance to the Privacy Rule on July 6, 2001 responding to concerns raised by the ADA and other covered entities. Among other things, specifically, the Guidance stated that soundproofing of healthcare offices and other healthcare facilities was not required.

Key provisions of the new proposed rule to modify the Privacy Rule include:

- written consent for release of health information prior to use or disclosure for purposes of treatment, payment or health care operations is now optional;
- a new requirement that providers must make a good faith effort to obtain an individual's written acknowledgment of receipt of the provider's notice of privacy practices;
- clarification that providers may discuss a patient's treatment with other doctors involved in the patient's care without fear of violating the rule if they are overheard; and
- provides up to an additional year for covered entities to change existing contracts with business associates.

In order to help dentists understand the Rule, the Association has created the HIPAA Privacy Kit: Policies and Procedures For Your Office, Forms, Checklists and More! The Kit contains an overview of the Rule, a notice, checklist, forms and policies and procedures. In addition, the Association is making available a seminar entitled "HIPAA Privacy For Dentists" to help explain the obligation of dentists under the Rule. A representative from the Division of Dental Practice and from the Division of Legal Affairs will co-present the program. So far, over 40 dental societies have booked the program for local meetings.

Forensic Dentistry Symposium and Workshops: The Councils on Dental Practice (CDP), Scientific Affairs (CSA) and Access, Prevention and Interprofessional Relations (CAPIR), along with the American Board of Forensic Odontology, an outside organization, presented the program, "2001 Forensic Dentistry Conference: A Symposium with Workshops" on July 19-21, 2001, at the ADA Headquarters Building in Chicago.

The three-day program began with a full day of introductory remarks and instructions about the symposium's workshops. The multiple half-day, hands-on workshops followed on day two and day three. The workshops were titled:

1. Missing/Unidentified in America - The Never Ending Disaster;
2. Bite Marks and Patterned Injuries;
3. Introduction to Digital Imaging and Transmission;
4. Introduction to Expert Testimony; and
5. Mock Aircraft Mishap.

The program speakers included military and civilian experts in forensic dentistry. Over 150 dentists, staff members and others attended the symposium. The Council has begun preliminary planning for a two-day forensic workshop in 2003.

Dental Team Advisory Panel: The Council's Dental Team Advisory Panel (DTAP) for 2002 includes the following members: Dr. Howard Bell, chairman, Florida; clinical assistants—Ms. Cheryl Ennis, CDA, New York, and Ms. Susan Price, Florida; business managers—Ms. Francine Bergeron, Connecticut, and Ms. Patricia DeHart, West Virginia; dental hygienists—Ms. Susan Donnelly, RDH, Connecticut, and Ms. Debra Edinger, RDH, CDA, Florida; and dental laboratory technicians—Mr. Tim Sweeney, CDT, Nebraska, and Mr. Ron Skipper, South Carolina. The purpose of the DTAP is to assist the Council in creating and developing projects or activities that support and enhance the dental team concept. One of the activities initiated by this Panel was a "Team Building" column in the *ADA News* targeted to dental team members. The DTAP will meet on June 29, 2002.

Team Building Conference: The Councils on Dental Practice and ADA Sessions and International Programs cosponsored the national Team Building Conference VI on October 12-13 at the 2001 ADA annual session held in Kansas City. This was the sixth consecutive year for the Conference. Some two years in development, the Conference originated within a dental team committee created in 1993 by the Council on Dental Practice to explore ways in which the profession could enhance the team concept. Scheduling the Conference during the annual session facilitated the scheduling of well-known speakers, reduced associated costs and also fit well into the travel plans of dental teams attending the program.

With attendance sold-out, the 2001 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 panel discussions, the Conference taught dental team members how to create a motivating climate, use conflict to resolve issues, improve problem-solving ability, promote initiative in each member of the dental team and develop positive strategies for dealing with the daily stresses of working in dentistry's highly technical, time sensitive world. Attendees overwhelmingly agreed that the Conference met their expectations and that they would recommend other teams attend, as reported in the post-Conference evaluation forms.

The 2002 Team Building Conference "Making it easy in the Big Easy" in New Orleans will take place October 18-19, 2002.

Liaison With the American Dental Hygienists' Association (ADHA): The ADHA sent representatives to the Council meeting held November 8-10, 2001. Several topics relating to dental hygiene were discussed, including: access to dental services for the underserved; the Surgeon General's Report on Oral Health; the link between oral health and overall health; and current dental hygiene workforce availability.

Council on Dental Practice staff, along with senior Association management, met with the ADHA executive director and staff in January to discuss areas of mutual concern, such as the Waddell case, HIPAA and ADA dental hygienist career recruitment materials. Council staff attended the ADHA's 79th Annual Session held in Beverly Hills, California, June 21-24, 2002.

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 2002 DARW, March 3-9, was cosponsored by the Canadian Dental Association and the Canadian Dental Assistants Association. The Council worked in cooperation with the American Dental Association's Department of Salable Materials to promote DARW recognition travel coolers and mugs. Advertisements for DARW appeared in the *ADA News* and ADA.org. DARW kits were distributed by both the ADAA and the Council to dental offices requesting them. Awards in each of four categories are given to dental offices, dental assisting schools and associations that utilize creative, innovative ways of celebrating this week. First-place, second-place and honorable mention winners were selected in the spring in the following categories: dental assisting associations; dental assisting schools; dental offices with five or fewer assistants; and dental offices with more than five assistants.

Ms. Jennifer Blake, ADAA past president and director, Education, and ADAA executive director, Mr. Lawrence Sepin, made an appearance at the May 2002 Council meeting to discuss issues of mutual concern regarding dental assistants, in particular the need of setting educational standards, the ADAA Fellowship program and shortage of dental assistants. Ms. Cynthia Bradley, ADAA president, and Mr. Sepin also met with ADA senior management in March 2002 to discuss ADAA concerns about dental assisting workforce shortages and ways the two organizations might work together on this problem.

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 annual meeting in Tampa, Florida on October 26-27, 2001. Dr. Michael T. Rainwater, Council chairman, and one staff member attended the meeting. Dr. Rainwater addressed the NADL meeting.

Dr. James Robson replaced Dr. John Burton as trustee of the National Board for Certification (NBC) for 2002-2003. The Council is very supportive of this representation with NBC because it allows for expanding communication between NBC and the Council. The last several years have been particularly crucial for the laboratory industry since NBC and NADL are going through a restructuring of their entire organizations and changes in organization management.

Ms. Ricki Braswell, deputy executive director, NADL, attended the November 2001 CDP meeting and updated the Council on recent NADL management changes and discussed current training/education and shortages of certified dental technicians. One of NADL's main concerns is the shortage of dental laboratory technicians, the decline in the number of accredited programs (28 programs) and the impact these conditions will have on the laboratory industry. Recent activities of NADL include creation of a slide presentation to be used for recruitment of dental laboratory technicians.

The Council supported a request from NADL to be a participant in the *Something to Smile About—Careers in the Dental Profession* campaign for dental laboratory technicians, if this program is approved.

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 diseases 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 2001-2002: Dr. David Okano, chairman, Wyoming; Dr. Stephen Abel, New York; Dr. Dennis A. Johnson, Oregon; Dr. John W. Drumm, D.C.; Dr. Mary E. Martin, Oklahoma; Dr. Peter Pruden, New York; Dr. Kenneth Yarnell, Wisconsin, and Dr. Bruce Walker, California. S. Richard Lavine, M.D. of California is the Council's psychiatric consultant. The Alliance of the American Dental Association sent a liaison to the DWAC meeting, with the intent of identifying ways the Alliance can support the Association's efforts in this area.

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 March 8-9, 2002.

Major items on the agenda of the 2002 DWAC meeting were review of the draft questionnaire for the 2002 Women Dentists Well-Being Survey, review of the draft handbook for the constituent dentist well-being programs, and preliminary planning for a Well-Being Institute in 2003. In addition, recommendations to provide informational resources on the psychological adjustment to retirement were reviewed by the Council at its May 2002 meeting.

The 9th National Institute on Dentist Well-Being, "Healthy Dentists, Healthy Families," was held August 16-18, 2001, at

ADA Headquarters in Chicago. There were 143 attendees and program evaluations were strongly positive in all areas. The conference was budgeted to be revenue-neutral; it generated approximately $1,300 in revenue, with the assistance of corporate support. Corporate sponsors were The Professional Recovery Program of the Betty Ford Center; COPAC; The William J. Farley Center at Williamsburg; FirstLab; Forest Irons and Associates, Inc; Illinois Institute for Addiction Recovery; Masters and Johnson at River Oaks; Palmetto Addiction Recovery Center; Pine Grove Next Step; Rush Behavioral Health; Springbrook Northwest; and Talbott Recovery Center.

The Council sponsored the well-being booth at the Association's annual session in Kansas City, as it has for the last several years. A variety of information on chemical dependency, mental health, infectious diseases and stress management was available. Visitor comments support this activity as a valuable service. The booth serves several functions, such as educating session attendees about the Council's well-being programs, providing materials to attendees about issues known to be of concern to dentists and providing a point of connection at the annual session for well-being volunteers in attendance.

The annual survey of dentist assistance programs was done, with all but two constituents completing the form. Two constituents reported there are no assistance services available to troubled dentists, whether through the dental society, a dental board-sponsored program or an outside agency. Five constituents rely exclusively on outside agencies to serve their dentists, so dentist well-being volunteers are not involved. Eight constituent societies employ someone to manage their well-being programs, and these societies, not surprisingly, report the highest utilization rates.

New projects include the 2002 Women Dentists Well-Being Survey, a handbook for constituent dental society well-being programs and implementation of mental health screening as part of the Health Screening Program at the ADA annual session.

Utilization of the Council's well-being informational resources has been high in the last year. Requests for collaboration from other professional groups—the American Bar Association, the American Medical Association, the American Veterinary Medicine Association, the Federation of State Physician Health Programs, specialized treatment centers and others—reflect the positive image of the Association for its leadership in this area. Individual dentists, whose calls are precipitated by some sort of crisis, continue to express appreciation that this support is available through their professional association.

Ergonomics and Disability Support Services Program: The ergonomics and disability support activities of the Council include identifying resources for physically disabled dentists; educating dentists about ergonomics; consulting with other Association agencies regarding these matters; representing the Association at the ANSI Z-365 meeting; and offering technical assistance to the Council on Dental Practice in carrying out its ADA *Bylaws* responsibilities.

In order to carry out these responsibilities, the Council with Board approval, created the Ergonomics and Disability Support Advisory Committee (EDSAC) in 1997. Two members of the Council serve on the Committee; one of these CDP members chairs the Committee. The other members include a volunteer from the Council on Scientific Affairs and three consultants. Committee members are Dr. William R. Calnon, (CDP), New York, chairman; Dr. Max Martin, (CDP), Nebraska; Dr. David Ahearn, Massachusetts; Dr. William J. Sullivan, Illinois; Mr. Scott W. Smith, California; and Dr. Patricia Blanton, (CSA), Texas. Dr. Connie Verhagen, Michigan, is a consultant to the Committee.

The Committee met for two days in June 2001 and again in April 2002. In the future, the Committee will meet once a year for one day.

The Council gives support to educational programs first proposed by the Committee that are intended to educate dentists and others about ways to help prevent ergonomically-related injuries and illnesses that may be associated with the dental workplace, and to improve productivity and efficiency using sound ergonomic principles. For example, the Council endorses the idea of outside agencies cooperating with the ADA to seek ways to support clinical research on the effects of dental instrument design, and operator hand and wrist stress as related to hand-held instruments and ultrasonic scalers.

In addition, the Council accepted the Committee's recommendation this year to develop a new awareness course and a platform presentation on ergonomics.

The Council also urged the Association to consider working with the Occupational Safety & Health Administration (OSHA) on a project to demonstrate how voluntary industry practices could successfully reduce injury rates.

ADA staff will attend and participate in the industry consensus work group (Z-365) that may write voluntary ergonomics guidelines for industry. Association staff will also attend and participate in the ANSI work group developing standards for hand instruments.

The Council is modifying its existing ergonomics seminar in the ADA Seminar Series to reflect the findings of good ergonomics research. In addition, the Council is developing an ergonomics white paper, and an entirely new ergonomics seminar that could eventually replace the current ergonomics seminar in the Series.

The Council, at the request of the EDSAC, will develop a network of disabled dentists helping each other.

Finally, the Council approved the EDSAC's recommendation that the American Academy of Physical Medicine & Rehabilitation (AAPMR) be accepted as a source of information to disabled dentists who contact the Council. This acceptance is not considered to be an endorsement of AAPMR.

Dental Office Waste Water and Biofilm Contamination: During its November 2001 and May 2002 meetings, the Council discussed the implications for dental practices of management of waste water and waterline contamination. Regarding biofilm contamination of waterlines, the Council urged the Council on Scientific Affairs to challenge the dental equipment industry to find more convenient and cost effective measures to control biofilm contamination.

The Council also urged CSA to support a data collection project in conjunction with the use of amalgam separators. In

the opinion of the Council, such data would help determine the actual benefit of amalgam separators in dental offices to a community's water supply.

Tooth Whitening Services: The Council has been following the growing public interest in various tooth whitening techniques and services. Reports received about retail outlets providing mouth trays directly to the public using non-dentally licensed or supervised personnel, prompted the Council to recommend the adoption of an Association policy on the matter. The Council believes that the Association should be on record opposing the making of impressions for the fabrication of oral appliances to be used with tooth whitening products by anyone other than a licensed dentist or supervised auxiliaries. The Council, therefore, recommends the adoption of the following resolution. This resolution supports the Strategic Plan Goal on Advocacy.

9. Resolved, that it is policy of the American Dental Association that only licensed dentists or supervised dental auxiliaries, in compliance with applicable state law, should be permitted to make impressions for the fabrication of oral appliances used with tooth whitening products, and be it further

Resolved, that this information be communicated to all organizations (e.g., state boards of dentistry and the Centers for Disease Control and Prevention) working to protect the public from harm and infectious disease.

Summary of Resolutions

9. Resolved, that it is policy of the American Dental Association that only licensed dentists or supervised dental auxiliaries, in compliance with applicable state law, should be permitted to make impressions for the fabrication of oral appliances used with tooth whitening products, and be it further

Resolved, that this information be communicated to all organizations (e.g., state boards of dentistry and the Centers for Disease Control and Prevention) working to protect the public from harm and infectious disease.

Commission on Relief Fund Activities

Ellwein, Orin W., South Dakota, 2002, chairman
Pierce, Jack L., Texas, 2002, vice chairman
Comeau, Roger L., Wisconsin, 2005
Drummond, Trucia A., Illinois, 2004
Ferry, Edward T., Rhode Island, 2004
Miller, Joseph B., Kentucky, 2003
Parrish, Jeffrey L., Washington, 2005
Procini, Charles P., New Jersey, 2003
Mountz, Marsha L., director

Meetings: The Commission met in the Headquarters Building on September 6-7, 2001 and May 2-3, 2002. Dr. Dennis E. Manning, Board of Trustees liaison to the Commission, attended the May meeting. The next meeting of the Commission is scheduled for September 19-20, 2002.

Election of Chairman and Vice Chairman: The 1989 House of Delegates approved Resolution 44H-1989 (*Trans*.1989:557), which amended the *Bylaws* to allow the Commission on Relief Fund Activities to elect its chairman. Dr. Orin W. Ellwein was elected chairman and Dr. Jack L. Pierce was elected vice chairman for 2001-2002.

Personnel: The Commission announced the addition of two new members: Dr. Roger L. Comeau, Wisconsin, and Dr. Jeffrey L. Parrish, Washington. The 2002 annual session will mark the completion of the terms of service of Dr. Orin W. Ellwein and Dr. Jack L. Pierce. The Commission expresses its gratitude to these individuals for their leadership and contributions during their tenure.

The Commission appreciates the guidance and leadership Dr. Albert H. Guay provided to the Commission during his tenure as director. Ms. Marsha L. Mountz was appointed director of the Commission in November 2001.

President's Committee to Review the CRFA Self-Study Report: The ADA president set up a special committee during this year, for the purpose of reviewing how the Relief Fund is structured and how funds are allocated. The Commission chairman participated on the Committee and former chairman, Dr. Michael P. Banks, served as the special committee chairman. The President's Committee is making several recommendations to the ADA Board of Trustees designed to streamline the structure, improve visibility of the Relief Fund, and improve the Fund's effectiveness and operational efficiencies. These recommendations are under consideration at the time of this writing.

Future of Dentistry Report: The 2001 Future of Dentistry report will be an agenda item for discussion at the Commission's meeting in September 2002.

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 emergency needs and daily living expenses.

For the 12 months from July 1, 2000 to June 30, 2001, the total number of persons receiving grants was 41 of which 8 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 $399,010, an increase of $100,000 from the prior year. The average monthly grant awarded in 2001 was $824, while the largest monthly grant was $2,000.

Financial Operations: As of June 30, 2001, the ADA Relief Fund contributions generated by the 2000-2001 annual fund-raising campaign were $296,103 of which $218,136 was rebated to constituent society relief funds. The Commission established a national campaign goal of $250,000 to determine each state's assigned quota for contributions and amount to be awarded in grants.

From the ADA Relief Fund, $183,977 was disbursed in grants for the year ended December 31, 2001, an increase of $19,494 from the previous year. In 2001, a $50,000 grant was awarded to the ADA Emergency Fund, Inc. for assisting those dentists affected by the September 11 World Trade Center disaster. Other expenses included $262,962 in general and administrative expenses and $82,116 in fund-raising expenses. As of December 31, 2001, the Relief Fund had an unaudited balance of $6,315,593 to support its charitable program activity.

Investment Activities: The Relief Fund's portfolio is currently managed by Rorer Asset Management LLC, value equity investment manager; Dearborn Partners LLC, growth equity manager; Roxbury Capital Management LLC, small cap equity manager; Cutler & Company LLC, fixed income manager; and LaSalle National Bank, custodian.

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 composition 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 assists it in performing its fiduciary responsibilities.

The Relief Fund's money 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.

The asset distribution of the Relief Fund portfolio was comprised of 60% in high-grade equities, 33% in fixed income securities, and the remaining 7% in cash equivalents in 2001. In the fixed income segment, the portfolio's return for 2001 was 9.1% compared with the Merrill Lynch Intermediate Government/Corporate Bond Index return of 9.7%. The Fund's value equity investments had a return of -15.2% and growth equities demonstrated a -17.6% return compared to -11.9% from the S&P 500. The small cap investments, which comprise 10% of the Relief Fund's assets, had a portfolio performance of 1.38% compared to 8.10% from the S&P 400. Total equity assets were distributed over ten major industry sectors.

2001-2002 Relief Fund Campaign: The Commission conducts an annual campaign to solicit charitable contributions on behalf of constituent dental society relief funds. Contributions from the campaign are rebated to state relief funds for grant-making activities.

The fund-raising campaign consists of three mailings, the first of which was sent November 13, 2001, the second on February 1, 2002, with the third mailing planned for May 1. Total contributions through April 10, 2002 amounted to $267,374. Acknowledgment letters are sent to those dentists who contribute $250 or more.

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.

Division of Education

Commission on Dental Accreditation

Council on Dental Education and Licensure

Joint Commission on National Dental Examinations

Notes

Commission on Dental Accreditation

Jancar, Susan L., Nevada, 2003, chair, American Dental Association
McTigue, Dennis J., Ohio, 2003, vice chair, American Academy of Pediatric Dentistry
Ammons, William F., Jr., Washington, 2002, American Academy of Periodontology
Avery, William A., Michigan, 2002, American Dental Association
Bell, Homer Clark, III, North Carolina, 2002, American Association of Dental Examiners
Bolick, Gerald M., North Carolina, 2004, Public Member
Braun, Thomas W., Pennsylvania, 2005, American Association of Oral and Maxillofacial Surgeons
Byrd, Lanier, Texas, 2005, Public Member
Christensen, Mark, Utah, 2003, American Association of Dental Examiners
Cohen, Ruben, Louisiana, 2003, American Dental Education Association/American Student Dental Association
Dunsky, Joel L., Massachusetts, 2004, American Association of Endodontists
Freeman, Irving, Pennsylvania, 2003, Public Member
Goldblatt, Lawrence I., Indiana, 2002, American Dental Education Association
Graham, Bruce S., Illinois, 2005, American Dental Education Association
Green, Frank P., Illinois, 2004, American Dental Association
Hunt, Ronald J., Virginia, 2004, American Association of Public Health Dentistry
Kalkwarf, Kenneth L., Texas, 2004, American Dental Education Association
Meyerowitz, Cyril, New York, 2005, American Dental Education Association/American Association of Hospital Dentists
Nimmo, Arthur, Florida, 2005, American College of Prosthodontists
Norris, Lonnie H., Massachusetts, 2003, American Dental Education Association
Overman, Pamela, Missouri, 2003, American Dental Hygienists' Association
Phinney, Donna, Washington, 2004, American Dental Assistants Association
Poulton, Donald R., California, 2003, American Association of Orthodontists
Ruprecht, Axel, Iowa, 2003, American Academy of Oral and Maxillofacial Radiology
Simonian, Roger B., California, 2005, American Dental Association
Sims, Barbara, Florida, 2002, Public Member
Tatum, Richard Carlos, Maryland, 2005, American Association of Dental Examiners
Tomich, Charles E., Indiana, 2002, American Academy of Oral and Maxillofacial Pathology
Weiss, Leonard P., Ohio, 2004, American Association of Dental Examiners
Wilson, James W., II, California, 2005, National Association of Dental Laboratories
Hart, Karen M., director
Horan, Catherine A., manager
Monehen, **Rosemary,** manager
Parker, Cheryl R., manager
Parks, Linda A., manager
Schmidt, Colleen, manager
Soeldner, Peggy, manager
Tooks, Sherin, manager

Meetings: The Commission conducted its meetings on July 27, 2001 and February 1, 2002. The Commission's discipline-specific review committees, which provide comments and recommendations on policy and accreditation matters, met two to three weeks prior to the July 2001 and February 2002 meetings of the Commission.

The Commission liaison from the Board of Trustees, Dr. Edwin S. Mehlman, trustee, First District, attended the Commission's July 2001 meeting; Board of Trustees Liaison, Dr. Lloyd J. Hagedorn, Seventh District, attended the February 2002 Commission meeting.

Acknowledgments: The Commission acknowledges with appreciation the many significant contributions made by those members who will complete their terms in 2002: Dr. William F. Ammons, Jr., Dr. William A. Avery, Dr. Homer Clark Bell, III, Dr. Lawrence I. Goldblatt, Ms. Barbara Sims and Dr. Charles E. Tomich.

The Strategic Plan of the American Dental Association: The Commission's activities are consistent with the Plan's Goal on Advocacy, Objectives ix and x. The Commission and its Standing Committee on Outcomes Assessment (OA) devote considerable time to strategic planning activities annually at the Commission's summer meeting.

The Commission has developed goals, objectives, action plans and evaluation mechanisms reflective of its Mission Statement. The OA Committee has the responsibility of monitoring the Commission's Operational Effectiveness Assessment Plan, reporting its findings and making

recommendations related to the plan to the Commission. During this reporting period, the Committee recommended several minor adjustments to the Plan. The OA Committee reviewed current policies and procedures of the Commission to ensure currency. As recommended by the OA Committee, the Commission made modifications to the Plan, revised five current policies and adopted one new policy. 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 and operational effectiveness initiatives.

Future of Dentistry Report: At its February 1, 2002 meeting, the Commission considered Resolution 54H-2001, which called for the *Future of Dentistry Report* to be received and distributed to councils and committees for further consideration. The Commission noted that its mission is to serve the public by establishing, maintaining and applying standards that ensure the quality and continuous improvement of dental, advanced dental and allied dental education and reflect the evolving practice of dentistry. As part of its strategic planning and operational effectiveness initiatives, the Commission believed that the American Dental Association's *2001 Future of Dentistry Report* should be used as a resource. Specifically, the Commission believed that the *Report*'s Education Recommendations five, eight, 16, 17, and 26 were worthy of note.

Summary of Accreditation Actions: The Commission's accreditation actions from July 2001 through February 2002 are summarized in Table 1. At the July 2001 and February 2002 meetings, a total of 533 accreditation actions were taken. These actions were based on site visit reports and progress reports submitted by educational programs and their sponsoring 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 13 dental hygiene programs, five dental assisting programs, 14 advanced specialty programs and four postdoctoral general dentistry programs. As indicated in Table 2, the total number of educational programs currently accredited is 1,325, representing a decrease of two programs from the previous reporting period. Of the 1,325 accredited programs, 50 (3.8%) hold the initial accreditation status of "Accreditation Eligible" or "Preliminary Provisional Approval." One thousand two hundred and eleven programs (91.4%) are in compliance with all requirements and have been awarded "Approval *Without* Reporting Requirements." During this reporting period, 64 programs (4.8%) were found to have deficiencies/areas of noncompliance and hold the status of "Approval *With* Reporting Requirements." Each of the 64 programs has been given a specified time period to demonstrate compliance with all accreditation standards. Failure to do so will result in accreditation being withdrawn.

Also during this reporting period, initial accreditation was denied to one advanced specialty program. Accreditation was withdrawn from one advanced specialty program. 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, 20 programs closed and discontinued their participation in the Commission's accreditation program.

Enrollment: Dental, advanced dental and allied dental education programs' enrollment and graduate figures for 2001-02 can be obtained from the Association's Survey Center.

Table 1: Accreditation Actions: July 2001—February 2002

	Dental	Advanced Education		Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
		Specialty	General				
Accreditation Eligible		3			13		16
Preliminary Provisional Approval		11	4	5			20
Approval (without reporting req.)	11	124	76	50	53	4	318
Approval (with reporting req.)	5	35	18	41	53	5	157
Accreditation Denied		1					1
Discontinued Programs	1	6	6	4	1	2	20
Accreditation Withdrawn		1					1
Decision Appealed							0
Number of Accreditation Actions	17	181	104	100	120	11	533

Table 2: Number of Accredited Programs: February 2002

	Dental	Advanced Education		Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
		Specialty	General				
Accreditation Eligible		1			9		10
Preliminary Provisional Approval		21	8	11			40
Approval (without reporting req.)	52	391	287	230	227	24	1,211
Approval (with reporting req.)	2	11	7	18	24	2	64
Number of Accredited Programs	54	424	302	259	260	26	1,325

Development/Revision of Accreditation Standards: The Commission has *Bylaws* authority for the development and revision of educational standards for dental, advanced dental and allied dental education programs. Accreditation standards are developed and revised when there is a demonstrated need. 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 has been demonstrated.

As an accrediting agency recognized by the United States Department of Education (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 the USDE to take adverse action (i.e., withdraw accreditation) against the program. Revised *Accreditation Standards for Dental Education Programs* became effective January 1998. The revised *Accreditation Standards* for programs in postdoctoral general dentistry, advanced specialties (including clinical fellowships in oral and maxillofacial surgery), and the three allied disciplines became effective January 2000. These revised documents emphasize the importance of student achievement and program outcomes; innovation and flexibility are encouraged. The current requirements for all disciplines can be found on the Association's Web site.

In addition to the comprehensive revisions noted above, the Commission also revises specific accreditation standards as needed. The following *Accreditation Standards* documents underwent revision during this report period: Standard 4. Curriculum of the *Accreditation Standards for Advanced Specialty Education Programs in Periodontics*; Standards 3-7 and 3-8 Faculty of the *Accreditation Standards for Dental Laboratory Technology Education Programs*; and Standard 3-8 Administration, Faculty and Staff of the *Accreditation Standards for Dental Assisting Education Programs*.

Accreditation Standard Related to Advanced Standing. At its July 2000 meeting, the Commission considered issues related to accredited programs that allow students/residents to complete a program in less time, providing the individual's competency level, upon completion of the program, is comparable to that of students/residents completing a traditional program (*Reports* 2001:64). The Commission affirmed the role and responsibilities of accreditors to call on institutions and programs to develop clear policy and practice regarding advanced standing by adopting the following policy statement on advanced standing for all accredited programs:

> The Commission supports the principle, which would allow a student to complete an education program in less time providing the individual's competency level upon completion of the program is comparable to that of students completing a traditional program. Further, the Commission wishes to emphasize the need for program directors to assess carefully, for advanced placement purposes, previous educational experience to determine its level and adequacy. It is required that the institution granting the degree or certificate be the institution that presents the terminal portion of the educational

experience. It is understood that the advanced credit may be earned at the same institution or another institution having appropriate level courses.

The Commission's position reflects that which currently exists in the field of higher education accreditation. To further strengthen the Commission's role in advanced standing, the Commission circulated a proposed revised accreditation standard on advanced standing to the communities of interest for review and comment. The Commission adopted the following standard, for all accredited programs, effective July 1, 2002:

> Admission of students with advanced standing must be based on the same standards of achievement required by students regularly enrolled in the program. Transfer students with advanced standing must receive an appropriate curriculum that results in the same standards of competence required by students regularly enrolled in the program.
>
> Examples of evidence to demonstrate compliance include:
>
> - policies and procedures on advanced standing
> - results of appropriate qualifying examinations
> - course equivalency or other measures to demonstrate equal scope and level of knowledge

Policies and Procedures: The Commission is responsible for developing and publishing policies and procedures in order to conduct the accreditation process. During this reporting period, the following policies and procedures were revised.

Terms and Procedures Used in Considering Applications for Initial Accreditation. At the time of the Commission's re-recognition review by the United States Department of Education (USDE), the USDE questioned the terms used by the Commission to designate initial accreditation status, i.e., "Accreditation Eligible" and "Preliminary Provisional Approval." The Department believed that the term "Accreditation Eligible" may be confusing since the Commission considers programs with this status to be accredited, rather than eligible for accreditation. Further, the Department noted that "Preliminary Provisional Approval" could not be recognized by the USDE because the status is granted to dental assisting, dental laboratory technology, postdoctoral general dentistry, and advanced specialty programs [other than oral and maxillofacial surgery residencies] based on a written application without the conduct of a site visit.

The Commission reviewed the current terms and procedures used in considering initial accreditation applications and considered possible revisions to the current process. After careful study, the Commission agreed with the USDE that the term "Accreditation Eligible" might be misinterpreted by the public and should be changed. Further, the Commission believed that it would be advantageous to an accredited program, as well as good accreditation practice, to have both initial accreditation processes/statuses recognized by the USDE. Accordingly, the Commission directed that the written application process be converted to a site visit process for all programs seeking initial accreditation and that the terms "Accreditation Eligible" and "Preliminary Provisional Approval" be replaced with "Initial Accreditation," for new programs which are not yet fully operational.

> "Initial Accreditation" is defined as: *The accreditation classification granted to any dental, advanced dental or allied dental education program which is in the planning and early stages of development or an intermediate stage of program implementation and not yet fully operational. This accreditation classification provides evidence to educational institutions, licensing bodies, government or other granting agencies that, at the time of initial evaluation(s), the developing education program has the potential for meeting the standards set forth in the requirements for an accredited educational program for the specific occupational area. The classification "initial accreditation" is granted based upon one or more site evaluation visit(s) and until the program is fully operational.* The term and procedures for "Initial Accreditation" will be implemented in January 2003.

Policy Statement on Accreditation of Off-Campus Sites Reaffirmed. At its 2001 meeting, the Commission's Standing Committee on Outcomes Assessment (OA Committee) considered a request from the Review Committee on Postdoctoral General Dentistry Education (Postdoc RC), regarding the Policy Statement on Accreditation of Off-Campus Sites. The Postdoc RC had questioned whether the requirement of site visiting off-campus locations where 20% or more of the students'/residents' clinical instruction occurs had become cumbersome and may not need to be applied in every circumstance. Following careful review, the OA Committee recommended, and the Commission concurred, that the policy be referred for discussion and possible revision at the January/February 2002 meetings of all Review Committees and the Commission.

At its February 1, 2002 meeting, the Commission received feedback from the review committees and concluded that the policy is appropriate and continues to ensure that a program establishing additional locations where clinical instruction occurs continues to meet the *Accreditation Standards*.

Revision of the Rules of the Commission on Dental Accreditation: The 1973 American Dental Association House of Delegates approved the establishment of the Commission on Dental Accreditation as the agency responsible for the profession's accreditation program with sufficient autonomy to develop and approve educational standards, policies and procedures affecting the accreditation program (*Trans.*1973:695). The Commission was granted operational independence as it relates to accreditation affairs.

The *Constitution and Bylaws* of the American Dental Association provides for the Commission to develop rules for the conduct of its business, contingent on approval by the House of Delegates. Since the approval of the *Rules of the Commission on Dental Accreditation* by the House of Delegates in 1973, revisions were approved in 1982, 1987 and 1997.

In January 2001, the Commission adopted a revised mission statement (*Reports* 2001:62). At that time, it was noted that because Article I of the *Rules of the Commission on Dental Accreditation* is the mission statement, a revision of the *Rules* would be pursued. The Commission also believed that an overall review of the *Rules* should be considered in an effort to simplify the document. At its next meeting, in July 2001, the Commission considered proposed amendments to the *Rules*, including the substitution of the new mission statement, several editorial corrections (e.g., name change of the American Association of Dental Schools to the American Dental Education Association), and revisions to Article IV, Sections 2. and 3. to clarify the conduct of hearings. The Commission directed that the proposed revisions be circulated to the communities of interest for review and comment. No comments were received.

On February 1, 2002 the Commission adopted the revised *Rules*. According to the American Dental Association *Bylaws*, Chapter XIV. COMMISSIONS, Section 120. Duties, amendments to the *Rules* must be submitted to the American Dental Association House of Delegates for approval by majority vote either through or in cooperation with the Council on Dental Education and Licensure (CDEL). Therefore, the Commission requested the CDEL to consider the amended document at its April 2002 meeting; the CDEL supported the revised *Rules*. The Council on Ethics, Bylaws and Judicial Affairs also reviewed the revised *Rules* in April and found the amendments consistent with the American Dental Association *Constitution and Bylaws*. The Commission directed that the following resolution be forwarded to the 2002 American Dental Association House of Delegates, recommending approval of the revised *Rules*. This resolution is submitted in cooperation with the Council on Dental Education and Licensure.

1. Resolved, that the *Rules of the Commission on Dental Accreditation* be approved as revised (Appendix 1).

Consideration of Initiating an Accreditation Program for New Areas of Dental Education: At its January 2001 meeting, the Commission considered a request from the American Society of Dentist Anesthesiologists (ASDA) to initiate an accreditation program for postdoctoral general anesthesia programs for dentists (*Reports* 2001:65). The request from ASDA was the first such request since 1979, when the American Dental Association House of Delegates requested the Commission to adopt accreditation requirements for advanced educational programs in general dentistry. The Commission determined that further study of the issues and implications related to the possible development of an accreditation program for these programs, and possibly others, including the financial and logistical considerations, should be conducted. Accordingly, the Commission directed that an ad hoc committee be appointed to conduct a study of the issues.

The Commission considered the ad hoc committee's report at its February 1, 2002 meeting. The Commission noted that the committee reviewed documents including the Mission Statement of the Commission on Dental Accreditation, United States Department of Education recognition language, the duties of the Commission as outlined in the *Bylaws* of the American Dental Association, and the American Dental Association Requirements of Specialty Recognition. Also noted was the 1979 historical precedent of accrediting advanced education programs in general dentistry. Following study of the documents, the committee affirmed that accreditation review of programs in areas other than predoctoral dental education and the dental specialties is under the purview of the Commission, as evidenced by its review of programs in advanced general dentistry, dental hygiene, dental assisting and dental laboratory technology. Further, the committee believed that other areas of dentistry might also request initiation of accreditation review of their training programs. The committee concluded that prior to consideration of review of any additional areas of dental education, criteria should be developed for use by the Commission in determining eligibility for inclusion in the accreditation process.

The Commission carefully considered the ad hoc committee's proposed Criteria for the Initiation of an Accreditation Program in a New Dental Education Area. The Commission agreed that an area of dentistry requesting initiation of a new accreditation program should be required to meet the criteria and directed that the proposed Criteria be circulated to the communities of interest for review and comment. An open hearing was conducted at the 2002 Annual Session of the American Dental Education Association. In an effort to provide the communities with sufficient opportunity to comment, the written comment period was extended from May 15, 2002 to June 14, 2002.

The Commission noted that the charge to the ad hoc committee also included the consideration of the organizational and financial implications of initiating an accreditation process for new dental education programs. If new dental education areas are considered, the structure of the review committees might need to be reconfigured accordingly. Additional review committees may need to be established, depending on specific circumstances. The Commission determined that it would make such determinations on a case-by-case basis. The day-to-day management of accrediting a new dental education area would also be considered. While the number of programs in new areas of dental education that may be interested in pursuing accreditation at this time may be managed by existing accreditation staff, it was noted that if the Commission were to accredit programs in additional areas, additional staff support would be necessary.

At its August 1, 2002 meeting, the Commission will consider the final report of the ad hoc committee, including

all comments received from the communities of interest. The Commission will report further progress on this activity to the House of Delegates.

United States Department of Education Recognition: In November 2000, the Commission applied to the Secretary of the United States Department of Education for continued recognition as a programmatic accrediting agency (*Reports* 2001:65). The Secretary's National Advisory Committee on Institutional Quality and Integrity reviewed the Commission's petition for renewed recognition on May 23-25, 2001 and concluded that the Commission was in full compliance with the Secretary's *Criteria for Recognition of Accrediting Agencies*.

The Committee recommended to the Secretary that recognition as the accrediting agency for dental, advanced dental and allied dental education programs be renewed for the maximum five-year period. In a letter dated December 17, 2001 to the Commission on Dental Accreditation, the Secretary of Education concurred with the Committee and "renewed for a period of five years the recognition of the American Dental Association Commission on Dental Accreditation as a nationally recognized accrediting agency."

Commission on Dental Accreditation of Canada: A reciprocal accreditation agreement between the American Dental Association Commission on Dental Accreditation and the Commission on Dental Accreditation of Canada (CDAC) has been maintained and expanded since its adoption in 1956. Under this agreement, each Commission recognizes the accreditation of educational programs in specified categories accredited by the other agency.

In 2001 (*Reports* 2001:65), the Commission determined that its recently adopted Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Radiology were comparable to the CDAC's Oral Radiology Program Education Requirements. Accordingly, the Commission directed that the Accreditation Standards be transmitted to the CDAC with a request that the reciprocal agreement between the two accrediting agencies be expanded to include the accreditation of oral and maxillofacial radiology programs. The CDAC considered the request at its November 2001 meeting and approved the expansion of the reciprocal agreement.

Asociación Dental Mexicana: At its July 27, 2001 and February 1, 2002 meetings, the Commission received reports from representatives of the Asociación Dental Mexicana (ADM). The Mexican National Council on Dental Education has accredited 15 of the 58 dental schools in Mexico. Copies of the *Mexican Predoctoral Accreditation Guidelines and Procedures* were presented for the Commission's review at the February meeting. ADM is hopeful that a reciprocal agreement can be established between the Mexican National Council on Dental Education and the American Dental Association Commission on Dental Accreditation. The Commission stressed that a reciprocal agreement would have to be based on a demonstration that the accreditation standards, policies and procedures used by both agencies are equivalent. The Commission and its Review Committee on Predoctoral Dental Education Programs will monitor the progress of and provide assistance to the Asociación Dental Mexicana and the Mexican National Council on Dental Education with regard to the accreditation of Mexican dental schools. Reports of progress will be provided to the House of Delegates.

Response to Assignments from the 2000 House of Delegates: Resolution 59H-2000 (*Trans*.2000:477) requested the Commission to review the predoctoral dental education standard 2-25 regarding pediatric dentistry clinical skills. To better assist the Commission in determining if a standard revision was warranted, the Commission sought input from the broad communities of interest. The Commission participated in a symposium co-sponsored by the American Academy of Pediatric Dentistry (AAPD) and the American Dental Education Association (ADEA) related to pediatric dentistry instruction in the predoctoral dental curriculum and reviewed data collected annually via the "Annual Survey of Dental Education Programs" and the "History and Analysis of Accreditation Standards Reports." In addition, at its August 2002 meeting, the Commission will review the results of a survey conducted by the ADEA and AAPD, which collected detailed information regarding the state of pediatric dentistry clinical education and student competency at the predoctoral level. Based on the data and information collected, the Commission will consider whether today's dental school graduate is provided with adequate clinical instruction and experience to provide oral health care within the scope of general dentistry for the pediatric patient, i.e., today's graduate is a "safe beginner." The Commission will report its conclusions to the 2003 House of Delegates.

Summary of Resolutions

1. Resolved, that the *Rules of the Commission on Dental Accreditation* be approved as revised (Appendix 1).

Appendix 1

AMENDMENTS* APPROVED BY THE COMMISSION
for Transmittal to the ADA House of Delegates
February 1, 2002

*Deletions are ~~stricken~~; additions are underscored.

RULES OF THE COMMISSION ON DENTAL ACCREDITATION

Article I. MISSION

~~The Commission on Dental Accreditation's mission is to ensure the quality of dental and dental-related education by conducting accreditation reviews to determine the degree to which individual programs meet the Commission's published accreditation standards and their own stated goals and objectives. The Commission recognizes only those programs meeting the accreditation standards that are developed and agreed upon by the various communities of interest, including the public. The Commission's second purpose is to enhance and encourage improvement in the quality of its accredited educational programs.~~

~~The Commission's accreditation program ensures that quality education is available for dentists, dental specialists and allied dental personnel. Quality education ultimately leads to quality dental care for the public.~~

~~Thus, the Commission's voluntary accreditation program serves to ensure educational quality and to improve the quality of the educational programs in 14 dental and dental-related disciplines. These disciplines include: dentistry, dental assisting, dental hygiene, dental laboratory technology, dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics, general practice residency and advanced general dentistry.~~

The Commission on Dental Accreditation serves the public by establishing, maintaining and applying standards that ensure the quality and continuous improvement of dental and dental-related education and reflect the evolving practice of dentistry. The scope of the Commission on Dental Accreditation encompasses dental, advanced dental and allied dental education programs.

Article II. BOARD OF COMMISSIONERS

Section l. LEGISLATIVE AND MANAGEMENT BODY: The legislative and management body of the Commission shall be the Board of Commissioners.

Section 2. COMPOSITION: The Board of Commissioners shall consist of:

Four (4) members shall be nominated by the American Dental Association Board of Trustees on a rotational system by trustee district from the active, life or retired members of the American Dental Association, no one of whom shall be a member of a faculty of a school of dentistry or a member of a state board of dental examiners. The members nominated by the Board of Trustees shall be elected by the American Dental Association House of Delegates.

Four (4) members who are active, life or retired members of the American Dental Association shall be selected by the American Association of Dental Examiners from the active membership of that body, no one of whom shall be a member of a faculty of a school of dentistry.

Four (4) members who are active, life or retired members of the American Dental Association shall be selected by the American ~~Association of Dental Schools~~ Dental Education Association from its active membership. These members shall hold positions of professorial rank in dental schools accredited by the Commission on Dental Accreditation and shall not be members of any state board of dental examiners.

The remaining Commissioners shall be selected as follows: one (1) certified dental assistant selected by the American Dental Assistants Association from its active or life membership, one (l) licensed dental hygienist selected by the American Dental Hygienists' Association, one (l) certified dental laboratory technician selected by the National Association of Dental Laboratories, one (l) student selected jointly by the American Student Dental Association and the Council of Students of the American ~~Association of Dental Schools~~ Dental Education Association, one (1) dentist for each ADA recognized dental

specialty who is board certified in the respective special area of practice and is selected by the respective specialty sponsoring organization, one (1) dentist representing postdoctoral general dentistry who is jointly appointed by the American ~~Association of Dental Schools~~ Dental Education Association and the American Association of Hospital Dentists and four (4) consumers who are neither dentists nor allied dental personnel nor teaching in a dental or allied dental education institution and who are selected by the Commission, based on established and publicized criteria. In the event a Commission member sponsoring organization fails to select a Commissioner, it shall be the responsibility of the Commission to select an appropriate representative to serve as a Commissioner. A member of the Standing Committee on the New Dentist (when assigned by the ADA Board of Trustees) and the Director of the Commission shall be ex-officio members of the Board without the right to vote.

Section 3. TERM OF OFFICE: The term of office of the members of the Board of Commissioners shall be one four (4) year term except that the member jointly selected by the American ~~Association of Dental Schools~~ Dental Education Association and the American Student Dental Association shall serve only one two (2) year term.

Section 4. POWERS:

A. The Board of Commissioners shall be vested with full power to conduct all business of the Commission subject to the laws of the State of Illinois, these *Rules* and the *Constitution and Bylaws* of the American Dental Association.

B. The Board of Commissioners shall have the power to establish rules and regulations not inconsistent with these *Rules* to govern its organization and procedures.

Section 5. DUTIES:

A. The Board of Commissioners shall prepare a budget at its winter meeting each year for carrying on the activities of the Commission for the ensuing fiscal year and shall submit said budget to the Board of Trustees of the American Dental Association for funding in accordance with Chapter XIV of the *Bylaws* of the American Dental Association.

B. The Board of Commissioners shall submit an annual report of the Commission's activities to the House of Delegates of the American Dental Association and interim reports, on request, to the Board of Trustees of the American Dental Association.

C. The Board of Commissioners shall appoint special committees of the Commission for the purpose of performing duties not otherwise assigned by these *Rules.*

D. The Board of Commissioners shall appoint consultants to assist in developing accreditation standards and conducting accreditation evaluations, including on-site reviews of predoctoral, advanced dental educational and allied dental educational programs.

Section 6. MEETINGS:

A. REGULAR MEETINGS: There shall be two (2) regular meetings of the Board of Commissioners each year.

B. SPECIAL MEETINGS: Special meetings of the Board of Commissioners may be called at any time by the Chairman of the Commission. The Chairman shall call such meetings on request of a majority of the voting members of the Board provided at least ten (10) days notice is given to each member of the Board in advance of the meeting. No business shall be considered except that provided in the call unless by unanimous consent of the members of the Board present and voting.

C. LIMITATION OF ATTENDANCE DURING MEETINGS: In keeping with the confidential nature of the deliberations regarding the accreditation status of individual educational programs, a portion of the meetings of the Commission, and its committees shall be designated as confidential, with attendance limited to members, the American Dental Association Trustee Liaison, selected staff of the Commission and affiliated accreditors. During this part of the meeting, only confidential accreditation actions may be considered.

Section 7. QUORUM: A majority of the voting members of the Board of Commissioners shall constitute a quorum.

Article III. APPEAL BOARD

Section 1. APPEAL BOARD: The appellate body of the Commission shall be the Appeal Board which shall have the authority to hear and decide appeals filed by predoctoral and advanced dental educational and allied dental educational programs from decisions rendered by the Board of Commissioners of the Commission denying or revoking accreditation.

Section 2. COMPOSITION: The Appeal Board shall consist of four (4) permanent members. The four (4) permanent members of the Appeal Board shall be selected as follows: one (1) selected by the Board of Trustees of the American Dental Association from the active, life or retired membership of the American Dental Association giving special consideration whenever possible to former members of the Council on Dental Education and Licensure, one (l) member selected by the American Association of Dental Examiners from the active membership of that body, one (1) member selected by the American ~~Association of Dental Schools~~ Dental Education Association from the active membership of that body and one (l) consumer member who is neither a dentist nor an allied dental personnel nor teaching in a dental or allied dental educational program and who is selected by the Commission, based on established and publicized criteria. In addition, a representative from either an allied or advanced education discipline would be included on the Appeal Board depending upon the type and character of the appeal. Such special members shall be selected by the appropriate allied or specialty organization. Since there is no national organization for general practice residencies and advanced education programs in general dentistry, representatives of these areas shall be selected by the American ~~Association of Dental Schools~~ Dental Education Association and the American Association of Hospital Dentists. One (l) member of the Appeal Board shall be appointed annually by the Chairman of the Commission to serve as the Chairman and shall preside at all meetings of the Appeal Board. If the Chairman is unable to attend any given meeting of the Appeal Board, the other members of the Appeal Board present and voting shall elect by majority vote an acting Chairman for that meeting only. The Director of the Commission shall provide assistance to the Appeal Board.

Section 3. TERM OF OFFICE: The term of office of members on the Appeal Board shall be one four (4) year term.

Section 4. MEETINGS: The Appeal Board shall meet at the call of the Director of the Commission, provided at least ten (10) days notice is given to each member of the Appeal Board in advance of the meeting. Such meetings shall be called by the Director only when an appeal to the appellate body has been duly filed by a predoctoral or advanced dental educational or allied dental educational program.

Section 5. QUORUM: A majority of the voting members of the Appeal Board shall constitute a quorum.

Section 6. VACANCIES:

A. In the event of a vacancy in the membership of the Appeal Board of the Commission, the Chairman of the Commission shall appoint a member of the same organization, or in the case of a consumer of the general public, possessing the same qualifications as established by these Rules, to fill such vacancy until a successor is selected by the respective representative organization.

B. If the term of the vacated position has less than fifty percent (50%) of a full four-year term remaining at the time the successor member is appointed, the successor member shall be eligible for a new, consecutive four-year term. If fifty percent (50%) of more of the vacated term remains to be served at the time of the appointment, the successor member shall not be eligible for another term.

Article IV. ACCREDITATION PROGRAM

Section l. ACCREDITATION STANDARDS: The Commission, acting through the Board of Commissioners, shall establish and publish specific accreditation standards for the accreditation of predoctoral and advanced dental educational and allied dental educational programs.

Section 2. EVALUATION: Predoctoral and advanced dental educational and allied dental educational programs shall be evaluated for accreditation status by the Board of Commissioners on the basis of the information and data provided on survey forms and secured by the members of, and consultants to, the Board of Commissioners during site evaluations.

If the Board of Commissioners decides to deny, for the first time, accreditation to a new educational program or to withdraw accreditation from an existing program, the Board of Commissioners shall first notify the educational program of its intent to deny or withdraw accreditation. Such notice, together with announcement of the date of the next meeting of the Board of Commissioners, shall be sent to the educational program by certified mail, return receipt requested, within fourteen (14) days

following the intent to deny or withdraw decision of the Board of Commissioners. Within thirty (30) days after receipt of such notice, the educational program may, in writing, request a hearing before the Board of Commissioners at its next meeting. Within fifteen (15) days after receipt of the request, the Board of Commissioners shall schedule a hearing and notify the educational program of the date, time and place of such hearing. A request for a hearing due to the Board of Commissioner's decision to deny for the first time, accreditation to a new program, shall automatically stay the decision to deny accreditation. In the event the educational program that has been denied initial accreditation for the first time does not make a timely request for a hearing, the Board of Commissioners' findings and proposed decision to deny accreditation shall become final.

Section 3. HEARING: ~~Upon completion of an evaluation for accreditation status, the Board of Commissioners shall notify the predoctoral or advanced dental educational or allied dental educational program (hereinafter called "educational program") of its factual findings and proposed decision regarding the program's accreditation status. If the Board of Commissioners decides to deny accreditation to a new educational program or withdraw accreditation from an existing educational program, the Board of Commissioners shall notify the educational program of its intent to deny or withdraw accreditation. Such notice, together with announcement of the date of the next meeting of the Board of Commissioners, shall be sent to the educational program by certified mail, return receipt requested, within fourteen (14) days following the proposed intent to deny or withdraw decision of the Board of Commissioners. Within thirty (30) days after receipt of such notice, the educational program may, in writing, request a hearing before the Board of Commissioners at its next meeting. Such request for a hearing shall automatically stay the Board of Commissioners' proposed decision and shall result in the Board of Commissioners scheduling such hearing and notifying the educational program within fifteen (15) days of the date, time and place of such hearing. At the hearing, the educational program may offer evidence and argument in writing or orally or both tending to refute or overcome the factual findings and proposed decision of the Board of Commissioners. However, any written evidence or argument must be received by the Director of the Board of Commissioners at least thirty (30) days prior to the hearing. The educational program may be represented by legal counsel at the hearing. The educational program need not appear in person or by its representative at the hearing, but may offer evidence and argument in writing tending to refute or overcome the factual findings and proposed decision of the Board of Commissioners. Upon conclusion of the hearing or review of written materials, the Board of Commissioners will render and notify the educational program of the Board of Commissioners' findings and decision by registered or certified mail. In the event the educational program does not make a timely request for a hearing, the Board of Commissioners' findings and proposed decision shall become final.~~ Upon completion of an evaluation for accreditation status, the Board of Commissioners shall notify the predoctoral, advanced or allied dental educational program (hereinafter called "educational program") of its findings and decision regarding the program's accreditation status. Two types of hearings can be held to review the appropriateness of the decision made by the Commission:

A. CHALLENGE: This type of hearing is available to a program/institution that wishes to challenge the decision of the Commission to change its accreditation status or to a new program that wishes to challenge the decision of the Commission to deny, for the first time, initial accreditation. When an institution/program believes that the Commission has made an error in judgment, a hearing may be requested. The hearing before the Commission would be held at the next regularly scheduled meeting. Representatives of the institution/program may present arguments that the Commission, based on the information available when the decision was made, made an error in judgment in determining the accreditation status of the program. The educational program need not appear in person or by its representatives at the hearing. Legal counsel may represent the educational program at the hearing. During the hearing, the educational program may offer evidence and argument in writing or orally or both tending to refute or overcome the factual findings of the Board of Commissioners. The director of the Board of Commissioners must receive any written evidence or argument at least thirty (30) days prior to the hearing. No new information regarding correction of the deficiencies may be presented.

B. SUPPLEMENT: An institution/program may request a hearing in order to supplement written information, which has already been submitted to the Commission. A representative of the institution would be permitted to appear in person before the Commission to present this additional information.

   When a hearing to provide supplemental information is desired, a written request is to be made to the director of the Commission thirty (30) days prior to the meeting. The chairman and the director of the Commission determine the disposition of the request and inform the requestor of the date, hour and amount of time which will be allocated for the hearing.

Section 4. APPEAL: In the event the final decision of the Board of Commissioners is a denial or withdrawal of ~~approval~~ accreditation, the educational program shall be informed of this decision within fourteen (14) days following the Commission meeting. Within fourteen (14) days after receipt of the final decision of the Board of Commissioners, the educational program may appeal the decision of the Board of Commissioners by filing a written appeal with the Director of the Board of Commissioners. The filing of an appeal shall automatically stay the final decision of the Board of Commissioners. The Appeal Board of the Commission shall convene and hold its hearing within sixty (60) days after the appeal is filed. The educational

program filing the appeal may be represented by legal counsel and shall be given the opportunity at such hearing to offer evidence and argument in writing or orally or both tending to refute or overcome the findings and decision of the Board of Commissioners. No new information regarding correction of the deficiencies may be presented. The educational program need not appear in person or by its representative at the appellate hearing. The Appeal Board shall advise the appellant educational program of the Appeal Board's decision in writing by registered or certified mail. The decision rendered by the Appeal Board shall be final and binding. In the event the educational program does not file a timely appeal of the Board of Commissioners' findings and decision, the Board of Commissioners' decision shall become final.

Section 5. HEARING AND APPEAL COSTS: If a hearing is held before the Board of Commissioners, the costs of the Commission respecting such hearing shall be borne by the Commission. If an appeal is heard by the Appeal Board, the costs of the Commission respecting such appeal shall be shared equally by the Commission and the appellant educational program filing the appeal except in those instances where equal sharing would cause a financial hardship to the appellant. However, each educational program shall bear the cost of its representatives for any such hearing or appeal.

Article V. OFFICERS

Section l. OFFICERS: The officers of the Commission shall be a Chairman and a Director and such other officers as the Board of Commissioners may authorize. The Chairman shall be elected by the members of the Commission. The Chairman shall be an active, life or retired member of the American Dental Association.

Section 2. DUTIES: The duties of the officers are as follows:

A. CHAIRMAN: The Chairman shall preside at all meetings of the Board of Commissioners. If the Chairman is unable to attend any given meeting of the Board of Commissioners, the other members of the Board of Commissioners present and voting shall elect by majority vote an acting chairman for the purpose of presiding at that meeting only.

B. DIRECTOR: The Director shall keep the minutes of the meetings of the Board of Commissioners, prepare an agenda for each meeting, see that all notices are duly given in accordance with the provisions of these *Rules* or as required by law, be the custodian of the Commission's records, and in general shall perform all duties incident to the office of Director.

Article VI. MISCELLANEOUS

The rules contained in the current edition of "Sturgis Standard Code of Parliamentary Procedures" shall govern the deliberations of the Board of Commissioners and Appeal Board in all instances where they are applicable and not in conflict with the *Rules* or the previously established rules and regulations of the Board of Commissioners.

Article VII. AMENDMENTS

These *Rules* may be amended at any meeting of the Board of Commissioners by majority vote of the members of the Board present and voting subject to the subsequent approval of the House of Delegates of the American Dental Association.

Revised 11/82; 10/87; 10/97

Council on Dental Education and Licensure

Ohtani, Deron J., Hawaii, 2002, chairman, American Dental Association
Reed, Michael J., Missouri, 2002, vice chairman, American Dental Education Association
Assael, Leon A., Kentucky, 2004, American Dental Education Association
Comer, Robert W., Georgia, 2005, American Dental Education Association
Dolinsky, Herbert B., New Jersey, 2002, American Dental Association
Giorgio, Douglas J., Jr., Georgia, 2005, American Dental Association
Hayes, Mary J., Illinois, 2004, American Dental Association
Hinterman, Douglas J., Michigan, 2002, *ex officio*[*]
Houfek, Scott W., Wyoming, 2005, American Association of Dental Examiners
Jaeger, J. Roedel, Maryland, 2003, American Association of Dental Examiners
Kolb, Charles, Texas, 2004, American Dental Association
Lightfoot, William J., Ohio, 2004, American Association of Dental Examiners
Marks, Ronald B., Louisiana, 2002, American Association of Dental Examiners
Peskin, Robert M., New York, 2003, American Dental Association
Sanders, Charles F., Jr., Washington, D.C., 2003, American Dental Education Association
Smith, Gerald A., New Hampshire, 2003, American Dental Association
Wood, Roger E., Virginia, 2005, American Dental Association
Nix, Judith A., director
Boehm, Diane M., manager
Haglund, Lois J., manager
Krause, Tina B., manager

Meetings: The Council on Dental Education and Licensure (CDEL) met in the Headquarters Building on November 16-17, 2001 and April 26-27, 2002. Dr. Clifford Marks, Seventeenth District, serves as the Board of Trustees' liaison to the Council.

Organization: As directed by the American Dental Association *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 and Testing, the Committee on Specialty Recognition, the Committee on Anesthesiology 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 2002 annual session will mark the completion of terms of service of four Council members: Dr. Herbert B. Dolinsky, Dr. Ronald B. Marks, Dr. Deron J. Ohtani and Dr. Michael J. Reed. Dr. Howard M. Landesman resigned from the Council in October 2001. The Council wishes to express its appreciation to these individuals for their thoughtful, determined leadership and for their many contributions during their tenure.

Mission of the Council on Dental Education and Licensure: The Council on Dental Education and Licensure adopted the following mission statement in 1997 to reflect its *Bylaws* duties.

> The Council on Dental Education and Licensure (CDEL) is the agency dedicated to promoting high quality and effective processes of dental education, dental licensure and credentialing in the United States.
>
> The CDEL, through its tripartite representative structure (ADA, ADEA, AADE), fulfills its mission by:
>
> 1. monitoring and disseminating information on dental education and licensure issues,
> 2. conducting studies and providing recommendations to the ADA's policy-making bodies on these matters,
> 3. serving as liaison to related organizations which also serve dental education and licensure, and
> 4. implementing the directions of the Board of Trustees and the House of Delegates of the ADA.

The Strategic Plan of the American Dental Association: The Council conducted strategic planning activities during its November 2001 and April 2002 meetings to support implementation of the *ADA Strategic Plan: 2002-2005*. During its two meetings, the Council continued to clarify its action plans and suggested strategies associated with implementation of specific objectives under each goal of the Strategic Plan. The Council also carefully considered its action plans in conjunction with its 2003 budget request. As directed by the

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

Board of Trustees, the Council reviewed existing programs to determine continued relevancy to the Strategic Plan goals and objectives, incorporated new action plans, and continued its efforts to identify metrics and to use these metrics where applicable to determine future initiatives and actions. The Council also reviewed the criteria for measuring effectiveness of its action plans and provided evaluation information as available. In addition to its usual strategic planning activities, and based on the metrics related to several licensure activities, the Council utilized an ADA Interagency Licensure Planning Task Force to assist in identifying its future licensure activities. This Task Force assisted the Council in ensuring that an Association-wide perspective on licensure issues is encompassed in the Council's future licensure activities. More information on this Task Force is contained under the "Licensure" section on page 83 of this report.

Throughout the strategic planning process, the Council has sought guidance from the Office of Strategic Planning and Consulting. The Council's new issues and key accomplishments for 2002 are highlighted in this report.

Review of the 2001 ADA Future of Dentistry Report: The Council reviewed and discussed the 2001 ADA Future of Dentistry Report and Recommendations. Specifically, the Council's discussion focused on the following chapters: Chapter 2. Vision and Recommendations, Chapter 5. Licensure and Regulation of Dental Professionals, Chapter 6. Dental Education and Chapter 8. Global Oral Health. The Council concluded that its initiatives regarding student indebtedness, the cost of dental education and dental faculty shortages are closely aligned with the information noted in the Report. Further, the Council determined that Chapters 2, 5 and 8 would be included as resource materials for the Interagency Licensure Planning Task Force. Additionally, the Council recommended that Chapters 2 and 5 be included as resource materials for the 2002 Dental Education Summit. The Council will also continue to use the Report as a resource in its strategic planning activities.

Dental Education

Minority Recruitment and Retention Program: Over the last several years, activities of the ADA/ADEA Joint Steering Committee on Minority Recruitment and Retention (later referred to as the Oversight Committee) have been reported (*Reports* 1997:84, 1998:81, 1999:78, 2000:73, 2001:67). This committee was charged with the responsibility to develop a national minority recruitment proposal for dentistry, including a proposed budget and possible sources of funding.

Between 1997 and early 2000, the Oversight Committee developed the proposal and identified potential funding sources. The joint ADA/ADEA project is titled ACHIEVING DIVERSITY and ACCESS: 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 project outlined 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. The project proposed 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.

During 2000-2001, the grant proposal and a letter of inquiry were sent to 14 foundations to request funding to provide grants to ten dental schools. The foundations identified included those with a history of funding proposals related to minority issues. Respondents indicated that their respective foundations would not be able to provide support for the proposed project.

In November 2001, a modified grant proposal was sent to the ADA Health Foundation (ADAHF). The proposal to the ADAHF requested funding to provide a grant to one or two dental schools that could serve as the prototype(s) for the project in seeking further foundation support. The ADAHF considered the proposal at its March 2002 meeting. The ADAHF subsequently advised that the grant application was not among those selected for funding.

The Council continued its efforts to recruit underrepresented minorities into the dental profession through its dental student recruitment campaign. Information regarding this activity is provided elsewhere in this report.

New Golden Apple Awards: Over the past year, the Council developed a proposal for two ADA golden apple awards to be given to dental educator members in recognition for outstanding mentoring of students interested in academic careers. Two awards will be given, one at the predoctoral level and one at the postdoctoral education level. The Council believed that these two new awards demonstrate Association support for strategies to recruit dental educators as recommended in the 2001 Dental Education Summit Meeting report. The Council's proposed criteria, eligibility and entry guidelines for these awards are consistent with those established for other Association Golden Apple Awards. The Board of Trustees approved the proposal for these two new awards, and the Council has subsequently developed a mechanism for the annual selection of award winners beginning in 2003. These new awards will be promoted to constituent and component dental societies along with other Golden Apple Award information. Additionally, the Council will request the assistance of the American Dental Education Association to promote the new Golden Apple Awards to the education community.

Campaign to Attract Qualified Students into Dentistry: The 2001 House of Delegates directed the Association to establish a national campaign to attract qualified students into dentistry by the adoption of Resolution 17H-2001 (*Trans.*2001:467). An Oversight Committee was constituted composed of one member from the Council who served as chair, two representatives from the American Dental Education Association (ADEA), a representative from the American Society of Constituent Dental Executives (ASCDE), a representative from the National Association of Advisors for the Health Professions (NAAHP) and a member from the

Committee on the New Dentist (CND). The Oversight Committee met on February 25, 2002, to begin implementing the program's goals to attract and encourage students into dentistry, while being sensitive to the recruitment of qualified underrepresented minorities as directed in the second resolving clause of Resolution 17H. At its April 2002 meeting, the Council considered the report of the Oversight Committee and supported development of the dental resource materials described in the report. These new resources include developing a new fact sheet, brochure, and poster on careers in dentistry, as well as a PowerPoint presentation and a career day outline to use for career events. It is anticipated that these resources will be available in the fall of 2002. The Council also supported development of promotional activities targeted at both the national and local levels. An integral component of the campaign will include activities to assist constituent and component dental societies to implement a mentor program.

The Oversight Committee also identified additional career resources it believes should be developed as a next phase of the campaign. These resources include a six to ten-minute career video and purchase of three tabletop exhibits on dental careers, similar to the tabletop exhibits developed for promoting allied careers. Funding for these resources was requested in a decision package with the Council's 2003 budget proposal. Additionally, the Council supported the establishment of a seven-member ad hoc committee comprised of representatives from appropriate national dental organizations to assist in developing initiatives to attract underrepresented minorities into dentistry.

Details of the Committee's report and the Council's recommendations are provided in a separate report on page 95.

Specialty Recognition

The American Academy of Craniofacial Pain's Request for Recognition of Craniofacial Pain as a Dental Specialty: An application from the American Academy of Craniofacial Pain (AACP) was received on June 1, 2001, for recognition of craniofacial pain 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, and national dental organizations through a letter from the Council Director dated July 2001. A notice to the profession regarding receipt of the application was published in the June 21, 2001 issue of the *ADA News*. Comments on the application from interested individuals and organizations were invited. Additional supplemental information, "Fact Sheets," was received from the AACP in correspondence dated November 1, 2001. The supplemental information was subsequently provided to the Council prior to its November 2001 consideration of the AACP application.

All submitted information was evaluated in light of the established *Requirements* for specialty recognition to determine the extent to which compliance with each requirement had been demonstrated. It should be noted that the Council's task was to review the application submitted by the AACP, not the field of craniofacial pain in a broader sense beyond the application.

Related applications previously considered include the American Federation of Orofacial Pain Organizations (AFOPO), whose application for specialty recognition was considered in 1997. The Council transmitted a recommendation to the 1997 House of Delegates that the AFOPO's request for specialty recognition be denied. The AFOPO withdrew the application before the 1997 ADA House of Delegates considered it.

In 1999 the American Academy of Orofacial Pain submitted an application for specialty recognition. The Council transmitted a recommendation to the 2000 House of Delegates that the AAOP's request for specialty recognition be denied. The 2000 House determined that orofacial pain should not be approved by the ADA as a dental specialty because the AAOP did not meet Requirements 2, 3 and 4.

The Committee on Specialty Recognition (Committee G) reviewed the application and all other pertinent information during two meetings; the first meeting was held by conference call on August 24, 2001, and the second meeting was held at the ADA Headquarters on March 22, 2002. The Committee reviewed its report to the November 2001 Council, additional written comments received from the communities of interest, the Council's November 2001 report and the Council's action as transmitted to the AACP. Additionally, the AACP's written response, dated March 1, 2002, to the Council's November 2001 report was carefully considered. Committee G also considered additional information presented during the AACP's special appearance. The AACP's application was also referenced during the Committee's discussion.

Dr. H. Clifton Simmons, III, AACP president, was the primary spokesperson for the AACP during the special appearances before Committee G and at the Council's April 2002 meeting. In addition to Dr. Simmons, five representatives from the AACP were present at the special appearance before Committee G: Dr. Robert Talley, Dr. Steven Kilpatrick, Dr. Charles Holt, Dr. Larry Tilley and Dr. James Fricton. The AACP representatives attending the special appearance before the Council included Dr. H. Clifton Simmons, III, Dr. Robert Talley, Dr. Steven Kilpatrick, Dr. Larry Tilley and Dr. Pamela Steed. At each special appearance, the Chair reviewed the established procedures for special appearances prior to the AACP's opening remarks. These procedures were also provided to the AACP prior to the special appearances.

In its oral presentation before the Council, the AACP's representatives highlighted preliminary results of a February 2002 survey of the field of craniofacial pain. The AACP stated that the survey was intended to supplement the information provided in the application and in the AACP's written response concerning Requirements 2, 3 and 4. The survey was sent to program directors of advanced specialty education

*Note: For purposes of consideration of this application, *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists*, adopted by the 1995 House of Delegates [68H-1995 (*Trans*.1995:695)] apply.

programs in periodontics, prosthodontics, orthodontic and dentofacial orthopedics and oral and maxillofacial surgery. According to the AACP, the survey questions were specialty-specific and were intended to collect information regarding the amount of time these specialty programs devote to providing didactic and clinical instruction in the diagnosis and treatment of TMD/craniofacial pain and chronic pain. The AACP stated that it expects to publish the results of this survey.

The Council provided the following comments as a result of its discussion concerning the AACP application.

Summary of Council's Assessment of Applicant's 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.

The application states the AACP is the organization with the largest group of dentists diagnosing and treating craniofacial pain.

Information presented in the application states that in 2001, the name of the sponsoring organization was changed from the American Academy of Head, Neck and Facial Pain to the American Academy of Craniofacial Pain.

The application also states that the AAOP has supported the AACP's efforts in the development of this specialty and submission of this application. According to the application, membership in AACP currently includes 501 craniofacial pain dentists who devote a major part of or all of their practice to the diagnosis and treatment of craniofacial pain.

However, the Council noted that associate member status might be extended to individuals possessing a degree in a health care field other than dentistry. Since the AACP's membership was not broken out into the different classes of membership, it was unclear how many of the 501 members as listed in the application on page 1-4 are dentists.

Following review of information presented in the application, in the AACP's written response and from responses to questions during the special appearances, the number of AACP member dentists who devote a major part or all of their practice time to the field of craniofacial pain remains unclear.

The AACP's application references the AAOP's 1999 request for specialty recognition, noting that the major distinction between the AACP and the AAOP is in the proposed specialty definition. Further, the AACP application states that the scope of the discipline of craniofacial pain is broader than orofacial pain, encompassing both chronic and complex acute pain disorders. The Council noted in its November 2001 report that information contained on page 6-1 in the application appears to conflict with this assertion because it states that "the terms craniofacial pain and orofacial pain are interchangeable." In the AACP's written response to the Council's concern, the AACP states that the phrase was taken out of context and that the complete sentence was "intended to show that the advanced education programs are now known as orofacial pain programs." Further, the response states that reading this information, "one should think of them as the future craniofacial pain programs." The Council did not believe that this response adequately addressed the concern regarding the conflicting terminology.

Based on the information provided in the application, the Council believed the nature of the relationship between the AACP and the AAOP is unclear, particularly as it relates to demonstrating that the AACP has met Requirement 1, part (a). In a letter attached to the AACP's written response, the President of AAOP notes that the AACP and AAOP have recently collaborated on several projects within the field, and plan to continue to collaborate on future ADA specialty or discipline applications for specialty recognition, including revising the AAOP clinical guidelines, integrating the Boards, holding future joint meetings, revising curriculum guidelines and developing joint ethics statements. The AAOP letter also notes that the two organizations, along with representatives of the major TMD and oral pain organizations, have established a Task Force to collaborate on specific activities in the field.

Further, the AACP's relationship with other related organizations whose membership is comprised of individuals who have a specific interest in orofacial pain disorders is unclear because it was not described in the application (e.g., the American Academy of Gnathologic Orthopedics, International College of Craniomandibular Orthopedics, The American Academy of Pain Management, The Society for Occlusal Studies). The AACP's response regarding its relationship with other related organizations in the community of interest indicated that none of these organizations focus on craniofacial pain, but have a common bond in their interest in TMD. The AACP further states that a close relationship exists with all these organizations since the AACP was instrumental in founding the American Alliance of TMD Organizations. However, the AACP goes on to state that none of the organizations have a common bond for the advancement of craniofacial pain as defined in the application.

The Council's established procedures call for comments from the communities of interest regarding a specialty recognition application. The Council reviewed approximately 135 responses commenting on the AACP application. A significant number of responses address issues concerning compliance with Requirement 1. Specifically, many respondents state that the application is not based on consensus regarding 1) the scope of the specialty and 2) the need for the specialty within the field of craniofacial pain. The Council noted that many organizations, whose interests involve various aspects of this field, stated that in their opinion the AACP does not represent the community of interest, i.e., that there is a lack of continuity and agreement on accepted approaches to care and management of craniofacial pain patients and is therefore, not representative of the majority of dentists involved in treating craniofacial pain disorders. Further, some organizations stated that they do not believe the proposed craniofacial pain specialty would benefit the profession or the public.

The Council noted that in 1985, the AACP established a certifying board, the American Board of Craniofacial Pain (ABCP), responsible for administering an examination that

tests the advanced knowledge, skill and competence in craniofacial pain management. The AACP's application states that its certifying board is modeled after the ADA recognized dental specialty certifying boards. The application also notes that there are currently only 22 ABCP diplomates and no candidates have been granted certification through a grandfather clause. The Council noted that the AACP application did not include information regarding criteria for granting credentials to dentists in practice who have not graduated from a two-year postdoctoral program. The AACP's response included criteria for granting these credentials to dentists who have not graduated from a two-year program. The Council believed that the listed criteria as presented were vague and provided too many options for qualifying to complete the diplomate examination.

The application included a copy of the parameters of care for orofacial pain as approved by the AAOP entitled, *Orofacial Pain: Guidelines for Assessment, Diagnosis and Management*. The application indicated that the newest revision of the AACP guidelines would be completed in 2002; however the current Guidelines were not submitted with the AACP application. The application and written response states that the AACP supports the *Journal of Craniomandibular Practice* and the *Journal of Orofacial Pain*. The Council believed there was still some ambiguity regarding the AACP's sponsorship of its own journal and involvement in other related journals. Further, there was limited documentation describing the degree to which the AACP's membership has fostered research activities in the discipline.

After review of all information provided including additional information in the AACP's written response to the Council's report and consideration of information presented during the special appearances, the Council believed that the AACP has not satisfactorily demonstrated that its organization is reflective of the area of practice of craniofacial pain as defined by the AACP. Further, the Council concluded that the AACP has not presented sufficient evidence to demonstrate the ability to establish a certifying board that meets the Council's requirements. Therefore, the Council concluded that the AACP has not met 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 AACP defined craniofacial pain as follows: "Craniofacial pain is the discipline of dentistry, which includes the assessment, diagnosis and treatment of patients with complex acute and chronic craniofacial pain and dysfunction disorders, temporomandibular disorders, orofacial pain, oromotor and jaw behavior disorders, and chronic head, neck and facial pain, as well as the pursuit of knowledge of the underlying pathophysiology and mechanisms of these disorders." Additionally, the information presented in the application compared and contrasted the unique knowledge and advanced skills of a practitioner of dental craniofacial pain disorders to those of a dental school graduate.

The Council discussed the definition presented by the AACP and noted that the definition is very broad. Further, the Council believed that many conditions listed in the definition may not always be attributable to dental-related pain but overlap into areas of medicine, such as neuropathic craniofacial pain disorders, neuromuscular pain disorders, and the underlying pathophysiology of chronic head, neck and facial pain, craniofacial dyskinesia and dystonias, and craniofacial sleep disorders.

In reply to the Council's report, the AACP's written response states that "the definition of craniofacial pain appears to be very broad due to the enormous complexity of the head, face and neck." Further, the AACP's response goes on to explain the definition as follows: "Perhaps a better way to state the definition of craniofacial pain would be the assessment, diagnosis and treatment of patients with acute and chronic pains of the head, face and neck. Specifically, the field includes pains such as trigeminal neuralgia, pretrigeminal neuralgia, migraine type pain in the teeth and face, sympathetically maintained pains (phantom tooth pain), masticatory muscle pains, headaches, TMD, jaw parafunctions and sleep disorders treatable with appliance therapy." During the special appearances, the AACP representatives stated that this information was not intended to serve as a substitute definition, but rather was intended to provide clarifying information about the definition as presented in the AACP application.

The Council believed that based on information presented in the AACP's response, the definition of craniofacial pain remains broad and extends beyond the Association's definition of dentistry. In considering this additional information, the Council was uncertain about the role of the craniofacial pain practitioner, specifically whether he/she is the primary care provider or plays an adjunctive role with medical personnel in the patient's care.

Most members of the Council believed that the information presented in the application provides some evidence that some of the knowledge and skills required of graduates in the field of craniofacial pain exceeds the scope and depth of what is currently defined by the predoctoral accreditation standards. However, the Council believed that many of the topics listed in the proposed accreditation standards for advanced education programs in craniofacial pain (Appendix 2 in the application) are, in fact, included in the predoctoral curriculum of most dental schools. In the Council's opinion, conditions that include craniofacial pain are taught in dental schools, and dental school graduates readily manage these conditions.

The application references data from a 1999 clinical practice survey of 311 general dentists (Look, 1999). According to the application, "data from the 1999 practice survey of 311 general dentists found that 89% of general dentists want to refer their patients (patients with chronic orofacial pain disorders) to a craniofacial pain dentist and that general dentists supported an ADA specialty in craniofacial pain by an 8 to 1 margin. Thus, the field is distinct and well defined in comparison to the definition of all other specialties in dentistry." The Council did not agree with the AACP's conclusions that the data from the 1999 survey demonstrates that the field of craniofacial pain is distinct and well defined in comparison to the definition of all

other dental specialties. Additionally, the Council questioned the relevance of using data from the survey to demonstrate compliance with this requirement given the scope of the definition of craniofacial pain as defined in the AACP application. For these reasons, the Council concluded that data from the survey does not provide sufficient evidence to demonstrate that this requirement has been met.

The Council considered information presented in the AACP's written response regarding an AACP opinion survey of 4,000 dentists conducted in October 2001. According to the AACP, the survey data presents a strong case for recognition of craniofacial pain as a dental specialty. The Council did not concur with the AACP's conclusion because it appeared to the Council that the survey primarily focused on the collection of information regarding TMD disorders.

The Council believed that, based on the definition provided in the application and the additional information in the AACP's response and at the special appearances, the AACP has not demonstrated that craniofacial pain is a distinct and well-defined field. Therefore, it was the Council's opinion that Requirement 2 has not been met.

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 compared the definition of craniofacial pain with the definitions of each of the nine recognized dental specialties. The AACP states in this section of the application and in its response that the recognized specialties do not include chronic and complex acute craniofacial pain diagnosis and treatment within their definitions. The AACP further states that the advanced knowledge and skills under the curriculum sections of the accreditation standards of each recognized specialty include only a minimal reference to chronic and complex acute craniofacial pain. The AACP also states that the most significant difference between the field of craniofacial pain and the recognized dental specialties is that none of these specialties include training in managing the complex acute and chronic craniofacial pain patient. Further, the AACP states that the proposed specialty cannot be readily incorporated within the scope of a recognized specialty nor can it be accommodated by a combination of recognized specialties.

While advanced study in craniofacial pain may develop practitioners who have the skill and expertise in managing patients with a variety of craniofacial pain disorders, the Council did not believe that sufficient evidence was presented to demonstrate that the field of craniofacial pain is separate and distinct from any recognized specialty or combination of any recognized specialty. Because pain is so closely associated with all areas of dentistry, the Council believed that there are varying degrees of overlap in the scope of craniofacial pain and the scope of most recognized dental specialties. In this section of the application, the AACP includes a reference to data obtained from a 1996 survey of 402 practitioners conducted by the AAOP regarding the percent of dental specialists who do not treat specific craniofacial pain disorders and prefer to refer patients elsewhere for this treatment. Of the 402 practitioners surveyed, only 97 were specialists. The Council was of the opinion that basing the practice patterns on this small sample of specialist practitioners is an inappropriate extrapolation. Therefore, the Council did not believe that this survey data provides sufficient evidence to demonstrate that this requirement has been met.

Additionally, in the Council's judgment, the AACP did not present satisfactory evidence to support its assertion that "there is no actual or perceived overlap between the field of craniofacial pain and any existing dental specialty." The Council received information at the special appearance during its April 2002 meeting that the AACP recently conducted a survey of periodontic, prosthodontic, orthodontic and dentofacial orthopedic and oral and maxillofacial surgery advanced specialty education programs in the United States regarding instruction in diagnosis and treatment of TMD/craniofacial pain. Based on the information presented by AACP during its special appearance, the Council concluded that the survey results did not provide sufficient evidence to demonstrate compliance with Requirement 3.

The Council concluded that the application and the additional information presented in the AACP's response and during the special appearances did not demonstrate that craniofacial pain is separate and distinct from any recognized specialty or combination of recognized specialties. Further, the Council believed that the application and additional information did not provide evidence that the scope of the specialty cannot be accommodated through minimal modification of a recognized specialty or combination of recognized specialties. The Council concluded that the AACP has not met 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 Council considered the information presented in the application including epidemiological data on the demand for treatment of patients with craniofacial pain disorders and noted that the application indicated that current general practitioners or dental specialists do not treat these patients adequately.

The Council believed that the evidence presented in the application from several different studies conducted by the AACP and/or the AAOP was inconclusive. Further, the Council questioned the validity of some of the data cited in the application, particularly the data related to need for services. Five of the six prevalence studies cited in the application and in the October 2001 opinion survey of 4,000 dentists focused primarily on TMD disorders. Because the scope of the proposed specialty of craniofacial pain as described in the application encompasses a much broader field than TMD disorders, the majority of the data presented is inconclusive in demonstrating the demand for services provided by the craniofacial pain practitioner.

According to the application, the need for services provided by the craniofacial pain dentist is justified largely on the basis of a 1996 AAOP Survey of Practitioners. It purports to show

how general practitioners and specialists manage 12 highly specific craniofacial pain disorders. Although the respondents indicated that they treat some patients with these disorders, approximately 86% of these patients are referred elsewhere for treatment. According to the survey data, almost 90% of the referrals are to the "orofacial pain dentist." The Council believed that this study based on a survey of only 402 dentists is not sufficiently broad-based to support the AACP's conclusion that there is sufficient need and demand for all the services provided by the craniofacial pain practitioner.

Further, the Council noted that the methodology used for some of the studies referenced in the application was unclear or insufficient to provide a valid conclusion in support of AACP's assertions. It was noted that one of the primary surveys referenced in this section of the application reflected practice patterns in only one region of the country. Additionally, some of the data presented suggests that the majority of patients suffering with craniofacial pain are currently being referred to dentists described as "orofacial pain" dentists, who may or may not be practicing the full scope of what AACP has defined as craniofacial pain. The Council believed that the AACP's application and its written response do not provide well-documented evidence regarding the patient demographics, prevalence of unmet needs of craniofacial pain patients and the number of craniofacial pain dentists needed to treat these types of patients.

Further, the Council noted that there is conflicting information presented in the AACP's application under Requirements 1, 4 and 6 and in its written response as to the exact number of dentists currently devoting full-time or the majority of their time to practice of craniofacial pain. Additionally, the application states under Requirements 4 and 6 that there is a great demand for the services of dentists treating craniofacial pain and these two sections of the application present different estimates of the number of craniofacial pain dentists needed over the next five years. Also, considering the assumption that the need for services is on the rise, the Council noted the contrasting fact that AACP's membership trends over the last ten years have been fairly stable.

Based on all of the information presented, the Council was of the opinion that the AACP did not present satisfactory evidence in the application, the written response or during the special appearances to demonstrate that there is substantial need for the services provided by the craniofacial pain dentist. Additionally, the Council was of the judgment that after review of all of the information presented, the AACP failed to demonstrate that general dentists and dental specialists are not meeting the need and demand for services. Therefore, the Council concluded that the AACP has not met this requirement.

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

The application cited six broad areas of craniofacial pain services that are provided in a variety of settings including, private dental offices, hospitals, dental schools, managed care clinics and medical settings. The areas of health services provided to the public as detailed in this section of the application are based on the AACP's consensus based diagnosis and treatment guidelines (*Orofacial Pain Guidelines for Assessment, Diagnosis, and Management*). Some members of the Council believed that the services provided by the craniofacial pain dentist may directly benefit some aspects of patient care. However, the majority of the Council did not believe that the applicant had provided sufficient information in this section of the application to demonstrate that the requirement has been met. Some members also questioned the value of patient testimonials as evidence.

The Council noted that no new information or data was provided in the AACP's response or during the special appearances regarding this requirement. Based on review of all information presented, the Council concluded that the AACP has not met 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 application included information about eight dental schools/institutions that sponsor formal advanced education programs in orofacial pain (not craniofacial pain) of two or more years in length. Further, as previously noted earlier in this report, the AACP states that in its response related to this requirement, the term "orofacial pain" will be accepted as interposing and essentially synonymous with craniofacial pain. Information provided in several places in the application and in the supplemental material emphasizes that craniofacial pain as defined by the AACP is broader and more encompassing than orofacial pain as defined by the AAOP. Accordingly, it is not clear how the terms can be used synonymously in this section of the application.

In its response to the Council's concern, the AACP states that its statement about the terms "orofacial pain" and "craniofacial pain" being synonymous was taken out of context. Further, the AACP's written response reflects that the statement was intended to show that the advanced educational programs are now known as orofacial pain programs but should be thought of as the future craniofacial pain programs.

According to AACP, only seven educational programs are currently operational. The Council noted in its report that the letters from several of the chief executive officers at the respective institutions verifying sponsorship of the programs were not current. It was noted that the AACP's response did not include any updated letters from CEO's of these institutions to verify current sponsorship.

Further, the AACP application states that in addition to the clinically based certificate specialty programs, three of the programs listed also offer the option of enrolling concurrently in a PhD program in neuroscience and orofacial pain. The application further states that 120 dentists currently in practice have received two or more years of formal advanced education in the specialty. According to the AACP, in 2000 there were 15 first year students enrolled in the orofacial pain programs.

Over the last five years, there have been 67 graduates from these programs in orofacial pain. The Council discussed the adequacy of the number of graduates in conjunction with the projected needs in the field over the next five years. According to information in this section of the application, there will be an estimated shortage of 2,390 craniofacial pain dentists. This estimate conflicts with other estimates noted elsewhere in the application. In its written response, the AACP indicated that the number of additional craniofacial pain dentists needed is 2,500.

The Council believed that the AACP's response and information presented during the special appearances did not present sufficient evidence to conclude that this requirement has been met. The Council expressed concern that, based on enrollment data contained in Table 20 of the AACP application, the advanced education programs listed in orofacial pain are not fully enrolled and further, that the data presented in the response did not include current enrollment information.

The application indicated that all of the programs currently meet AACP's core curriculum according to its 1999 survey of graduate programs. Based on review of the curricular requirements included in this section of the application, the Council questioned whether or not the advanced programs could provide the in-depth level of knowledge and skills required to practice the specialty as defined by the AACP in its application and written response.

The Council concluded that, information verifying the sponsorship of all programs was incomplete. Further, the information provided in the application in this section failed to document that the advanced education programs in orofacial pain were teaching the full scope of craniofacial pain, which according to the AACP under Requirement 1 is broader than orofacial pain, encompassing both chronic and acute pain disorders. For these reasons, the Council believed that the AACP has not demonstrated that formal advanced education programs of at least two years beyond the predoctoral curriculum exist. Therefore, the Council concluded that this requirement has not been met.

Summary: The Council on Dental Education and Licensure recommends the following resolution for transmittal to the 2002 House of Delegates. This resolution supports Strategic Plan Goal, Advocacy.

11. Resolved, that the AACP has **not met 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, and be it further

Resolved, that the AACP has **not met 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, and be it further

Resolved, that the AACP has **not met Requirement 3**: The scope of craniofacial pain (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, and be it further

Resolved, that the AACP has **not 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, and be it further

Resolved, that the AACP has **not met Requirement 5**: A specialty must directly benefit some aspect of clinical patient care, and be it further

Resolved, that the AACP has **not 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, and be it further

Resolved, that the American Academy of Craniofacial Pain's request for the recognition of craniofacial pain as a dental specialty be denied.

Implementation of Revisions to the Specialty Recognition Process and Application for Specialty Recognition: The 2001 House of Delegates adopted Resolution 61H-2001 (*Trans*.2001:470) directing that the Report of the Task Force to Study the Specialty Recognition Process and the Re-recognition Process of Existing Specialties (*Supplement* 2001:5046) be forwarded to the Council for consideration and implementation of revisions to the specialty recognition process and the application for specialty recognition. The Council was requested to present a progress report on implementation of the revisions to the 2002 House of Delegates.

The Council approved a revised specialty recognition application incorporating the specific revisions called for in the Task Force Report. The revised application reflects the changes in the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists* as approved by the 2001 House of Delegates with the adoption of Resolution 60H-2001 (*Trans*.2001:469). The Task Force's suggested content regarding the information to be compiled under Requirement 4 of the application has also been incorporated. The revised application will be used by applicants whose applications are received beginning June 1, 2002.

Procedures for special appearances associated with review of specialty recognition applications were also revised to reflect revisions called for by the Task Force. The revised special appearance procedures allow applicants to appear only before the Council. However, at its discretion, the Council has the option of referring information back to the Committee on Specialty Recognition (Committee G) for review and recommendation. The Council discussed the circumstances for such referral and determined that if it believes substantial new information has been presented during a special appearance, the information would be referred to Committee G for study and recommendation. When applied, this procedure could delay forwarding an application to the ADA House of

Delegates, but allows for comprehensive consideration of the information provided. The revised specialty recognition application and procedures for special appearances will be used for the review of applications received beginning June 1, 2002.

Criteria for selection of members and the chair of Committee G have also been developed as directed in the Task Force Report. The newly established criteria were used in identifying a new member of Committee G for 2002-2003.

The Task Force Report also included comments regarding alternative approaches to specialty recognition that would require more comprehensive study. Three specific areas were noted in the report: 1) alternative approaches to specialty recognition including the recognition of subspecialty areas; 2) the possibility of transferring authority for specialty recognition to an outside entity; and 3) the desirability and feasibility of a process for formal acknowledgment of disciplines of dentistry (non-specialty interest areas). These issues were discussed by both Committee G and the Council. It was noted that the recognition of subspecialty areas raises concerns regarding the fairly consistent balance in the ratio of general dentists versus specialists and the potential impact of fragmentation of dental interest areas on patient care. Further, it was noted that it was unlikely there would be support for transferring the House of Delegates authority for specialty recognition to an outside entity. For these reasons, the Council concurred with the opinion of Committee G and adopted a resolution indicating that further study of alternative approaches to specialty recognition is not warranted at this time and would not be the best use of the Association's time and resources.

The Council has thoroughly reviewed the Task Force Report and has implemented revisions to the specialty recognition process and the application for specialty recognition as called for in the report and in response to Resolution 61H-2001.

Request for Approval of the Revised Definition of Prosthodontics as Proposed by the American College of Prosthodontists: A proposed revised definition of prosthodontics was submitted to the Council by the American College of Prosthodontists. In April 2002, the Council directed that the definition be circulated to the communities of interest for review and comment. In accordance with its established procedures for consideration of a new or revised specialty definition, the Council will consider all comments received at its November 2002 meeting. Following approval by the Council, the definition will be revised in the Council's list of definitions of ADA recognized dental specialties and will be reported to the House of Delegates.

Advanced Education

Annual Meeting of the ADA Recognized Specialty Certifying Boards and Specialty Organizations: In August 2001, the Council hosted a joint meeting of the representatives of the recognized dental specialty certifying boards and the dental specialty organizations at the Association's Headquarters in Chicago.

Agenda topics at this meeting included an update on recent activities of the specialty certifying boards and the Dental Specialty Group; the Association's use of computer testing for the Dental Admissions Test (DAT) and the National Board Dental Examinations; a report on recent activities of the Commission on Dental Accreditation; an update on the Council's Study of Specialty Education and Practice and a report on recent activities of the Royal College of Dentists of Canada. Meeting participants also discussed the value of this meeting and unanimously concurred that the meeting should continue to be held on an annual basis. The next meeting of the specialty certifying boards and organizations is scheduled for August 26, 2002, at the Association's Headquarters in Chicago.

Anesthesiology

Proposed Revisions to the Association's Anesthesiology Documents: The 2001 House of Delegates adopted Resolution 115H-2001 (*Trans*.2001:466) directing that the appropriate agency of the Association study the impact of continuing education courses being offered on enteral sedation that are not in accordance with the Association's *Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry (Guidelines for Teaching)*, the *Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists (Guidelines for Dentists)* and *The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry (Policy Statement.* Resolution 115H-2001 was referred to the Council on Dental Education and Licensure. Subsequently, the Council's Committee on Anesthesiology conducted a study of the impact of continuing education courses on enteral sedation and reported its findings to the Council. Based on the Committee's recommendation, the Council determined that two Association documents, the *Guidelines for Teaching* and the *Guidelines for Dentists,* should be revised to incorporate language that addresses the technique of repeated dosing of orally-administered sedative agents in an effort to achieve a desired level of sedation. The proposed revisions to the guidelines documents were circulated to the communities of interest for comment in May 2002 with a deadline date in July for receipt of written comments. The Committee on Anesthesiology and the Council will review and consider all comments received and finalize the proposed revisions. It is expected that a report and recommendations for revision of the guidelines documents will be transmitted in a supplemental report to the Board of Trustees and the 2002 House of Delegates for consideration in response to Resolution 115H-2001.

Allied Education

Proposed Amendments to the Comprehensive Policy Statement on Dental Auxiliaries: Resolution 124H-2001 (*Trans*.2001:474) directed the Council on Dental Education and Licensure to review the Comprehensive Policy Statement on Dental Auxiliaries with respect to replacing the term

"dental auxiliary" with a more contemporary term, such as "allied dental health personnel." The Council reviewed this policy as directed and considered two terms for inclusion into the document; "allied dental health personnel' and "allied dental personnel." During its discussion of this issue, the Council noted that the Association's Future of Dentistry Report utilized the term "allied dental personnel." Further, the Council believed this was the more contemporary term and noted it was used frequently in textbooks and articles when referring to dental assisting and dental hygiene personnel. For these reasons, the Council determined it would recommend replacing the term "dental auxiliary" with "allied dental personnel" wherever it appears in the policy. In response to Resolution 124H-2001, the Council presents the following resolution for consideration. This resolution supports Strategic Plan Goals Advocacy and Practice Support.

12. Resolved, that the Comprehensive Policy Statement on Dental Auxiliaries (*Trans.*1996:699; 1997:691; 1998:713; 2001:467), be amended by replacing the term "dental auxiliary" wherever it appears in the policy with the term "allied dental personnel."

Career Resources: The 1999 ADA House of Delegates directed the Association to develop and maintain a national allied dental personnel recruitment and retention program by adopting Resolution 68H-1999 (*Trans.*1999:936). The following year the House of Delegates provided additional financial support for the program by adoption of Resolution 35H-2000 (*Trans*.2000:476). As a result of the ongoing financial support, allied career videos on dental assisting and dental hygiene and three new tabletop exhibits were produced in 2001. These upbeat and colorful career resources are in addition to the other newly developed resources that are part of the *Something to Smile About—Careers in the Dental Profession* packet. The Council established a purchase price for the videos and a loaner's fee of $35 for use of the tabletop exhibits at career events. Complimentary copies of the career videos were distributed to constituent dental societies as well as to accredited dental assisting and dental hygiene education programs in early 2002.

The new allied resource materials have been promoted in a variety of ways. An article highlighting the *Something to Smile About – Careers in the Dental Profession* materials and innovative recruitment initiatives appeared in the December 2001 issue of the *ADA News*. Three *In the Spotlight* articles were sent to constituent dental societies and newsletter editors highlighting different dental societies' innovative recruitment initiatives. Information about the resource packet has been publicized in the Executive Director's Update and information regarding online career resources has also been noted in ADA Email. The career videos and other materials were showcased at the President-Elect's Conference in January 2002 and were exhibited at the American Dental Education Association's annual meeting in March 2002 in San Diego. Allied dental recruitment and retention resources new Web address is http://www.ada.org/goto/allied/index.html. Career information has also been added on the Public side of ADA.org under Teacher & Speaker Resources and under the Teen category.

Other career promotion activities that occurred in the past year included an invitation to constituent dental societies to participate and share information with member dentists about the National Groundhog Job Shadow Day for 2002. This event promoted careers in the dental profession and provided the opportunity for participating dentists to connect with local school systems. Additionally, 19 constituent and component dental societies participated in the informational exchange of ideas regarding allied dental recruitment initiatives during the March Seminar Conference Call sponsored by the Department of Dental Society Services.

The ADA sponsored its first Take Our Daughters/Sons To Work Day on April 25, 2002. This national event provided an opportunity for ADA staff to share with young students the many career facets of the ADA workplace. Planned activities included a variety of hands on experiences, a round table discussion highlighting science and high tech careers, and a job shadowing activity. An article highlighting this event appeared in the May 6, 2002 issue of the *ADA News*. Constituent dental societies were also urged to invite member dentists to participate in the 2002 Take Our Daughters/Sons To Work event, offering a unique opportunity to showcase careers in the dental profession and mentor young people.

National Board for Certification of Dental Laboratory Technicians' Request for Continued Recognition: The 1998 House of Delegates adopted C*riteria for Approval of a Certification Board for Dental Laboratory Technicians* (NBC), Resolution 7H-1998 (*Trans*.1998:713). The NBC was notified of the adoption of the new C*riteria* and was advised that in order to maintain its recognition, it must reapply to demonstrate compliance with the revised C*riteria*. In accordance with established procedures, the Council has responsibility for the approval of national certifying boards for allied dental areas. The NBC submitted a new application for continued recognition as the certification board for dental laboratory technicians in August 2000. A call for comments from the communities of interest appeared in the November 6, 2000 issue of the *ADA News*. The Council considered the application at its April and November 2001 meetings. Following initial review of the application in April, the Council requested clarification and additional information from the NBC.

Subsequently, the Council considered the additional information submitted by the NBC in November 2001. All submitted information was evaluated in light of the House established criteria for the recognition of a certification board for dental laboratory technicians. The Council evaluated the application to determine the extent to which compliance with the criteria had been demonstrated. The Council's findings regarding each criterion follow.

Organization of the Board. The *Criteria for Recognition* specifies that the certification board's membership should be representative of or affiliated with a national organization of the dental laboratory industry and have authority to speak officially for that organization. Further, it is required that each dental laboratory technician member of the Certification Board

hold a certificate in one of the areas of dental laboratory technology.

Appropriate dental laboratory technology organizations and communities of interest are represented on the NBC Board of Directors and the dental laboratory technician members on the Board are certified dental technicians. The Council found the NBC's application demonstrated that this criterion has been met.

Authority and Purpose of the Board. The *Criteria* specify that the Board submit data annually to the Council relative to its financial operations, applicant admission and examination procedures and results thereof. Further, it is required that the principal functions of the Certification Board shall be: a) to determine the levels of education and experience of candidates applying for certification examination within the requirements for education established by the Commission on Dental Accreditation; b) to prepare and administer comprehensive examinations to determine the qualifications of those persons who apply for certification; and c) to issue certificates to those persons who qualify for certification and to prepare and maintain a roster of certificants.

During evaluation of all submitted information, the Council noted some concerns related to criterion II. (b), preparation and administration of examinations. Specifically, the Council noted that based on information in the application, the NBC does not routinely calibrate and conduct a statistical analysis of the results of the NBC's practical examination. To monitor progress on this matter, the Council has requested that the NBC submit a progress report that addresses (1) calibration and assessment of the practical examination and (2) plans to routinely conduct a statistical analysis of the results of the practical examination. The Council requested that this information be included in the next NBC annual report for consideration at the Council's November 2002 meeting. Although the Council has requested additional information regarding the practical examination, based on all information considered, the Council concluded that this criterion has been met.

Qualifications of Candidates. According to the *Criteria*, the current minimum requirements established by the Certification Board for the issuance of a certificate must include the following: satisfactory legal and ethical standing in the dental laboratory industry; graduation from high school or an equivalent acceptable to the Certification Board; a period of study and training as outlined in the Commission on Dental Accreditation's Standards for Dental Laboratory Technology Education Programs, plus an additional period of at least two years of work experience as a dental laboratory technician; or five years of education and/or experience in dental technology; and satisfactory performance on an examination(s) prescribed by the Certification Board. The Council found the NBC's application demonstrated that this criterion has been met.

Following careful review of the NBC's application and supplemental information, the Council has determined that the NBC meets the C*riteria for Approval of a Certification Board for Dental Laboratory Technicians* and should continue to be recognized by the Association as the certification board for dental laboratory technicians. Therefore, the Council approved the following resolution for transmittal to the 2002 House of Delegates. This resolution supports ADA Strategic Plan Goal, Practice Support.

13. Resolved, that the National Board for Certification of Dental Laboratory Technicians' request for continued recognition as the certification board for dental laboratory technicians be approved, and be it further

Resolved, that the Association's policy that "acknowledges" the National Board for Certification of Dental Laboratory Technicians as the national agency to certify dental laboratory technicians (*Trans*.1970:442) be rescinded.

Proposal to Develop Recruitment Resources to Attract Individuals into Dental Laboratory Technology Careers: The *Something to Smile About—Careers in the Dental Profession* career resource packet was developed by the Council in response to the House of Delegates adoption of Resolution 68H-1999 (*Trans*.1999:935) and Resolution 35H-2000 (*Trans*.2000:476). The resources developed focused on dental assisting and dental hygiene careers. Concerns about a shortage of dental laboratory technicians (DLT) were brought to the attention of the Council through the Council on Dental Practice (CDP) and correspondence from the President of the National Association of Dental Laboratories (NADL). The Council also noted concerns expressed about DLT shortages in an article published in the March 2001 issue of the *Journal of Prosthodontics*. Additionally, the Council on Dental Practice's Dental Team Advisory Panel recommended consideration of developing resource materials for a career in dental laboratory technology.

The Council discussed the impact of the DLT shortage, the need to consider developing resources and a plan for recruiting qualified individuals into this field during its November 2001 meeting. Following the November meeting, the Council corresponded with the NADL and the American College of Prosthodontists (ACP) to assess these organizations' interest in collaborating on development and implementation of DLT career resource materials similar to the Council's *Something to Smile About—Careers in the Dental Profession* resource materials for dental assisting and dental hygiene. Additionally, the Council appointed a subcommittee to develop a DLT career recruitment proposal for consideration by the Council in April 2002.

The Council's Subcommittee met by conference call on Friday, February 15, 2002 and discussed the need to increase the number of dental laboratory technicians. Data from the 2000 U.S. Census Bureau indicates that there will be more people in the U.S. who will need dental care over the next 25 years, in particular crown and bridge and cosmetic procedures. Additional data impacting this issue is the decrease in the number of trained dental technicians as reflected in the Association's 1999/2000 Survey of Allied Dental Education. Specifically, the number of DLT graduates from accredited DLT education programs decreased from 722 in 1989-90 to 378 in 1999-00. Further,

the data reflects that in 1990 there were 49 DLT accredited education programs; this number decreased to 26 by 2001.

During discussion related to the shortages of DLTs, it was also noted that today's dental students' laboratory experiences are limited. The Subcommittee believed and the Council concurred that the combined effect of reduced dental student laboratory experiences and a continuing decline in the number of trained dental laboratory technicians substantiates the need for the dental profession to work with the dental laboratory industry to develop recruitment resources for DLT careers to increase the number of individuals entering this field.

DLT Career Resource Materials. The Council proposes that the resources complement the information in the current DLT brochure and be similar to those resources included with the Council's existing packet *Something to Smile About—Careers in the Dental Profession*. While the resource materials would be designed and developed primarily for use by constituents/components, member dentists and DLT education programs, the materials could also be available for purchase by dental laboratory owners, dental team members, high school guidance counselors and others. Single complimentary copies of the newly developed resources will be provided to constituent dental societies; multiple copies will be available for purchase. The Council believed that it would be reasonable to utilize the fee mechanism already in place for purchase of dental assisting and dental hygiene resource materials in the sale of DLT career brochures. The fee mechanism allows the Association to recover a portion of the initial expenses for creation of these resource materials, as well as a portion of the ongoing expenses related to duplication and mailing of the materials. The Council recommends that the following resources be developed and distributed:

- Posters—one-page "slick" on DLT career using photos from current brochure;
- PowerPoint presentation describing a career as a DLT in floppy disk and CD ROM format, with companion narration and handouts;
- Career Day Outline—suggested activities for a career day presentation using the multimedia resources in the packet;
- Tabletop exhibit on DLT careers; and
- Updated DLT career information for ADA.org.

The Council also recommends that the following promotional activities be implemented:

- Investigate the feasibility of showcasing examples of alternate pathways for DLT training including work study programs; develop and distribute Spotlight articles on various DLT recruitment initiatives that have been undertaken by constituent and component dental societies and DLT education programs.
- Promote additional information on DLT careers to high school guidance counselors by providing the constituent dental societies with guidance counselors' state contact information.
- Provide appropriate federal agencies, including the military with DLT career information.
- Provide state/component society editors with available DLT career information; prepare draft articles that can be used.
- Encourage constituent and component dental societies to request that member dentists invite area DLTs to join them in participating in high school career days.
- Encourage constituent/component dental societies to identify community groups, e.g., Boy Scouts, Girl Scouts, Boys and Girls Clubs for recruitment activities.
- Seek corporate sponsorship for the development of a DLT career video.

The Council also identified some outcome measures for this activity that are consistent with those identified for measuring the success of the dental assisting and dental hygiene recruitment campaign. Some of these measures include tracking the number of requests for information, number of Web site hits, increases in enrollment in existing DLT programs and the number of newly developed programs. Other measures include working with NADL, the ACP and others to establish recruitment benchmarks to assess the number of additional personnel that enter the field over the next five to ten years.

Oversight Committee. The Council noted that the NADL and the ACP are interested in collaborating on this project. The Council recommends forming a joint Oversight Committee to oversee the recruitment project and review proposed designs of new resource materials. It is proposed that the Oversight Committee composition include six members: two representatives from the Council, two representatives from the CDP, one representative from the NADL and one representative from the ACP.

Summary: This report describes the activities to be undertaken to develop recruitment resources to attract individuals into dental laboratory technology careers. Funding for these resources was requested in a decision package with the Council's 2003 budget proposal. This funding will support the initiatives planned for 2003.

Dental Assisting National Board's (DANB) Pilot Pathway for Certification: At its April 2002 meeting, the Council considered correspondence from the DANB and approved a two-year pilot pathway for certification. This pilot pathway to be offered from January 2002 through December 2003 allows candidates who are graduates of DANB-approved vocational dental assisting programs to qualify to take the certified dental assistant (CDA) examination or the General Chairside (GC) component of the CDA examination. This alternate pathway includes dental assisting students who graduated from dental assisting programs not accredited by the Commission on Dental Accreditation to be eligible for examination. The Council considered this matter in conjunction with its responsibility to approve national certifying boards for allied dental areas and in accordance with the Association's *Criteria for Recognition of a Certification Board for Dental Assistants (Trans*.1989:520).

The DANB reported that the new pathway is an effort to reach the 86% of dental assistants in the workforce that are not certified. The DANB emphasized that the pilot study will be undertaken in a scientific and methodical manner. Further, the DANB has advised that in order for the new pathway to be considered equivalent to other pathways, a sufficient number of candidates must apply through the pilot pathway to make a statistically sound judgment of their abilities. Additionally, candidates' pass rates must be statistically equivalent to the pass rates of candidates from the established pathways. If not, the DANB has indicated that the pilot pathway will be discontinued.

The Council has requested that the DANB include information on the pilot study in annual progress reports until such time as the project has been completed and a detailed analysis of the findings have been reported to and reviewed by the Council. Based on the results of the two-year pilot study, the Council will determine if the pathway should be approved for continuation.

Licensure

The Licensure Planning Task Force: At its February 2002 meeting, the Board of Trustees approved the Council's recommendation that an Interagency Licensure Planning Task Force be established to assist the Council in reevaluating its licensure goals. The Council believed that broad-based Association input would be essential in establishing the Council's future goals in order to adequately address the needs of the Association's members related to licensure issues. This Interagency Task Force meeting was held in place of the Council's 2002 annual invitational licensure conference. The Task Force met in March 2002 and included representatives from the Council on Dental Education and Licensure, the Council on Dental Practice, the Council on Government Affairs, the Council on Access, Prevention and Interprofessional Relations, the Committee on the New Dentist, the Board of Trustees, members at large and the American Student Dental Association. The Council on Membership was invited but unable to participate.

At its April 2002 meeting, the Council reviewed the report and recommendations of the Task Force. The Task Force reviewed extensive information that included summary information about the Council's past invitational licensure conferences, information on state licensure requirements and procedures, ADA licensure policies, relevant sections of the Future of Dentistry Report and other licensure-related information. Based on review of the background materials and extensive discussion, the Task Force identified four areas in which it believed the Council should focus its licensure activities in the next five to ten years: 1) mutual recognition by state boards of results of state and regional clinical licensure examinations; 2) licensure by credentials; 3) specialty licensure; and 4) issues associated with licensure for international dentists. When reviewing the Task Force report, the Council agreed with the Task Force's conclusion about the primary areas of focus. The Council also supported the majority of the strategies proposed by the Task Force to address these issues. It should be noted that issues related to the use of human subjects in clinical examinations were purposefully omitted from the Task Force's discussion, since these issues were addressed by the ADA Task Force on the Role of Patient Based Examinations (Resolution 114H-2001, *Trans*. 2001:403).

Using the Task Force report, the Council identified potential activities and strategies that it could undertake. During discussion, the Council focused specifically on proposed licensure-related activities for 2003 and determined that these activities will include conducting an invitational licensure conference, developing new Association policies on licensure, revising existing policies and continuing efforts to facilitate changes in the dental licensure process. The Council will continue discussion on its licensure activities at its November 2002 meeting.

Other strategies related to the four areas identified by the Task Force that the Council will continue to discuss include reviewing Association policy regarding licensure of international dental graduates, encouraging more dental schools to offer advanced standing programs to international dentists and facilitating efforts to achieve parity/mutual recognition of clinical examinations within the next five years. Additionally, the Task Force recommended that the Council consider other strategies such as continuing to address the

objectives on the Agenda for Change (*Supplement* 1997:454), developing guidelines for use by clinical testing agencies and dental schools on remediation of candidates who have failed a clinical licensing examination and continuing to investigate alternatives to the current clinical licensure examination process. The Council will continue to utilize the Task Force report as a strategic planning document to implement future licensure initiatives.

Association Participation In Interagency Committee Activities Related to Clinical Licensure Examination Guidelines: During the past year, the American Dental Association has participated in two American Association of Dental Examiners interagency committees: the Interagency Committee to Develop a Guidelines Document on Best Scoring Practices and Post-Examination Analysis and the Interagency Committee to Review the Guidelines for Valid and Reliable Dental Clinical Examinations. Members of the Council on Dental Education and Licensure were appointed to represent the Association on these committees.

AADE Interagency Committee to Develop a Guidelines Document on Best Scoring Practices and Post-Examination Analysis. As previously reported, *(Reports* 2001:71) this interagency committee is charged with development of a guidelines document that describes the characteristics (best practices) of a scoring system and post-examination analysis that will be available for use by dental clinical testing agencies. The Committee is comprised of four psychometricians (testing specialists), representatives from the four regional testing agencies, a representative of the Dental Board of California, one individual to represent the remaining independent testing agencies and liaison appointees from the ADA, the ADEA and the ASDA. The Committee met in November 2000 and March and September 2001. The draft document developed by the committee was circulated to the communities of interest for comment in February 2002. Based on the comments received, the Committee made further revisions to the document. It is anticipated that the final draft document, Guidance for the Scoring and Post-Examination Analysis of Dental and Dental Hygiene Clinical Licensure Examinations, will be presented to the AADE General Assembly for approval in October 2002.

AADE Interagency Committee to Review the Guidelines for Valid and Reliable Dental Clinical Examinations. This interagency committee is charged with reviewing and updating the ADA/AADE documents, Guidelines for Valid and Reliable Dental Clinical Examinations (*Trans*.1992:628) and Guidelines for Examiner Standardization (*Trans*.1998:713; *Supplement* 1998:447). In addition, upon approval by the AADE General Assembly in October 2002 of the newly developed document, Guidance for the Scoring and Post-Examination Analysis of Dental and Dental Hygiene Clinical Licensure Examinations, the Committee is charged with incorporating the updated 1992 and 1998 guidelines documents into the new document. This will provide the examining community with one, comprehensive guidance document that will assist the clinical dental testing agencies in developing their examinations.

Proposed Revisions to Guidelines for Licensure: At its November 2001 meeting, the Council proposed an amendment to the section "Licensure by Credentials" of the policy Guidelines for Licensure (*Trans*.1976:919; 1977:923; 1989:529; 1992:632; 1999:936). Further, as part of its periodic review of Association policies, the Council reviewed the policy Specialty Licensure (*Trans.*1992:632).

Section "Licensure by Credentials." The Council proposed deletion of item c, section "Licensure by Credentials" of the Guidelines for Licensure. Item c requires dentists to be in practice or full-time dental education for a minimum of five years immediately prior to applying for licensure by credentials. The Council believed that the five year practice requirement places an undue burden on dentists who have been in practice less than five years, since no data exists to support any specific amount of time in practice as adequate to assess an individual's competence. The Council also believed that removing this arbitrary experience requirement from the Association's policy would allow for greater freedom of movement for dentists, especially the younger members of the profession who may not have been in practice for five years.

New Section "Specialty Licensure." In conjunction with its proposed amendment to the Guidelines for Licensure, the Council also reviewed the policy Specialty Licensure as part of its periodic review of Association policies (*Trans*.1995:659). The policy reads as follows:

Resolved, that the Association urge constituent societies and state boards of dentistry to implement specialty licensure by credentials and/or specialty licensure examination as a top priority, and be it further

Resolved, that a specialist be required to have a general dentistry entry level license in a state, before being eligible to be credentialed or take a specialty licensure examination in another state, and that a specialist not be required to pass an additional general dentistry examination when applying for a license to practice the specialty, and be it further

Resolved, that states without a specialty licensure provision be urged to enact provisions by which a dental specialist licensed in another jurisdiction may be issued a license by credentials to allow the dental specialist (e.g., board qualified, board eligible, board certified) to practice the specific specialty, and be it further

Resolved, that specialty licensure examination and criteria for credentialing be reviewed annually for reliability and validity and updated regularly to protect the public, and be it further

Resolved, that Resolution 29H-1976 (*Trans.*1976:921), Licensure of Specialists by Credentials, be rescinded.

The Council believed that the majority of the language from the policy Specialty Licensure could be revised to be consistent with and incorporated into the Guidelines for Licensure at the end of the policy as a new section, "Specialty Licensure." The Council believed adding this new section would make the Guidelines for Licensure more

comprehensive. In conjunction with its review of Specialty Licensure, the Council also considered feedback it received from the dental specialties at the 2001 Annual Meeting of the Dental Specialty Certifying Boards and Sponsoring Organizations regarding the Association's specialty-related policies. Specifically, based on the specialty groups' comments, the Council proposes that, in the revised language to be added as a new section of the Guidelines for Licensure, the words "board qualified," as stated in the third resolving clause of the existing policy, be deleted because this term is not used by the specialty certifying boards. Further, the Council recommends that language be added to this new section that states that specialists who hold diplomate status from an ADA-recognized dental specialty certifying board or have successfully completed a specialty examination in another state and meet all other state requirements for licensure should not be required to take any additional examinations when applying for licensure by credentials. Accordingly, the Council recommends that a new section "Specialty Licensure" be added as follows at the end of the policy Guidelines for Licensure:

Specialty Licensure: The American Dental Association urges constituent dental societies and state dental boards to implement specialty licensure by credentials and/or specialty licensure as a top priority. The Association urges states to consider the following provisions regarding specialty licensure by credentials:

a. Specialists should be required to have a general dentistry entry-level license in a state before being eligible to be credentialed or take a specialty licensure examination in another state.
b. Specialists should not be required to pass an additional general dentistry examination when applying for a license to practice the specialty.
c. Specialists who have passed a specialty licensure examination in another state should be granted licensure by credentials without further examination.
d. States without a specialty licensure provision should be urged to enact provisions by which a dental specialist licensed in another jurisdiction may be issued a license by credentials to allow the specialist (e.g., board eligible or board certified) to practice the specific specialty.
e. Specialists who hold diplomate status from an ADA-recognized dental specialty certifying board and meet all other state requirements for licensure should not be required to take any additional examinations.
f. Specialty licensure examinations and criteria for credentialing should be reviewed annually for reliability and validity and updated regularly to protect the public.

Call for Comments. At its February 2002 meeting, the Board of Trustees approved the Council's request to circulate the proposed revisions to the Guidelines for Licensure to the communities of interest for comment. Regarding the new section "Specialty Licensure," the comments received by the Council overwhelmingly supported the proposed revised language to be added to the Guidelines to Licensure.

Regarding the proposed revision to the section "Licensure by Credentials" of the Guidelines for Licensure, comments were evenly distributed between support for and opposition to the proposed changes. Those in support of the proposed revisions believed that elimination of the five-year practice requirement would be a positive step towards increasing freedom of movement and access to care. Among concerns that were expressed by those in opposition to the proposed changes were the following: 1) the practice requirement is *the* main credential that is considered in granting a license to an applicant who has taken a state or regional examination that is not accepted by the state board where the applicant is applying for licensure; and 2) elimination of the practice requirement may have the unintended consequences of having states discontinue licensure by credentials, or it could deter states that currently do not have licensure by credentials from implementing the process.

Based on its review of the comments from the communities of interest, the Council proposed an alternative revision to the section "Licensure by Credentials" of the Guidelines for Licensure. Rather than deleting the entire item c, the Council proposed deletion of only the words "for a minimum of five years." The Council believed that this alternative proposed revision would still allow the new dentist the opportunity to apply for licensure by credentials, while at the same time give flexibility to state boards that wish to require that a dentist be in practice or full-time dental education immediately prior to applying for licensure by credentials. The Council also believed that this alternative proposed revision is a reasonable compromise that most communities of interest would find satisfactory because it supports the principle of a practice requirement.

For these reasons, the Council recommended that the Guidelines for Licensure, section on "Licensure by Credentials," item c be amended as follows by deleting the words "for a minimum of five years" (~~strikethrough~~=deletion).

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:

c. has been in practice or full-time dental education ~~for a minimum of five years~~ immediately prior to applying.

Accordingly, the Council approved the following resolution for transmittal to the Association's 2002 House of Delegates. This resolution supports ADA Strategic Plan Goals Advocacy and Member and Support Services.

14. Resolved, that the Guidelines for Licensure (*Trans.*1976:919; 1977:923; 1989:529; 1992:632; 1999:936) be amended by deleting the words "for a minimum of five years" from item c, section "Licensure by Credentials," so the amended policy would read:

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:

c. has been in practice or full-time dental education immediately prior to applying.

and be it further
Resolved, that the Guidelines for Licensure be amended by adding a new section, "Specialty Licensure" at the end of the policy to read as follows:

Specialty Licensure: The American Dental Association urges constituent dental societies and state dental boards to implement specialty licensure by credentials and/or specialty licensure as a top priority. The Association urges states to consider the following provisions regarding specialty licensure by credentials:

a. Specialists should be required to have a general dentistry entry-level license in a state before being eligible to be credentialed or take a specialty licensure examination in another state.
b. Specialists should not be required to pass an additional general dentistry examination when applying for a license to practice the specialty.
c. Specialists who have passed a specialty licensure examination in another state should be granted licensure by credentials without further examination.
d. States without a specialty licensure provision should be urged to enact provisions by which a dental specialist licensed in another jurisdiction may be issued a license by credentials to allow the specialist (e.g., board eligible or board certified) to practice the specific specialty.
e. Specialists who hold diplomate status from an ADA-recognized dental specialty certifying board and meet all other state requirements for licensure should not be required to take any additional examinations.
f. Specialty licensure examinations and criteria for credentialing should be reviewed annually for reliability and validity and updated regularly to protect the public.

and be it further
Resolved, that Resolution 96H-1992 (*Trans*.1992:632), Specialty Licensure, be rescinded.

Proposed Revision to Policy on Dental Licensure: In response to the call for comments on the draft proposed policy, Guidelines for Licensure (*Trans.*1976:919; 1977:923; 1989:529; 1992:632; 1999:936), the Council received comments in a letter signed by the ADA-recognized dental specialty certifying boards supporting the Council's recommendations regarding the proposed new section "Specialty Licensure" at the end of the Guidelines for Licensure (See section Proposed Revisions to Guidelines for Licensure of this report). The specialty certifying boards further recommended that the Council consider adding new language to the Association's Policy on Dental Licensure (*Trans*.1998:720) that is similar to language in the proposed new section "Specialty Licensure." Specifically, the proposed new language would state "that each state accepts satisfactory completion of the certification process by an ADA-recognized dental specialty board as satisfactory performance on the clinical dentistry examination for licensure by credentials." The Council believed that the addition of new language to this policy would make it consistent with the language proposed for incorporation into a new section of the Guidelines for Licensure. Subsequently, the Council recommended that the Policy on Dental Licensure be amended as follows by adding a new item 4.

4. that each state accepts satisfactory completion of the certification process by an ADA-recognized dental specialty board as satisfactory performance on the clinical dentistry examination for licensure by credentials.

Accordingly, the Council approved the following resolution for transmittal to the Association's 2002 House of Delegates. This resolution supports ADA Strategic Plan Goals Advocacy and Member and Support Services.

15. Resolved, that the Policy on Dental Licensure (*Trans.*1998:720) be amended by adding a new item 4 that states:

4. that each state accepts satisfactory completion of the certification process by an ADA-recognized dental specialty board as satisfactory performance on the clinical dentistry examination for licensure by credentials.

and be it further
Resolved, that items 4 through 8 in the policy be renumbered 5 through 9, so the amended policy would read:

The following policies of the American Dental Association were adopted with the knowledge, understanding and agreement that they are guidelines for each individual state and are to be implemented at the discretion of each constituent society and state board of dental examiners.
The American Dental Association recommends:

1. that the state board of dentistry in each state should be the sole licensing and regulating authority for all dental personnel, including dental specialists;

2. that each state continue to require of all candidates for licensure satisfactory performance on the National Board Dental Examinations, Parts I and II;

3. that each state accepts satisfactory performance on National Board examinations as fulfilling its requirement of satisfactory performance on a written examination for licensure;

4. that each state accepts satisfactory completion of the certification process by an ADA-recognized dental specialty board as satisfactory performance on the clinical dentistry examination for licensure by credentials;

5. that each state continue to require of all unlicensed candidates for licensure satisfactory performance on an individual state clinical examination or clinical examination conducted by a regional testing service of the dental profession;

6. that each state consider active participation in regional clinical examinations;

7. that each state consider requiring dentists to show evidence of continuing education as a condition for re-registration of their licenses;

8. that states consider including in their practice acts provisions to require for licensure maintenance, proof of remedial study for those dentists identified through properly constituted peer review mechanisms as being severely deficient; and

9. that state dental associations, state boards of dentistry and dental schools work in close cooperation to provide supplemental clinical education opportunities for those dentists who lack clinical proficiency but are otherwise eligible for a dental license.

Lifelong Learning

As previously reported (*Reports* 2000:81), the Council has developed a series of goals related to lifelong learning. Its initial goal was achieved in 2000 with the adoption of Resolution 16H-2000 (*Trans.*2000:467), Policy Statement on Lifelong Learning. In follow-up to this action, the Council appointed a subcommittee comprised of two representatives each from the Council and the ADA CERP Committee to discuss implementation of the long-term goals for lifelong learning (*Reports* 2001:72). The subcommittee was charged with identifying the next steps to be taken in implementing these goals, specifically, the goal of developing a curriculum model for lifelong learning. The subcommittee met several times in 2001 and again in March 2002. Subsequently, the Council considered a progress report of the subcommittee, endorsed a proposed draft voluntary curriculum model for lifelong learning and directed that comments on the proposed curriculum model be sought from the communities of interest. The Council approved the subcommittee's proposed changes to the curriculum model based on comments from the communities of interest and approved the subcommittee's recommendation to review the language of the draft curriculum model to ensure that it is "user friendly." When finalized, it will be presented to the Council for approval.

The Council directed that the subcommittee present a progress report for consideration at the Council's November 2002 meeting that will address further plans to implement goals associated with lifelong learning activities. The Council will continue to work towards implementing its long-term goals related to lifelong learning and will keep its communities of interest informed as it proceeds with these initiatives.

Continuing Dental Education

Report on the ADA Continuing Education Recognition Program:

ADA CERP Recognized Provider Statistics. The ADA CERP Committee meets twice annually; its report and recommendations are subsequently forwarded to the Council for final action. As a result of actions taken in November 2001 and April 2002, currently there are 330 ADA CERP recognized providers. Fifteen percent of ADA CERP recognized providers are ADA constituent or component societies and 20% are U.S. and Canadian dental schools.

The ADA CERP includes an extended approval process through which ADA CERP recognized constituent dental societies and recognized dental specialty organizations can extend approval to their component societies and affiliates. This is the fifth year of the extended approval process, and during this period 14 constituent dental societies, the American Academy of Oral and Maxillofacial Pathology, the American Association of Endodontists and the American Association of Orthodontists have extended recognition to 116 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 to the ADA CERP *List of Recognized Continuing Education Providers,* a description of the ADA CERP, a Fact Sheet, and other materials with information about the program are posted and regularly updated on ADA.org or are available by mail. The ADA CERP providers also receive a periodic newsletter that highlights program benefits and provides updates on recent policy changes and resources. The newsletter is also posted online.

International Providers. In 2001 the Board of Trustees requested that the Council study the issue of continuing education obtained at international sites, including options as to how continuing education conducted at international venues can qualify for ADA CERP recognition and approval (B-128-2001, *Trans.*2001:349). To implement this directive, the Council adopted a resolution to rescind the ADA CERP eligibility requirement mandating that applicants must be based in the United States or Canada, thereby allowing internationally based providers to participate in the ADA CERP. The Council directed that the requirement be rescinded for a trial period of three years effective July 2002, and that the impact of this change be monitored and periodically reported to the Committee and the Council. The international community of interest has been advised of these changes. Several internationally based providers have subsequently expressed interest in seeking ADA CERP recognition.

Modifications to Eligibility Requirements, Standards and Procedures. During the past year, in an effort to continually improve the program and be responsive to comments received

from its communities of interest, the Council made modifications to several ADA CERP eligibility requirements, standards and procedures. With regard to the eligibility requirements, modifications include: 1) revision of one eligibility requirement to more clearly define the CE provider's responsibilities for ensuring that courses offered have a sound scientific basis; and 2) rescission of the eligibility requirement that applicants be able to demonstrate 12 months of CE activity prior to application. With regard to the ADA CERP Standards, Standard XIV. Record Keeping was revised to clarify the language with regard to acceptable CE participant verification forms. The Council also approved the American National Standard (ANSI/ADA Specification 1001) for the Design of Educational Software and directed that language be added under Standard XV. Electronically Mediated Distance Learning specifically recommending that educational software should be designed in accordance with the ANSI/ADA Specification 1001 for the Design of Educational Software whenever possible. The Council also expanded its policy on joint sponsorship and added a definition of "joint sponsor" to the ADA CERP Lexicon of Terms.

ASCDE Issues. The Council considered concerns raised by the American Society of Constituent Dental Executives (ASCDE) about the ADA CERP. Members of the ASCDE expressed concern regarding the extensive ADA CERP application process, particularly related to the requirement that recognized providers must reapply every three years. Questions were also noted about the relationship between the ADA CERP and the AGD PACE (a similarly structured CE provider recognition program) and about the ADA CERP Extended Approval Procedures (EAP). In an effort to be responsive to the concerns expressed by members of the ASCDE, the ADA CERP Committee and the Council considered a comprehensive report detailing specific concerns and outlining specific approaches to resolving the concerns and improving the program. Following careful consideration of all information and in response to the concerns and feedback received from members of the ASCDE about the ADA CERP, the Council took several actions to address the concerns. Specifically the Council directed that 1) the composition of the ADA CERP Committee be expanded to allow for the appointment of a representative from the ASCDE to serve on the ADA CERP Committee, and 2) an ad hoc committee be appointed to review, consider and recommend changes related the ADA CERP policies and procedures. It is anticipated that the ASCDE's representative will attend the Committee's October 2002 meeting and the ad hoc committee's report will be considered at the fall 2002 meetings of the ADA CERP Committee and the Council.

Additionally, other initiatives to improve the ADA CERP will be undertaken. While some improvements can be immediately implemented, others will take longer. The Committee and Council are committed to continuing to improve the program and be responsive to providers' concerns.

Continuing Education Course Listing: Since 1991, the Council has compiled and published the semiannual Continuing Education (CE) Course Listing as a resource for dentists and allied dental personnel. Typically, between 1,100 and 1,500 courses offered by 130 to 150 recognized providers recognized by the ADA CERP are included in the course listing. The CE Course Listing is available for purchase by members and nonmembers through the ADA Department of Salable Materials and can be ordered through the *ADA Catalog*. ADA members are charged a nominal fee for a print copy of the CE Course Listing. Nonmembers are assessed a 50% surcharge over the subtotal for orders placed through catalogue sales. Additionally, members continue to have free access to the CE Course Listing in the members-only section of ADA.org. The online version of the CE Course Listing was revised and re-designed in order to make it more accessible and user-friendly for members. Also, ADA CERP recognized providers now have the option to update provider and course information directly online. It is anticipated that in the near future nonmembers will be able to access and search the CE Course Listing online for a fee.

Dental Admission Testing Program

Dental Admission Testing Program (DAT) Trends: During 2001, the DAT was administered exclusively on computer at Sylvan Technology Centers throughout the United States. The numbers of examinees participating in the DAT Program have increased for the last two years. The number of examinees in 2001 (7,313) represented a 1.1% increase in examinees from 2000 (7,231).

The percentages of males and females participating in the testing program have been changing slightly each year, with the female examinees constituting approximately 46.7% of the DAT examinee pool in 2001. There have also been changes in the ethnic distribution of the cohorts participating in the program. During the five-year period ending in 2001, the percentage of examinees identifying themselves as Asian has decreased from 31.6% to 21.6%. This decrease is being offset by increases in the percentages of white examinees, which have increased from 56.6% to 63.5% over the same time period. The percentages of American Indian, African Americans and Hispanic examinees have remained relatively stable during this period at 1%, 6%, and 7% respectively.

Average examinee performance has increased steadily in recent years. On average, these annual increases have been slight, however. For example, over the five-year period ending in 2001, the mean DAT Academic Average for first-time examinees increased from 17.1 to 17.9 on a measurement scale that ranges from 1 to 30. Average Perceptual Ability Test scores have increased from 16.0 to 17.5. Predental grade point averages have also increased during this period.

Dental Admission Testing Program Development and Research Activities: Development activities related to the testing program include an online computer application and score report request process. In the near future, individuals will be able to access a section of the Association's Web site to complete the entire DAT application process. The portion of the Web site devoted to the DAT is being developed so that individuals will be able to submit the application directly and

pay fees using a credit card account. A closely related online site will allow examinees to request additional score reports after the time of application.

Research related to the DAT continues in several traditional areas. These include annual validation studies concerning the degree to which the content of the DAT is relevant to the dental school admission process and studies concerning the extent to which the DAT predicts performance in dental school didactic and technique courses. Other areas of research involve analyses to determine if the items on the DAT are differentially familiar to any particular group of examinees and research related to the possible inclusion of a critical thinking test on the DAT battery. With regard to validation research, an analysis of the test content confirms that overall the DAT is relevant to the admission process and annual studies indicate that the DAT continues to be the best nationally available predictor of dental school performance. Predental science and non-science grade point averages tend to be strong predictors as well. Concerning the other areas, research findings indicate that no scored items are differentially familiar to any one group of examinees. Finally, with regard to the possible inclusion of a critical thinking test, a measure for evaluating the performance of fourth-year students in the dental clinic has been successfully piloted. Along with clinic grades, performance on this measure will be used to evaluate the adequacy of a critical thinking test. It is anticipated that this test will be piloted at a representative sample of dental schools during 2002.

2002 Dental Education Summit Meeting

The Association will host a Dental Education Summit Meeting on June 12-13, 2002. Agenda items for this year's meeting include: 1) an update on the status of problems facing dental education and potential solutions identified at the 2001 Dental Education Summit Meeting (*Supplement* 2001:5065); 2) addressing implementation of the recommendations adopted by the 2001 House of Delegates related to the cost of dental education, student indebtedness and dental faculty shortages (Resolutions 62H-67H-2001, *Trans.*2001:466, 471); 3) an update from participating organizations, American Dental Education Association and some of the dental specialty organizations on activities they have undertaken since the 2001 Summit Meeting; and 4) fundraising and implementation of a national endowment for dental education. Invited participants include representatives from a number of Association agencies and the members-at-large, the ADA Health Foundation, the ADEA, the American Student Dental Association, the American Association of Dental Research, the National Institute of Dental and Craniofacial Research, the nine recognized dental specialty sponsoring organizations, the dental industry, the Canadian Dental Association, and the Association of Canadian Faculties of Dentistry. A report detailing the 2002 Summit Meeting's deliberations will be presented to the 2002 House of Delegates.

Association Policies Recommended for Rescission

In response to Resolution 15H-1995 (*Trans*.1995:660), the Council on Dental Education and Licensure reviewed current Association policies to determine whether any redundancies or irrelevancies existed. Based on this review, the Council recommended rescission of one Association policy.

Prosthodontic Education and Training: The Council determined that the policy Prosthodontic Education and Training (*Trans.*1977:937) is outdated and should be rescinded because the Guidelines for Valid and Reliable Dental Licensure Clinical Examinations include removable prosthodontic components for licensure examinations and the Commission on Dental Accreditation Standards for Predoctoral Dental Education Programs require competencies for removable prosthodontics. In addition, oral health needs have changed substantially since Resolution 7H-1977 was adopted. The policy reads as follows:

> **Resolved,** that the American Association of Dental Schools be encouraged to recommend to each of its member schools that removable prosthodontic clinical and didactic training for dental students be strengthened, and be it further
> **Resolved,** that the American Association of Dental Examiners be encouraged to recommend to each board of dentistry that an evaluation of the candidate's clinical competence in removable prosthodontics be further strengthened in licensure examinations.

The Council, therefore, recommends adoption of the following resolution.

16. Resolved, that Resolution 7H-1977 (*Trans*.1977:937), Prosthodontic Training and Examination, be rescinded.

Response to Assignments from the 2001 House of Delegates

Campaign to Attract Qualified Students into Dentistry: Resolution 17H-2001 (*Trans*.2001:467) directs the Association to implement resources and activities to attract qualified students into dentistry. A detailed report regarding implementation of this resolution and proposed plans for additional resources in 2003 are provided elsewhere in this report.

Amendment to the Comprehensive Policy Statement on Dental Auxiliaries Regarding the Definition of a Dental Laboratory Technician: As directed by Resolution 18H-2001 (*Trans*.2001:467), the Comprehensive Policy Statement on Dental Auxiliaries has been amended to reflect the revised definition of Dental Laboratory Technician in the section entitled “Glossary of Terminology Related to Dental Auxiliary Personnel Utilization and Supervision.” The revised policy was transmitted to the communities of interest in correspondence dated December 2001. Additional amendments to this policy are proposed for consideration by the 2002 House of Delegates and are provided elsewhere in this report.

Revision of Association Policy on Acceptance of Results of Regional Boards: Resolution 19H-2001 (*Trans*.2001:468) amended the second resolving clause of the Association’s policy, Acceptance of Results of Regional Boards. In response to Resolution 19H-2001, a copy of the revised policy was provided to the constituent dental societies, state boards of dentistry and dental deans in correspondence dated December 2001.

Comprehensive Study of Dental Specialty Education and Practice: In response to Resolution 20H-2001 (*Trans*.2001:468), the Council, as the appropriate Association agency, will continue to conduct a periodic review of dental specialty education and practice at ten-year intervals and will present the next report of its review to the 2011 ADA House of Delegates. The communities of interest were notified of this action in correspondence dated December 2001. Additionally, a notification will be sent to the appropriate communities of interest as the Council prepares to develop this report for 2011.

Monitor and Increase Number of ADA Recognized Board Certified Specialists: In response to Resolution 21H-2001 (*Trans*.2001:469), a copy of this resolution was provided to the constituent dental societies, state boards of dentistry, dental deans and the recognized dental specialty organizations. Additionally, the Council publishes an annual report containing information collected from the dental specialty certifying boards on the number of board certified specialists. Further, the Council hosts an annual meeting for the recognized dental specialty certifying boards and sponsoring organizations that provides an opportunity for these organizations to share information regarding common concerns and interests, including efforts to increase the number of board certified dental specialists.

Revised Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists: Resolution 60H-2001 (*Trans*.2001:469) approves the revised *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists*. The *Requirements* document has been updated to reflect the approved revisions and will be effective with the review of new applications for specialty recognition received as of June 1, 2002. The communities of interest received the revised *Requirements* in correspondence dated December 2001. The *Requirements* are also available on ADA.org.

Implementation of Revisions to the Specialty Recognition Process and the Application for Specialty Recognition: In response to Resolution 61H-2001 (*Trans*.2001:470), the Council implemented the revisions to the specialty recognition process and the application for specialty recognition as noted in the Report of the Task Force to Study the Specialty Recognition and the Rerecognition Process. Additional information regarding this activity is provided elsewhere in this report.

Member Awareness of Problems Facing Dental Education: In response to Resolution 62H- 2001 (*Trans*.2001:466), a copy of the resolution was provided to constituent dental societies in correspondence dated December 2001. Additionally, articles on issues related to the cost of dental education, student indebtedness and faculty shortages were reported in the *ADA News* on May 1, 2001, August 6, 2001, August 20, 2001, and October 1, 2001. These topics will be a primary focus of discussion during the Association’s 2002 Dental Education Summit Meeting. A report detailing the 2002 Summit Meeting’s deliberations will be presented to the 2002 House of Delegates.

Federal Lobbying Efforts that Support Dental Education: Resolution 63H-2001 (*Trans*.2001:471) was transmitted to the American Dental Education Association in correspondence dated December 2001. Additionally, the Council reviewed this resolution in conjunction with all resolutions related to the 2001 Dental Education Summit. The Association has continued its joint efforts with ADEA this past year in lobbying to support dental education. The ADA’s efforts have been reported in articles in the *ADA News* on June 18, 2001, January 21, 2002, February 18, 2002, April 15, 2002, and May 16, 2002 . The Council on Government Affairs will report in greater detail in its Supplemental Report on specific lobbying actions taken by the Association, often working collaboratively with ADEA. This resolution will also be considered at the Association’s 2002 Dental Education Summit. A report detailing the 2002 Summit Meeting’s deliberations will be presented to the 2002 House of Delegates.

State Funding for Dental Education: Constituent dental societies were advised of the adoption of Resolution 64H-2001 (*Trans*.2001:471) this resolution in correspondence dated December 2001. This resolution will be considered at the Association’s 2002 Dental Education Summit. A report detailing the 2002 Summit Meeting’s deliberations will be presented to the 2002 House of Delegates.

Support for the Association's Dental Education Endowment Fund: In response to Resolution 65H-2001 (*Trans.*2001:466), a portion of the Association's 2002 Dental Education Summit Meeting will be devoted to discussions concerning the feasibility and potential mechanisms for establishing a national dental education endowment. A report detailing the 2002 Summit Meeting's deliberations will be presented to the 2002 House of Delegates.

Member Contributions to Dental Education Endowment Fund: Resolution 66H-2001 (*Trans*.2001:471) will be a topic of discussion at the Association's 2002 Dental Education Summit Meeting. A report detailing the 2002 Summit Meeting's deliberations will be presented to the 2002 House of Delegates.

Association Comprehensive Debt Consolidation Programs: In response to Resolution 67H-2001 (*Trans*.2001:472), the resolution was transmitted to constituent dental societies in correspondence dated December 2001. Additionally, in 2001, ADA Business Enterprises, Inc. launched a loan program for dentists who wish to consolidate private or federal loans. This resolution and issues related to student indebtedness will be considered at the Association's 2002 Dental Education Summit Meeting. A report detailing the 2002 Summit Meeting's deliberations will be presented to the 2002 House of Delegates.

Dental School Curriculum to Include Guidelines of Care on the Age One Visit for Infants: Resolution 74H-2001 (*Trans*.2001:466) directs that the Council urge dental schools to provide clinical experience for teaching the guidelines on the age one visit for infants into the predoctoral curriculum according to the adopted ADA Statement on Early Childhood Caries (*Trans*.2000:454). In response to this directive, this resolution was mailed to dental deans and to the American Dental Education Association in correspondence dated December 2001.

Dental School Satellite Clinics: Resolution 85-2001 (*Trans*.2001:472) was referred to the Council for further study. As presented to the 2001 House of Delegates, the proposed resolution called for the ADA to advocate policy that will establish education, research and access to the underserved as the sole mission of dental clinical training programs, and that revenue generated should support only dental clinical training programs and their parent institutions. The second resolve of the proposed resolution stated that the ADA believes that appropriate supervision of pre and post doctoral students must continue in dental clinical training programs to ensure patient safety.

In its consideration of this resolution, the Council thoroughly reviewed and discussed a chronology of related resolutions and reports that have been previously considered by the ADA Board of Trustees and the House of Delegates over the past few years. Specifically, the Council's review included the following resolutions: two Board resolutions (B-21-1997, *Trans*.1997:525 and B-108-1997, *Trans*.1997:580) and Resolution 84H-1997 (*Trans*.1997:684) calling for a comprehensive review and study of dental school satellite clinics; a 1998 progress report on the study of satellite clinics (*Reports* 1998:90); a 1999 comprehensive report detailing the results of the study of satellite dental school clinics (Board Report 12, *Supplement* 1999:602) and two related resolutions. Resolution 49H (*Trans*.1999:935) directed that issues associated with the operation of dental school satellite clinics continue to be monitored and Resolution 50H-1999 (*Trans*.1999:939) encouraged dental schools and dental societies to work together in matters relative to dental school satellite clinics. In a related action, the 1999 House of Delegates adopted Resolution 131H-1999 (*Trans*.1999:979) calling for an evaluation of the present system of management and funding of advanced education programs in general dentistry (AEGD). Also in 1999, Resolution 107-1999 (*Trans*. 1999:946) concerning the mission of dental school satellite clinics was referred for further study to the Council on Government Affairs (CGA). In response to Resolution 131H-1999, the 2000 House of Delegates received a comprehensive report regarding management and funding of AEGD programs (*Supplement* 2000:5096), and adopted Resolution 95H-2000 (*Trans*.2000:467) calling for the Association to continue to monitor issues associated with these training programs. That same year, the House of Delegates also received a progress report on Resolution 107-1999 (*Supplement* 2000:6121). In 2001, Resolution 107-1999 was amended by the CGA and presented to the 2001 House of Delegates as Resolution 85-2001 (*Supplement* 2001:5095). As previously noted Resolution 85 was subsequently referred to the Council for study.

Based on its review of these reports and resolutions, the Council concluded that multiple issues surrounding satellite clinics have been comprehensively addressed over the last six years. The Council believes the studies conducted have adequately addressed concerns related to dental school satellite clinics and the resolutions adopted have appropriately included directives that call for continued monitoring of these issues.

In conjunction with its study of Resolution 85, the Council also considered the mission of a dental school as defined in current ADA policy (*Trans*.1995:640) and was of the opinion that the policy is broad enough to allow institutions the latitude to appropriately define their specific goals. The Council also discussed issues related to the quality of patient care and supervision of students at some dental school satellite clinics. The Council concluded that such matters are appropriately addressed through the Commission on Dental Accreditation's established policies and procedures.

Additionally, as part of its review of this matter, the Council discussed proposed plans to monitor issues associated with the operation of dental school satellite clinics on a periodic basis as directed in Resolutions 49H-1999 and 95H-2000. One option involves monitoring the outcomes of the Robert Wood Johnson Foundation Pipeline, Profession and Practice Project. This Project is intended to expand the clinical training of dental students using private practices and other venues such as satellite clinics to assist dental schools to strengthen their missions in public service to populations in need of oral health care. The Council believed that review and evaluation of the outcomes data from the Project closely aligns with the Council's efforts to continue monitoring issues associated with

satellite clinics. Accordingly, the Council directed that the feasibility of collaborating with the RWJF to review and evaluate the outcomes of this current project be explored. Additionally, the Council also supported the feasibility of conducting a modified version of the 1998 study of dental school satellite clinics in 2004. The Council believed that this timeframe allows sufficient time to elapse since the 1998 study was conducted. The Council also believed that a modified study would be more cost-effective than the previous study. A report detailing the estimated costs for this study and suggested content areas to be covered in the study will be presented for consideration at the Council's November 2002 meeting in order that funding for the activity can be included in the Council's 2004 proposed budget request.

In response to the referral of Resolution 85-2001, the Council has thoroughly reviewed all related resolutions and reports from 1997-2001. Additionally, the Council has developed plans to continue to monitor issues related to satellite clinics. For these reasons, the Council concluded that no further action is required regarding Resolution 85-2001. Further, the Council will continue to keep the House of Delegates apprised of its activities to monitor issues associated with dental school satellite clinics.

Clinical Licensing Examination Process: Resolution 89H-2001 (*Trans*.2001:411) encourages the dental testing agencies to collaborate with the dental educators to investigate offering clinical licensing examinations on patients early enough in the year to allow those students who do not pass to be remediated prior to graduation. In response to Resolution 89H-2001, a copy of the resolution was provided to the constituent dental societies, state boards of dentistry and dental deans.

Policies Relating to the Use of Patients in Clinical Licensing Examinations: Resolution 114H-2001 (*Trans*.2001:403) directs the Association to sponsor a Task Force to include representation from the American Association of Dental Examiners, the American Student Dental Association, the American Dental Association and the Committee on the New Dentist to consider the role of patient-based examinations and other potential methods for evaluating clinical competency for licensure. In accordance with this directive, the Task Force was appointed and met in April 2002. A report on the Task Force's findings is currently under development and will be forwarded to the 2002 House of Delegates for consideration. Further, the constituent dental societies, state boards of dentistry and dental deans were advised of the adoption of this resolution.

Enteral Sedation: Resolution 115H-2001 (*Trans*.2001:466) calling for the study of the impact of continuing education courses being offered on enteral sedation that are not in accordance with the Association's anesthesia guidelines documents was referred to the Council for implementation. The Council will forward a report and recommendations in a supplemental report to the 2002 House of Delegates for consideration in response to Resolution 115H. Additional information related to this resolution is presented under the "Anesthesia" section of this report.

Review of the Comprehensive Policy Statement on Dental Auxiliaries: Resolution 124H-2001 (*Trans*.2001:474) requests that the Council on Dental Education and Licensure review the Comprehensive Policy Statement on Dental Auxiliaries with respect to replacing the term "dental auxiliary" with a more contemporary term. More information on the Council's response to this recommendation can be found under the "Allied Education" section of this report.

Summary of Resolutions

11. Resolved, that the AACP has **not met 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, and be it further

Resolved, that the AACP has **not met 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, and be it further

Resolved, that the AACP has **not met Requirement 3**: The scope of craniofacial pain (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, and be it further

Resolved, that the AACP has **not 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, and be it further

Resolved, that the AACP has **not met Requirement 5**: A specialty must directly benefit some aspect of clinical patient care, and be it further

Resolved, that the AACP has **not 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, and be it further

Resolved, that the American Academy of Craniofacial Pain's request for the recognition of craniofacial pain as a dental specialty be denied.

12. Resolved, that the Comprehensive Policy Statement on Dental Auxiliaries (*Trans*.1996:699; 1997:691; 1998:713; 2001:467), be amended by replacing the term "dental auxiliary' wherever it appears in the policy with the term "allied dental personnel."

13. Resolved, that the National Board for Certification of Dental Laboratory Technicians' request for continued recognition as the certification board for dental laboratory technicians be approved, and be it further

Resolved, that the Association's policy that "acknowledges" the National Board for Certification of Dental Laboratory Technicians as the national agency to certify dental laboratory technicians (*Trans*.1970:442) be rescinded.

14. Resolved, that the Guidelines for Licensure (*Trans.*1976:919; 1977:923; 1989:529; 1992:632; 1999:936) be amended by deleting the words "for a minimum of five years" from item c, section "Licensure by Credentials," so the amended policy would read:

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:

c. has been in practice or full-time dental education immediately prior to applying.

and be it further
Resolved, that the Guidelines for Licensure be amended by adding a new section, "Specialty Licensure" at the end of the policy to read as follows:

Specialty Licensure: The American Dental Association urges constituent dental societies and state dental boards to implement specialty licensure by credentials and/or specialty licensure as a top priority. The Association urges states to consider the following provisions regarding specialty licensure by credentials:

a. Specialists should be required to have a general dentistry entry-level license in a state before being eligible to be credentialed or take a specialty licensure examination in another state.
b. Specialists should not be required to pass an additional general dentistry examination when applying for a license to practice the specialty.
c. Specialists who have passed a specialty licensure examination in another state should be granted licensure by credentials without further examination.
d. States without a specialty licensure provision should be urged to enact provisions by which a dental specialist licensed in another jurisdiction may be issued a license by credentials to allow the specialist (e.g., board eligible or board certified) to practice the specific specialty.
e. Specialists who hold Diplomate status from an ADA-recognized dental specialty certifying board and meet all other state requirements for licensure should not be required to take any additional examinations.
f. Specialty licensure examinations and criteria for credentialing should be reviewed annually for reliability and validity and updated regularly to protect the public.

and be it further
Resolved, that Resolution 96H-1992 (*Trans*.1992:632) Specialty Licensure, be rescinded.

15. Resolved, that the Policy on Dental Licensure (*Trans.*1998:720) be amended by adding a new item 4 that states:

4. that each state accepts satisfactory completion of the certification process by an ADA-recognized dental specialty board as satisfactory performance on the clinical dentistry examination for licensure by credentials.

and be it further
Resolved, that items 4 through 8 in the policy be renumbered 5 through 9, so the amended policy would read:

The following policies of the American Dental Association were adopted with the knowledge, understanding and agreement that they are guidelines for each individual state and are to be implemented at the discretion of each constituent society and state board of dental examiners.
The American Dental Association recommends:

1. that the state board of dentistry in each state should be the sole licensing and regulating authority for all dental personnel, including dental specialists;

2. that each state continue to require of all candidates for licensure satisfactory performance on the National Board Dental Examinations, Parts I and II;

3. that each state accepts satisfactory performance on National Board examinations as fulfilling its requirement of satisfactory performance on a written examination for licensure;

4. that each state accepts satisfactory completion of the certification process by an ADA-recognized dental specialty board as satisfactory performance on the clinical dentistry examination for licensure by credentials;

5. that each state continue to require of all unlicensed candidates for licensure satisfactory performance on an individual state clinical examination or clinical examination conducted by a regional testing service of the dental profession;

6. that each state consider active participation in regional clinical examinations;

7. that each state consider requiring dentists to show evidence of continuing education as a condition for re-registration of their licenses;

8. that states consider including in their practice acts provisions to require for licensure maintenance, proof of remedial study for those dentists identified through properly constituted peer review mechanisms as being severely deficient; and

9. that state dental associations, state boards of dentistry and dental schools work in close cooperation to provide

supplemental clinical education opportunities for those dentists who lack clinical proficiency but are otherwise eligible for a dental license.

16. Resolved, that Resolution 7H-1977 (*Trans*.1977:937), Prosthodontic Training and Examination, be rescinded.

Special Report of the Council on Dental Education and Licensure

A Response to Resolution 17H-2001—Campaign to Attract Qualified Students into Dentistry

Background: In 1999 the House of Delegates adopted Resolution 78H-1999 (*Trans*.1999:941) directing that a more organized and concentrated effort in educating qualified students to the opportunities in dentistry be developed, while being sensitive to recruitment of underrepresented minorities. This resolution was assigned to the Council on Dental Education and Licensure (CDEL). Using an Interagency Committee, the Council developed a detailed proposal to attract qualified students into dentistry. The Council transmitted the proposal including financial implications for consideration by the 2000 House of Delegates. The House of Delegates considered the proposal and, because of concerns expressed related to the costs for development of a career brochure, other related resource development costs and the House of Delegates' request that the campaign emphasize the role of one-on-one mentoring by member dentists, the proposal was referred to the Council for further study (Resolution 42-2000, *Trans.*2000:476). In response to these concerns, the Council transmitted a new proposal to the 2001 House of Delegates for consideration. The funding request to support the new proposal was reduced by almost half of the original request. Subsequently, the 2001 House adopted Resolution 17H-2001 (*Trans*.2001:467), which reads as follows:

> **17H-2001. Resolved,** that the Association implement the proposed career guidance program to attract and encourage students into dentistry as described in the Council on Dental Education and Licensure's 2001 annual report, and be it further
> **Resolved,** that the materials be sensitive to the recruitment of qualified underrepresented minorities, and be it further
> **Resolved,** that the Council on Dental Education and Licensure establish an oversight career guidance committee whose membership should include dental practitioners, dental educators, a health professions career advisor, a dental school admissions officer, an appointee from the ADA Committee on the New Dentist or the Council on Membership and representation from an ADA constituent society for the purpose of overseeing implementation of the career guidance program, and be it further
> **Resolved,** that the Association explore the feasibility of establishing formal partnerships with the American Dental Education Association, the American Student Dental Association and other appropriate dental related organizations.

Resolution 17H-2001 was assigned to the Council on Dental Education and Licensure (CDEL). An Interagency Committee was constituted following the Council's November 2001 meeting and includes Dr. Mary Hayes, Chair (Council on Dental Education and Licensure—CDEL); Dr. Richard Carr, (American Dental Education Association—ADEA); Ms. Gerri Cherney, (American Society of Constituent Executive Directors—ASCED); Dr. Hugo Lane, (National Association of Advisors for the Health Professions—NAAHP); Dr. Tasha Strait, (Committee on the New Dentist—CND); and Dr. Denee Thomas, (ADEA). Subsequently, the Interagency Committee met on February 25, 2002, at the Association's Headquarters in Chicago with all members present.

The Interagency Committee was charged with implementing the proposed career guidance program to attract and encourage students into dentistry while being sensitive to the recruitment of qualified underrepresented minorities. As noted in a later section of this report, the Committee discussed ways to establish formal partnerships with appropriate dental related organizations as directed in the fourth resolving clause of Resolution 17H-2001. The Interagency Report was adopted by the Council for transmittal to the 2002 House of Delegates.

Consideration of Trends and Demographics: The Committee reviewed and discussed a variety of background information provided in their meeting materials. Background materials included information from the ADA Future of Dentistry Report—2001 on the dental workforce; the ADEA Trends in Dentistry and Dental Education Report; information describing other health care professions recruitment activities; and examples of the Committee on the New Dentist (CND) and other professions' mentor programs. The Committee noted that according to the ADA dental workforce data, the number of professionally active dentists and private practitioners increased during the 1990s. However, their growth rates were slightly less than the growth in the United States population. As a result, dentist-to-population ratios started declining around 1995 and have continued to decrease. The Committee also reviewed 2000 U.S. census data as reported in the ADEA Trends in Dentistry and Dental Education Report. According to the census data, the U.S. population is projected to exceed 400 million by 2050, more than a 42% increase from the year 2000. With people increasingly living longer and improving oral health, the number of teeth to be cared for is increasing at a faster rate than the population. Further data indicates that in the year 2014 the number of retiring dentists will surpass the number of graduates coming out of dental schools. The Committee reaffirmed and the Council concurred that this data further substantiates the need to begin to develop a national

campaign to attract and encourage students to consider a career in dentistry in order to ensure that the profession continues to meet the public's need and demand for dental care.

Purpose and Goals of a National Campaign, the Target Audience and Diversity Issues:

Mentoring. In response to the House of Delegates request that one-on-one mentoring be an integral part of the campaign, the Committee focused considerable attention on discussing how this concept could be incorporated into a national campaign to attract students into dentistry. The Committee discussed how the Association could assist constituent dental societies to implement a mentor program by providing information on different mentoring mechanisms that have been effective. The Committee believed that a mentor program should be established at the grassroots level and should be viewed as a long-term endeavor. Further, the Committee believed that mechanisms for mentoring and career resources should be easily accessible to members, presented in a user friendly format and targeted to different education levels from grade school through college (K-16) using a variety of approaches, e.g., providing help with science projects, inviting students to the mentor's office for job shadowing and talking to students at job fairs and career events.

An example of a mentor program highlighted during the discussion was the Alliance in Texas initiative in which the three Texas dental schools combine their resources to use the schools' alumnae as mentors. These mentors talk to dental students about their experiences in dental practice. Although this initiative focuses on mentoring individuals who have already selected a career in dentistry, the Committee viewed it as a good example of the role members can play as mentors. The Committee noted that the previous ADA/AADS SELECT Career Guidance Program mentor network is still active in some states. This program was jointly sponsored by ADA and AADS, (now known as ADEA) and operated from 1985-1993. One particularly successful component of the program was the dentist mentor network. Examples of mentor programs from other health care associations, such as the American Association of Colleges of Podiatric Medicine, were also reviewed and discussed.

Target Audience. The Committee discussed the target audience in terms of development of appropriate recruitment materials and strategies, and agreed that the target audience should include students at the K-6, 6-12 and 12-16 education levels. It was the opinion of the Committee, based on its members' various experiences, that approximately 25% of students are likely to make a career choice prior to college. Therefore, students interested in the basic sciences should be encouraged early in the education pipeline so that they are adequately prepared to successfully complete undergraduate science courses in preparation for entering dental school. Further, the Committee noted that pediatric dentists, orthodontists and general dentists often play a pivotal role in influencing young students interested in dentistry.

A major problem for young students that may be interested in a career in dentistry is access to information. The Committee agreed that students today want easy access to the facts—quick "sound bites" of information that provide answers to questions such as "How can I become a dentist?", "What courses do I need to take in high school and college?" and "How much can I earn?"

Diversity. The Committee and the Council reaffirmed the intent of the second resolving clause in Resolution 17H that a national campaign to attract students into dentistry must include an effort to attract underrepresented minorities into careers in dentistry. During the discussion, the Committee noted that there are an inadequate number of role models in the underrepresented minority groups. The Committee and the Council believed that the ADA should establish partnerships with the National Dental Association (NDA), the Hispanic Dental Association (HDA), the Society of American Indian Dentists (SAID) and other similar organizations. Combining efforts to develop career resources with input from these organizations will enhance the goals of the campaign and will support the Association's membership recruitment initiatives. Further, the Committee suggested that these same organizations should be invited to review draft copies of the resource materials and provide information relative to their organization's dental recruitment activities. The Council further recommended that an ad hoc committee be constituted for a one-day meeting to consider specific initiatives regarding recruitment of underrepresented minorities into careers in dentistry. A resolution describing the composition of this committee appears at the end of this report.

Part of the Committee's discussion on diversity included information on two major grants that the ADEA has recently received related to recruitment of underrepresented minorities into dentistry. The Robert Wood Johnson Foundation (RWJF) project is intended to assist ten dental schools in the country strengthen their mission in public service to populations in need of oral health care. The second collaborative grant is from the W.K. Kellogg Foundation, a $1 million grant to help increase the number of minority students and faculty members in U.S. dental schools. The Committee learned that for each of the next four years, based on certain eligibility requirements, those dental schools awarded grants will receive funds to distribute to students and faculty as scholarships and financial aid, postdoctoral and fellowship support, or to use for faculty, student and campus development.

Discussion of Development and Implementation of Short-Term Goals (2002):

Collection of Information from Constituents/Components and NAAHP. The Committee believed and the Council agreed that it would be beneficial to request information from constituent dental societies about what they are currently doing to promote careers in dentistry, to learn what kind of resources the constituents think would be the most helpful and to determine what communication method they would prefer the Association use to send them ongoing information about the national campaign (fax, e-mail, Internet, mail). Additionally, the Committee suggested that information be collected to assess how much time constituents are currently devoting to

promoting careers in dentistry and to request that constituents identify a staff person or volunteer who is, or could be assigned to coordinate efforts at the state level. A suggestion was made that state and local dental societies might want to consider using past presidents as mentor coordinators.

At the suggestion of the NAAHP representative, the Committee also directed that a questionnaire be prepared to collect information from NAAHP members at their biennial meeting in June 2002 on how best to collaborate with predental advisors in promoting careers in dentistry. The Committee learned from the NAAHP's representative that the NAAHP's handbook, *Medical Professions Admission Guide—Strategy for Success*, includes a section devoted to the dental profession. The NAAHP has expressed a strong interest in working to increase the number of underrepresented minorities that enter dental school.

Mechanisms for Mentoring and Other Partnerships. The Committee emphasized the importance of students connecting with a dentist mentor at the local level. The Committee noted that the amount of time and effort constituent and component dental societies can spend on recruitment and mentoring will vary from state to state based on interest levels and staff/volunteer resources to support the initiative. Nonetheless, the Committee believed that whatever mechanism for mentoring is established at the constituent/component level, it should be readily accessible and, allow for communicating through e-mail, fax machine or possibly by designating a separate area of the ADA Web site to transmit information.

It was noted that through its Transition Program, the CND works closely with junior and senior dental students as they prepare to enter dental practice. The Committee believed that the CND should consider including information into the Transition Program to encourage these new members of the profession to play an active role in mentoring young students who might be interested in dental careers. The Committee determined that further discussion is needed on development of mechanisms for connecting a student to a mentor and suggested that this topic be included on the agenda for the Committee's next meeting in fall 2002. This would also allow time for the Committee to collect information from constituent dental societies regarding their current activities to attract students into dentistry careers.

The Committee believed it is also essential to work with the American Student Dental Association (ASDA). The Committee noted that ASDA representatives often participate as members on component dental society committees. The Committee believed that these student representatives could serve as potential mentors and continue on in this role following graduation from dental school. The Committee suggested that an ASDA staff member be invited to attend the next meeting of the Oversight Committee to help identify ways to coordinate mentoring and promotional activities, including working with ASDA to establish predental member representatives in colleges and universities.

As noted in a previous section of this report, the Committee recognized the important role pediatric dentists and orthodontists play in a young student's life. Therefore, the Committee suggested that consideration be given to the feasibility of collaborating with the American Association of Orthodontists (AAO) and the American Association of Pediatric Dentists (AAPD) regarding career initiatives. The Committee also believed it would be beneficial to establish a partnership with the National Institute of Dental and Craniofacial Research (NIDCR) for the purpose of obtaining guidance for promoting research careers. The Council supported these collaborative initiatives and suggested that these areas be further explored.

Resource Materials and Promotional Activities. The Committee directed that an updated fact sheet on dental careers be the first priority in the development of resource materials. The dental career facts should be succinct and include information on topics in which today's students are most interested related to a career in dentistry, such as information on predental courses, requirements for admission into dental school and a dentist's earning potential.

Other materials that will be developed in 2002 as part of a multi-media packet include a brochure, poster, and PowerPoint presentation continuing with the theme "Something to Smile About—Careers in the Dental Profession" and containing salient facts on practice and academic/research careers. The packet will include instructions on how to effectively use the materials for different career initiatives at various education levels. Further, the materials will be designed so that they can be customized for constituent/component dental societies and/or member dentists. For example, space would be available on the brochure or poster that could be used to insert a logo or individual name and any other customized information that dental societies and members might want to include.

The Committee discussed several promotional activities that could enable dentistry to compete with other attractive career options. Some of these activities will be designed for implementation at the association level, while others will be targeted for use at the local dental society level. The Committee and the Council supported the following activities:

- Urge individual dentists to purchase the packet of career resource materials for donation to local and/or school libraries; this could also serve as an excellent public relations/marketing tool;
- Place an article(s) in the *ADA News* publicizing individual dentists' successful experiences being good mentors.
- Develop a dedicated Web site area on the public side of ADA.org with information on dental careers describing all facets of dentistry—practice, teaching, research, public health dentistry, etc.;
- Expand examples of student science projects that students and mentors can reference under the career section on ADA.org. The information might include subjects such as tooth bonding, teeth whitening and caries information (the Committee noted that several science projects are currently listed), and establish a link with state science organizations;
- Highlight different lifestyles enjoyed by practicing dentists in rural and urban areas;

- Coordinate promotion of careers in dentistry with activities around Children's Dental Health Month working closely with teachers and counselors.
- Use the NAAHP's electronic forum, HLTHPROF, as a site to discuss issues in dental education with the goal of encouraging advisors to identify appropriate candidates for the dental profession.

Proposed Materials/Activities to be Developed and Implemented as Long-Term Goals: The Committee also discussed future development of other resource materials/activities not currently funded but identified as long-term goals and carefully considered the estimated financial implications.

Career Video. The development of a six to ten-minute video on careers in dentistry was recommended. The Committee noted that a career video has been a valuable tool for an individual member dentist to use at different career events. The Committee learned that frequent requests from member dentists for a career video are made through the Council's Career Guidance area. The value of developing a video was weighed against the estimated financial implication and the Committee concluded that a career video would be an effective promotional tool that could be used in a variety of ways by individual dentists, high school guidance counselors and others. The Committee suggested that a video could also be used in local libraries, and by civic organizations such as local chapters of Boy and Girl Scouts, Boys and Girls Clubs of America, etc. Constituent dental societies could be encouraged to purchase multiple copies of the video and then establish a reasonable loan mechanism for their members and others in the community. If funding for the video is approved, the Interagency Committee could be continued for another year for consultation regarding development of the video. While funding to support another Committee meeting has not been requested, it is anticipated that the Committee could conduct business by conference call. The Committee and the Council strongly supported the development of a video highlighting dental careers including clinical practice, academic dentistry and research.

Tabletop Exhibit. The Committee and the Council also supported development of a tabletop exhibit similar to the one recently developed for allied careers in dental assisting and dental hygiene. The new colorful, lightweight and easily assembled tabletop exhibits promoting dental assisting and dental hygiene careers have been well received and are now being loaned out to constituent and component dental societies and members on a regular basis.

Therefore, the Committee recommended and the Council agreed that funding be requested to support the development of three tabletop exhibits similar to the tabletop exhibits promoting careers in dental assisting and dental hygiene.

Next Steps: The Committee will provide continued guidance as activities and resources are developed. Campaign priorities for 2002 supported by the Committee and the Council include the following:

1. Develop a questionnaire to collect information from constituent dental societies and NAAHP. The questionnaire sent to NAAHP should include a request for information on promoting careers in academic dentistry.
2. Develop resource materials beginning first with creating "quick" facts on dentistry for ADA.org, develop a career brochure, poster, PowerPoint presentation and accompanied narration.
3. Address diversity issues in all resource materials, and contact NDA, SAID and HDA to request information on their recruitment initiatives regarding careers in dentistry; invite these organizations to participate in review of resource materials developed and to serve on an ad hoc committee to consider specific initiatives related to the recruitment of underrepresented minorities into careers in dentistry. Additionally, invite ASDA, ADEA, AAO and AAPD to also serve on the ad hoc committee.
4. Begin to identify other appropriate links for career materials on ADA.org.
5. Develop a proposal for mentoring networks.

Outcomes Measures: Possible outcomes measures that could be used to determine the effectiveness of the national campaign were discussed. These will be further discussed at the Committee's next meeting in September.

Summary: This report describes the activities that are being undertaken to implement a national campaign to attract students into careers in dentistry in response to Resolution 17H-2001. Funding to support implementation of the long-term goals was requested as a decision package in the CDEL's 2003 budget. This funding will support the initiatives planned for 2003.

Joint Commission on National Dental Examinations

Young, Stephen K., Oklahoma, 2003, chairman, American Dental Education Association
Stamatelakys, Constantine, Wisconsin, 2002, vice chairman, American Dental Association
Awadalla, Eleanore, Ohio, 2005, American Association of Dental Examiners
Berwind, John M., Washington, 2003, American Association of Dental Examiners
Dorvinen, Harry, Minnesota, 2002, American Association of Dental Examiners
Higgins, Michael S., Illinois, 2005, American Dental Association
Hindin, Allen, Connecticut, 2003, American Dental Association
Hobbs, Evelyn, Arizona, 2002, American Dental Hygienists' Association
Holcomb, Stephan F., Georgia, 2004, American Association of Dental Examiners
Kramkowski, Tom, Colorado, 2002, American Student Dental Association
MacNeil, R. Lamont, Connecticut, 2005, American Dental Education Association
Sandoval, Victor, Texas, 2004, American Dental Education Association
Small, Stanley A., New York, 2004, American Association of Dental Examiners
Winder, Ronald L., Oklahoma, 2005, American Association of Dental Examiners
Wood, Martha, Connecticut, 2002, Public Member
Foertsch, Mary A., 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 ADA Strategic Plan by furthering the Association's commitment to quality dental care; promoting excellence and consistency in the education and evaluation of the dental team members; providing uniform written licensure examinations; and 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 20, 2002. 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 March 19, 2002. The fourth standing committee of the Joint Commission, the Committee on Research and Development, met February 8, 2002.

The Annual National Dental Examiners' Advisory Forum, sponsored by the Joint Commission, met in Chicago on the morning of March 19, 2002. Approximately 150 state board representatives and dental educators from more than 40 states attended the Forum. The program addressed various issues related to the National Board Examinations: revision of Parts I and II Test Specifications; changing the structure of Part I; conducting a validity study for the National Board Dental Hygiene Examination; and computerization of Part I and Dental Hygiene National Board Examinations.

Twenty-six meetings of test development committees were held at the Headquarters Building during the year to develop new editions of National Board Dental and Dental Hygiene Examinations.

Acknowledgments: The Joint Commission acknowledges with appreciation the contributions made by Dr. Harry Dorvinen, Dr. Constantine Stamatelakys, Dr. Martha Wood, Ms. Evelyn Hobbs and Mr. Tom Kramkowski who complete their terms on the Joint Commission this year.

Trends in the Number of Test Candidates and Pass Rates:

National Board Dental Examinations, Part I. The number of Part I candidates in 2001 was the highest in the past ten years. The number of candidates from accredited dental schools (4,663) decreased minimally, compared with the previous year, while candidates who graduated from nonaccredited dental schools (5,337) increased by 31%. Performance of Part I candidates from accredited schools, which was fairly stable from 1992-2001 with pass rates of 84-90%, continued to remain stable in 2001 with an overall pass rate of 90%. Performance of Part I candidates from nonaccredited dental schools has improved slightly from an overall pass rate of 35% in 2000 to 36% in 2001.

National Board Dental Examinations, Part II. The number of 2001 Part II candidates from accredited dental schools (4,692) declined by less than 1% from the previous year. The overall Part II performance of candidates from accredited dental schools improved compared with the previous year, with a pass rate of 90%. The number of candidates from nonaccredited dental schools was the highest in the past ten years (2,129). Performance of Part II candidates from nonaccredited dental schools has improved in 2001 compared with the pass rates of the past four years, with rates between 42% and 61%. Analyses of the performance of candidates on the computerized and printed/written Part II suggest that the format of the examination does not affect performance.

National Board Dental Hygiene Examination. The numbers of candidates taking the dental hygiene examination in 2001 reached a ten-year high (6,542). Performance on this examination (89% pass rate), increased slightly from the passing rate (86%) in 2000.

Pass Rates of Repeating Candidates. As in the past, candidates who failed the examination in 2001 and chose to repeat the examinations had pass rates significantly lower than those of first-time candidates. Part I candidates from accredited dental schools who were taking the examination for the first time had a pass rate of 92%, while repeating candidates had a pass rate of only 67%. Part II candidates from accredited schools who were taking the examinations for the first time had a pass rate of 94%, while repeating candidates had a pass rate of only 65%.

Graduates of nonaccredited dental schools who were taking Part I for the first time in 2001 had a pass rate of 43%, while repeating candidates from nonaccredited schools had a pass rate of only 29%. Part II candidates from nonaccredited programs who were taking the examination for the first time had a pass rate of 72%, while candidates from nonaccredited schools who were repeating the examination had a pass rate of only 40%. Repeating dental hygiene candidates from accredited programs had pass rates significantly lower than first-time candidates. In 2001, the repeating dental hygiene candidates had a pass rate of only 51%, while the pass rate for first-time candidates was 94%.

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 65 dental test constructors and 22 dental hygiene test constructors to another one-year term and selected 9 new dental test constructors.

Research and Development Program:

Technical Report. The Department of Testing Services performs routine research studies on the National Board Examinations each year. The examinations are monitored to maintain standards of validity and reliability, as reported in the *2002 Technical Report*. The Joint Commission, recognizing the importance of publishing a technical report that contains a complete description of the validity evidence in support of the use of the examinations in the licensure process, wants the *Report* to be disseminated as widely as possible, which includes placing it on the ADA Web site.

Format of Part I Examination. During 2001, the Joint Commission addressed the concern that Part I of the National Board Dental Examination contained a high percentage of items that were at a recall level by deciding to include a greater proportion of items requiring reasoning and application level cognitive behavior. To achieve this, the Joint Commission supported the development of a comprehensive Part I examination that would include interdisciplinary testlets involving key feature items. In order to evaluate the validity of a restructured Part I examination, a pilot will be developed and administered during the spring or summer of 2003.

Future of National Board Examinations. At its annual meeting in March of 2001, the Joint Commission on National Dental Examinations directed that a task force explore the future of the National Board Examinations and provide recommendations to the Committee on Research and Development regarding the development of a long-range plan for the next generation of National Board examinations and information on other potential approaches to testing. This task force met on October 26-27, 2001 and provided a report to the Committee on Research and Development including recommendations for making items more clinically relevant and for expanding the computerization of examinations.

Revision of Test Specifications for Part I and Part II. The Joint Commission approved the Part I Biochemistry-Physiology and Microbiology-Pathology Test Construction Committees' recommended minor revisions. For biochemistry-physiology, the changes reflect an increased emphasis in the areas of metabolism, molecular and cellular biology, and renal with a decreased emphasis on the nervous system. Additionally, a new section, Oral Physiology, was added to the specification outline. For the microbiology-pathology test specifications, a new area, Hemodynamic Disorders, was added.

Categories of Test Items. The Commission reviewed a report on the distribution of test items on the 2000 dental examinations. The Commission noted that the test construction committees continue to incorporate clinical applications in the Part I item construction process, as well as a multidisciplinary approach (basic and clinical) in the Part II item development. However, clear delineation of the items by discipline and cognitive level is at times challenging.

National Board Dental Hygiene Validity Study. The Joint Commission approved a set of competencies based upon the Accreditation Standards for Dental Hygiene Education Programs and American Dental Education Association competencies for entry into the profession of dental hygiene. These competencies are a part of the practice analysis being conducted to provide validity evidence supporting the use of scores from the dental hygiene examination in the licensure process.

Discontinuation of Support for the Dental Interactive Simulations Corporation (DISC). At its March 2002 meeting, the Joint Commission voted to withdraw financial support for the research and development of the DISC interactive computerized patient simulations for testing, effective immediately. However, the Joint Commission will continue to collect fees from each Part I and Part II candidate and from each dental hygiene candidate through the 2002 exam cycles for the purpose of outsourcing appropriate research projects

and establishing a research agenda for small grants to encourage innovations in the Joint Commission testing programs.

Computerization of Part I of the National Board Dental Examination. The Joint Commission determined that it should proceed with the computerization of Part I of the National Board Dental Examination before the end of 2002. A computerized Part I would provide candidates an opportunity to test at a time other than a regular test date. The Joint Commission decided that a minimum of 90 days must separate a candidate's re-examination on Part I and that a candidate cannot take the computerized version of Part I more than twice in any one calendar year.

Computerization of National Board Dental Hygiene Examination. The Joint Commission voted to continue administering a written National Board Dental Hygiene Examination and to also deliver the examination on the computer network of an appropriate vendor.

Update on Examination Eligibility Requirements. The Joint Commission also received a report on examination eligibility requirements of graduates of dental and dental hygiene programs from a special committee appointed in 2001 to address this issue. The committee surveyed state boards regarding their satisfaction with current eligibility requirements and concluded that no changes should be made at this time. The Joint Commission resolved to keep the present policy in place.

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 several dental organizations in developing new examinations, revising test specifications, and reviewing examination quality. This support was provided to 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.

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

Division of Finance

Council on Insurance

Notes

Council on Insurance

Trager, Peter S., Georgia, 2002, chairman
Cubbon, H. Todd, Illinois, 2003, vice chairman
Bethea, Robert P., South Carolina, 2005
Colton, Harris N., New Jersey, 2004
Comar, Terence R., Michigan, 2002
Feldman, Joel T., New York, 2004
Haag, Russell E., California, 2003
Haas, David G., Ohio, 2002
Hart, Robert S., Florida, 2004
Hauer, Michael, Arizona, 2005
Kolb, Ronald G., North Dakota, 2002
Limestall, James D., Oklahoma, 2003
Nally, William D., Tennessee, 2003
Petersen, David, Washington, 2004
Shapiro, Denise M., Rhode Island, 2005
Stainbrook, Robert D., Pennsylvania, 2004
Stewart, Debra G., Texas, 2005
Dwyer, David R., director

Meetings: The Council met at the Headquarters Building on August 24-25, 2001 and March 22-23, 2002. It is scheduled to meet again August 23-24, 2002.

Vice Chairman: Dr. Todd Cubbon was elected vice chairman of the Council.

Personnel: The Council acknowledges with appreciation the many significant contributions made by those members who will complete their terms in 2002: Dr. Terence Comar, Dr. David Haas, Dr. Ronald Kolb and Dr. Peter Trager. The success of the Association-sponsored insurance and retirement programs is due in no small part to the sound judgment and thoughtful leadership of these members.

The Strategic Plan of the American Dental Association: The Council supports the Strategic Plan's goal of providing dentists with resources to maximize their clinical practice and management skills and personal well-being. It does this by offering competitively priced insurance and retirement programs designed to meet the particular needs of dentists and their families. The Council is also helping dentists become more knowledgeable consumers of professional liability insurance by making available directories of insurance companies selling coverage in each state and offering information that helps dentists better understand their policies. In the professional liability section of www.ada.org, the Council maintains a library of articles that can help dentists improve their ability to defend themselves against unfounded allegations of malpractice as well as to cope with the experience of being sued. Because each of these programs and services is available exclusively to Association members, they support the Strategic Plan's objective of achieving at least 75% membership market share by year-end 2005.

At its March 2002 meeting, the Council reviewed membership utilization of its major programs and activities. Even though the member insurance and retirement programs have an excellent record of value and periodic enhancement, they are experiencing low or negative rates of growth. The Council attributes this problem to adverse trends in the Association's membership, especially among young dentists who are the prime market for the insurance programs. To reinvigorate growth in the insurance and retirement programs, the Council has intensified marketing and awareness-building initiatives, as well as improved related content areas on www.ada.org.

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 available in the market. The programs are marketed without the use of agents and are experience rated. They are sponsored by the Association on a not-for-profit basis. 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, 2001, approximately $26 billion of insurance was in force under the Program.

At year-end, 61,588 member dentists were participating in the Term Life Plan and the average amount of coverage carried per member was approximately $361,773. In addition, 21,731 members were insuring their spouse and 10,008 were insuring their eligible, dependent children.

A total of 4,943 undergraduate student members were participating in the Noncontributory Life Insurance Plan for Dental Students. 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 2001, approximately 42% of the Student Plan participants who graduated in 2000 elected to continue coverage under the ADA Term Life Plan on a premium-paying basis.

The Term Plus Insurance Plan had 2,228 participants as of December 31, 2001 and the average amount of coverage in force was $314,161. The Plan combines life insurance with a tax-advantaged savings account. Participants may make premium contributions that exceed the cost of the life insurance and $50/year administrative fee. 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 $6 million to their cash accumulation accounts in 2001, raising the Plan's total invested assets to over $45.6 million.

Benefits totaling approximately $36.8 million were paid to the beneficiaries of the 364 Life Insurance Program participants who died during 2001. The deceased included 338 member dentists, three student members, 18 spouses and five children.

Based upon the financial experience of the Life Insurance Program in 2001, a premium credit of 40% is being applied to reduce the participants' coverage costs in 2002. This compares to a credit of 46% in the prior year.

Income Protection Plan: As of December 31, 2001, 20,302 members were participating in the Income Protection Plan. During the year, approximately $23.8 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 Association-sponsored 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.

Improving Financial Experience. In the 1990s, it had become apparent that the premium structure of the Income Protection Plan was insufficient to support the cost of benefit enhancements introduced during the 1980s. As a consequence, premiums were increased by 25% on May 1, 1997 and May 1, 1998. The Council is pleased to report that these premium increases have restored the Plan's financial stability and no further premium increases are anticipated.

Student Disability Insurance Plan. The Student Disability Insurance Plan offers a choice of either a $1,000 or $2,000 monthly benefit, 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 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. 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 retirement from active practice.

Despite intensive advertising and promotional efforts, it has been difficult to increase participation in the Student Disability Insurance Plan. During 2001, enrollment remained almost unchanged at 484. As most dental students have no access to disability insurance and as the Association's Plan offers coverage at very low cost, the Council attributes the difficulty in increasing enrollment to the financial challenges facing dental students.

MedCash Insurance Plan: The MedCash Insurance Plan offers coverage that supplements primary health insurance policies by offering benefits that are intended to help pay the costs of hospitalization and recovery. The Plan provides up to $500 a day for hospital stays and outpatient surgery. Critical condition benefits of up to $50,000 can be paid when an insured person is diagnosed with one of 17 medical problems, such as stroke, heart attack, AIDS, life threatening cancer, etc.

As of December 31, 2001, there were 6,917 members insured under the MedCash Plan. Also insured were 3,555 member spouses, including 99 who are widowed, and 2,625 children. During 2001, $1,260,600 in benefits were paid to participants.

Based on the favorable financial experience of the MedCash Plan, the premiums were reduced by a 45% credit during 2001.

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, 2001, participation in the Office Overhead Expense Plan declined slightly to a total of 8,961 members. During the year, $3,133,431 in benefits was paid to disabled participants. As a result of the Plan's favorable

financial experience, premiums were reduced by a 35% credit on the February 1, 2001 renewal and by a 37% credit on the August 1, 2001 renewal. Based upon 2001 year-end financial results, a 40% credit was applied to reduce the February 1, 2002 premium renewal.

Coverage and Benefit Changes. Effective February 1, 2003, the coverage provided by the Office Overhead Expense Insurance Plan will be significantly improved. An analysis of other policies available in the market showed the Association-sponsored Plan was probably the lowest in cost, but that there were opportunities to improve its benefits. The Great-West Life & Annuity Insurance Company presented a conceptual proposal for restructuring the Plan to the Council at its August 2001 meeting. The Council recommended a number of changes and a revised proposal was accepted at the Council's March 2002 meeting and reported to the ADA Board of Trustees at its April 2002 meeting.

The restructured Plan will provide participants with expanded coverage that will necessitate a reduction in the magnitude of the premium credits that have been granted in recent years. However, even with the anticipated reductions in the premium credits, the ADA-sponsored Plan will still be among the most competitively priced policies on the market. The major changes to the Plan's benefit and price structure are as follows:

- A residual disability benefit will replace the current benefit for partial disability. Unlike the current benefit, the residual benefit will not require a qualifying period of prior total disability. It will be payable for up to 24 months as compared to three months for the current benefit. It will provide reimbursement as high as 100% of the maximum monthly benefit selected by the insured member as compared to 50% for the current benefit.
- A new Salary Replacement Benefit will provide the insured member with income to help pay the salary for a dentist that is hired on a temporary basis to maintain the practice until the insured can return to work.
- Participants will be given the option to reduce premiums by 20% by selecting a 12-month benefit payment period in lieu of the current 24-month benefit payment period. For both benefit payment period options, if at the time of claim, the insured member receives benefit payments that are less than the maximum amount available for the coverage s/he has selected, the excess coverage may be used to extend the maximum benefit payment period for up to four years.
- The current 15-day elimination period will be discontinued and all participants will be reissued coverage with a 30-day elimination period. However, the longer elimination period will be offset by a liberalization in the way it may be satisfied. Under the restructured plan, the elimination period may be satisfied with days of partial disability as well as total disability; and it will no longer be required that the days of disability be consecutive.
- The maximum monthly benefit available under the Plan will be increased from $15,000 to $25,000.
- The coverage enhancements will increase the net premiums paid by participants currently having the 30-day waiting period option from 23% to 32%, depending upon age, assuming the Plan's premium credit remains at 40%. For the approximate 22% of the participants who currently have the 15-day waiting period, the impact upon net premiums will vary from a reduction of 6% to an increase as high as 11%, assuming the premium credit remains at 40%.

The Council believes the restructuring of the Office Overhead Expense Plan will greatly improve the quality of coverage held by participating members while maintaining the Plan's position as one of the lowest cost policies available on the market.

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 2001, 7,531 members were participating in the ADA Members Retirement Program. Their retirement plans covered a total of 27,252 individuals and held assets totaling $1,218,793,925.

The Program offers a choice of plans that have been pre-approved by the Internal Revenue Service and designed especially for dentists, as well as full record keeping and tax reporting services. The master plans include pension, profit sharing, and 401(k) plans, including "Simple 401(k)" and "Safe Harbor 401(k)" arrangements. The master plans are maintained by the Equitable Life Assurance Society of the United States. The Company also serves as custodian 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 as such, under New York law, are protected from the claims of the Company's creditors and other policyholders.

Participants and their employees have a choice of 11 investment funds and accounts. These investment options are also available to members who are not participating in the Program but who wish to use them for the investment of individually designed tax qualified retirement plans. As Trustees of the Program, the Council selects the investment options with the goal of 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, 2001, the participants' assets were invested as follows:

Money Market Guarantee Account. Participants allocated 26% of their funds, or $319.2 million, to the Money Market Guarantee Account. It offers a guarantee of principal and yields comparable to those of money market funds that change monthly.

Three-year and Five-year Guaranteed Rate Accounts. Participants allocated 8% of their funds, or $97.3 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. The GRA deposits at year-end were as follows:

Dates of Issuance	**Insurance Company**	**Account Value as of December 31, 2001**
July 31, 1996 – July 30, 1997	Principal Mutual	$6,191,048
July 31, 1997 – July 29, 1998	Metropolitan Life	$8,627,196
July 29, 1998 – July 27, 1999	John Hancock	$14,122,469
July 28, 1999 – July 25, 2000	Metropolitan Life	$35,963,790
July 26, 2000 – July 24, 2001	Principal Mutual	$23,488,640
July 26, 2001 – July 23, 2002	Principal Mutual	$8,857,870

The participants deposited the remaining 65.8% 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	$278.8 million (22.9%)
Aggressive Equity	$148.3 million (12.2%)
Equity Index	$141.2 million (11.6%)
Foreign	$ 68.7 million (5.6%)
Lifecycle Conservative	$ 11.9 million (1.0%)
Lifecycle Moderate	$106.4 million (8.7%)
Equity Income	$ 14.7 million (1.2%)
Large Cap Growth	$ 22.2 million (1.8%)
Real Estate	$ 10.1 million (0.8%)
Total	$802.3 million (65.8%)

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, rates of return shown are after deduction of investment management fees but before deduction of Program expense charges.

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 2001, the Account's unit value decreased 18%, as compared to a 11.9% decrease in the Standard & Poor's 500 Stock Index (S&P 500) and a 19.6% decrease in the Russell 3000 Growth Index. For the five-year period ending December 31, 2001, the Fund's unit value increased by an annual average of 3.1% as compared to average annual increases of 10.7% in the S&P 500 and 7.7% in the Russell 3000 Growth Index.

ADA Aggressive Equity Fund. The Aggressive Equity Fund is entirely invested in shares of the Massachusetts Financial Services (MFS) Emerging Growth Fund. This Fund invests in companies that are expected to have a greater than average rate of growth. For calendar year 2001, the Aggressive Equity Fund's unit value decreased by 25.8%. This compares to a 19.6% decrease in the Russell 3000 Growth Index. Over the five-year period ending December 31, 2001, the Fund's unit value increased by an annual average of 4.5% as compared to an average annual increase of 7.7% in the Russell 3000 Growth Index.

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. This Fund invests in a portfolio of common stocks that is intended to track the performance of the S&P 500. During 2001, the Equity Index Fund's unit value decreased 12.1%, as compared to an 11.9% decrease in the S&P 500. Over the five-year period ending December 31, 2001, the Fund's unit value increased by an annual average of 10.5% as compared to an average annual increase of 10.7% in the S&P 500.

ADA Equity Income Fund. The Equity Income Fund was introduced as an investment option in July 1999. It is entirely invested in shares of the Putnam Equity Income Fund. The Putnam Fund invests primarily in stocks of large companies that have a higher dividend yield, lower price to book ratio and lower price to earnings ratio than the overall market. During 2001, the Equity Income Fund's unit value decreased 1.6% as compared to an 11% decrease in the S&P 500.

ADA Large Cap Growth Fund. The Large Cap Growth Fund was introduced as an investment option in October 1999. It is entirely invested in shares of the Invesco Growth Fund, which holds stocks of large companies that are expected to appreciate in value at a rate greater than that of the overall market. During 2001, Large Cap Growth Fund's unit value decreased by 49.1% as compared to an 11.9% decrease 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 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, Australian 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, 2001, the value of a unit of investment in the Lifecycle Fund Moderate declined 4.4%. For the five-year period ending December 31, 2001, the Fund's unit value increased by an annual average of .7%.

For the calendar year ending December 31, 2001, the value of a unit of investment in the Lifecycle Fund Conservative increased 1%. For the five-year period ending December 31, 2001, the Fund's unit value increased by an annual average of 6.8%.

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 82 properties having a value of approximately $1.9 billion. For the 2001 calendar year, the Real Estate Fund's unit value increased by 2.6%, as compared to a 7.3% increase in the National Council of Real Estate Investment Fiduciaries (NCREIF) Index. For the five-year period ending December 31, 2001, the Prime Property Fund's unit value increased by an annual average of 12.8% as compared to an annual average return of 13.6% for the NCREIF 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 2001 calendar year, the Foreign Fund's unit value decreased by 7.9% as compared to a 21.2% decrease in the Morgan Stanley Capital International European Australian and Far Eastern Stock Index (EAFE). For the 5-year period ending December 31, 2001, the Foreign Fund's unit value increased by an annual average of 4.6% as compared to a 1.2% average annual increase in the EAFE Index.

New Investment Funds. At its March 2002 meeting, the Council selected two mutual funds to be offered as investment options for the Members Retirement Program. The new investment options, to be available to the Program's participants in the summer of 2002 are as follows.

The *ADA Bond Fund* will invest 100% of its assets in shares of the Western Core Asset Fund, managed by the Western Asset Management Company, a wholly owned subsidiary of the Legg Mason Corporation. The Fund will offer participants the ability to invest in an intermediate term bond portfolio, which holds primarily investment grade debt. The Western Core Asset Fund had its inception in 1990 and currently has $630 million in assets. On average, its portfolio is rated AA, has a duration of 5.8 years and is currently yielding 5.7%. For the one-year period ending December 31, 2001, the Fund produced a return, after deduction of investment management fees, of 10.1% as compared to an 8.4% return for the Lehman Brothers Aggregate Bond Market Index. For the five-year period ending December 31, 2001, the Fund produced an average annual return, after deduction of investment management fees, of 7.9% as compared an average annual return of 7.4% for the Lehman Brothers Index. The Fund currently has a five-star rating by Morningstar.

The *ADA Small Cap Fund* will invest 100% of its assets in shares of the Strong Advisor Small Cap Value Fund, managed by Strong Capital Management. It will offer participants the ability to invest in the stocks of primarily small companies, which the portfolio managers believe to be undervalued. The Strong Fund's stock selection process uses quantitative screening with fundamental analysis to find companies that are generally under-followed by the market and have unrecognized catalysts for future growth. The Fund holds stocks of companies that have a total market capitalization ranging from $100 million to $2 billion. The Fund had its inception in 1997 and currently has approximately $1.1 billion in assets. For the one-year period ending December 31, 2001, the Fund produced a return, after deduction of investment management fees, of 18% as compared to a 2.5% return for the Russell 2000 Stock Index. For the three-year period ending December 31, 2001, the Fund produced an average annual return, after deduction of investment management fees, of 24.1% as compared to an average annual return of 6.4% for the Russell 2000 Stock Index. The Fund currently has a five-star rating by Morningstar.

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 nine funds managed by 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 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 in one- or three-year guaranteed rate accounts that

are invested with Equitable in its general account. Two additional funds were added to the Program on May 18, 2001. They include the Alliance Technology Fund and the AXP New Dimensions Fund.

As of December 31, 2001, there were 1,537 participants in the ADA-endorsed IRA. The total value of their investments was $91.3 million. These funds were allocated among the investment options as shown in the chart below. The chart also shows the reported changes in the unit values for the funds for the 2001 calendar year, net of fees and expenses. These returns assume that deposits were invested for the entire year and are not an indication of future performance.

Investment Option	**Percentage of Total Assets**	**Annualized Rate of Return for Year 2001**
Guaranteed Rate Accounts	4.6%	Variable
Money Market Fund	11.6%	3.4%
Common Stock Fund	%	-10.9%
Government Securities Fund	1%	7.4%
Balanced Fund	2.7%	-2.5%
High Yield Fund	.6%	.6%
Aggressive Stock Fund	3.6%	-26.2%
Global Fund	3.9%	-20.7%
Growth Investors Fund	1.9%	-13%
Growth & Income Fund	5.8%	-1.7%
Bankers Trust Equity Index Fund	.9%	-12.7%
Lazard Small Cap Value Fund	.03%	17.2%
MFS Emerging Growth Fund	2.4%	-34.4%
T. Rowe Price International Stock Fund	.3%	-22.2%

Activities Relating to Professional Liability Insurance

Trends in Dental Professional Liability: Each year, the Council meets with professional liability insurance companies for the purpose of obtaining information on the incidence, severity and causes of dental malpractice allegations as well as conditions in the professional liability insurance market.

At its March 2002 meeting, the Council met with representatives of two long-standing dental professional liability insurance programs. It met for the first time with the Redwoods Group and its sponsor, the National Society of Dental Practitioners (NSDP), a non-profit organization formed in 1986 to provide dental professional liability insurance and a program of risk management. The Redwoods Group Program is currently insured by the Connecticut Indemnity Insurance Company. The Council also met with the CNA Insurance Companies, which underwrites professional liability insurance offered through the Professional Protector Plan managed by Brown & Brown, Inc.

In past years, the Council has met with the American Association of Orthodontists Insurance Company, Cincinnati Insurance Company, Dentists Advantage Program (Fireman's Fund Insurance Company) Eastern Dentists Insurance Company, Frontier Insurance Company, Medical Protective Insurance Company, ProNational Insurance Company, Safeco Insurance Company and The Dentists Insurance Company.

Based upon the information provided by these insurance companies, the Council does not believe there are malpractice claim trends in dentistry that are likely to produce increases in the cost of coverage of the magnitude currently being faced by many physicians and hospitals. However, there are indications that loss trends may result in smaller premium increases for dentists, the magnitude of which will vary geographically. Among dentists, the Council anticipates that oral surgeons will experience larger premium increases than other specialists and general practitioners. Although loss trends among dentists generally appear stable, many insurers have been foregoing needed premium increases in recent years due to extremely competitive market conditions. However, as a result of conditions in the financial markets, insurers may no longer be able to avoid increasing premiums as they are less able to subsidize underwriting losses with investment income on reserves. In some cases, insurers may also need premium increases to cover losses they have incurred on other property/casualty product lines.

In the past year, there have been major changes in the market for professional liability insurance. These changes have been largely driven by the insurance companies' experience with physician malpractice insurance. A number of long term underwriters of professional liability insurance, most notably the St. Paul Insurance Company and the Safeco Insurance Company, have elected to withdraw from the market altogether. Both companies insured sizeable numbers of dentists. Other withdrawals from the dental market include the Frontier Insurance Company, Reliance Insurance Company, Gulf Insurance Company and the AIG Insurance Company.

Despite the withdrawal of some insurers, conditions in the dental professional liability insurance markets are still very competitive with a number of insurers expanding their business into additional states. In all areas of the country, dentists able to meet reasonable underwriting criteria have a choice of insurers. For this reason, the Council recommends that dentists who receive premium increases they believe are unreasonable, should not hesitate to investigate alternative policies. This can be easily done using the lists of professional liability insurers for each state, which the Council maintains for ADA members on www.ada.org.

Professional Liability Risk Management Seminar: As part of its effort to assist dentists in reducing 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 2001 scientific program was developed and presented by The Dentists Advantage Program. Titled "You be the judge!," the seminar was a mock trial designed to highlight areas of practice management including informed consent, record keeping, referrals, proper diagnosis

and post operative care. The seminar was well attended and received a very favorable audience evaluation. For their efforts in making the 2001 seminar a success, the Council wishes to acknowledge with appreciation John S. Davis, D.D.S., J.D., John C. Versnel, III, J.D., Patrick McCarthy, J.D., Mr. Mark Buzcko, vice president, Mr. Steven Little, assistant vice president, and Ms. Gina Rogers, risk management coordinator, Dentists Advantage Program.

As a result of the success of the 2001 seminar, the Council on ADA Sessions and International Programs has granted permission for another risk management seminar during the 2002 scientific session. The 2002 seminar will be developed and presented as a joint effort of the CNA Insurance Companies, the Redwoods Group and the National Society of Dental Practitioners.

Response to Assignments from the 2001 House of Delegates

Study of Bylaws Duties: Resolution 6H-2000 (*Trans*.2000:433) called for the Council on Insurance to study its *Bylaws* duties and report to the 2001 House of Delegates. The 2001 House of Delegates was advised by President Anderton that the Board of Trustees and the Council had agreed to continue this study during 2002 and that a report on its findings would be reported to the 2002 House of Delegates.

At its February 2002 meeting, the Board adopted the following Resolution B-24-2002:

> **Resolved,** that in the case of all Association-sponsored insurance programs, the ADA Board of Trustees, with the advice and recommendations of the Council on Insurance, shall make and be responsible for those decisions affecting a change in a program or plan that involves five percent (5%) or more of that plan's then total assets, or that the Board of Trustees has specifically established should be a decision of the Board and for all changes to any Great-West administrative agreement, and be it further
>
> **Resolved,** that where it is unclear that a particular decision involving an Association-sponsored insurance program is to be made by the ADA Board of Trustees under the foregoing guidelines, the Council on Insurance shall make a recommendation to the Board and the Board shall determine whether it or the Council on Insurance should make the particular decision involving the program, and be it further
>
> **Resolved,** that the Council on Insurance shall report to the ADA Board of Trustees no less frequently than semi-annually all financial reimbursements made by insurance carriers under Association-sponsored insurance programs as well as on its activities generally with respect to those programs.

The Council is supportive of the Board's action and agrees that it clarifies the Council's duties with respect to the members insurance programs. The Council further believes that the *Bylaws* accurately describe its duties and responsibilities with respect to the ADA Members Retirement Program, professional liability and other insurance programs and assisting the constituent dental societies.

Study of Constituent and Component Society Methods of Providing Health Insurance: Resolution 1H-2001 (*Trans.*2001:406) called for a study of the methods used by the constituent and component dental societies to provide health insurance for their members. Although health insurance encompasses a broad range of coverage, the Council on Insurance assumes major medical insurance is the focus of this resolution.

Major medical insurance services are provided almost entirely by the constituent dental societies. Few component societies offer such services. The American Dental Association has never sponsored a major medical insurance plan, but it did offer a group excess major medical plan between 1973 and 1985. Currently, the Association offers the MedCash Insurance Plan, which provides hospital indemnity and critical conditions benefits to supplement the members' major medical coverage.

Although Resolution 1H-2001 calls for a study of the methods by which health insurance is provided, in this report, the Council has also elected to comment on the broader matter of conditions in the major medical insurance market.

Methods of Providing Health Insurance. The Council contacted 51 constituent dental societies or their endorsed insurance brokers to determine the method by which they provide health insurance for their members.

There are 15 constituent societies that do not sponsor or endorse any form of medical insurance or brokerage services for their members. The majority, 31 constituent societies, endorse brokerage services or insurance companies which assist members in purchasing policies that are issued on a individual (member plus dependents) or small-group (member, dependents and employees and their dependents) basis. In some states, a choice of companies may be offered. Of the 31 constituent societies that provide health insurance in this way, 16 are using insurance brokerages that are for-profit subsidiaries of the society.

The Council believes there are only three constituent societies that sponsor traditional group plans in which participating members are insured under a single master insurance policy that is experience-rated. There are two constituent societies that sponsor group plans that are self-insured.

Association Group Medical Insurance Market. The Council observes that the current practices of constituent societies with respect to providing health insurance for their members is significantly different than in past years. Previously, many societies offered a master policy under which premiums were usually determined by the claim experience of the participants in the dental society's group combined with the claim experience of other similar groups underwritten by the insuring company.

Over time, the cost of coverage offered through many of these dental society plans rose to levels that some dentists viewed as being non-competitive. One possible explanation is that the utilization of health care services by dentists may be different from that of the general population. Although no studies have been made, dentists and their families may have

higher rates of utilization of health care since they are more knowledgeable about disease patterns, treatment possibilities and therapies. If so, premium levels for group plans comprised of dentists could rise to levels higher than those of the general population.

Whatever the cause, once a dental society's plan's premiums rise to levels where non-group policies become an attractive alternative for members who are in good health, adverse selection begins to occur. A plan suffering from adverse selection insures an ever-rising proportion of individuals who have a greater than average incidence and severity of claims. As the claims of these individuals impact loss ratios, premiums must be increased, thus motivating individuals or dental office groups that do not have health problems to investigate coverage alternatives. Eventually, the society's plan becomes the coverage of last resort for members who, because of pre-existing medical problems, are either not able to obtain other policies or would face even higher premiums in the general market.

Adverse selection affects group plans in which the insured persons pay for the costs of their insurance themselves and where they have access to and the propensity for considering other policies available in the general market. By comparison, adverse selection is generally not a significant problem for large employer group plans, especially if premiums are partially or fully paid by the employer.

The difficulties adverse selection present to associations trying to manage group medical insurance plans has been exacerbated by the 1996 Health Insurance Portability and Accountability Act (HIPAA). This legislation prevents group insurance plans from declining or substantially limiting coverage to individuals having pre-existing conditions and who were previously insured through another group plan. In some states, the HIPAA laws have been applied to individual policies (i.e., "groups of one").

Proposed Federal Legislation. The Council is aware that legislation has been introduced in Congress that would allow association-sponsored medical insurance plans offered on a multi-state basis to be exempt from certain state laws and coverage mandates. In May 2001, Representative Ernie Fletcher (R-KY) sponsored association health plans legislation in the House of Representatives (H.R. 1774) and Senator Hutchinson introduced a companion bill in the Senate (S. 858). The Council is advised that this legislation would exempt association health plans from benefit requirements mandated by states and provide for greater flexibility in establishing rates for plans that are formed to cover association members on a multi-state basis.

The Council believes this legislation would provide association-sponsored plans with some of the advantages of employer group plans. To the degree it would allow association-sponsored plans greater latitude in coverage design and rate making, it could improve their competitiveness versus the individual policy market. The competitive advantages could come from lower claim costs as well as administrative and marketing efficiencies resulting from the standardization of coverage among insured persons in different states. Although most constituent societies have now elected to discontinue sponsoring traditional group plans, there may be other non-employer groups, such as small business group associations that might benefit from this legislation. The Council is advised that coalitions have been formed to support this legislation and believes the Association should investigate these coalitions.

The Council is concerned, however, that association group plans still need to address the issue of adverse selection. No matter how carefully designed or how large they may be, group plans in which enrollment is largely voluntary cannot finance the cost of medical care for large numbers of individuals who have significant health problems. Unless there is some way of maintaining an adequate ratio of low-risk and high-risk insured persons in the group, claims experience will eventually drive premiums to levels that exceed the cost of non-group policies. The only way of controlling such adverse selection is to adopt stringent underwriting and premium surcharges for high-risk persons to the extent they are permitted by law. Unfortunately, such underwriting requirements and surcharges defeat the need for an association plan since it would then have the same characteristics of the policies already available in the market.

The "Uninsurable" Member. The majority of dental societies are now directing their members to brokers who assist them in purchasing either individual or small group policies. The Council believes such brokerage services can offer dentists a wider array of coverage choices than is possible under traditional group insurance arrangements. However, these services cannot always assist the member who must insure individuals having impaired health. Depending upon state laws, such members may not be able to obtain coverage or may face substantially higher premiums.

In some states, members who are themselves or have family members who are considered uninsurable, may find it impossible to obtain medical insurance at any price. If these individuals were not previously insured under a group policy, they may not be eligible for the guaranteed coverage provisions of HIPAA. Depending upon their state's laws, they may not be able to obtain insurance from any commercial insurance company and a high risk health insurance pool may be the only alternative.

High-risk health insurance pools have been introduced in 29 states[1] to provide major medical insurance to uninsurable individuals. The coverage they offer is subsidized by premium

taxes on other health insurance policies sold in the state and/or the state's taxpayers. Usually, the premiums they charge are capped at 150% of comparable policies generally available on the market. At points in time, these pools may not be available to new enrollees because of funding limitations and waiting lists may develop.

In some of the states that do not offer high-risk pools, laws limit the ability of insurance companies to decline coverage to individuals who were previously insured but now need to find replacement policies. For members in these states, availability of coverage may not be a problem as long as they were previously insured. However, these guaranteed issuance laws tend to increase the costs of insurance both because of the impact of the claims presented by medically impaired individuals and because the resulting higher premiums cause other people to go without insurance. The loss of healthy individuals from the insured population drives up the cost of coverage for all other policyholders as the cost of funding claims is spread over a smaller population.

Finally, even when the "uninsurable" member is able to purchase coverage, the affordability of premiums is a very significant problem. Premiums for coverage under high risk health insurance pools as well as for policies sold in compliance with HIPAA, are significantly more expensive than policies sold to individuals who can meet standard underwriting criteria.

Rising Cost of Medical Insurance. There are a number of factors increasing health insurance premiums that are unrelated to the underlying expense of medical care. One of the greatest problems is the growing number of healthy Americans who are uninsured. Some are not able to afford health insurance, but others opt out of the system for various reasons. Either way, they are not sharing in the cost of claims, thus driving up the cost of insurance for those who are insured.

Federal tax policy has long had an adverse impact on the cost of medical insurance for those Americans not insured under large employer group plans. Because premiums paid for health insurance have not been fully tax-deductible, major medical insurance is relatively more expensive for the self-employed and small employer groups. Consequently, some individuals who would ordinarily purchase these policies elect to be non-insured. The Council understands that the federal tax laws will eliminate this inequity by 2003.

State laws are also negatively affecting the cost of medical insurance. Mandated benefits, however laudable, make health insurance incrementally more unaffordable. In states that have mandated guaranteed issuance of insurance, the problems of coverage availability may have been addressed for the medically impaired, but the resultant increase in the cost of insurance has driven some individuals out of the system.

[1].www.Insure.com: AL, AK, AR, CA, CO, CT, IL, IN, IA, KS, KY, LA, MN, MS, MO, MT, NB, NH, NM, ND, OK, OR, SC, TN, TX, UT, WA, WI, WY

The Council recognizes there are other factors increasing the cost of medical insurance. Among these is cost shifting by health care providers from patients covered by under-funded federal programs such as Medicare and Medicaid to patients covered by private insurance. Similarly, some hospitals recoup the costs of treating indigent patients by raising fees paid by patients covered by insurance.

Medical Savings Accounts. Health insurance can be made more affordable for some individuals through the use of Medical Savings Accounts (MSAs). Contributions to an MSA are deductible in determining adjusted gross income for federal income tax purposes and there is generally no federal tax on the MSA's investment income. Self-employed individuals and those working for small employers are eligible to establish MSAs if they have medical insurance policies having deductibles of at least $1,500 but no more than $2,250 for an individual policy or at least $3,000 but no more than $4,500 for a family policy.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a five-year MSA demonstration project for employees of firms with 50 or fewer workers and self-employed individuals. According to the Council for Affordable Health Insurance (CAHI), a research and advocacy association of insurance carriers active in the individual and small group medical insurance markets, MSAs are handicapped by rules that limited their availability and growth. The HIPAA MSA project was scheduled to terminate on December 31, 2000, but Congress renewed it until December 31, 2002. On February 28 President Bush proposed that MSAs be made permanent and liberalized. The Bush administration's budget plan for fiscal year 2002 would remove HIPAA's cap on the number of MSAs and the restriction related to employer size. All employees and individuals covered by a high-deductible health plan would be eligible for MSAs. The Bush MSA reforms would lower the minimum annual deductible amount eligible for tax advantages as a high-deductible health plan, allow annual MSA contributions up to 100% of the applicable maximum deductible, and permit employees and employers to combine their MSA contributions to reach that annual limit.[2]

Recommendations. The Council believes the problems of the medical insurance marketplace in the United States are of such complexity that addressing the needs of ADA members is not feasible outside of a broader solution addressing the entire medical insurance system. The Council believes solutions to these problems must come from the state and federal governments.

In order to bring more Americans into the insured population and thus create a greater pool of individuals to fund the cost of medical care, the Council recommends the following measures as possible discussion points:

[2] Cato Policy Analysis No. 411: Medical Savings Accounts Progress and Problems under HIPAA, August 8, 2001

1. Establishing high risk health insurance pools in all states and the elimination of guaranteed issue laws;
2. Opening high risk pools to medically impaired individuals eligible for small-employer group plans but whose inclusion in the employer group would limit the employer's ability to obtain coverage;
3. Supporting federal legislation to facilitate association health plans;
4. Supporting federal legislation to control the cost of policies sold to individuals claiming HIPAA eligibility; and
5. Supporting federal legislation to make Medical Savings Accounts permanent, allowing annual MSA contributions up to l00% of the insurance policy's deductible, and lowering the annual deductible amount for policies eligible for use with MSAs.

Acknowledgments

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 SUCCESS Program: 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.

Resolution

Amendment of the ADA *Bylaws*, Council on Insurance Name Change: Providing resources to the membership to maximize their personal well being is an objective of the Strategic Plan. One of the most direct ways the Association supports this objective is through the ADA Members Retirement Program, which had more than 27,000 participants and $1.2 billion in assets at the end of 2001. Under the *Bylaws*, it is a duty of the Council on Insurance to serve as Trustees of the Retirement Program. Given the Program's great size and the growing number of its investment options, its management and oversight now requires more of the Council's time than do the Association-sponsored insurance programs. For these reasons, the Council believes that its name should be changed to reflect its duties in both the insurance and retirement investment arenas and proposes the following resolution.

4. Resolved, that Chapter X. COUNCILS, Section 10. NAME, of the *Bylaws* be amended by changing the name of the Council on Insurance to the Council on Members Insurance and Retirement Programs, so the amended Section 10 reads as follows (new language underscored):

Section 10: NAME: The councils of this Association shall be:

Council on Access, Prevention and Interprofessional Relations
Council on ADA Sessions and International Programs
Council on Communications
Council on Dental Benefit Programs
Council on Dental Education and Licensure
Council on Dental Practice
Council on Ethics, Bylaws and Judicial Affairs
Council on Government Affairs
Council on Members Insurance and Retirement Programs
Council on Membership
Council on Scientific Affairs

and be it further

Resolved, that in all other places in the *Bylaws* where the name "Council on Insurance" appears, the name be changed editorially to the "Council on Member Insurance and Retirement Programs."

Divisions of Government Affairs and Legal Affairs

Council on Ethics, Bylaws and Judicial Affairs

Council on Government Affairs

Notes

Council on Ethics, Bylaws and Judicial Affairs

Schwartz, Arthur I., Massachusetts, 2002, chairman
Chichetti, Richard J., Florida, 2002, vice chairman
Edgar, Bryan C., Washington, 2003
Epstein, Ralph H., New York, 2005
George, Lloyd A., Texas, 2004
Gill, Eleanor A., Mississippi, 2004
Graeber, John J., New Jersey, 2005
Hamlin, Christopher, Virginia, 2002
Harris, James M., Iowa, 2004
Hochstatter, Jerome P., Illinois, 2003
Jones, Kenneth D., Jr., Ohio, 2005
Lancione, Raymond R., Pennsylvania, 2003
Lee, Darryl L., California, 2002
Morgan, Stephen S., Utah, 2005
Rosin, Timothy J., Wisconsin, 2004
Squire, Charles F., Kansas, 2004, *ad interim*
Zust, Mark R., Missouri, 2003
Wils, Wendy J., director

Meetings: The Council on Ethics, Bylaws and Judicial Affairs met on December 13-14, 2001 and April 5-6, 2002 at the Association's Headquarters Building in Chicago. Dr. Bernard K. McDermott, who served as the Board of Trustees' liaison during the year, attended both meetings. Ms. Carrie A. Graziani attended the December Council meeting as liaison for the American Student Dental Association.

Chairman and Vice Chairman: The Council forwarded the name of Dr. Mark R. Zust to the Board of Trustees for approval as the Council's chairman for next year. Dr. Lloyd A. George was elected as vice chairman for the next year.

Personnel: The Council welcomed five new members: Dr. Ralph H. Epstein, Dr. John J. Graber, Dr. Kenneth D. Jones, Jr. and Dr. Stephen S. Morgan. Dr. Charles F. Squire was appointed by ADA President Dr. D. Gregory Chadwick in February 2002 to fill a vacancy in the Council's membership created by the resignation of Dr. Philip S. Zivnuska. The 2001 annual session will mark the completion of the terms of service of four Council members: Dr. Arthur I. Schwartz, chairman; Dr. Richard J. Chichetti, vice-chairman; Dr. Christopher Hamlin and Dr. Darryl L. Lee. 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 is the professional association of dentists committed to the public's oral health, ethics, science and professional advancement…." The Council's activities primarily support the following three goals: Image, Ethics and Professionalism; Practice Support and Member and Support Services. The Council supports these goals by fostering the public's perception of dentistry as a trusted and respected profession. One of the hallmarks of a profession is the commitment to put the patient's welfare ahead of all other considerations. The Council fosters this commitment through the development of relevant codes of ethics and the issuance of advisory opinions that apply the code to contemporary ethical issues 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 component dental societies on judicial matters and serving as the appellate body in the tripartite system's disciplinary process. Through these activities, the Council helps to maintain dentistry's public image as a highly respected profession. The Council also provides 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.

At its December 2001 meeting, the Council reviewed the ADA Strategic Plan: 2002-2005 with assistance from staff of the Office of Strategic Planning and Consulting and conducted a strategic planning session. The Council determined that successful levels of achievement were attained in its appellate procedures, publication policies, speaking programs and dissemination of guidance on ethical matters. With regard to the ethics component of the SUCCESS Program for junior and senior dental students, the Council discussed strategies to increase the program's penetration in the dental schools, which included expansion of the speakers' pool. The Council amended its own strategic plan to clarify its role in assisting constituent and component dental societies in their efforts to

eliminate false and misleading advertising by dentists and its efforts to increase member awareness of the *Code* through workshops and continuing education.

Future of Dentistry: In response to the Future of Dentistry Report submitted to House of Delegates in 2001, the Council initiated a comprehensive review to identify recommendations germane to the Council's *Bylaws* responsibilities. Members were assigned specific chapters to review and were asked to report to the chairman suggestions and ideas that might be developed into concrete proposals. The full Council will review the suggestions in conjunction with the Council's strategic planning session at its next regular meeting in December 2002.

Judicial Affairs

Appeals from Disciplinary Hearings: One of the Council's *Bylaws* duties is to sit as an appellate body to review decisions of the constituent and component societies in disciplinary matters. The Council is to determine whether the evidence before the society that preferred charges against the accused member supports the decision or warrants the penalty imposed. The Council also reviews the disciplinary procedures used to render the decision to make sure they are fair and in accordance with the *Bylaws.* Since its last report, the Council rendered one appellate decision and denied a request for an appeal from a dentist who was no longer a member. Edited copies of the Council's opinions and decisions in these cases are provided below.

Appeal of Dr. [ ]*: Dr. [ ](Appellant) appealed to the Council from a penalty of expulsion imposed by his constituent dental society (Respondent). Respondent received a complaint about the quality of a denture Appellant provided. The complaint was assigned to Appellant's component peer review committee. Appellant was notified of the complaint and asked to provide all relevant information. Based on an examination of the patient and review of the relevant records and information from the parties, the component peer review committee found that the maxillary denture provided by Appellant was unacceptable and asked him to refund the patient $2,500. The patient was instructed to return the denture.

The patient filed a timely appeal requesting additional reimbursement for two allegedly faulty root canals. The request was not part of the patient's original complaint, but was part of the overall treatment provided by Appellant. Appellant was given a copy of the patient's appeal request regarding reimbursement and the opportunity to submit additional information bearing on the patient's claims. The Respondent's peer review committee subsequently upheld the component peer review committee's decision and, in addition, asked Appellant to refund an additional $700 for the two root canals to the patient. Appellant was also asked to take eighteen credit hours of continuing education in the areas of risk management, treatment planning or patient communications by a specified date.

Appellant requested an immediate judicial hearing before Respondent's ethics committee, bypassing an ethics hearing at the component society level. Respondent's ethics committee issued charges against Appellant for violating Section 3 of Respondent's Standards of Ethics and Code of Professional Conduct for failure to comply with the peer review requests. A hearing was conducted at which Appellant was represented by legal counsel and was given the opportunity to cross-examine witnesses and answer the charges against him. Respondent's ethics committee found Appellant guilty and imposed the penalty of expulsion. The penalty was stayed, conditioned on Appellant's compliance with the requests of the component and constituent peer review committees.

Appellant appealed the decision to Respondent's board of trustees. Respondent's board of trustees affirmed the ethics committee's decision, but extended the deadline for compliance with the conditions of probation. Appellant filed a timely appeal to this Council. Both Appellant and Respondent filed written briefs and appeared before the Council in the person of their attorneys to present oral argument.

The Appellant raised a number of substantive and procedural issues which the Council considered in turn.

1. *Production of Records From Ethics Committee Disciplinary Proceedings.* Appellant contended that Respondent had not complied with Chapter XII, Section 20D(e) [formerly Section 20D(d)] of the ADA *Bylaws*, which requires the agency that preferred charges against the accused to furnish either a transcript or an officially certified copy of the minutes of the hearing accorded the accused, as well as certified copies of any affidavits or other documents submitted into evidence to support the charges against the accused. The record provided by Respondent for the case below appeared complete and Appellant has been unable to point to any specific omission that impaired his ability to bring the appeal. Therefore, the Council found the contention to be without merit.

2. Sufficiency of the Evidence. Appellant alleged that Respondent erred in basing its disciplinary decision on the actions of the peer review committees because the actions were based on incomplete information. Appellant alleged that pertinent patient records he delivered to the component peer review committee were lost or destroyed and thus, not considered by the committee in reaching its decision. Appellant indicated that he did not become aware of this fact until after the patient's appeal to Respondent's peer review committee was decided. As a result, he alleged this prevented him from providing the committee with relevant information and the committee was deprived of this pertinent information when it decided the patient's appeal. This was the basis of Appellant's request to Respondent's peer review committee for reconsideration of its decision. The record indicated that the Respondent's committee responded to Appellant's request by allowing him to supplement the record. After a review of the supplemental information, Respondent's peer review committee decided not to revisit its decision.

* The names of the parties have been purposefully omitted.

Appellant raised the issue of incomplete records at the hearing on the ethics charges before Respondent's ethics committee and was afforded the opportunity to present evidence on the issue. Respondent's ethics committee found that while Appellant did supply records, he did not provide sufficient evidence to demonstrate that clear and complete records were provided in a timely manner, as requested by the component's peer review committee. As an example, Respondent's ethics committee pointed out that the duplicate radiographs Appellant submitted to the component's peer review committee were not clear, and yet the original radiographs he later submitted to Respondent's peer review committee were clear enough that readable duplicates could be made. Respondent's board of trustees upheld the decision.

The fact that Appellant did not agree with the conclusions of Respondent's ethics committee did not mean that the evidence supporting its findings was not supported by the record. The evidentiary standards in a disciplinary proceeding are not as strict as in a court of law. In reviewing the decision of a constituent or component society, the Council will typically ask if there was sufficient reliable evidence bearing on a charge that a reasonable hearing panel could have reached the same conclusion. The Council determined this standard was satisfied.

3. *Respondent's Authority to Impose Sanctions.* Appellant contends by requiring him to refund $3,200 to a patient and to complete 18 hours of continuing education, Respondent exceeded its authority under Respondent's bylaws, the ADA *Bylaws* and applicable state law.

Chapter VII, Section 2 of Respondent's bylaws incorporates the provisions of Chapter XII, Section 20B of the ADA *Bylaws* dealing with disciplinary penalties. Section 20B of the ADA *Bylaws* states in relevant part:

> A member may be placed under a sentence of censure or suspension or may be expelled from membership for any of the offenses enumerated in Section 20A of this Chapter.

Appellant maintains that this section does not authorize Respondent to require him to refund money to a patient or to complete continuing education. However, Appellant misunderstands the actual disciplinary sanction imposed against him, which was expulsion. Expulsion is one of the expressly enumerated sanctions in Chapter XII, Section 20B of the ADA *Bylaws* and Chapter VII of Respondent's bylaws. The sanction of expulsion was stayed and probation was imposed on the condition that Appellant comply with the peer review committees' requests. Chapter XII, Section 20B of the ADA *Bylaws* states in pertinent part:

> Probation, to be imposed for a specified period and without loss of rights, may be administratively and conditionally imposed when circumstances warrant in lieu of a suspended disciplinary penalty. Probation shall be conditioned on good behavior. Additional reasonable conditions may be set forth in the decision for the continuation of probation.

As a voluntary membership organization, the ADA and its component and constituent societies may adopt and enforce reasonable requirements for membership as long as they are fairly applied.

The ADA *Bylaws* give the constituent societies the power to condition membership on cooperation with peer review bodies (ADA *Bylaws*, Chapter I, Section 30. DEFINITION OF "IN GOOD STANDING"). This is consistent with the ADA's long-standing support for peer review as a service to the public and the profession. Respondent is one of a number of ADA constituents that have chosen to mandate compliance with peer review as a condition of membership. Respondent's bylaws, Chapter I, Section 3A. Definition of "In Good Standing" provide:

> Members of this Association shall be considered to be in good standing provided their:
>
> > A. Professional conduct conforms to the Standards of Ethics and Code of Professional Conduct of this Association.

Section 3 of Respondent's Standard of Ethics and Code of Professional Conduct states:

> If a member fails to comply with a request and/or refuses to cooperate with a committee which is charged with the responsibility of ethical or judicial considerations, including but not limited to component society and [Respondent] peer review committees, on dental care and ethics, such failure to cooperate shall be considered a violation of the Standards of Ethics and the member failing to cooperate shall be subject to the sanction of Chapter I, Sections 3 and 6 and Chapter VII of the [Respondent's] Bylaws and Chapter XII of the ADA *Bylaws*.

The authority of Respondent's peer review bodies to request a member to make a refund or participate in continuing education is clearly stated in [Respondent's] peer review/dental care manual (Manual), which is adhered to by the component in accordance with [Respondent's] bylaws, Chapter II, Section 3G. Section 3G states:

> It [the component society] shall provide a Peer Review Committee on Dental Care and a Peer Review Committee on Ethics within the component's boundaries and such committees shall follow the procedures stated in the constituent's Peer Review Manual and the Peer Review Ethics Manual.

The Manual describes a system for mediating and reviewing patient complaints on quality of care issues and rendering decisions. It provides in relevant part:

> Section 4.2. Peer Review; When Mediation is not Successful.
>
> - Decision. "...The subcommittee or constituent's CPR/DC may require, in selected cases, that the

practitioner participate in continuing education courses relating to the treatment in question...."

- Refunds. "…When a peer review decision calls for a refund of fees paid, the following principles will be considered:

> The peer review system will not assess punitive damages. Neither the dentist nor the patient will inure from this arrangement.
>
> In cases where treatment is rendered under and covered by a dental benefit plan other than a fee-for-service, a fair market value for the service may be determined by the reviewing committee and that amount will constitute the amount to be refunded. This amount will include any patient copayment paid to the treating dentist.
>
> In that circumstances of each case differ, the peer review system reserves the right to determine the refund amount based upon specifics and uniqueness of the case (e.g., coordination of benefits)."

The Manual goes on to state that "if a member fails to comply with a request and/or refuses to cooperate with a committee on peer review/dental care such failure to cooperate shall be considered a violation of the *Standards of Ethics* of the constituent and the member failing to cooperate shall be subject to the sanctions of Article IV, Chapter I, Section 6b and Chapter VII of the [Respondent's] Bylaws."

Clearly, Respondent had the authority under its bylaws and the ADA *Bylaws* to impose disciplinary sanctions for failure to comply with peer review requests. Under Respondent's bylaws, peer review committees are authorized to request that a member refund money to a patient or participate in continuing education.

Appellant argued that he could not be compelled to comply with peer review as a matter of state law. In support, he cited a legal case which stood for the proposition that arbitration is a matter of contract, and that a party cannot be required to arbitrate an issue which he has not agreed to submit to arbitration. The Council determined it did not need to reach the issue of whether the peer review process afforded by Respondent was in the nature of an arbitration proceeding, since Appellant consented to participate in peer review and to be bound by its outcome as a condition of voluntary membership in Respondent dental society. If members could opt in and out of peer review, the effectiveness of the system would be nullified.

Appellant also argued that Respondent exceeded its corporate charter so that its acts in disciplining Appellant were illegal. Under the state's Nonprofit Corporation Act, a nonprofit corporation could be organized "for any lawful purposes not involving pecuniary gain or profit for its officers, directors, shareholders, or members." The Articles of Incorporation of Respondent state that the purpose and object of the society are to encourage the improvement of the health of the public and to promote the extension of the benefits of the science and art of dentistry to members of the public. Peer review serves these purposes by resolving questions about the appropriateness of dental care and quality of treatment.

Through the peer review process, Respondent has made available a simple, inexpensive and efficient way for its members to resolve disputes with patients about the quality of care and avoid litigation. In return for this benefit, Respondent requires members to comply with the decisions of its peer review bodies in order to remain in good standing. This is a reasonable requirement of membership which Respondent has the authority to adopt and enforce under the ADA *Bylaws*, Respondent's bylaws and applicable state law.

4. *Reasonableness of Disciplinary Penalty.* Appellant charges that the penalty imposed against him was "arbitrary" and "excessive." The Council rejected this argument. Respondent had determined that compliance with peer review requests is essential to the effective operation of its peer review system. Through its bylaws and code of ethics, Respondent mandated compliance and made noncompliance a ground for member disciplinary action, up to and including expulsion. Nothing in the record suggests that Appellant was unaware of this requirement. Nothing in the record suggests that Appellant was treated differently than any other member who refuses to comply with peer review requests.

Appellant was given the opportunity to avoid expulsion simply by refunding money to the patient and participating in 18 hours of continuing education. Respondent's peer review manual establishes guidelines for the refund of fees. The guidelines include a prohibition against punitive damages. The refund in this case was limited to fees actually paid to Appellant. No penalty was imposed. The request that Appellant participate in continuing education was directly related to quality of care issues that were the basis of the peer review complaint. Eighteen hours was not deemed as an excessive requirement. Many states laws mandate annual continuing education for dentists in excess of this amount. The Council held that the sanctions imposed on Appellant were reasonable under the circumstances.

5. *Notice of Complaint About Root Canal Treatment.* Appellant charged that Respondent's peer review failed to provide him with adequate notice about the patient's complaint regarding the root canal treatment. The parties agree that the root canal treatment was not specifically addressed in the patient's initial peer review complaint. The failure to complete root canal treatment was the basis for the appeal filed by the patient to Respondent's peer review committee. The record from the proceedings below failed to show that Appellant raised the notice issue before Respondent's ethics committee. An objection at this juncture was untimely and may be deemed to be waived. However, even on its merits the Council found that Appellant's argument failed. Appellant did not dispute that he received a copy of the patient's request for appeal and was informed that he could provide information bearing on the patient's claim. Nothing in Respondent's peer review procedures required the patient to file a new or amended complaint or required Respondent's peer review committee to refer the case back to the local level for decision about the adequacy of the root canal procedures. Appellant's brief to the Council acknowledged that the root canals were part of the work done in preparation for the patient's dentures and, thus,

were considered part of the treatment plan implicated by the patient's original complaint. The Council was satisfied that Appellant received adequate notice of the nature and reason for the patient's appeal as well as an opportunity to rebut the patient's complaint if he had so desired.

The Council also rejected Appellant's contention that notice for peer review complaints should have comported with the procedures set forth in Chapter VII, Sections 5 and 6 of Respondent's bylaws for ethics proceedings. Imposing elaborate due process procedures on peer review would be contrary to its purpose, which is to offer patients and dentists a simple, inexpensive and efficient way to resolve disputes about the quality of dental care.

For these reasons, the Council upheld the decisions of the Respondent's board of trustees and ethics committee that Appellant violated Section 3 of Respondent's *Standards of Ethics and Code of Professional Conduct* for noncompliance with peer review and merited the penalty imposed.

Denial of Appeal Request by Dr. [ ]*: A dentist asked the Council to hear an appeal from a member disciplinary decision rendered against him by a constituent dental society. The constituent found him guilty of violating its bylaws and imposed a penalty of expulsion. As a preliminary matter, the Council had to decide whether the dentist is a member entitled to an appeal.

The American Dental Association (ADA) is a private, nonprofit professional association. Membership is voluntary. The conditions of membership, rights of members and rules governing disciplinary proceedings are set forth in the ADA *Bylaws*. Under the tripartite structure, to be a member of the ADA a dentist must also be a member of the applicable constituent and component dental societies. The ADA *Bylaws* empower the constituent and component dental societies with the authority to select tripartite members, so long as they act in accordance with the ADA *Bylaws* (Chapter II, Section 30A; Chapter III, Section 20A). Under the ADA *Bylaws,* the constituent and component societies are given the authority to institute disciplinary proceedings against members (Chapter II, Section 30D, Chapter III, Section 20C; Chapter XII, Section 20A). The ADA *Bylaws* provide specific procedural safeguards to which members are entitled in disciplinary matters (Chapter XII). No constituent or component society can establish bylaws, rules and regulations that conflict with or limit the ADA *Bylaws* (Chapter II, Section 30C, Chapter III, Section 20B). Before a constituent or component dental society may impose a disciplinary sentence upon a member, the accused member has a right of appeal to this Council (Chapter XII, Sections 20D). Conversely, the ADA *Bylaws* limit the jurisdiction of this Council to hearing appeals from members in disciplinary matters (Chapter X, Section 110Gc).

In the Council's opinion, a nonmember is not entitled to an appeal and no disciplinary decision can be issued against a dentist who is not a member on the date in which the decision is rendered. This is because the only meaningful discipline that can be imposed against a member is loss of membership privileges, up to and including expulsion. For nonmembers, these sanctions simply have no force or effect. The Council is aware that from time to time a small number of members have used this jurisdictional limit to evade disciplinary proceedings. Notwithstanding, constituent and component societies are free to inquire into a dentist's past ethical conduct on a membership application, should such an individual choose to apply for membership at a future date.

The ADA *Bylaws* provide that the dues of members are payable on January 1 of each year (ADA *Bylaws*, Chapter I, Section 50A). Further, an active member whose dues have not been paid by March 31 of the current year shall cease to be a member (ADA *Bylaws*, Chapter I, Section 50I). There was no doubt that the dentist's tripartite membership lapsed. The dentist did not pay his dues on the March 31st deadline. He received an extension, which he allowed to expire. The dentist had a choice on whether to continue his membership. Regardless of the reasons, he elected to allow his membership to lapse. The dentist later attempted to apply for new membership through another component society of the constituent and his application was denied. Therefore, the Council finds that the dentist has no right to appeal because he is not a member. As a nonmember, the ADA and its constituent and component societies have no *Bylaws* jurisdiction over his professional conduct. Any pending member disciplinary proceedings and actions became moot.

The ADA *Bylaws* empower only the constituent and component dental societies with the authority to select tripartite members, so long as they act in accordance with the ADA *Bylaws* (Chapter II, Section 30A; Chapter III, Section 20A). This Council has no authority under the ADA *Bylaws* to declare the dentist a member in light of the denial of his membership application by the component and constituent dental societies.

*The names of the parties have been purposefully omitted.

Response to Assignments from the 2001 House of Delegates

Revision of the ADA *Constitution and Bylaws*: The current edition of the ADA *Constitution and Bylaws*, revised to January 1, 2002, reflects amendments that were approved by the 2001 House of Delegates.

ADA *Constitution and Bylaws*

Rewrite of Chapter I of the ADA *Bylaws*: The Council was asked by the Council on Membership to assist in the rewrite of Chapter I of the ADA *Bylaws*. The goal of the joint project is to simplify the complex language and organization of the chapter. The Councils expect to present the rewritten chapter to the 2002 House of Delegates in a supplemental report.

Editorial Review of the ADA *Bylaws*: One of the Council's responsibilities is to recommend editorial changes to improve the consistency, clarity and style of the ADA *Bylaws* (Chapter X, Section 110Gg). The authority to "recommend" has been interpreted to mean that the Council is not authorized to make

such corrections by itself, but rather must submit them to the House of Delegates in the form of a *Bylaws* amendment.

In 2000, the Council appointed a subcommittee to undertake a comprehensive editorial review of the ADA *Bylaws*. The review was completed this year. Based on recommendations from the subcommittee, the Council is forwarding the resolution below for the House's consideration. The amendments it contains would only make editorial changes in the *Bylaws* to improve their clarity, consistency and style. The deletion of two outdated footnotes is also proposed:

2. Resolved, that the following editorial changes to the ADA *Constitution and Bylaws* be approved:

Amend Chapter XII. PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT AND JUDICIAL PROCEDURE, *Section 20*. DISCIPLINE OF MEMBERS, Subsection B. DISCIPLINARY PENALTIES, by deleting the word "rights" after the words "loss of" in the fifth paragraph on probation in line 2401 and substituting in its place the word "privileges."

Amend Chapter XII. PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT AND JUDICIAL PROCEDURE, *Section 20*. DISCIPLINE OF MEMBERS, Subsection B. DISCIPLINARY PENALTIES, in the last paragraph in line 2416 by deleting the words, "active, life or retired" before the word "member."

Amend Chapter X. COUNCILS, *Section 20*. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection A, paragraph on the composition of the Council on Membership, by deleting the asterisk after the word "district" in line 1909 and the corresponding footnote.

Amend CHAPTER XIV. COMMISSIONS, *Section 60*. TERM OF OFFICE, by deleting of the asterisk after the words "four (4) years" in line 2748 and the corresponding footnote that describes the lottery initially used to establish the rotation system for ADA members when the Commission on Dental Accreditation was restructured in 1996 (*Trans*.1996.725).

Amend Chapter X. COUNCILS, *Section 20*. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection A, pertaining to the Council on Dental Education and Licensure, subsection a. Nominations and Selection, by adding the words "or jurisdictional dental licensing agency" after the words "state board of dental examiners" in lines 1854 and 1868," to address the District of Columbia, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

Amend Chapter XIV. COMMISSIONS, *Section 20*. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection A. COMMISSION ON DENTAL ACCREDITATION, paragraph two, by adding the words "or jurisdictional dental licensing agency" after the words "state board of dental examiners" in lines 2637 and 2650 to address the District of Columbia, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

Amend Chapter XIV. COMMISSIONS, *Section 20*. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection B. JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS, by adding the words, "or jurisdictional dental licensing agency," after the words "state board of dental examiners" on lines 2660 and 2672, to address the District of Columbia, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

ADA *Principles of Ethics and Code of Professional Conduct*

Proposal to Amend the *ADA Code* to Address Sexual Relationships Between Dentists and Their Patients: The Council completed a comprehensive study on whether dentist sexual misconduct should be addressed in the ADA *Principles of Ethics and Code of Professional Conduct* (ADA *Code*). The Council recommended the subject be addressed and voted to submit a proposal to the House of Delegates.

The study was prompted by a request from the Council on Dental Practice (CDP). CDP reported that data gathered in a three-year pilot study conducted by its Well Being Committee identified dentist-patient sexual relationships as one of the contributing factors to stress in the dental office. CDP also informed the Council that presenters at its Well Being Conferences complained that the ADA *Code* cannot not be used as a frame of reference for dentists undergoing treatment or counseling for sexual misconduct. Recent inquiries submitted to the Division of Legal Affairs and Office of the Council by constituent dental societies and state attorneys general for guidance on the subject also lent support to the need for this study.

The Council believes this subject must be analyzed in the context of what it means to be a professional. Ethicists advocate that professions are readily distinguished from trade and occupational groups by four chief characteristics. Professions have an exclusive expertise based on special knowledge, education and skills. The expertise is a source of important benefits to those who seek assistance from the profession. Because of their expertise, professions are afforded autonomy in practice, which is exclusive and is not available to the ordinary person. Most importantly, professions have special obligations to the public at large and within their own community. One of the hallmarks of every true profession is a code of ethics.

Dentistry, without question, meets all the attributes of a profession. Dentists provide unique and valuable services to the public. Dentists meet rigorous education and training requirements and must obtain and maintain licensure for practice. Dentists have autonomy in their professional work. To avail a dentist's care, patients are required to complete confidential medical and dental history forms, which they trust will be held in confidence. Patients are asked to disclose information about their physical and psychological health, including venereal diseases, AIDS, hepatitis, and medications such as contraceptives, antibiotics, tranquilizers, anti-

depressants, recreational drugs, and alcohol. Dentists make treatment decisions based on the information patients disclose. Undertaking a course of treatment is stressful to patients. Patients must trust and rely on the dentist to make decisions in their best interests. Dentists touch patients in the performance of their duties and place them in supine positions for treatment, rendering them immobile. Dentists are trained in pain and anxiety control and may use analgesics, conscious sedation, deep sedation and general anesthesia in their work. As a result, there is inherently unequal power in the dentist-patient relationship which renders the patient vulnerable.

As in other professional relationships, the dentist-patient relationship is readily characterized as "fiduciary." In a fiduciary relationship, one party places trust and confidence in another party, who accepts and encourages that trust in an undertaking. The more powerful party is held to a higher standard that requires him or her to act only in the best interest of the other. Professionals, unlike lay persons, are in a unique position of power by virtue of their professional status.

In the course of its study, the Council reviewed the codes of ethics of other professions to assess their positions on sexual relationships between professionals and patients or clients. There is a long standing consensus within the medical profession that sexual contact between physicians and patients is unethical. The prohibition was first articulated in the Hippocratic oath, which states in relevant part, "I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief, and in particular sexual relations with both male and female persons...." In 1989, the American Medical Association adopted an ethical rule that is unequivocal:

> Sexual contact that occurs concurrent with the physician-patient relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well being.
>
> If a physician has reason to believe that non-sexual contact with a patient may be perceived as or may lead to sexual contact, then he or she should avoid the non-sexual contact. At a minimum, a physician's ethical duties include terminating the physician-patient relationship before initiating a dating, romantic, or sexual relationship with a patient.
>
> Sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions or influence derived from the previous professional relationship.

The American Osteopathic Association's ethical principle is similarly unequivocal in its *Code of Ethics*:

> It is considered sexual misconduct for a physician to have sexual contact with any current patient whom the physician has interviewed and/or upon whom a medical or surgical procedure has been performed.

The American Chiropractic Association published an addendum to its *Code of Ethics* which reads as follows:

> *Sexual Intimacies With A Patient*
> The ACA Ethics Committee ("Committee") has received numerous requests for clarification relative to the ethical implications of sexual intimacies between a doctor of chiropractic and a patient he or she is treating. This advisory opinion is intended to resolve any misunderstanding and to state that it is the opinion of the Committee that sexual intimacies with a patient is unprofessional and unethical based on the existing ethical provisions in the ACA Code of Ethics: A(6), A(7), A(10) and C(2).
>
> The physician/patient relationship requires the doctor of chiropractic to exercise utmost care that he or she will do nothing to "exploit the trust and dependency of the patient." Doctors of chiropractic should make every effort to avoid dual relationships that could impair their professional judgment or risk the possibility of exploiting the confidence placed in them by the patient.

The American Psychological Association's (APA) *Ethical Principles of Psychologists and Code of Conduct* provides:

> *Sexual Intimacies With Current Patients or Clients*
> Psychologists do not engage in sexual intimacies with current patients or clients.
>
> *Therapy With Former Sexual Partners*
> Psychologists do not accept as therapy patients or clients persons with whom they have engaged in sexual intimacies.
>
> *Sexual Intimacies With Former Therapy Patients*
> Psychologists do not engage in sexual intimacies with a former therapy patient or client for at least two years after cessation or termination of professional services.

The APA's code also provides expectations for psychologists who wish to engage in an intimate relationship with a former patient after two years. The APA, however, has a draft of a new code for member comment that proposes a perpetuity rule that would prohibit relationships no matter how much time has elapsed since the last client visit.

Though lawyers are not healthcare providers, the legal profession has similar professional stature and accountability to the public. The American Bar Association's Model Rules of Professional Conduct also prohibit client-lawyer sexual relationships:

> A lawyer shall not have sexual relations with a client unless a consensual sexual relationship existed between them when the client-lawyer relationship commenced.

Certain religious organizations have faced sharp criticism from the public and consumer advocates for the manner in which they've handled sexual transgressions between its clergy and parishioners leading to eroding public trust in such institutions.

The Council considered applicable dental practice acts and dental board rules as part of its study, with assistance from the Division of Legal Affairs and the Department of State Government Affairs. The majority of states reference sexual misconduct by using broad language, such as "engaging in lewd or immoral conduct," "making lewd, lascivious or improper advances toward or upon a patient," "convictions of crimes of moral turpitude," "immoral conduct" and "gross immorality" as a basis for unprofessional conduct. Several states specifically defined sexual misconduct and state that it is grounds for disciplinary action, including acts constituting sexual battery (Florida, Mississippi, California, Nebraska and Maine).

The Council was informed that two dental boards have disciplined dentists for engaging in consensual sexual activity with their patients. In Massachusetts, the dental board disciplined a dentist for engaging in an 18-month consensual sexual relationship with a patient. The board found that regardless of the patient's consent, the dentist breached his duty by permitting the relationship to develop in the context of dental treatment and that the dentist's conduct was a grave and serious breach of professional ethics. Similarly, a California appeals court rejected a dentist's contention that unless the patient has been deceived under the guise of treatment, there is no basis for dental board discipline. The state appeals court reasoned that doctors may use their status to induce patients to consent to sexual activity and that the doctor's professional judgment may be compromised by the dentist's sexual interest in the patient.

The reasoning applied in the Massachusetts and California cases is consistent with ethical views published in the dental literature on this subject. In discussing the appropriate boundaries between dentists and patients, ethicists point out that sexual contact between dentists and patients is unethical, legally perilous, may be cause for professional discipline, and can be viewed by the public as an outrageous transgression. They suggest that dentists who find themselves romantically attracted to patients should either avoid initiating a more intimate relationship or refer the patient to another dentist.

Ethicists explain that the position of power in the dentist-patient relationship is not equal. Dentists are highly respected and revered by their patients and society. Patients are particularly vulnerable, both physically and emotionally, when they seek dental care and place great trust in their dentists when undergoing treatment. The trust the patient reposes in the dentist, the inherently unequal power, and the patient's vulnerability when combined raise ethical questions on whether patients can be disproportionately influenced by their dentists and whether meaningful consent for sexual contact can be obtained. By avoiding sexual relationships with current patients, ethicists contend that dentists preserve patient trust and help ensure that nonprofessional considerations do not intrude in the dentist-patient relationship.

Based on this information, the Council recognizes that professional standards in this area are evolving and recommends a change in the ADA *Code*. The Council believes it is vital to dentistry's ability to manage critical issues that it continue to be perceived by the public as a highly ethical profession. Silence on a subject with the potential for such egregious consequences is a void which should be filled. The ADA *Code* states in pertinent part, "...Although ethics and the law are closely related, they are not the same. Ethical duties may-and often do-exceed legal duties." An amendment on this subject would strengthen the ADA *Code*'s utility as a teaching tool and serve as a frame of reference for all members, including those referred for treatment because of sexual misconduct, and the public which the profession serves.

The proposal which the Council developed presents language which is simple and straightforward. It satisfies an essential element of fairness in that it provides adequate notice about the type of conduct that would be ethically prohibited. The Council considered, but rejected, a partial ban that would have limited the prohibition to only those sexual relationships that are "improper" or "take advantage of the dentist-patient relationship." The Council believes such language is unclear, and subject to varying interpretations, and would not adequately prevent the unintended problems that inevitably can develop. For these reasons, the Council recommends the following resolution:

3. Resolved, that the ADA *Principles of Ethics and Code of Professional Conduct* be amended by addition of the following new Code of Professional Conduct:

> 2.G. PERSONAL RELATIONSHIPS WITH PATIENTS. It is unethical for a dentist to engage in a dating, romantic or sexual relationship with a current patient of record. This prohibition does not apply to relationships between a dentist and his or her spouse or equivalent domestic partner.

For purposes of this proposal, dating and romantic relationships are equivalent to sexual relationships. A current patient of record is any individual who has received dental services provided by the dentist and remains under that dentist's continuing care.

The Council recognizes there will be instances wherein dentists and patients may wish to engage in a dating, romantic or sexual relationship. This is not a situation unique to dentistry. Other professions face these circumstances as well. The dentist can meet his or her ethical duty by simply terminating the professional relationship and transferring the patient to another practitioner.

Review of Advisory Opinion Related to Removal of Amalgam: At its April 2002 meeting, the Council considered, at the request of the Board of Trustees, Advisory Opinion 5.A.1. Dental Amalgam to the ADA *Principles of Ethics and Code of Professional Conduct* (*Code*). Advisory Opinion 5.A.1 was adopted by the Council in 1987 in response to policy adopted by the House of Delegates the previous year (*Reports* 1987:116). The House had found, based on available science, that the use of dental amalgam as a restorative material did not pose a health hazard to the nonallergic patient. The House concluded that for a dentist to advocate to a patient

or the public removal of serviceable dental amalgam solely to substitute a material that did not contain mercury was "unwarranted and violated the [*Code*]" (*Trans*.1986:536).

The Council received an update from staff of the ADA Division of Science on scientific evidence about amalgam safety and a report from staff of the ADA Health Foundation's Paffenbarger Research Center on developments and trends in dental restorative materials. Based on this information, the Council noted that the scientific assessments on the safety of dental amalgam have not changed since the advisory opinion was adopted. Advisory opinions are written to address specific fact situations that might come before the Council in a judicial proceeding. They generally address a significant ethical question on which members of the profession have sought guidance. This was the case with Advisory Opinion 5.A.1. At that time, dental amalgam was by far the most commonly used direct restorative material. This is no longer the case, and the Council affirms that every material that is used in the human body must be assessed in terms of safety and efficacy.

The Council voted to amend the advisory opinion to acknowledge these considerations and the ethical issues they raise. As amended by the Council, the advisory opinion will read (deleted material is struck through; new material is underlined):

> Advisory Opinion 5.A.1. Dental Amalgam and Other Restorative Materials.
>
> Based on ~~available~~ current scientific data, the ADA has determined ~~through the adoption of Resolution 42H-1986 (*Trans*.1986:536),~~ that the removal of amalgam restorations from the non-allergic patient for the alleged purpose of removing toxic substances from the body, when such treatment is performed solely at the recommendation or suggestion of the dentist, is improper and unethical. The same principle of veracity applies to the dentist's recommendation concerning the removal of any dental restorative material.

Review of Advisory Opinions Relating to Human Immunodeficiency Virus (HIV): By Resolution 106H-1990 (*Trans*.1990:575), the House of Delegates requested that the Council continually monitor scientific developments concerning the human immunodeficiency virus (HIV) to ensure that the Council's advisory opinions in this area remain compatible with current scientific knowledge. The Council considered reports from staff of the Division on Science and Division of Legal Affairs regarding recent scientific and legal developments related to HIV/AIDS. The Council also reviewed a report from the Board of Trustees to the House of Delegates titled, "*AIDS Update*" *1999* (*Supplement* 1999:700). Based on this review, the Council determined that no changes in its advisory opinions were warranted.

The Council notes that its ethics reviews are largely dependent on scientific developments and that the *AIDS Update 1999* indicated that future reports to the House of Delegates on the scientific and other developments would be presented triennially, unless circumstances dictate otherwise. Likewise, the Council believes that future reports on these advisory opinions may be transmitted to the House when other HIV/AIDS updates are submitted, unless circumstances dictate otherwise. Guidance on an appropriate system to coordinate the reporting process in a manner that will expedite the work of the House of Delegates will be sought from the Board of Trustees.

Amendment of Advisory Opinion 2.B.1. on Second Opinions: At the request of the American Association of Endodontists (AAE), the Council provided guidance on use of the term "third party" in Advisory Opinion 2.B.1. SECOND OPINIONS. The Council determined that "third party payers" is the intended meaning of the term. The Council concurred with AAE's suggestion to clarify the term in the text of the advisory opinion and amended 2.B.1 by adding an asterisk after the words "third party" and an explanatory footnote. As amended, the advisory opinion reads follows (new language underscored):

> 2.B.1 SECOND OPINIONS.
>
> A dentist who has a patient referred by a third party* for a "second opinion" regarding a diagnosis or treatment plan recommended by the patient's treating dentist should render the requested second opinion in accordance with this Code of Ethics. In the interest of the patient being afforded quality care, the dentist rendering the second opinion should not have a vested interest in the ensuing recommendation.
>
> *A third party is any party to a dental prepayment contract that may collect premiums, assume financial risks, pay claims and/or provide administrative services.

Council Activities

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 Office of the Council 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 7. Nominations submitted to

the Council for the 2002 award will be voted upon by the Council by confidential mail ballot.

Ethics Component of the SUCCESS Program: The year 2002 marks the eighth 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 to the following dental schools in the 2001-2002 academic year: University of Oklahoma College of Dentistry (October 22, 2001); Ohio State University College of Dentistry (October 30, 2001); Southern Illinois University School of Dental Medicine, (October 30, 2001); Virginia Commonwealth University School of Dentistry (November 13, 2001); Medical College of Georgia School of Dentistry (November 14, 2001); University of Nebraska Medical Center College of Dentistry (January 28, 2002); University of Missouri at Kansas City School of Dentistry (February 7, 2002); University of Connecticut School of Dental Medicine (February 13, 2002); University of Illinois at Chicago College of Dentistry (February 13, 2002); and Meharry Medical College School of Dentistry (February 25, 2002).

Through the fund-raising efforts of the Council on Dental Practice (CDP), corporate underwriting was obtained for seven of the ten seminars. The Council gratefully acknowledges CDP's assistance.

During the Council's December 2001 meeting, various means of expanding the penetration of the SUCCESS Ethics Program were discussed. A tentative action plan for program expansion was developed and incorporated into the Council's proposed 2003 budget proposal.

Summary of Resolutions

2. Resolved, that the following editorial changes to the ADA *Constitution and Bylaws* be approved:

Amend Chapter XII. PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT AND JUDICIAL PROCEDURE, *Section 20*. DISCIPLINE OF MEMBERS, Subsection B. DISCIPLINARY PENALTIES, by deleting the word "rights" after the words "loss of" in the fifth paragraph on probation in line 2401 and substituting in its place the word "privileges."

Amend Chapter XII. PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT AND JUDICIAL PROCEDURE, *Section 20*. DISCIPLINE OF MEMBERS, Subsection B. DISCIPLINARY PENALTIES, in the last paragraph in line 2416 by deleting the words, "active, life or retired" before the word "member."

Amend Chapter X. COUNCILS, *Section 20*. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection A, paragraph on the composition of the Council on Membership, by deleting the asterisk after the word "district" in line 1909 and the corresponding footnote.

Amend CHAPTER XIV. COMMISSIONS, *Section 60*. TERM OF OFFICE, by deleting of the asterisk after the words "four (4) years" in line 2748 and the corresponding footnote that describes the lottery initially used to establish the rotation system for ADA members when the Commission on Dental Accreditation was restructured in 1996 (*Trans*.1996.725).

Amend Chapter X. COUNCILS, *Section 20*. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection A, pertaining to the Council on Dental Education and Licensure, subsection a. Nominations and Selection, by adding the words "or jurisdictional dental licensing agency" after the words "state board of dental examiners" in lines 1854 and 1868," to address the District of Columbia, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

Amend Chapter XIV. COMMISSIONS, *Section 20*. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection A. COMMISSION ON DENTAL ACCREDITATION, paragraph two, by adding the words "or jurisdictional dental licensing agency" after the words "state board of dental examiners" in lines 2637 and 2650 to address the District of Columbia, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

Amend Chapter XIV. COMMISSIONS, *Section 20*. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection B. JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS, by adding the words, "or jurisdictional dental licensing agency," after the words "state board of dental examiners" on lines 2660 and 2672, to address the District of Columbia, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

3. Resolved, that the ADA *Principles of Ethics and Code of Professional Conduct* be amended by addition of the following new Code of Professional Conduct:

2.G. PERSONAL RELATIONSHIPS WITH PATIENTS. It is unethical for a dentist to engage in a dating, romantic or sexual relationship with a current patient of record. This prohibition does not apply to relationships between a dentist and his or her spouse or equivalent domestic partner.

Council on Government Affairs

Sterritt, Frederic C., New Jersey, 2002, chairman
Nolan, Michael F., Louisiana, 2002, vice chairman
Alfano, Martin A., Pennsylvania, 2005
Anderson, K. David, Alabama, 2002, *ex officio*[*]
Carnahan, Richard H., Jr., Texas, 2003
Dwight, Gary H., Michigan, 2004
George, Raymond, Jr., Rhode Island, 2004
Hadnot, Douglas S., Montana, 2002
Harrell, James A., Jr., North Carolina, 2003
Ivey, N. Tyrus, Georgia, 2004
Johnson, Curtis Ray, South Dakota, 2005
McGinty, Charles C., Missouri, 2002
Mito, **Ronald S.,** California, 2003
Osborne, Larry W., Illinois, 2004
Pope, Theodore R., Ohio, 2005
Powley, W. Brian, Arizona, 2005
Reitz, John V., Pennsylvania, 2002, *ex officio*[†]
Triftshauser, **Roger W.,** New York, 2003
Walton, James F., Florida, 2004
Spangler, Thomas J., director

Meetings: The Council met February 1-3, 2002 in Washington, D.C. The Council's second and third meetings are scheduled for May 31, June 1-2, 2002 and September 20-22, 2002.

The Strategic Plan of the American Dental Association: The Council's activities support the ADA Strategic Plan Goal, Advocacy. In its 2002 report to the Board's Strategic Planning Committee, the Council adjusted how it measures success in meeting its advocacy objectives. If Congress and/or federal agencies respond to ADA issues in a manner that advances the Association's goals and objectives, then the Council believes the ADA's federal lobbying efforts can be judged as successful. If constituent and component societies indicate they received timely and effective support, then actions taken by the ADA's Department of State Government Affairs (DSGA) will be judged to have been successful. The following are some key successes as of May 2002 in the Association's lobbying activities concerning Congress and federal agencies and the efforts of the DSGA in assisting constituent and component dental societies to address legislative and regulatory matters of concern to them.

Access to Oral Health Care: Representatives John Murtha (D-PA) and Fred Upton (R-MI) in January introduced the Children's Dental Health Act (H.R. 3659), as a House companion to the bill (S. 1626) introduced in 2001 by Senator Jeff Bingaman (D-NM). H.R. 3659 would make money available for states to use in accordance with their needs to improve dental access for children from low-income families. The ADA and every other major oral health group have endorsed the bills.

Maintaining the Federal Oral Health Infrastructure is also important to ensuring access. After a great many meetings and other communications with top Bush administration officials and staff to discuss ways Health and Human Services (HHS) can maintain an adequate oral health presence at all levels of the department, the Centers for Medicare and Medicaid Services (CMS) is considering establishing a dental officer position to ensure dentistry is represented by a dentist when issues affecting Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP) are discussed. The ADA has also included in the discussions an explanation of the importance of maintaining a distinct dental infrastructure within the Oral Health Division at the Centers for Disease Control and Prevention and ensuring the independence of the National Institute of Dental and Craniofacial Research in NIH. ADA met with HHS Deputy Secretary Claude Allen, CMS Deputy Administrator Ruben King-Shaw and Mark McClellan, White House economic advisor to the president. In addition, at the request of the ADA, the three dentist members of Congress—Representatives John Linder (R-GA), Charlie Norwood (R-GA) and Michael Simpson (R-ID)—in late March urged HHS Secretary Tommy Thompson to maintain an appropriate dental presence within the department.

Last year, states were relatively successful in improving access to dental care through SCHIP. But building on this trend will be difficult. As a response to the massive budget

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[*] Committee on the New Dentist member without the power to vote.
[†] American Dental Political Action Committee member without the power to vote.

shortfalls experienced by state governments, many states will slash spending for Medicaid and other publicly funded dental care programs. Because the Medicaid budget alone averages approximately 15% of the average state's general spending, it is a large line item and, therefore, an attractive target for budget cutters. To assist states facing the budget ax, the DSGA prepared a set of talking points and arguments for constituent societies. The talking points include discussions of the federal Medicaid match, facts on the prevalence of dental disease, and a discussion of how dental care programs actually have a minimal impact on state budgets.

Health Insurance Portability and Accountability Act (HIPAA)—Privacy Rule: The ADA is urging Congress to delay implementation of the HIPAA regulation's penalty provisions in favor of a structured penalty system that would distinguish between major medical institutions and individual practitioners. The Association also called for an easing of the paperwork burden of compliance at a meeting with Democratic members of the House Small Business Committee.

On March 21, HHS published a proposed rule modifying the patient privacy regulation. The proposed rule would remove the requirement for all providers to obtain written consent from patients before using or disclosing protected health information. A patient's written consent would now be optional. In its place, providers would be required to make good faith efforts to obtain from patients a written acknowledgement of receipt of the provider's notice of privacy rights and practices. The proposed rule also covers procedures related to marketing, business associates, minimum necessary disclosures, oral communication, the rights of minors and other issues.

The administration has given no indication it intends to change the compliance date for the original privacy rule, which is scheduled to take effect on April 14, 2003. The Association has put together a member education campaign on the new privacy rules that includes:

- a HIPAA Web site at www.ada.org/goto/hipaa;
- numerous print and electronic reports in the *ADA News*, Today's News at ADA.org and in Department of State Government Affairs publications;
- a new privacy seminar series that starts in July; and
- publication of a dental office privacy kit this summer.

Workplace Safety—Ergonomics: Consistent with ADA's recommendation, on April 5 the Occupational Safety and Health Administration (OSHA) issued voluntary guidelines on ergonomics, thereby rejecting the regulatory approach taken by the Clinton administration. Failure to implement a guideline will not by itself be a violation of law. Furthermore, OSHA stated it would not focus enforcement on employers who are making good faith efforts to reduce ergonomics' injuries.

The issuance of voluntary guidelines is consistent with the message given to ADA leadership in a March meeting with OSHA administrator John Henshaw and other Labor Department officials. Mr. Henshaw said that in addition to enforcement, OSHA must also protect workers before injuries occur. He agreed with the ADA that dentists are the agency's best resource in understanding how to protect dental workers and said that OSHA would make sure that inspectors understand the phone-fax process and that new inspectors receive proper training.

Medicare Reform: At the ADA's request, the House-passed H.R. 3391, the Medicare Regulatory and Contracting Reform Act, included a provision to prevent health plans from requiring a Medicare claim denial before processing a claim when the service in question clearly is not a Medicare covered benefit. The ADA is seeking inclusion of the same provision in a Senate bill.

The ADA, in conjunction with CMS, has developed a dental-specific Medicare advance beneficiary notice (ABN), which is available on the ADA's Web page. The notice is intended to be used by dentists to help them inform Medicare beneficiaries of the limitations of the program's dental coverage. The goal of the notice is to reduce unnecessary billing for services that are obviously not covered.

Dental Office Wastewater and Amalgam Safety: At least 15 states this year were considering either legislative or regulatory activity to reduce mercury discharge that could have a substantial impact on dental practices. From every indication, it appears these trends will continue to intensify and expand to other areas of the country. The DSGA has responded to a number of constituent requests for assistance and provided a coordinated ADA response to which several ADA divisions contributed. Staff worked with environmental consultants to implement a plan to assist constituents, components, and members with dental office wastewater issues as directed by Resolution 82H-2001 (*Trans*.2001:461).

Legislation to restrict or prohibit the placement of amalgam fillings has been introduced in the 2002 session of state legislatures in Alabama, Alaska, Arizona, California, Georgia, Illinois, New Hampshire, New York and Washington. The list of states keeps growing, but as of mid-May, no state has banned or restricted the use of amalgam. Also, Representative Diane Watson (D-CA) introduced an anti-amalgam bill (H.R. 4163) in Congress in April, calling for the elimination of dental amalgam by January 2007. ADA has joined forces with the National Dental Association in opposition to the Watson bill. Indications are that the legislation will not move out of the committee to which it has been assigned.

Licensure: The New York State Dental Association, with the support of the state's five dental schools, got a bill introduced in the state legislature in 2002 that would eliminate the clinical licensure (NERB) exam as a requirement for licensure in the state, substituting instead the completion of a one-year graduate dental residency. As of mid-year, the bill was still pending. Mississippi responded in a unique way to the debate over the use of human subjects in dental clinical exams by passing a law giving its dental board the authority to require the use of human subjects in clinical exams.

By the end of 2001, with the addition of California and Nevada, the number of states that permit dentists to become licensed by credentials in their states reached a total of 38, and bills to authorize (or require) state dental boards to implement licensure by credentials were introduced in 2002

in Alabama, Arizona, North Carolina (a 2001 bill), and Tennessee. Hawaii had a number of licensure bills before the Hawaii legislature.

Once again, legislators in several states are considering making revisions to licensure requirements to increase access to dental care, alleviate shortages of faculty or pediatric dentists, or to satisfy other legislative goals. Temporary dental licenses or guest licenses were under consideration in 2002 in several states. New types of special dental licenses were proposed in a few states. For example, a special license would allow dentists to come to Nebraska to serve on a dental school faculty and to Hawaii to practice as volunteers or employees of safety net dental providers, defined as private, nonprofit, tax-exempt charitable organizations providing dental services to the needy and disabled.

Although the vast majority of states require graduates of foreign dental schools to either graduate from an accredited dental school or to complete at least two years of study in such institution, there are indications that some states may make it easier for foreign graduates to apply for state licenses. In Minnesota, for example, a law passed this year prohibits the dental board from automatically disqualifying graduates of foreign dental schools from taking the licensure exam. If the dental board determines that the training in the foreign school is at least equivalent to that of a school accredited by the Commission on Dental Accreditation, then the board must allow the applicant to take the exam.

At a meeting of the Council on Licensure, Enforcement and Regulation (CLEAR) earlier this year, the issue of unlicensed practice was discussed. State health professions regulatory boards expressed frustration that law enforcement agencies are not aggressive in prosecuting for unlicensed practice. One suggestion was to raise the penalty for unlicensed practice from a misdemeanor to a felony, thinking this might make prosecutors more apt to take action. At present, only about a dozen states have laws treating the unlicensed practice of dentistry as a felony. Georgia passed such legislation in 2002.

Dental Hygiene: Although Colorado remains the only state in which hygienists can practice totally without supervision in all settings; nine others permit some degree of unsupervised practice in institutional settings. Unsupervised practice differs from general supervision in that the hygienist is not required to receive authorization from a dentist before performing basic hygiene services on a patient. Limited refers to the fact that the unsupervised practice is not permitted in all settings. Limited unsupervised practice bills were introduced in 2002 in Arizona, Illinois, Kansas and New York. Minnesota joined New Mexico, becoming the second state to allow hygienists to practice in collaborative arrangements with dentists.

Organized dental hygiene has jumped on the access to dental care bandwagon telling legislators that unsupervised practice is the answer. As of mid-year of 2002, 30 states allowed hygienists to administer local anesthesia and 24 allowed administration of nitrous oxide.

Denturism: As has become customary each year, a bill to legalize the practice of denturism was introduced in Kentucky, and once again it was defeated. It has been several years since any additional states have legalized denturism; the number remains at six.

HMO Liability: Tennessee had a bill pending in 2002 that would allow patients to sue managed care organizations (MCOs) for failure to exercise ordinary and reasonable care in making treatment decisions after exhausting internal and external appeals procedures. About a dozen states have laws to subject MCOs to patient lawsuits under various legal theories.

Response to Assignments from the 2001 House of Delegates: Listed below are the responses to a few of the resolutions assigned to the Council. The majority of the resolutions will be addressed in the Council's June or September meeting and included in a supplemental report to the House of Delegates.

Expansion of State Subsidies for Dental Education. Resolution 64H-2001 (*Trans.*2001:471) encourages constituent dental societies to give the highest priority to lobbying efforts that support the expansion of state subsidies for dental education, including state appropriations for loan forgiveness and scholarship programs and increased support for the provision of dental services for the underserved populations. The DSGA has notified the constituent societies of this resolution.

Designation of the National Museum of Dentistry. Resolution 78H-2001 (*Trans.*2001:437) provides for the establishment of The Dr. Samuel D. Harris National Museum of Dentistry in Baltimore, Maryland as *the* National Dental Museum by an act of Congress. Senator Paul Sarbanes and Representative Benjamin Cardin, both of Maryland, have agreed to introduce legislation to accomplish the intent of this resolution.

Future of Dentistry Report: The Council discussed at its February meeting a number of workforce issues presented in the report. It was noted that this is a complicated issue with a general recognition that there is an imbalance of dentists nationwide that could result in a shortage in certain locations. Also discussed were the role of technology and increased use of auxiliaries in increasing productivity; the relative ease of expanding post-doctoral training as compared to pre-doctoral training; and the potentially significant role of state legislators in making changes in practice acts, thereby warranting close attention by the Council to the workforce issue. The Council will further review these matters at its June meeting.

Acknowledgments: The Council on Government Affairs announces the addition of four new members: Dr. Martin A. Alfano, Pennsylvania; Dr. Curtis Ray Johnson, South Dakota; Dr. Theodore R. Pope, Ohio; and Dr. W. Brian Powley, Arizona. The 2002 annual session will mark the completion of the terms of service of four Council members: Dr. Frederic C. Sterritt, New Jersey; Dr. Michael F. Nolan, Louisiana; Dr. Douglas S. Hadnot, Montana; and Dr. Charles C. McGinty,

Missouri. The Council expresses its appreciation to these members for their efforts in assisting the Council in addressing the needs and concerns of the dental profession.

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

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

Hutter, Jeffrey W., Massachusetts, 2002, chairman
Siegel, Michael A., Maryland, 2003, vice chairman
Blanton, Patricia L., Texas, 2003
Bowen, William H., New York, 2003, Gold Medal Award recipient
Bushick, Ronald D., Pennsylvania, 2004
De Paola, Louis G., Maryland, 2005
Drisko, Connie Hastings, Kentucky, 2002
Greenspan, Deborah, California, 2003
Hilton, Thomas J., Oregon, 2005
Jeske, Arthur H., Texas, 2004
Lawton, Lawrence R., Washington, 2003
Menke, Richard A., Ohio, 2002
Murdoch-Kinch, Carol Anne, Michigan, 2004
Navazesh, Mahvash, California, 2004
Sarrett, David C., Virginia, 2005
Tussing, Gerald J., Nebraska, 2002
Zero, Domenick T., Indiana, 2005
Burrell, Kenneth H., senior director
Lynch, Michael C., director, Scientific Information
Whall, Clifford W., Jr., director, Acceptance Program
Wozniak, Wayne T., director, Guidelines and Standards Development
Elseweifi, Yasser A., assistant director, Scientific Information
Ristic, Helen, assistant director, Acceptance Program
Said, M. Mazhar, assistant director, Acceptance Program

Meetings: The Council's final scheduled meeting of 2001 (September 19-21, 2001) was cancelled in the wake of the September 11, 2001 attacks on the United States. To conduct Council business, this meeting was held as a half-day telephone conference call on September 20, 2001, with Association staff convening at the ADA Headquarters Building in Chicago.

In 2002, the Council on Scientific Affairs (CSA) met in the ADA Headquarters Building on January 15-17 and May 14-16. The Council's final meeting of 2002 is scheduled for September 10-12. Dr. Edwin S. Mehlman, First District trustee, served as the Board of Trustees' liaison to the Council.

Personnel: Dr. Jeffrey W. Hutter served as Council chairman for the 2001-2002 term, with Dr. Michael A. Siegel serving as vice chairman. The Council also welcomed four new members: Dr. Louis G. De Paola, Dr. Thomas J. Hilton, Dr. David C. Sarrett, and Dr. Domenick T. Zero, replacing outgoing members Dr. Gordon P. Trowbridge III (chairman), Dr. Kenneth J. Anusavice, Dr. Frank C. Grammer, and Dr. J. Robert Kelly.

The Strategic Plan of the American Dental Association: The ADA *Strategic Plan: 2002-2005* serves as a useful framework to guide the Council's primary activities in the areas of science and research, particularly in processing, synthesizing and disseminating clinically relevant information based on sound science to the public and the profession. In full support of the goals, guiding principles and core objectives outlined in the Strategic Plan, the Council promotes high-quality oral health care and public health, assists members' personal and practice decisions, provides strategic management of emerging scientific issues for the Association, and reports results on the latest scientific developments to practicing dentists. The Council is the primary resource of scientific information for the Association. It considers the "Information" and the "Image, Ethics and Professionalism" goals to be core elements of its professional mission.

The Council conducted annual strategic planning activities during its January 2002 and May 2002 meetings, using evaluation criteria previously developed by the Council pursuant to Board Resolution B-79-1998 (*Trans.*1998:609). At its January 2002 meeting, the Council held a strategic planning session and assessed its ongoing program activities and new initiatives in relation to the Strategic Plan. In May 2002, the Council made quantitative measurements to evaluate the effectiveness of its activities and their alignment with the Strategic Plan. Subsequently, in mid-2002, the Council submitted its final report on 2000/2001 Strategic Plan implementation to the Board of Trustees via the Office of Quality and Strategic Planning.

In harmony with the Association's goals of "Information" and "Practice Support" the Council continued to address a variety of major scientific issues of patient and provider safety currently affecting dentistry, including amalgam wastewater issues, the Association's action plan on evidence-based dentistry, treatment-oriented research of emerging importance in the diagnosis and management of oral diseases, and the laboratory evaluation of amalgam separation technologies. Investigating complex issues that affect clinical practice, the Council provided

scientific guidance on such issues as drug interactions between oral contraceptives and antibiotics, clinical infection control, the safety and effectiveness of dental restorative materials, and the performance and use of safety needle devices in clinical settings. In addition, the Council worked to develop Council and Association reports on such topics as xerostomia, office emergencies and emergency kits, and oral malodor, as well as various position statements and recommendations for publication in *The Journal of the American Dental Association*, *ADA News* and online at ADA.org. Commensurate with the ADA's strategic "Information" goal, the Council continued to disseminate information on the safety, efficacy, promotional claims and proper use of dental therapeutic agents, their adjuncts and dental cosmetic agents, and drafted an updated version of the ADA Statement on the Safety of Home-Use Tooth Whitening Products. The Council also served as lead agency in establishing a leadership role for the Association in evidence-based dentistry and current scientific and clinical research on the interrelationship between systemic diseases and oral health.

As the leading resource on the science of dentistry, the Council works to ensure that the Association remains the premier source of information on oral health. Each year, the Council promotes oral health research by conducting a comprehensive review of the ADA Research Agenda and circulating it to appropriate allied health care organizations and funding agencies for their consideration. In formulating and revising the Association's Research Agenda, the Council identifies priority research areas and monitors new research of importance to the practitioner, tests new methodologies, develops standards and establishes guidelines for acceptance of various dental products, resolves issues relative to product acceptance and safety, and addresses other critical issues in the face of emerging scientific knowledge. The Council effectively increased membership awareness of the Association's Research Agenda by broadening its visibility through annual publication in *The Journal of the American Dental Association* and online at ADA.org.

The Council's Seal of Acceptance Program supports the Association's "Information" and "Practice Support" goals by "enhancing the effectiveness of dentists and their staff," "provid[ing] services and products that help dentists manage the clinical and operational aspects of their practice and personal well-being," and disseminating relevant product information to the public and the profession. With 98 new product applications in 2001, the Seal Program essentially met its established annual goal of 100 new product submissions for Seal consideration. The Council also provides members with clinically relevant information through the development of dental product standards and guidelines for the Seal Program. The processing and completion of these standards and guidelines indicate how well the Council is keeping abreast of advances in product development, as well as safety and efficacy issues related to novel dental materials, instruments, equipment and therapeutics. The Council has also maintained its longstanding practice of disseminating bloodborne pathogens guidelines and new product developments to the profession through peer-reviewed publications, regulatory updates and ADA.org.

To "represent and promote the profession's perspective . . . with governmental agencies, the business sector and others," as addressed under the "Advocacy" goal of the Strategic Plan, the Council maintains close collaboration with regulatory, research, government and allied health care organizations. In 2001-2002, the Council's outreach efforts included attendance at an FDA- and NIDCR-sponsored Dental, Oral and Craniofacial Technology Forum Workshop, preliminary discussions with NIDCR to organize a consensus conference on xerostomia, and correspondence with the FDA to request new guidelines for dental radiographs. In addition, the Council has continued to work with the CDC on revisions to their *Recommended Infection-Control Practices for Dentistry, 1993*, which is scheduled for publication in late 2002, and to identify research protocols and develop a proposed study for the objective evaluation of current and emerging safety needle devices.

Future of Dentistry Report: In accordance with House Resolution 54H-2001 (*Trans.*2001:408), the Council on Scientific Affairs reviewed the 2001 Future of Dentistry report, which was commissioned by the ADA and coordinated by a Board-appointed Oversight Committee that presented the final report to the 2001 House of Delegates. At its January 2002 meeting, Council members were assigned to review the chapters covering the six critical areas identified in the report: clinical dental practice and management; financing of and access to dental services; dental licensure and regulation of dental professionals; dental education; dental and craniofacial research; and global oral health. In May 2002, the Council conducted its review of this report and subsequently forwarded its final set of comments and level of involvement in related activities to the Future of Dentistry Oversight Committee.

Response to Assignments from the 2001 House of Delegates

Labeling of Local Anesthetic Cartridges: Resolution 2H (*Trans.*2001:463) from the 2001 House of Delegates called for the Association to implement the ADA policy on uniform color coding of local anesthetic cartridges and to develop a time frame for implementation. To further this process, the Council on Scientific Affairs held a meeting on February 21, 2002, at Association Headquarters with manufacturers of ADA-Accepted local anesthetics. Among the items discussed were additions and deletions to the ADA Color-Coding System, a suggested format for the color code, and the time frame for implementation of the coding system. The manufacturers were highly supportive of the ADA's efforts in developing the color-coding system and agreed on a format for the color code (a colored band a specified distance from the plunger end of the cartridge), black lettering for all labeling on the cartridge, and a one-year time period for implementation. The manufacturers also agreed to assist the Association in promotion of the coding system.

The color-coding system and the format to which the manufacturers agreed are as follows, and will be implemented as part of the Seal Program requirements in 2003.

ADA Color Coding System for Local Anesthetic Cartridges

Product	PMS Color Code*
Lidocaine 2% with Epinephrine 1:100,000	Red: 185, 186, 199 or 200
Lidocaine 2% with Epinephrine 1:50,000	Green: 347, 348, 355 or 356
Lidocaine Plain	Light blue: 279
Mepivacaine 2% with Levonordefrin 1:20,000	Brown: 471, 477, 478, 498 or 499
Mepivacaine 3% Plain	Tan: 466, 467 or 468
Prilocaine 4% with Epinephrine 1:200,000	Yellow: 108, 109, 110, 115 or 116
Prilocaine 4% Plain	Black
Bupivacaine 1.5% with Epinephrine	Blue: 300 or 301
Articaine 4% with Epinephrine 1:100,000	Gold: 871, 872, 873, 874 or 875

*Pantone Matching System (PMS), Pantone, Inc.,

Color Code Format

1. The color code shall consist of a band 3.0 ± 0.5 mm wide at a distance of 15 ± 5 mm from the stopper end of the cartridge.
2. Lettering on the cartridge shall be black and font size should follow FDA labeling guidelines (headings at least 8 point type and text at least 6 point type).
3. The end cap of the cartridge may be either color-coded to match the ADA Color-Coding System or given a silver color.
4. The stopper will not be color-coded and should not be indicative of the drug or color code.

Action Plan for Evidence-Based Activities: As part of an ongoing effort to define evidence-based dentistry (EBD) and the Association's role in this area, the Board of Trustees, at its December 2000 meeting, adopted a resolution to establish an interagency Task Force, led by the Council on Scientific Affairs, to coordinate all Association activities related to evidence-based dentistry (Resolution B-163-2000). The following Association councils were also asked to appoint a representative to this interagency EBD Task Force: Dental Practice; Dental Benefit Programs; Dental Education and Licensure; Ethics, Bylaws and Judicial Affairs; and Access, Prevention and Interprofessional Relations. A trustee liaison was also appointed to the Task Force, as well as two expert consultants.

The interagency Task Force on Evidence-Based Dentistry held its first meeting on August 2, 2001, at Association Headquarters to focus on the Association's short-term initiatives, including the review and adoption of a definition of evidence-based dentistry, the development of an EBD policy statement, and the education of ADA members regarding EBD-related issues. The Task Force recommended amending the Board-approved working definition of evidence-based dentistry (adopted in Board resolution B-163-2000) by replacing the word "melding" with "integration," which the Task Force felt to be a more precise and appropriate descriptor. The Task Force incorporated this revised EBD definition into the proposed policy statement and submitted it to the Board of Trustees for review and further guidance. The Board, in turn, referred the proposed ADA Policy Statement on Evidence-Based Dentistry and the Task Force's ideas on the action plan to the Council on Scientific Affairs for further development of specific action items and their cost implications. Additionally, the Board of Trustees requested that the Council submit a report for Board review before submitting it to the 2001 House of Delegates (B-121-2001). This evidence-based action plan and the EBD policy statement were reviewed and approved by the Board and ultimately adopted by the 2001 House of Delegates (Resolution 107H-2001, *Trans.*2001:462).

Besides various educational activities for members, the action plan for evidence-based activities cited three major efforts for 2002: (1) a conference on evidence-based dentistry, (2) the formation of an EBD advisory committee, and (3) resource development for clinical EBD studies. Accordingly, in November 2001, ADA President Dr. Gregory Chadwick appointed an ad hoc EBD advisory committee, which will hold its first meeting on May 31, 2002, at Association Headquarters. The purpose of this advisory committee is to ensure that all aspects of dental practice, education and research are considered when the Association addresses any EBD-related activity.

Educating the membership about EBD is a critical component to the evidence-based action plan. As an initial step in this undertaking, the Council on Scientific Affairs is sponsoring an educational program on evidence-based dentistry at the 2002 annual session in New Orleans. At this session, some of the preeminent authorities on this topic will discuss what EBD is, what it is not, and how members can introduce it into their patient care. Speakers will help to allay some members' fears that EBD is a "cookbook" that dentists must follow, and that it establishes a standard of care. To further educate the membership, the newly adopted ADA policy statement on evidence-based dentistry will be submitted for publication in *JADA*, along with an accompanying article that will appear in the upcoming "Practical Science" monthly feature and be authored by members of the ad hoc EBD advisory committee. The Council has additional EBD educational efforts underway as well, including posting the EBD policy statement and related information online at ADA.org.

Additionally, the House-adopted EBD action plan notes that there is a shortage of resources to conduct the clinical studies necessary to answer many of the clinical questions posed through the EBD process. The action plan calls for the Association to work with health foundations, industry, the National Institute of Dental and Craniofacial Research (NIDCR), and the Agency for Healthcare Research and Quality (AHRQ) to ensure that funding will be available to train dentist researchers and to conduct clinical studies. The Council hopes to identify these potential resources through the planned conference on evidence-based dentistry, which will bring together the ADA, NIDCR, AHRQ, American Association for Dental Research (AADR), American Dental Education Association (ADEA), the Cochrane Collaboration and dental specialty organizations to

discuss the following: the role an evidence-based approach should take in dentistry; what other organizations have done and are doing in the area of EBD; and ways in which the Association can take a leadership role in coordinating efforts to determine which clinically relevant diagnostic and treatment procedures require analysis. The Council anticipates holding this conference in late 2002, and will work to have the results of this conference evolve into future collaborations and EBD-related efforts among these leading agencies.

A supplemental report on the implementation of Resolution 107H-2001 will be prepared by the ad hoc EBD advisory committee for submission to the Board of Trustees.

Xerostomia (Dry Mouth Syndrome): In response to House Resolution 87H-2000 (*Trans.*2000:481), the Council on Scientific Affairs initially authorized preparation of a draft report on the problem of xerostomia. At its May 2001 meeting, the Council reviewed and approved this draft report and approved an action plan for effectively communicating with health care constituencies and member dentists about the problem of xerostomia. These documents were forwarded to the 2001 House of Delegates, which adopted the action plan as presented in the Council on Scientific Affairs' Supplemental Report 1 to the House of Delegates (*Supplement* 2001:9013).

The Council's action plan to address the issue of xerostomia included several short-term initiatives to be completed by the end of 2002, most of which have either been completed or are in progress. First, the Council's xerostomia report was published in the December 2001 issue of *JADA* and was accompanied by a "Dental Product Spotlight" feature on ADA-Accepted saliva substitutes (see "JADA Dental Product Spotlight" in the Product Evaluations and Evaluation Criteria section of this report). Also, a revised patient education brochure that addresses the problem of xerostomia and the role of dentists in treating this condition has been developed by the ADA Department of Salable Materials and Division of Science staff, in cooperation with the Council on Scientific Affairs. The revised xerostomia brochure was reviewed and approved by the Council, and is available to member dentists through the Department of Salable Materials.

Working with the Division of Communications, the Council made significant progress on additional action plan goals, including the following: emphasizing xerostomia in the Association's annual "Adult Oral Health Awareness" (AOHA) promotion; developing a statement on xerostomia in spring 2002, along with a link for frequently asked questions, for online publication in the public area of ADA.org; preparing a "For the Dental Patient..." page with xerostomia information for publication in *JADA*; preparing articles that are suitable for the Dental Editors' Digest; and training ADA spokespersons on communicating the problem of xerostomia to the press and other media outlets.

Additionally, the Council has held preliminary discussions with NIDCR in a collaborative effort to organize a conference that would cover the management of xerostomia through the cooperation of dentists, physicians and pharmacists. This conference, which requires extensive planning by participating agencies, is not expected to be held before 2003 at earliest.

Labeling of Latex-Containing Products: The 2001 House of Delegates referred Resolution 88H-2001 (*Trans.*2001:463), Labeling of Latex-Containing Products, to the Council on Scientific Affairs for implementation. This resolution directed the Association to urge that all products used in dentistry that contain latex (or latex-processing chemicals), either in the product or its packaging, be clearly identified as such by the manufacturer. This resolution extends the current FDA requirements for latex labeling on devices by requesting latex warning labeling on all dental products, including drugs and devices that are currently exempt from 510(k) requirements.

In accordance with this House directive, the Council required that Seal Program manufacturers of dental products with latex in the product or packaging add the following statements to product labeling where applicable: "Caution: This product contains rubber latex, which may cause allergic reactions"; and/or "Caution: The packaging of this product contains rubber latex, which may cause allergic reactions." Furthermore, the Council asked the manufacturers to comply with this House resolution in a prompt and reasonable fashion. A letter has been sent to manufacturers notifying them of the Association's policy regarding labeling of natural rubber latex-containing dental products. The Council also plans to inform non-Seal manufacturers about this House resolution through their respective trade associations.

Scientific Information and Research

Oral-Systemic Health Symposium Series: In June 2000, the Board of Trustees approved the Council on Scientific Affairs' proposal to plan and coordinate an annual symposium series addressing recent research and therapeutic recommendations on oral and systemic health interactions. Following Board approval, the ADA Health Foundation (ADAHF) provided funding and support for this ADA symposium series.

On July 26-27, 2001, the first installment of this symposium series, entitled "Taking Oral Health to Heart: Exploring the Interrelationship Between Oral and Cardiovascular Disease," was held at ADA Headquarters in Chicago. This well-received, one-and-a-half-day symposium explored the interrelationship between oral and cardiovascular disease, with particular emphasis on potential clinical implications for dentists.

The consensus among symposium speakers was that more work needs to be done to identify the relationship between these diseases. Studying the interrelationship of these diseases is extremely difficult because of the number of common risk factors and the likelihood of residual confounding. The speakers urged caution when interpreting the results of epidemiologic studies, and that these results should not serve as the basis for treatment recommendations. As noted at this symposium, while a concept may be biologically plausible, the ultimate test is whether intervening the progress of one disease (e.g., periodontitis) has an effect on the other (e.g., acute myocardial infarction). Proceedings from this first ADA oral-systemic symposium will be published in *JADA* in early summer 2002.

The second installment of the symposium series will be held during the ADA annual session in October 2002. In this second symposium, leading researchers and scientists will update member dentists and other interested attendees on the interrelationship of oral diseases with a variety of systemic conditions. Dr. Sol Silverman will serve as symposium moderator. The scheduled speakers and their specialty areas include Dr. Raul Garcia (cardiovascular diseases), Dr. Brian Mealey (diabetes), Dr. Michael Glick (immunocompromised patients) and Dr. Marjorie Jeffcoat (women's health issues, such as osteoporosis and the delivery of pre-term, low birthweight babies). As with the first symposium, this event will be underwritten by the ADAHF with support from Pfizer, Inc. The proceedings of this symposium are expected to be submitted for publication as well.

Comparison of Restorative Dental Materials: Over the years, patients have become more interested in being involved in the decision-making processes of their dental and medical treatment. Accordingly, there has been a growing demand for patient information on restorative dental materials.

In late 2001, the Council recognized the need for a chart with accurate and appropriate information comparing restorative materials for use by constituent/component dental societies and member dentists to help patients make informed decisions about their individual health care needs. The Council consulted with other Association agencies to develop model charts comparing direct restorative materials (amalgam, composites, glass ionomers and resin ionomers) and indirect restorative dental materials (ceramic, porcelain-fused to metal, gold alloys, and base metal alloys). At its January 2002 meeting, the Council developed the "Comparison of Indirect/Direct Restorative Dental Materials" fact sheets. These charts were sent via e-mail to executive directors of constituent dental societies, posted in the member section of the ADA Web site, and distributed to all member dentists via *ADA News*.

Also, in May 2002, the Council reasserted its strong support of sound science and patient choice by agreeing on the continued high priority of monitoring research on the safety and effectiveness of restorative materials and providing the ADA leadership and membership with emerging scientific information.

Women's Oral Health Research: At the 2001 ADA annual session, the House of Delegates adopted Resolution 86H-2001 (*Trans.*2001:460), which called for the Association to: a) support increased funding for, and enhanced grant opportunities in, women's oral health research; b) support federal agency efforts to ensure that women are adequately represented as research subjects in dental clinical trials; and c) help disseminate research information, hold educational briefings and provide educational materials on women's oral health issues as needed and appropriate.

In partial fulfillment of Resolution 86H-2001, the Council is sponsoring a session at the 2002 ADA annual session that will update attendees on the latest developments in the management and care of female patients with specific needs and conditions, such as dry mouth syndromes and osteoporosis, as well as issues of inadequate access for some expectant mothers. Scheduled speakers for this session include Dr. Marjorie Jeffcoat, Dr. Mahvash Navazesh, Dr. Dushanka Kleinman and Dr. Sharon Siegel.

Dental Students Conference on Research: On March 16-19, 2002, the Association held its 38th annual Dental Students Conference on Research, which was sponsored by the ADA through its Health Foundation (ADAHF) with the support of Pfizer Consumer Healthcare. This conference was hosted by NIDCR on the campus of the National Institutes of Health (NIH) in Bethesda, Maryland. Participating dental students were also given the opportunity to tour the Health Foundation's Paffenbarger Research Center (PRC).

Fifty-six students representing dental schools in the United States and Canada participated in the conference, and a variety of presentations from leaders in dentistry and oral health research were delivered. The conference introduced participants to a wide range of research opportunities in epidemiology, microbiology and oral medicine, as well as the educational opportunities available for advanced training in academic dentistry and dental research. Student attendees were also able to share their own experiences in dental research with fellow students, oral health researchers and academicians, the Council chairman, and staff from the ADA and PRC.

Dr. Lawrence Tabak, NIDCR director, opened the conference with a presentation on oral health research in the postgenomic era. Other speakers from NIDCR, the ADA Division of Science, PRC and the Council on Scientific Affairs delivered presentations to the students in attendance, providing perspectives on NIH-funded activities and the ADA's own research activities. Positive feedback from the dental students in attendance demonstrated their appreciation for this conference and underscored the continued success of this annual event.

Conference on the Diagnosis and Treatment of Oral Malodor: On November 6-7, 2001, the Council hosted an ADA-sponsored Scientific Conference on the Diagnosis and Treatment of Oral Malodor at Association Headquarters. The primary goals of this conference were to provide the Association with the most up-to-date research on oral malodor and to help the ADA as it offers guidance to the profession and the public on selecting safe and effective oral malodor products.

During this two-day conference, approximately 50 experts from private practice, academia and industry discussed the causes and diagnosis of oral malodor, clinical study designs, levels of efficacy, and measurement methods used to determine whether products are effective at controlling or preventing oral malodor. It was concluded that microbial deposits on the tongue are the cause of most oral malodor cases (greater than 80%). However, the experts also noted that a thorough medical, dental and halitosis history is necessary to determine whether a patient's complaint of bad breath is of oral or systemic origin. The conference attendees determined that treatment of oral malodor by improved mechanical oral hygiene procedures can be effective for many patients, but mouthwashes should only be recommended when clinical data on safety and effectiveness exist.

The panel of experts produced a draft statement on the status of oral malodor research and product development, which was

approved by the Council on Scientific Affairs in May 2002 and made available to the Division of Communications and ADA Publishing for publication. The leading researchers in attendance also provided numerous recommendations for the Council on Scientific Affairs to consider in its development of proposed Acceptance Program guidelines for evaluating oral malodor management products.

Research of Importance to the Practicing Dentist: In accordance with the ADA *Strategic Plan: 2002-2005* and the *Bylaws* of the Association, the Council on Scientific Affairs reviews the Association's Research Agenda on an annual basis, deliberates changes required due to emerging issues, seeks input from other Association councils to ensure that the research priorities are of clinical relevance, and forwards its recommendations to the Board of Trustees. The 2002 ADA Research Agenda, entitled "Research of Importance to the Practicing Dentist" and approved by the Board of Trustees in December 2001, is set forth below. The Council acknowledges that the Agenda's list of research priorities is not exhaustive, but represents areas of particular research need. High-priority areas are marked with an asterisk.

Mission Statement

A major objective of the Association is to promote a good quality of life by improving the oral health of the public and encouraging optimal health behaviors. To achieve this objective, it is imperative that the Association take a leading role in promoting, conducting and critically reviewing research on topics related to dentistry and its relationship to the overall health of the individual. The Association should serve as a facilitator of the national dental research effort, help determine the priority of topics for research and ensure the timely dissemination of information to the profession.

I. Issues Related to the Science of Dentistry

- **Dental Biomaterials**
  1. *Promote systematic evaluation of the technique sensitivity of restorative materials.
  2. Promote research and development on sealants, adhesives and effective mercury-free biocompatible dental materials for posterior restorations.
  3. Promote research on biomimetic materials and other novel materials that minimize tooth loss or replace missing tissues.
  4. Promote research on biocompatible root canal and root end filling materials.
  5. Study the application of novel biologics in dental practice. This includes:
     - Diagnostics
     - Smart materials with diagnostic, restorative and controlled release capabilities.
  6. Create collaborative partnership to enhance the development and evaluation of engineered tissues.

- **Oral Care Management**
  1. Study the use of antibiotics, the development of antibiotic resistance and promote the development of guidelines for the use of antibiotics in dentistry, including identification of appropriate and inappropriate drug regimens and indications for antibiotic prophylaxis.
  2. *Continue research on the mechanisms of action of fluorides and the total fluoride exposure including dietary and environmental sources.
  3. Expand the research on pain and anxiety control, alternative approaches to local anesthesia, as well as approaches to intraoral and parenteral sedation and anesthesia.
  4. Promote research on regenerative procedures to maintain the natural dentition that has compromised periodontal support.
  5. Promote research in pulp biology and endodontic diagnosis and treatment to develop optimal means for maintaining the natural dentition.
  6. Promote research on the development of optimal methods for the replacement of missing teeth.
  7. Develop evidence-based indications for the placement, replacement or repair of dental restorations.
  8. Promote research on the cost-effectiveness of current dental treatment.
  9. Study the pre- and post-eruptive effects of fluoride on caries.

- **Oral Disease**
  1. *Expand research on the transmission of caries and periodontal disease.
  2. *Promote research on the early detection, diagnosis, prevention and treatment of oral and pharyngeal cancer.
  3. *Promote research for the prevention and management of oral mucosal viral disorders, such as recurrent herpetic infections.
  4. Encourage research on the diagnosis, classification and effectiveness of treatment of TMDs and orofacial pain.
  5. Promote research into the detection and treatment of early and "hidden" caries.
  6. Promote research on the etiology and treatment of pulp and periradicular disease.
  7. Expand research on the etiology, diagnosis, and classification of oral mucosal disorders, such as recurrent aphthous stomatitis and lichen planus.

- **Technology**
  1. Study the application of emerging technologies in dental practice and laboratories. This includes:
     - Diagnostic devices and methods
     - Lasers
     - CAD/CAM
     - Technology/genetic engineering
     - Imaging devices and methods

- Endodontic rotary file systems

2. Promote research to enhance imaging for determining the precise placement of implants.

- **Patient and Provider Safety**
  1. *Promote research on the use of safety devices to prevent percutaneous injuries in the dental setting.
  2. *Promote research on the health implications from exposure to aerosols generated during dental procedures.
  3. *Investigate the acceptable and attainable levels of nitrous oxide in the dental office.
  4. *Promote research on the health implications from exposure to dental materials such as dental amalgam, resins, latex and other chemicals in the dental work place.
  5. Continue research to improve procedures for the protection of patients, practitioners and allied health personnel against contact, air- and bloodborne pathogens (such as TB, HIV, HBV, HCV and HPV).
  6. *Study the need for and the cost-effectiveness of chemical collection devices (such as amalgam separators) and other aspects of waste management in dental practice.
  7. Promote studies on ergonomics as it relates to the health of practitioners and allied health personnel.
  8. Study the quality of water in waterlines in dental equipment and develop methodologies to ensure acceptable purity levels in coolant and irrigant systems.
  9. Study the potential adverse interactions between drugs used in dentistry and those used in medicine, and develop appropriate recommendations for the prevention and management of these interactions.

- **Development of Standards and Guidelines**
  1. Develop in vitro test methodologies predictive of clinical behavior to evaluate dental biomaterials and assist in standards development.
  2. Standardize protocol for clinical evaluations of dental biomaterials in both university-based and private practice-based research.

- **Systemic Health Considerations**
  1. *Promote research on the interrelationship between oral and systemic health and on clinical management as it relates to:
     - Acutely ill patients
     - Chronically ill patients
     - Cancer patients
     - Female patients
     - Pediatric patients
     - Geriatric patients
     - Saliva diagnostics
  2. Promote research on the relationship between oral (periodontal and endodontic) disease and systemic health and on clinical management as it relates to:
     - Cardiovascular disease
     - Preterm, low birthweight babies
     - Osteoporosis
     - Diabetes
  3. Study the effect that the use of different fluorosis indices has had on the reported prevalence of dental fluorosis over time.

2. **Economic, Environmental, Social and Management Issues Related to the Practice of Dentistry**

- **Access Barriers**
  1. Promote research on the socioeconomic, geographic and cultural barriers to health care and develop strategies for extending quality care to all Americans.
  2. Develop further research on the clinical management of patients who may have particular problems in obtaining access to appropriate regular care.
  3. Promote research on the links between oral disease and general health outcomes specifically regarding chronic conditions encountered in an aging population and handicapping conditions in children, and concomitant barriers to oral health care in those special populations.
  4. Promote research on the cost-effectiveness of community water fluoridation and other preventive modalities, particularly with respect to barriers to access to care.

- **Impact of Oral Health on Quality of Life**
  1. Study the social and economic impacts of oral diseases and treatments with special reference to quality-of-life functions.
  2. Study the causes of and treatments for xerostomia.

- **Practice Management Modalities**
  1. Develop simulation models to compare various oral health care delivery systems such as solo practice, multi-specialty and institution and hospital practices, as well as utilizing various combinations of auxiliary personnel, for assessment of long-term efficacy.
  2. Evaluate the electronic patient record and other aspects of oral health informatics, and their application to dental practice.

- **Environmental Issues**
  1. *Develop protocols for evaluating technologies and systems designed to reduce amalgam waste and mercury in dental wastewater.
  2. *Promote studies aimed at determining the effect of the release of amalgam waste on the environment.

3. **Issues of Information Transfer**

- **Interagency and Interprofessional Transfer**
  1. *Explore methods by which the ADA can disseminate research findings and other information available from the ADA, ADEA, NIDCR, AADR, CDC and other relevant agencies/organizations.

- **Intraprofessional Transfer**
  1. *Develop effective methods to disseminate currently existing protocols for various regimens for the prevention of oral diseases.
  2. Develop process(es) through which oral health care practitioners gain new knowledge to support life-long learning.
  3. Develop methods by which the ADA can expeditiously disseminate research findings and other information to the profession:
     - Ergonomics
     - Emerging infectious diseases
     - Evidence-based dentistry
     - Oral-systemic health interactions
     - Prevention and early detection of oral cancer
     - Waste management technologies

- **Public Transfer**
  1. *Develop methods to disseminate pertinent information on dental issues to the public.
  2. Develop effective oral health promotion strategies employed by organized dentistry to reach various public audiences.

Review of Association Policies and Statements

Use of Human Remains for Forensic and Scientific Purposes: At the 2001 ADA annual session, the House of Delegates adopted Resolution 28bH, which directed the appropriate agency of the Association to study the need for a policy that would recognize the need to preserve human remains for forensic and other scientific purposes. Accordingly, the Council on Scientific Affairs and the Council on Dental Practice were identified as the appropriate Association agencies to address this House resolution. A supplemental report on this topic will be provided to the 2002 House of Delegates.

Statement on the Safety of Home-Use Tooth Whitening Products: At its January 2002 meeting, the Council acted in response to increasing concerns about the safety and potential misuse of over-the-counter (OTC) whitening and bleaching products by recommending the revision of an existing statement on tooth bleaching agents that would include the most current scientific knowledge on tooth whitening and bleaching technologies. This statement is under development at the time of this writing. Information will be provided to the House in a subsequent report. The revised statement will be posted on ADA.org.

Product Evaluations and Evaluation Criteria

ADA Seal of Acceptance Program: The Association, through the Council's Seal of Acceptance Program, continues to provide practitioners and consumers with information on safe, effective dental materials, devices and therapeutic agents. At present, approximately 400 manufacturers are participating in the Council-administered Seal of Acceptance Program and 1,225 products carry the ADA Seal. Of the 1,225 Accepted products, 524 (43%) are over-the-counter dental drug and non-drug products, and 701 (57%) are professional products, such as dental materials, instruments, equipment and prescription drugs.

In 2001, the Seal Program essentially achieved its annual goal of 100 new product submissions by receiving 98 new product applications for Acceptance consideration. As of April 2002, 75 of the 98 new product submissions had been Accepted, though many did not meet the criteria for Acceptance upon initial review. The remaining 23 new product submissions still had not met the Seal Program's criteria for Acceptance.

***JADA* Dental Product Spotlight:** The "Dental Product Spotlight" is a monthly feature in *The Journal of the American Dental Association* that highlights an ADA-Accepted product or category of products. This feature is intended to provide dentists with current and useful information on Accepted products and to describe the scientific data that were evaluated for Acceptance.

In addition to the Spotlight feature, a companion piece has also been prepared monthly that provides useful scientific information on a topic relevant to the "Dental Product Spotlight." The ADA Division of Science, in cooperation with *The Journal of the American Dental Association*, prepares these reports. The following product spotlights/companion pieces were published in *JADA* between April 2001 and March 2002: high-speed handpieces/tips on high-speed handpieces; digital x-ray system; cassette autoclave/sterilization or disinfection of dental instruments; dentist-dispensed home-use bleaching agents/bleaching; whitening toothpastes/components of toothpastes; anticholinergics/salivation; endosseous implants/dental implants; chemotherapeutic agent to slow or arrest periodontitis/treatment of periodontitis; artificial

salivas/xerostomia; local anesthetic delivery system/local anesthetics; latex gloves/latex sensitivity; dental shade guides/tips on improving shade matching.

Council-Industry Open Sessions: Since its inception, the Council has invited industry to an annual open session to discuss issues pertaining to the Seal Program, including the *Provisions for Acceptance by the Council on Scientific Affairs* and Acceptance Program guidelines under revision or development. This year's open session was held on May 14, 2002, and provided manufacturers and industry representatives with an opportunity to meet and discuss issues of mutual interest with Council members.

Standards Activities: The Council, as part of its *Bylaws* responsibilities, provides technical expertise for the development of national and international standards for dental products. The primary vehicles for the Council's standards activities are the ADA Standards Committee on Dental Products (SCDP) and the International Organization for Standardization/Technical Committee 106, Dentistry (ISO/TC106).

ADA SCDP. In March 2002, the ADA SCDP met in San Diego to review its activities over the past year and its work program, which currently has over 95 projects registered with the American National Standards Institute (ANSI). At the meeting, the SCDP revised its operating procedures to include electronic voting and to provide a formal mechanism for consideration of ISO standards for adoption as ADA standards.

The ADA SCDP has 36 representatives from 26 dental-related organizations, including three voting members representing the Association. In 2002, Dr. Yiming Li, Council consultant, was recommended by the Council to be a voting representative of the Association.

ISO/TC106. Through the Council, technical expertise is provided to the Association-sponsored U.S. Technical Advisory Groups (US TAGs) for ISO/TC106, Dentistry. At the present time, the Association holds the Secretariats for two of the seven Secretariats in ISO/TC106: Subcommittee 2, Prosthodontic Materials, and Subcommittee 8, Implants.

The 37th ISO/TC106 meeting was held on September 10-15, 2001, in Lillehammer, Norway. The seven ISO/TC106 Subcommittees, including Subcommittees 2 and 8 and 42 Working Groups, met during this meeting. Approximately 300 delegates represented 21 countries, with 45 delegates and/or observers representing the United States. The relationship of ISO/TC106 with the FDI was discussed, and it is expected that a new agreement specifying responsibilities of the two organizations regarding standards development will be developed in 2002. At this meeting, the ISO/TC106 delegates also endorsed the concept of a standardized approach with regard to the naming of dentistry standards.

The importance of ISO standards development continues to increase on a global basis, and is having an impact on the United States as well. In particular, standardization of oral hygiene products is proceeding at a rapid pace and will soon have noticeable effects on the American marketplace. As of December 2001, 19 ISO standards have been adopted as ADA standards, with additional ISO standards also under consideration.

Outside Standards Committees: Although the Association conducts its own standards development activities, there are several outside standards organizations that develop standards that affect dentistry. These standards development activities have been addressing areas of critical importance to the dental profession (e.g., indoor air quality, laser safety), and the final voluntary standards adopted by these organizations may, in turn, be adopted by federal, state or local regulatory agencies. ADA participation in the development of these standards is essential to ensure that the practice of dentistry is properly represented in any standards or guidelines developed by these outside organizations.

In 2001-2002, Council-recommended representatives attended meetings of the following outside standards organizations to present Association positions on their standards: American Society of Heating, Refrigeration and Air Conditioning Engineers (ASHRAE), American Society of Testing and Materials (ASTM), Association for the Advancement of Medical Instrumentation (AAMI), National Fire Protection Association (NFPA), and the Laser Institute of America (LIA).

Guideline Development: The Council develops guidelines for the evaluation of products in its Seal Program where standards have not been established. Currently, the Council has completed or is developing guidelines in 54 product areas. In 2001, the Council revised or completed guidelines for automatic radiographic film processors, dentin and enamel adhesive materials, dental shade guides and visible light curing units. In 2002, guidelines are under development for products for the control of oral malodor, endosseous implants, orthodontic products and home-use stain removal products. In addition, the Council decided to initiate the development of guidelines for biofilm management in dental unit waterlines.

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

American Dental Association Health Foundation

Volpe, Anthony R., New Jersey, 2002, president
Lamacki, Walter F., Illinois, 2003, vice president
Feldman, Mark J., New York, 2003, treasurer
Bramson, James B., secretary
Austin, Joan D., Oregon, 2003, director
Barnett, Michael L., New Jersey, 2003, director
Farrell, Lawrence W., Illinois, 2003, director
Feldman, Cecile A., New Jersey, 2003, director
Finley, Leo R., Jr., Illinois, 2002, director
Haught, W. Richard, Oklahoma, 2003, director
Jones, D. Harry, Kentucky, 2002, director
Kess, Steven W., New York, 2002, director
Maggio, Frank A., Illinois, 2002, director
Powell, William D., Tennessee, 2004, director
Stamm, John W., North Carolina, 2002, director
Studstill, Zack D., Alabama, 2005, director
Sudzina, Michael R., Ohio, 2002, director
Tarrson, Linda C., Illinois, 2003, director
Payne, R. Barkley, senior director
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 in Chicago, on August 8, 2001 and on March 13, 2002.

Personnel: The close of the 2002 ADA annual session brings to an end the tenure of Dr. Leo R. Finley, Jr., a valued ADA trustee member of the Foundation's Board of Directors. The Foundation wishes to express its gratitude and appreciation to Dr. Finley for his leadership and contributions to the success of the Foundation. In addition, the following individuals were appointed to the ADAHF Board of Directors for the 2001/2002 term: Mr. Steven Kess, a public member, and Dr. Zack D. Studstill, serving as an ADA trustee representative on the Board.

The Mission of the American Dental Association Health Foundation: The ADA Health Foundation is a State of Illinois chartered 501(c)(3) organization. The mission of the ADAHF is to enhance clinical dentistry, and in turn, the oral health of America. The Foundation is a separate entity from the American Dental Association with its own purpose and programs. However, in fulfilling its charitable purposes, the Foundation materially assists the Association to "encourage the improvement of the health of the public and to promote the art and science of dentistry." For example, the ADAHF provides administrative assistance for the activities and programs of the ADAHF Paffenbarger Research Center (PRC) in Maryland and the ADAHF Research Institute (RI) in Chicago. In addition, consistent with its mission of enhancing clinical dentistry, the Foundation provides grants for a variety of worthwhile programs including dental research, scholarships, conferences and access programs.

Overview: Major strides were made in 2001 to further distinguish, or brand the ADA Health Foundation as a foundation dedicated to enhancing clinical dentistry. By funding relevant dental research, high quality education programs, competitive scholarships, innovative recognition awards and access to care projects, the ADAHF has positioned itself as America's leading charitable organization dedicated to making dentistry better for dentists and the patients they serve.

In 2001, the Foundation received 315 grant requests seeking more than $2.7 million in financial support. Following review, the Foundation Board adopted resolutions providing $769,690 in support of dental research, education/awareness and access programs in 2001. Of this amount, $305,026 was directed to research, $155,369 for education programs, and $309,295 for access/preventive dentistry programs. (Additional information on the programs receiving ADA Health Foundation grants is reported in the section titled ADAHF Grant Requests.)

To further heighten the awareness of the Foundation among its donors and non-donors, the ADAHF developed and implemented an awareness campaign in 2001. This campaign included various promotional activities that showcased the Foundation in mediums including numerous dental-related publications. The Foundation's newsletter, *CONTRIBUTOR,* was also published and distributed to nearly 4,000 friends, donors and corporate contacts.

In addition, the ADA Health Foundation continues to work with the American Dental Association in exploring a multi-million dollar fundraising initiative to help address the challenges facing dental education. The ADAHF has developed numerous administrative policies and projects that

will further position the organization to embark on such a comprehensive fundraising campaign.

Foundation Development Activities: The ADA Health Foundation annually conducts a development campaign to solicit contributions from individual, corporate, foundation and government sources. The 2001 Development Campaign included a variety of solicitations primarily through highly personalized letters sent to American Dental Association leadership, constituent and component societies, current and lapsed donors. Solicitation letters were also sent in order to acquire contributions from those who have never given to the ADAHF. Integrated with marketing strategies, the Development Campaign generated a 10% increase in the Foundation's donor base.

This Development Campaign generated approximately $1,763,623 in support, of which $1,616,906 was earmarked to support specific ADAHF charitable programs. Of this amount, $1,126,977 was received from Association members and/or dental organizations, $11,838 donated by nonmembers, $600,809 was received from companies and representatives from the dental industry, and $4,000 was received from foundations. The Foundation also received $40,000 from the benefit performance featuring Cirque during the ADA annual session. This benefit was made possible by Citibank USA through their partnership with the ADA Member Advantage Program.

In addition, the ADA Health Foundation secured a consultant to assist the organization in developing a planned giving program. As part of this process, a *Planned Giving Audit Report and Recommendations* were prepared by the consultant and approved by the Board of Directors. Recommendations from this report were incorporated into a three-year implementation plan. The planned giving program and a formal Gift Acceptance Policy will continue to be developed in 2002.

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 year ending December 31, 2001. This Circular requires an annual independent audit addressing financial, internal control and compliance matters. Concerning compliance, 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 was presented to the Audit Committee of the ADA Board of Trustees at the April 2002 meeting.

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 at the end of this report indicate that for the year ending December 31, 2001, $2,635,939 was expended for sponsored purposes. The major areas of expenses were federal government funded research totaling $1,088,269 and corporate and donor sponsored programs amounting to $1,547,670.

ADAHF Grant Program: During its August 2001 and March 2002 meetings, the ADA Health Foundation Board of Directors considered 48 requests for grant support for scientific research, educational and access-related projects. Two requests were in response to the Request for Proposal (RFP) for the New Dentist-Scientist Award.

The ADAHF Grant Administration Committee and the Board of Directors considered all 46 unsolicited grant requests. All requests submitted to the Foundation for consideration are 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 to discern the overall merit of the proposed activity.

Scientific Research Grants. The ADAHF Board reviewed six scientific research proposals and determined that two merited funding. (Additional information on these projects is reported in the section titled Funding for Research Fellowships.)

In addition, the Board reviewed and authorized the conversion the Instron material testing machines at the Paffenbarger Research Center (PRC) and the Research Institute (RI) as well as the acquisition of scientific equipment including a Thermo Nicolet Nexus Optical Spectrometer to further enhance the research conducted at PRC.

Dental Education Grants. During the reporting period, the Foundation Board reviewed several grant requests/proposals aimed at broadening educational opportunities for the profession and the public. This review resulted in ADAHF grant support for the following:

- ADA Council on Scientific Affairs Symposium titled: *Taking Oral Health to Heart: Exploring the Relationship Between Oral and Cardiovascular Disease*
- American Dental Education Center for Educational Policy and Research
- American Society of Dental Foundation Executives
- Annual National Conference of Special Care Dentistry
- Intel International Science & Engineering Fair
- National Museum of Dentistry *Mouth Power Tobacco Use Prevention & Oral Cancer Awareness Program*

Access-Related Grants. During the reporting period, the Foundation Board reviewed several grant requests for access programs. This review resulted in ADAHF grant support for the following:

- Howard Dental Clinic for HIV+/AIDS Oral Health
- Infant Welfare Society of Chicago
- Inner City Health Center, New Hope Dental Services Program
- The National Foundation of Dentistry for the Handicapped

- Special Olympics, Special Smiles
- St. Basil's Free Dental Clinic
- Su Salud

Samuel D. Harris Fund for Children's Dental Health Grants Program. With the successful completion of the second grants program associated with the Samuel D. Harris Fund for Children's Dental Health, a revised RFP was distributed in December 2000. Articles and other informational releases were placed in *ADA News*, the Executive Director's newsletter, as well as the Foundation's Web site to promote the grants program. As a result, 285 grant applications were received by July 31, 2001. Following reviews by the Harris Fund Advisory Committee and the ADAHF Board of Directors, $136,425 in grants were awarded to support 29 dental health care and education organizations. This amount represents the interest earned from the endowment fund and a generous contribution from the Procter & Gamble Company and Unilever Home & Personal Care. Recipients of the 29 cash awards included:

- Altoona Hospital Partnership—Altoona, PA
- Baylor College of Dentistry—Dallas, TX
- Board of Education of the City of New York—Scarsdale, NY
- Boone County Department of Public Health—Belvedere, IL
- Cape Girardeau County Public Health Center—Cape Girardeau, MO
- Capital Area Community Services—Lansing, MI
- Catawba Health District—Lancaster, SC
- Children's Hospital of Columbus—Columbus, OH
- Chinatown Health Clinic—New York, NY
- Christian Health Center, Inc.—Heber Springs, AR
- Community Resource Center—Buffalo, WY
- Dentists Who Care—Harlingen, TX
- Fairfield County Health Department—Winnsboro, SC
- Foundation for Excellence—Baton Rouge, LA
- Henry County/Napoleon City General Health District—Napoleon, OH
- Loma Linda University—Loma Linda, CA
- Lower/Outer Cape Community Coalition—Eastham, MA
- Maui County Dental Health Alliance—Wailuku, HI
- Missouri Coalition for Oral Health Access—Jefferson City, MO
- Polk County Health Center—Bolivar, MO
- Saint Mary's Health Network—Reno, NV
- Sixth District Dental Society—Northport, AL
- Southern Kentucky Area Health Education Center—Berea, KY
- Springfield Dental Foundation—Springfield, MO
- Texas Dentists for Healthy Smiles—Austin, TX
- United Way of Gordon County—Calhoun, GA
- University of Iowa, College of Dentistry—Iowa City, IA
- University of Rochester Medical Center—Rochester, NY
- Vista Community Clinic—Vista, CA

Funding for Research Fellowships: As part of its mission, the ADAHF provides financial support for research awards and fellowships.

American Association for Dental Research (AADR). The ADAHF Board of Directors approved funding for three AADR research fellowships. 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. The three AADR fellowship protocols receiving Foundation support in 2001 included studies titled: *Do Different Types of Hydrogels Used for Tissue-Engineering Effect Cell Adhesion Differently*, *An Evaluation of Parental Satisfaction and Perception of Pediatric Dental Treatment Using General Anesthesia*, and *Can Craniosynotosis be Prevented by Blocking TGF-Beta2*. Funding for these fellowships is made possible by the ADA Health Foundation through a $9,000 contribution from the Optiva Corporation.

Young Investigator Award. As a requirement of the Specialized Materials Science Research Grant from the National Institute of Dental Research, the ADAHF 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 made possible by the ADA Health Foundation through a $7,800 contribution from the Colgate-Palmolive Company.

Research Training Fellowship. The Research Training Fellowship program is conducted at the ADAHF Paffenbarger Research Center. The program includes a full-time fellow working in conjunction with the PRC's scientific research staff. This program is made possible by the ADA Health Foundation through a $30,000 contribution from the 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 Craniofacial Research (NIDCR) dentist scientist program. Candidates must have completed the NIDCR program within the past three years and have not received grant funding. In addition to the $7,500 awarded by the Foundation, each recipient was provided a $7,500 matching award from the researchers' institution. In 2001, the two research protocols receiving Foundation support included studies titled: *Targeting the Caspase-9 Apoptotic Pathway in Microvessels of Oral Tumors* and *Construction of an Actinobacillus actinomycetemcomitans fur Mutant*. This program is made possible by the ADA Health Foundation through a $15,000 contribution from Pfizer Consumer Healthcare, Pfizer Inc.

Funding for Extramural Programs and Awards: In fulfilling its commitment to other Association agencies and outside organizations, the Foundation provided financial support to the following extramural programs and awards.

Dental Student Research Conference. Managed by the Association's Council on Scientific Affairs, the Dental Student Research Conference introduces pre-doctoral dental students to the wide range of educational opportunities available to those preparing for careers in dental research. In 2001, the conference was held at the National Institute of Dental Craniofacial Research, Bethesda, Maryland. This program is made possible by the ADA Health Foundation through contributions totaling more than $45,700 from Pfizer Consumer Healthcare, Pfizer Inc. 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, dental school faculty and appointees have enhanced and broadened the scholarship programs. For the 2001/2002 scholarship program cycle, the Foundation provided $90,000, or one-half of the total amount awarded in scholarships by the Endowment Fund. The increased funding provided by both agencies resulted in an increased number of scholarships awarded. This program is made possible by the ADA Health Foundation through contributions from the Colgate-Palmolive Company, Procter & Gamble Company, Oral-B Laboratories, the Bosworth Company, Eastman Kodak Company and Handler Manufacturing Company.

ADA Health Foundation 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 created 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 Health Screening serves the public through early detection of oral cancers, heart disease and latex allergies. At the 2001 ADA annual session in Kansas City, Missouri, a total of 821 dentists, dental hygienists and dental assistants participated in the ADA Health Foundation's Health Screening Program (HSP). Dentist participation in the 2001 HSP increased 17.8% over the HSP held in Chicago one year earlier. In addition to promoting the HSP, this increase in participation may be partly attributable to the addition of three new serum tests offered in connection with the HSP: (1) N-telopeptide, a marker of osteoporosis; (2) thyroid stimulating hormone (TSH), a marker for thyroid gland function; and (3) prostate specific antigen (PSA), a marker for prostate cancer in men. These three tests were optional and offered at cost to the HSP participants. The other tests offered in Kansas City are part of the ADAHF's ongoing research into the occupational health of the dental team. More than $90,000 in Health Screening direct costs were underwritten by the Health Foundation and made possible by business and corporate contributions.

Community Preventive Dentistry Award. The Community Preventive Dentistry Award program, begun in 1972, recognizes individuals and organizations that 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 $2,500 were given to the Assistance League of Portland Children's Dental Center, Portland, Oregon. Also presented during 2001 were three meritorious awards winners which included: Happiness is a Healthy Smile, New York, New York; Dallas County Sealant Initiative of Dallas, Texas; and Anderson Center for Dental Care: Project Adopt – A – Home, San Diego, California. Each meritorious winner receives $500. This program is made possible by the ADA Health Foundation through a contribution from Johnson & Johnson Oral Health Products.

*Geriatric Oral Health Care Award***.** The Geriatric Oral Health Care Award was initiated in 1984. The award recognizes individuals and organizations that have improved the oral health care of older Americans through innovative community health care delivery projects. During 2001, the ADA Council on Access, Prevention and Interprofessional Relations identified the Carolinas Mobile Dentistry Program, Charlotte, North Carolina, as the $2,500 award recipient. This program is made possible by the ADA Health Foundation through a contribution from Pfizer Consumer Healthcare, Pfizer Inc.

*Gold Medal Award***.** The Gold Medal Award for Excellence in Dental Research was first awarded in 1981, and is bestowed every third year. At the 2000 annual session, Dr. William H. Bowen, of the Center for Oral Biology, School of Medicine and Dentistry, University of Rochester, was presented the Gold Medal Award. In addition to the gold medal, recipients of the award receive $25,000. This program is made possible by the ADA Health Foundation through a contribution from Unilever Home & Personal Care and a grant from 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 accomplishment in clinical investigation that has significantly contributed to the prevention of oral diseases. Based on a six-member selection committee recommendation, Dr. Lorne M. Golub, of the School of Dental Medicine, Stony Brook, New York, received the award and $5,000 in 2001. This program is made possible by the ADA Health Foundation through a contribution from Pfizer Consumer Healthcare, Pfizer Inc.

Frederick S. McKay Award. The Frederick S. McKay Award for Excellence in Preventive Dentistry was created to publicly recognize a dental practitioner who, while engaged in private practice or academia, has made a significant research or clinical contribution to the public's oral health care. Established in 1995, the award—in the amount of $5,000—is currently bestowed every other year and was awarded to Dr. James W. Bawden, University of North Carolina School of Dentistry, during the 2000 annual session of the Association. This program is made possible by the ADA Health Foundation through a contribution from the Crest family of oral care products.

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, 2001

Table 1: Federal Government Sponsored Research Program Expenditures

	Expenditures[*]
U.S. Department of Health and Human Services:	
National Institute of Dental Research	
Prevention of Dental Caries	$ 277,681
Improvement of Preventive and Restorative Materials	295,725
Calcium Phosphate Bone Repair Materials	199,154
Ceramic Whisker Reinforcement of Dental Composite Resins	105,118
Amorphous Calcium Phosphate Based Dental Materials	140,409
Remineralizing Pulp-Capping Cements and Bonding Agents	34,799
Total Federal Awards and Expenditures U.S. Department of Health and Human Services	**1,052,886**
U.S. Department of Commerce:	
Characterization of Pyrophosphates	9,563
Develop and Prepare Raman Standard Composition Glass	20,000
Synthesize Polyanhydride	5,820
Total Federal Awards and Expenditures U.S. Department of Commerce	**35,383**
Total Federal Sponsored Research Program Expenditures	**$1,088,269**[†]

[*] Expenditures include purchases of capital equipment for governmental and corporate sponsored projects.
[†] Federal Sponsored Research Activity is comprised of direct costs of $619,576 and indirect costs of $468,693. The recovered indirect costs are reimbursed to the American Dental Association for financial and administrative services rendered.

Table 2: Corporate Sponsored Program Expenditures

	Expenditures[*]
Research:	
Patent Royalties	
Calcium Phosphate Cements	$ 27,913
ACP Enamelon (Remineralization)	3,573
Ivoclar NA	2,000
Dentin Bonding	67,557
Bioactive Polymeric Dental Composites	9,463
Pulp-Capping Cement Award	27,693
Radiation Shielding	750
Patent Legal Fees	120,096
Staff Transition Funds	253,979
PRC Equipment Purchases	51,657
Foundation Equipment Maintenance	44,662
	609,343
Paffenbarger Research Center	
Corporate Grants	2,773
Micro Equipment Fabrication	394
Young Investigators Award	57,012
NMR Facility	9,754
Instrument Fabrication	35,149
Warner-Lambert Mouthrinse Study	57,874
Warner-Lambert Chewing Gum Study	31,402
Colgate Toothpaste Study	51,127
	245,485
Subtotal—Research	**854,828**
Extramural Programs:	
Dental Student Research Conference	45,718
Health Screening Program	88,604
Community Preventive Dentistry	11,949
Seminar Program	25,539
Geriatric Health Care	9,128
Oral and Systemic Health Interactions	35,370
Subtotal—Extramural Programs	**216,308**
Awards:	
General Fellowship/Grant project	15,057
Gold Medal	451
Norton M. Ross Award	10,639
Bernard J. Conway	56
Subtotal—Awards	**26,203**
Total Corporate Sponsored Program Expenditures	**$1,097,339**

[*] Expenditures include purchases of capital equipment for governmental and corporate sponsored projects and an allocation of annual investment returns.

Table 3: Other Program Expenditures

	Expenditures[*]
Education:	
Dental Education—Unrestricted	$ 36,000
Student Scholarship Program	99,000
Allied Health Scholarships	500
Subtotal—Education	**135,500**
Access:	
Access Program—Unrestricted	**15,000**
Trusts and Endowments:	
Magnuson Trust (Periodontal Research)	2,459
Harper Fund (Public Education in Dental Health)	210
Bartfield Bequest (Memorial)	883
Harris Fund—Children's Dental Health	150,762
ADABEI Dental Education Fund	5,281
Subtotal—Trusts and Endowments	**159,595**
Other:	
Prior Year Balance	125,236
Unrestricted Contributions	15,000
Subtotal—Other	**140,236**
Total Other Program Expenditures	**450,331**
Total Corporate and Donor Sponsored Programs	**1,547,670**
Total Sponsored Activity Expenditures (Tables 1, 2 and 3)	**$2,635,939**

[*] Expenditures include purchases of capital equipment for governmental and corporate sponsored projects and an allocation of annual investment returns.

ADA Health Foundation Research Institute

Fan, P. L., senior director
Siew, Chakwan, senior director, Laboratories
Batchu, Hanu, assistant director, Critical Issues
Gruninger, Stephen, assistant director, Safety and Biocompatibility

The Research Institute (RI), part of the American Dental Association Health Foundation (ADAHF) and located within the ADA Division of Science, conducts applied research in response to critical and emerging issues identified by the Council on Scientific Affairs and the ADA Research Agenda in the delivery and improvement of oral health care. The RI also participates in collaborative research with the ADAHF Paffenbarger Research Center (PRC) and hosts research externs from the American Student Dental Association (ASDA) and visiting faculties from several universities. As part of its core activities, the RI reviews research proposals received by the ADAHF and acts as scientific liaison to ADAHF-funded research projects, including the Health Screening Program.

The Strategic Plan of the American Dental Association: The RI's activities are in accord with the duties of the ADAHF and the strategic plan of the ADA through research on issues that impact the oral health of the public, the health of the dental team and the practice of dentistry.

Current and ongoing research projects focus on occupational health (via the Health Screening Program), safety and effectiveness of dental therapeutics and materials, dental office wastewater, dental unit waterlines, and safety in the dental office. Findings of the RI research are reported in peer-reviewed publications, abstracts and presentations at scientific meetings. Copies of published materials are available on request.

2001 Health Screening Program: At the 2001 ADA annual session in Kansas City, a total of 821 dentists, dental hygienists and dental assistants participated in the ADAHF Health Screening Program (HSP). Dentist participation in the 2001 HSP in Kansas City increased 17.8% over the HSP held in Chicago one year earlier. There were three optional serum tests that were offered at cost to participants: (1) N-telopeptide, a marker of osteoporosis; (2) thyroid stimulating hormone (TSH), a marker for thyroid gland function; and (3) prostate specific antigen (PSA), a marker for prostate cancer in men. The other tests offered at no cost to participants are part of the RI's ongoing research into the occupational health of the dental team.

Hepatitis B and C Results. Over 90% of the dentists participating in the 2001 HSP reported they were hepatitis B vaccine recipients. Of the 645 dentists who participated in testing for hepatitis C virus (HCV) antibodies, four initially tested positive for HCV through an enzyme-linked immunosorbent assay (ELISA). Two of these four individuals were repeat positives from previous years. Following immunoblot confirmation, three were determined to be definitively positive for HCV infection and one indeterminate (i.e., a borderline positive of HCV infection). In sum, less than 1% of participants in the 2001 HSP were HCV positive, which is below the level found in the general population of the United States (1.5-2.3%, as reported by the Centers for Disease Control and Prevention). These results further corroborate a previous publication by the Council on Scientific Affairs, which indicated that the chances of HCV transmission in dental settings appear remote.

Urinary Mercury. Among the 507 dentists who participated in the 2001 HSP, the average urinary mercury level was 4.1 µg Hg/L (ppb). This level is almost identical to the urinary mercury level of the general population (about 4 µg Hg/L [ppb]), further indicating the profession's compliance with ADA-recommended mercury hygiene practices.

Oral Cancer Screening. Oral cancer screening using computer-assisted brush biopsy technology was also included in the 2001 HSP. Out of 336 participants, 29 suspected lesions from 29 participants were brush-biopsied, and one was confirmed to be "atypical" and potentially neoplastic by computer-assisted brush biopsy technology. A private oral surgeon performed a follow-up scalpel biopsy of this lesion, and it was determined to be non-cancerous. During the previous two HSPs (1999 and 2000), a total of seven individuals were identified to have "atypical" and positive lesions by computer-assisted brush biopsy technology, with three of the seven confirmed by scalpel biopsy to have pre-cancerous lesions.

Latex Hypersensitivity Screening. Allergy to latex proteins has been a significant concern for healthcare providers, particularly since the Occupational Safety and Health Administration (OSHA) mandated the use of gloves for all procedures involving contact with a patient's bodily fluids. Upon completion of testing for immediate (Type I) allergy to gloves made from natural rubber latex (NRL) by performing skin-prick tests on HSP dental professionals, a clear trend has emerged in the data. Among dental professionals tested in the HSP, there has now been a six-year downtrend in the prevalence of immediate hypersensitivity to latex proteins. After a peak prevalence in 1996 (8.5%, N=866), the prevalence of latex hypersensitivity declined in subsequent years: 1997, 7.2% (N=614); 1998, 5.5% (N=651); 1999, 4.9% (N=633); 2000, 4.3% (N=626) and 2001, 1.8% (N=440). This significant decline in NRL sensitizations is most likely due to improved manufacturing and quality control techniques, which have minimized the amount of protein in examination gloves.

Safety and Effectiveness of Dental Therapeutics and Materials:

Natural Rubber Latex and Gutta Percha. Recent reports suggested the possibility of immuno cross-reactivity between natural rubber latex and gutta percha proteins in endodontic points. Using an inhibition ELISA assay, the RI conducted a study to assess cross-reactivity between antigenic proteins derived from gutta percha and NRL. Aqueous protein extracts were prepared from raw gutta percha, 13 brands of gutta percha points, and NRL gloves. After incubation with NRL antibodies, none of the extracts from raw gutta percha or gutta percha points were reactive. On the other hand, similar NRL glove extracts were highly reactive. This RI study demonstrated no immunologic cross-reactivity between raw gutta percha, gutta percha points, and proteins derived from NRL gloves. Thus, exposure to gutta percha endodontic points does not appear likely to initiate immediate hypersensitivity in individuals sensitized to NRL proteins.

Fluoride in Toothpaste. The RI continues to develop laboratory evaluation methods for product effectiveness. A previously used method to measure available and total fluoride in toothpastes has limitations in evaluating fluoride in newly introduced toothpastes that contain complex and novel ingredients. To address this issue, the RI developed a new method that utilizes suppressed ion chromatography to analyze fluoride in toothpastes. This method has shown to be applicable to fluoride determinations for toothpastes with complex formulations and is being incorporated into the Council on Scientific Affairs' Acceptance Program Guidelines for Fluoride-Containing Dentifrices.

Toothbrushes. Currently the designations of toothbrushes as "soft," "medium" and "hard" are not clearly defined. The RI evaluated the applicability of a proposed international standard to define these designations based on measuring the stiffness of the bristles of toothbrushes having brush heads featuring flat surfaces. Based on the results of toothbrush bristle stiffness testing, according to the proposed international standard, most of the 77 brands of toothbrushes tested could be properly designated. As the proposed standard cannot measure accurately the stiffness of bristles in toothbrushes that are designed to have more complicated brush heads and bristle surfaces, the RI is investigating whether a modification of the proposed test could extend the applicability of the proposed international standard to the toothbrushes whose brush heads are not flat surfaces.

Curing Lights and Depth of Cure of Resin-Based Composites. Adequate curing of resin-based composites is paramount in their clinical performance. The RI evaluated the curing light intensity and the depth of cure of resin-based composites using international standards for curing light intensity and depth of cure measurements. Curing lights with an intensity of 300 mW/cm^2 appear to effectively cure most resin-based composites to 2 mm depth of cure when appropriate curing times were used. The study also suggested an in-office method dentists can use to verify the depth of cure of their resin-based composites. The results of this study were published in: Fan PL, Schumacher RM, Azzolin K, Geary R, Eichmiller FC. "Curing-light intensity and depth of cure of resin-based composites tested according to international standards." *Journal of the American Dental Association* 2002;133(4): 429-434.

Dental Unit Waterline Contamination (DUWL): In early 2001, the RI surveyed contamination of water from dental unit waterlines in volunteer dental clinics to assess the impact of improvements in current technology for the reduction of dental unit water contamination. Approximately 30 mL of water were aseptically collected from each high-speed handpiece and air/water syringe at monthly intervals for six months. The dental units were connected to a tap water supply or self-contained water reservoirs. Diligent attention to DUWL disinfection was required to achieve and maintain less than 200 CFU/mL. The majority of clinics surveyed were unsuccessful in meeting the goal of 200 CFU/mL in dental unit water. Increased efforts to motivate clinicians to retrofit older dental units to reservoir systems, along with increased awareness that treatment regimens must be strictly followed, may increase compliance in minimizing dental unit water contamination.

Safe Needle Devices and Occupational Safety in the Dental Office: In an effort to protect health care workers from percutaneous injuries in the health care environment, the Occupational Safety and Health Administration (OSHA) revised its Bloodborne Pathogens Standard in January 2001 to clarify the duty to provide engineered sharps protection to health care workers at occupational risk of exposure to bloodborne pathogens. The revised standard requires dentists to evaluate, with input from at risk employees, commercially available safety needle devices and adopt those determined to be effective.

The RI is undertaking a study to gather scientific information from practicing dentists with regard to the use of safety needles. A specific objective of this study is to provide dentists with an evaluation tool to help them judge the effectiveness of commercially available safety needle devices and, furthermore, to evaluate new devices as they are introduced in the dental marketplace. Another objective is to facilitate the development of ADA guidelines for the acceptance of safety needle devices as appropriate and effective for use in dentistry.

Amalgam in Dental Office Wastewater: The RI conducted a laboratory evaluation of 12 commercially available amalgam separators for their amalgam removal efficiency using the international standard ISO 11143. During this test, the evaluation also measured the total mercury concentrations in effluent from the amalgam separators.

Using amalgam samples containing particles between 3.15 mm to 0.001 mm as defined by ISO 11143, the RI evaluation showed that all 12 amalgam separators exceeded the ISO 11143 requirement of 95% amalgam removal efficiency. The total mercury concentrations in the effluent ranged from 10

ppb to over 30,000 ppb. The results of this laboratory evaluation are published in: Fan PL, Batchu H, Chou H-N, Gasparac W, Sandrik J, Meyer DM. “Laboratory evaluation of amalgam separators.” *Journal of the American Dental Association* 2002;133(5): 577-584.

The RI continues to assist constituent and component dental societies by providing scientific support in responding to amalgam wastewater issues, including reviewing waste management documents, research protocols and research results. The RI also assisted the constituent dental societies of California, Minnesota, Ohio, Oregon, Washington and several other states in addressing amalgam wastewater issues.

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
Carey, Clifton, director, Administration
Bowen, Rafael L., distinguished scientist
Chow, Laurence C., assistant director and chief research scientist, Dental Chemistry
Dickens, Sabine H., chief research scientist, Polymer Chemistry
Vogel, Gerald L., chief research scientist, Dental Cariology
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, National Institutes of Health grants, industrial contracts and grants, service contracts, and in-kind contributions from NIST. In addition, the PRC has access to royalties paid to the Health Foundation from the sale of products based on patents emanating from PRC research. Nineteen active license agreements have resulted from these technology transfer efforts.

PRC scientists conduct basic and applied studies in clinical research, dental chemistry, polymer chemistry and dental cariology. Their research projects address the dental materials needs of practitioners and are increasingly responsive to the Association's 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. Descriptions of PRC projects can be accessed on the ADAHF Web page (www.adahf.org).

The Strategic Plan of the American Dental Association: PRC activities support the mission of the American Dental Association Health Foundation by advancing the oral health of the public through basic and applied research and the development of improved dental materials and treatment technologies. The objectives of the ADA Strategic Plan are advanced in:

- Education by providing quality continuing education (CE) programs for constituent organizations;
- Professionalism by communicating PRC accomplishments directly to the profession through programs, presentations and the public media;
- Public Presence by responding to critical issues through the ADA Division of Science and Council on Scientific Affairs, through direct participation in national and international standards organizations, and the promotion of ADA benefits to the public through media, tours and presentations;
- Data and Information by researching issues that have direct impact on clinical practice and public health, and the publication and dissemination of these research results.

Activities

Clinical Research: Clinical studies were completed for bone repair materials used in periodontal repairs and implantology, remineralizing chewing gums, and biocompatibility of new adhesives. Progress continued on a National Institute of Dental and Craniofacial Research (NIDCR)-funded project using single-crystal ceramic whiskers as high-strength reinforcement for composite resins, and a new project was initiated that investigates fracture analysis of tooth tissues and restorative materials.

Dental Chemistry: Remineralizing dental composites based upon amorphous calcium phosphate for orthodontic bracket bonding have been licensed to industry, and product development efforts are underway.

PRC-developed calcium phosphate bone cements have been licensed to a company that markets a product called BoneSource™ for cranioplasty and maxillofacial repairs. Clinical and laboratory studies are being conducted to broaden the applications to dental uses, such as implant grouting, periodontal repairs and ridge augmentation.

Other projects within the Dental Chemistry program include the study of calcified tissues with reflective infrared mapping, and standard reference materials for measuring the abrasivity of toothpaste.

Polymer Chemistry: PRC researchers continue to make progress improving adhesive bonding systems with new studies on remineralizing adhesives and the development of computerized molecular models of dental tissues.

An experimental calcium phosphate pulp-capping composite successfully completed biological evaluations. Instruments have also been developed and manufactured by PRC for

measuring shrinkage stress of dental composites during polymerization. Pilot studies have begun on new methods for reducing or eliminating shrinkage in dental composites.

Dental Cariology: An NIDCR-funded project on improved fluoride technologies is developing professionally applied slow-release remineralizing devices and more efficient fluoride mouthrinses, toothpastes and topical gels. Other studies include the development of measurement methods for fluoride release from dental materials, and microanalytical methods for measuring plaque and plaque fluid chemistry. A project refining the standard method and material for measuring toothpaste abrasivity is continuing.

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

ADA Business Enterprises, Inc.

Notes

ADA Business Enterprises, Inc.

For-Profit Subsidiary Annual Report and Financial Affairs

Hunt, Donald S., chairman (outside director)
Stratton, Debra, vice chairman (outside director)
Bramson, James B., secretary (ADA executive director)
Sweeney, James H., chief executive officer
Graboys, George, treasurer (outside director)
Barrett, Lee (outside director)
Bruce, Steven M. (ADA Board member)
Chadwick, D. Gregory (ADA president)
Chaput, Ronald M. (at-large member dentist)
Hagedorn, Lloyd J. (ADA Board member)
Hall, James B. (at-large member dentist)
Jones, T. Howard (ADA president-elect)
Kittredge, Roger R. (outside director)
Leone, Edward, Jr. (ADA Board member)
Marks, Scott P. Jr. (outside director)
McFadden, Judith (at-large member dentist)

Introduction: The American Dental Association is the sole shareholder of the Association's for-profit subsidiary, ADA Business Enterprises, Inc. (ADABEI). This annual report outlines the business and financial affairs of ADABEI and its business divisions for 2001 and the first four months of 2002.

Direction: The governance structure provides for a 16 member Board of Directors—three ADA trustee members; three at-large dentists; six outside non-dentist directors; the ADA president (non-voting); the ADA president-elect (non-voting); the ADA executive director (non-voting) and the chief executive officer. Board members are eligible to serve two three-year terms, with the exception of the ADA trustee appointments and those directorships tied to employment. The ADA president appoints ADA trustees to the Board for one three-year term. The CEO and ADA president, president-elect and executive director serve through their term in office. With the formation of ADABEI the initial terms of Board members were staggered.

At the end of 2001 the term of Dr. Henry Finger, ADA trustee expired. The ADABEI Board of Directors expresses its sincere appreciation to Dr. Finger for his keen participation and significant contribution. ADA President Dr. D. Gregory Chadwick appointed Dr. Lloyd Hagedorn as the next ADA trustee to the Board.

At the November 9, 2001 meeting of the Board of Directors, Dr. James B. Bramson was elected secretary and Ms. Debra Stratton was elected to serve another one-year term as vice chairman.

The ADABEI Board of Directors provides expertise, direction and leadership for the company. The Board of Directors met four times in 2001 and will hold three business meetings and one strategic planning session in 2002. This planning session will be held following the preparation of this report. It will focus on future new business expansion requiring use of company-retained earnings. The three Committees formed in 2000 have met regularly, either independently or prior to Board of Directors meetings: Compensation Committee, Finance and Audit Committee, and Nominating Committee.

Finance: ADABEI ended 2001 with net income after tax of $1,389,000, compared to a 2001 budget of $1,249,000 and a 2000 budget of $1,670,594. Year-end revenue was $13,729,000 for 2001, falling $471,000 short of budget. Expenses were favorable to budget $11,438,800 as compared to budget at $12,073,000. Total assets of the combined divisions are $8,779,716 with liabilities of $1,336,416 and total stockholder's equity of $7,443,300.

The ADA receives payments from its subsidiary in five ways, including the payment of a year-end dividend. The following recaps ADABEI's payments to the ADA in 2001:

Payment for Services	$ 904,760
Royalty Payments	684,776
Dividend	1,400,000
Support of ADA Initiatives	311,108
Charity	$ 60,000
Total	$3,360,677

Investment income for the subsidiary is reported in the Office of the Chief Executive Officer and is $248,434 for 2001.

Publishing Division

Overview: The ADA Publishing Division is financially sound and projecting a successful year. Although 2002 first-quarter revenues were behind target by 14.7% primarily because of advertising sales, first-quarter expenses were 17.4% lower than projected across the board, generating a net pre-tax gain of 1.1% ($370,000 in actual income vs. $366,000 budgeted).

Financials: Compared to 2000 actual, total revenues for 2001 declined by $341,000, from $10,290,000 to $9,948,000 or 9.7%. Pre-tax operating income in 2001 also decreased by $228,000, from $1,304,000 to $1,076,000, mainly because of a $54,000 decline in advertising revenues, from $7,694,000 to $7,640,000 and a decrease of single copy sales of the *ADA Guide to Dental Therapeutics* of $217,000 from $287,000 to $70,000. This decrease is due to lower bulk sales to the industry. Helping to offset these declines were savings in the new printing contract with Wisconsin-based Quad Graphics, which prints *JADA* and the *ADA News*. Savings contained in the new contract led to a $114,000 drop in total expenses, from $8,986,000 to $8,872,000.

***JADA* Editor Transition:** Dr. Marjorie K. Jeffcoat was named Editor of *The Journal of the American Dental Association*. Dr. Jeffcoat, who assumed her new duties as editor in January 2002, is professor and chair of the Department of Periodontics and assistant dean for research at the University of Alabama School of Dentistry, Birmingham. She is active in teaching, patient care and research, developing new methods for the diagnosis of periodontal disease, and has an active research program that applies these methods to clinical trials.

Prior to coming to the University of Alabama in 1988, Dr. Jeffcoat was an associate professor of periodontology and head of the Department of Diagnostic Systems and Biotechnology at the Harvard School of Dental Medicine, where she also served as director of postdoctoral education.

In 1986, Dr. Jeffcoat received the Young Investigator Award from the International Association of Dental Research and in 1990 she received the Distinguished Alumni Award from the Harvard School of Dental Medicine. In 1991, Dr. Jeffcoat was named the James Rosen Professor of Dental Research at the University of Alabama School of Dentistry. She received the American Academy of Periodontology award for Clinical Research in 1992. In 1995, Dr. Jeffcoat served as president of the American Association for Dental Research. She also served as president of the International Association of Dental Research from April 2000 until June 2001.

Dr. Jeffcoat is the author of more than 200 publications, including journal articles, book chapters and abstracts.

***JADA* Editorial Board:** Dr. Jeffcoat selected an Editorial Board and Associate Editors, retaining some of the existing Board members and editors while adding several new ones. The Board members are: Dr. Daniel M. Castagna; Dr. Anthony DiAngelis; Dr. Sharon M. Gordon; Dr. Carlos Interian; Dr. Dushanka Kleinman; Dr. Irwin Mandel; Dr. Jeff Morley; Dr. Lonnie Norris; and Dr. Michael Reddy.

The Associate Editors are: Dr. James H. Doundoulakis (Biomaterials/Restorative Dentistry); Dr. Paul A. Moore (Clinical Pharmacology); Dr. Grayson W. Marshall, Jr. (Esthetics and Implant Dentistry); Dr. Michael Glick (Dentistry and Medicine); Dr. Titus K. L. Schleyer (Informatics and Technology); and Dr. Leslie W. Seldin (Practice Management).

***JADA* Industry Advisory Board:** Dr. Jeffcoat has appointed a new *JADA* Industry Advisory Board for the central purpose of helping recruit research papers and other materials from all areas of industry on important new technologies in the field. The Board met for the first time on February 23 to discuss activities that would be mutually beneficial to *The Journal* and to the dental manufacturing community.

By establishing this new Board, *JADA* acknowledges that manufacturers themselves are funding or conducting much of the cutting-edge product research in dentistry today. The Board's mission is to tap into this research for the benefit of the dental profession and the patients it serves. *The Journal* will package this material in easy-access summaries, reviews and research papers, appropriately noting the source of each report, how it was developed and who funded the research behind it. Through these efforts, *JADA* will help improve the flow of information from the manufacturing community to the practicing dentist.

The *JADA* Industry Advisory Board reports to the editor, Dr. Marjorie K. Jeffcoat, and is chaired by Dr. Michael Bagby, associate professor, Department of Restorative Dentistry, in the dental school at West Virginia University. Industry representatives include: Gary W. Price, president and CEO, American Dental Trade Association; Dr. C. Yolanda Bonta, director of technology, Professional Marketing/External Relations, Colgate-Palmolive Company; Dr. Michael Romanowicz, vice president, Professional Affairs and Managed Care, CollaGenex Pharmaceuticals, Inc.; Dr. Steven Jefferies, vice president, Product Development, Dentsply International; Dr. David C. Alexander, director of professional communications, GlaxoSmithKline; Dr. George Tysowsky, vice president, Technology, Ivoclar Vivadent, Inc.; Martin J. Dymek, president, Nobel Biocare USA; and Dr. Sumita B. Mitra, corporate scientist, 3M ESPE Dental Products Laboratory, 3M Company.

Publishing representatives include the *JADA* editor, publisher and associate publisher, and a member of the ADA's Division of Science staff. Initial feedback from the participating companies has been very enthusiastic indicating that such a significant partnership with the ADA will benefit the profession as a whole.

A report on the Industry Advisory Board's mission and activities appeared in the March 18 *ADA News* and on ADA.org. An updated report also appeared in May edition of *JADA*. Names of the Board members were published on the June *JADA* masthead and will appear in every issue thereafter.

***JADA* Online:** Since its introduction in June 2001, *JADA* Online has emerged as one of the most visited features in the Profession section of the Association's Web site. To help build traffic to the site, *JADA* Online has been open at no charge to all visitors. Starting July 1, however, the site will be available

free-of-charge only to ADA members and paid subscribers. ADA Publishing will assess all other users an access fee of $20.00 per article.

JADA's monthly cover story, clinical and research articles, commentaries, letters to the editor and other features are accessible online from January 1998 to the present. Visitors to the ADA's Web site can explore *The Journal* using a keyword search engine.

This service is made possible through an alliance with ingenta inc., an Internet gateway providing access to more than 400 health care publications, including 30 international dental journals and more than 1.3 million articles from the ingenta collection and a MEDLINE database.

Nearly 200 scholarly publishers and societies have joined the ingenta network, collectively offering more than 5,400 journals to 9,000 academic institutions and libraries around the world.

Practical Science in *JADA*: *The Journal of the American Dental Association*, working in concert with the Division of Science, is launching a new monthly feature designed to provide practicing dentists with sound scientific information on issues of practical interest to clinicians.

Each column in this new "Practical Science" section of *JADA* will serve as a brief, readable treatise on a specific dental topic selected for its wide appeal to practicing dentists. With assistance from the Council on Scientific Affairs, authors have been chosen for their proven expertise in specific areas of dental care. To ensure readership, all columns will be held to a maximum length of three *JADA* pages, and will be written in an accessible, easy-to-read style.

More than a dozen articles are already in progress for this section, addressing such topics as materials safety, the use of antibiotics, implant dentistry, treating special patients and more. *JADA* expects to introduce the column during the summer months. Announcements of its arrival will appear in the *ADA News* and on the Web site.

***JADA* Supplement on Oral and Systemic Health Interactions:** In June 2002, a supplement exploring the link between oral disease and cardiovascular health was published as a companion to *JADA*. Produced in cooperation with the ADA Division of Science, the supplement is an outgrowth of an ADA-sponsored symposium held in July 2001.

The Journal is pursuing a number of other supplements on a wide range of topics of interest to practicing dentists.

***JADA* Foreign-Language Editions:** The Spanish-language (Spain) and the two Portuguese (Portugal and Brazil) editions of *JADA* are all suffering the effects of a global economic downturn and are currently behind schedule. Other foreign editions of *JADA* are being pursued. However, overseas publishers who have expressed an interest thus far (India and China) do not appear to be on solid footing financially. Other publishers who appear more likely to survive the current economic climate (Italy, Germany, France) have been less interested in the project.

ADA Member Initiatives: To aid in the success of the Association's "Tripartite Grassroots Membership Initiative," the *ADA News* is exploring new ways to spotlight Association activities that meet the needs of chairside dentists. The goal is to underscore what the ADA does for its members while maintaining the publication's strong news orientation and feel. In some cases, this has involved supplementing major stories with "sidebar" reports on what resources the ADA offers on the topic and what ADA policy says about the issue at hand.

Starting in February 2002, *JADA* began publishing a monthly ad on membership services. Meetings among *JADA* staff, scientific editor and the Division of Membership and the Executive Director are also planned to identify other ways to promote the value of membership in ADA publications.

***ADA Guide to Dental Therapeutics*:** Sales of the second edition have been doing well—in both single copies to individuals and bulk distributions to senior dental students.

The publication cycle for the *Guide* has been increased from two to three years, ensuring that each new edition is a substantial revision of its predecessor and allowing sufficient time to sell out existing inventory. The third edition will be published in October 2003.

A Spanish-language edition of the *Guide* will be published in Europe in 2003. A licensing agreement has been signed with the publishing house Masson, S.A—the same publisher that distributes the Spanish edition of *JADA* in Europe. ADA Publishing will receive royalties on all copies sold.

Online Dental Buying Guide: For many years, ADA Publishing has produced a new dentist buying guide to help familiarize graduating dental students with the manufacturers and distributors in the dental marketplace. The buying guide also has helped attract advertising dollars. Advertisers who purchase an ad in *JADA*'s May issue received a free ad in the buying guide.

In April of this year, ADA Publishing unveiled a new online buying guide available through ADA.org. Renamed the "Dental Buying Guide" to broaden its appeal to all dentists, this new online feature eliminated the print production and distribution costs associated with the old guide.

To ensure that the new online Guide is thorough and complete, vendors are not charged for a basic listing, which includes a manufacturer's name, product categories, address and contact information. Manufacturers may purchase more comprehensive listings that can include product brand names and company profiles as well as links to company Web sites. Visitors can use a keyword search engine to find specific brands. They also can search for manufacturers by name or location or access an alphabetical listing of all manufacturers.

To guard print revenues, manufacturers who advertise in the May *JADA* will receive a free banner ad online as an incentive for their continued support of *The Journal*.

Business and Financial Services Division

Overview: The mission of the Business and Financial Services Division is to enhance member value by providing a broad range of financial and business services from "best in class" providers, and grow revenue to support ADA's non-dues revenue stream. The key to achieving this mission is to have every ADA member turn to *ADA Member Advantage* first for his or her business and financial needs. The supporting strategy to accomplish this is to:

- build brand recognition of *ADA Member Advantage*;
- refine and enhance product offerings; and
- increase the number of members using more than one product.

Financials: Double-digit growth rate in revenue has been achieved for the second year in a row at 14%. Compared to 2000 actual, total division revenue increased in 2001 from $3,161,000 to $3,532,000. This Division reported net income for 2001 of $1,098,000 after taxes, as compared to $1,024,000 in 2000. Operational expenses were $1,730,000. Income tax expense for 2001 is $704,000. The first quarter results show revenue short of plan, $811,000 vs. $847,000. Expenses are favorable by $88,000, with net results ahead of plan, by $31,000.

Highlights: The year 2001 was significant for ADABEI in the areas of Marketing and Product Development. A new brand, *ADA Member Advantage*, was launched into the marketplace in August 2001, supported by a multi-channel marketing plan. Five new products were launched, including: Fee Recovery, Shipping, Postage Meters, Student Loan Consolidation and Office Products.

***ADA Member Advantage*:** Members will be able to find out about the *ADA Member Advantage* program throughout the year, as an integrated marketing and communications plan will be implemented including: direct mail, advertising, editorials, the Internet and tradeshows. Members will be able to access the many products and services *ADA Member Advantage* has to offer by calling toll-free at 800-ADA-2308, or by logging on to www.adamemberadvantage.com.

The *ADA Member Advantage* program currently includes a dozen product lines:

- Credit Card—offered by Citibank USA, two cards are available. The first is an airline card that allows points to be earned towards free travel. The program allows one to fly on any airline, with no blackout dates. The second card product has a low variable rate of prime plus 1.9%.
- Line of Credit—offered by Citibank USA, members might obtain an unsecured line of credit with check writing capabilities, and a competitive rate of prime plus 3.9%.
- Mortgage and Home Equity Loans—offered by CitiMortgage, one of the nation's most trusted mortgage lenders. Members will enjoy preferred member discounts on mortgages with $500 off closing costs, or a reduction of loan origination points of ¼%.
- Credit Card Processing—offered by Paymentech. Members can take advantage of an excellent rate of 1.82% with an average transaction less than $300 and 1.86% for an average rate greater than $299 for an electronic swipe. Additionally, Paymentech will perform a free competitive analysis on the member's current provider to determine if Paymentech can reduce their costs.
- Practice Financing—the Matsco Companies provide a complete line of financing for dental professionals, ranging from practice acquisition, start-up, and commercial real estate financing to practice expansion, working capital and business consolidation loans.
- Patient Financing—offered by Care Credit, members might now reduce their receivables and increase their treatment acceptance, by offering their patients various payment plans.
- Fee Recovery/Collections—offered by Diversified Services Group (DSG), ADA members can increase their cash flow by retaining DSG to collect delinquent receivables. ADA members will pay a substantially discounted fee of 27% on accounts that are actually collected.
- Payroll—ADA members can now utilize an online payroll service offered by Surepayroll. Members will enjoy free set-up, free processing for the first 30 days, and Free W-2's for the first year.
- Shipping—Discounts on overnight letters are offered by UPS.
- Postage Meters—ADA members can eliminate trips to the Post Office with a Pitney Bowes postage meter and scale. Members will receive a special offer of up to $50 in postage.
- Student Loan Consolidation—offered through Collegiate Funding Service, ADA members have the option of reducing monthly student debt payments, by consolidating all loans to a single bill and reducing the fixed interest rate by an additional 1.25%.
- Office Supplies, Furniture and Telecommunications—offered by Turnkey Dental, members can now purchase products to enhance their office workspace at discounted prices.
- Electronic Transactions—ADABEI endorses and promotes WebMD/Envoy's clearinghouse for electronic transactions. The agreement between ADABEI and WebMD/Envoy expires on December 31, 2002. Contract negotiations have been underway since the first of 2002.

During the year, several products were discontinued due to lack of member interest or significant changes in the agreement as a result of contract renewal. These included Electronic Claims Processing Software with Trojan Professional Services, Web Site Development with Netopia and rdental, and Printers and Copiers with Xerox.

Focus: The Business and Financial Service Division's focus in 2002 and beyond is to:

1. Add new customers and retain existing customers.
2. Manage the existing product lines.
3. Launch several new products in order to diversify the sources of income.
4. Grow awareness of *ADA Member Advantage*.

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

Notes

ADA Audit

Notes

Association Finances: A Joint Letter from the Treasurer and the Executive Director

Introduction

We are pleased to present this report to the membership summarizing the Association's financial position as of December 31, 2001. This report highlights the significant financial events that occurred during the year, provides an overview of the consolidated audit, analyzes our investment accounts including several special accounts set up to manage ongoing operations, discusses subsidiary operations, and concludes with a reconciliation of the operating results to the approved 2001 budget approved by the House of Delegates.

On a consolidated basis, the American Dental Association demonstrates a strong net asset position of $88.2 million at the end of calendar year 2001, a slight increase from the previous year end. Favorable results in the operating account, for-profit subsidiary and foundation as well as the renovation program assessment more than offset investment market losses in reserves, technology spending and depreciation of building improvements.

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 2001.

The accounting firm of Grant Thornton conducted each annual audit and in all cases expressed an unqualified opinion on the 2001 financial statements. These reports follow this introductory letter.

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 2001 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.

Transactions between components of the consolidated group, such as between a parent company and its subsidiaries, are eliminated in consolidation to remove double counting.

Consolidated activities are composed of the following:

- American Dental Association
  - Operating Division
    - Operating Account
    - Investment Account
    - Capital Improvement Account
    - Renovation Program
    - Building Fund
    - Technology Fund
    - ADA Tragedy Fund
  - Reserve Division
    - Capital Formation Account
    - Restricted Investment Account
- American Dental Real Estate Corporation
- ADA Health Foundation
- ADA Business Enterprises, Inc.

Consolidated Association Statement of Financial Position: The Association's equity position on a consolidated basis increased by $75,761 or less than 1% during 2001.

Consolidated, December 31:	2001	2000
Total Assets	$114,104,242	112,713,924
Total Liabilities	(25,932,195)	(24,617,638)
Total Net Assets	$88,172,047	88,096,286

Total assets increased primarily due to year-end receivables arising from insurance recoveries.

On the liability side, accounts payable and accrued liabilities were at a higher level than the prior year, partially offset by a decrease in notes payable due to the payoff of debt on the Washington Building.

Consolidated Association Revenues and Expenses:

Consolidated:	2001	2000
Total Revenues	$ 85,802,837	83,872,289
Total Expenses	(84,835,260)	(83,306,278)
Income tax expense	(891,816)	(1,332,629)
Increase (Decrease) in Net Assets	$ 75,761	$ (766,618)

Revenues of $85,802,837 represent an increase of $1,930,548 from the previous year mainly due to an increase in dues and contribution income partially offset by a decline in annual session revenues and decreased investment income. The increase in membership dues resulted from a net $6 dues raise and a $30 assessment for renovation approved at the 2000 House. Investment results are reflective of the adverse market in 2001. The decrease in meeting revenues was caused by the smaller annual session venue of Kansas City versus Chicago.

Expenses rose approximately $1.5 million or 2% from the previous year to $84,835,260 resulting primarily from staff compensation expense.

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.

Following is a recap of year-end balances for the five-year period ended December 31, 2001. These balances represent the total net assets in each account. The Operating and Reserve Division Investment accounts hold marketable securities that could be liquidated to satisfy future contingencies of the Association. The Capital Formation account balances are illiquid.

Recap of Year-End Balances
Investment Accounts

Year Ended	Operating Division	Reserve Restricted	Total Liquid	Capital Formation	Total Investment
1997	$ 4,609,355	21,880,320	26,489,675	7,372,149	33,861,824
1998	4,851,105	17,781,010	22,632,115	9,872,756	32,504,871
1999	5,086,437	22,322,564	27,409,001	14,210,845	41,619,846
2000	5,397,894	17,195,888	22,593,782	18,013,696	40,607,478
2001	5,606,634	12,823,817	18,430,451	17,873,648	36,304,099

Capital Improvement Account: Continuing work on the Capital Improvement Program during 2001 resulted in remodeling and asbestos abatement improvements to the Headquarters Building for tenant space and certain common areas totaling $275,503. 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.

This construction program anticipates total capital expenditures of $23.4 million plus any interest on bank or reserve borrowings used to finance the project. Through December 31, 2001, improvements with the following costs, net of depreciation, have been completed:

Asbestos abatement	$ 5,261,187
Remodeling	14,210,612
	19,471,799
Less accumulated depreciation	7,268,867
	$12,202,932

Unspent monies collected for this activity are maintained in a separate short-term investment account to generate interest earnings. At December 31, 2001 the Capital Improvement investment account had a balance of $4,791,420.

ADA Renovation Program: The 2000 House of Delegates approved a plan for renovation and asbestos abatement of Association occupied space in the Headquarters Building. To help fund this initiative, a six-year $30 dues assessment for Association members was enacted, effective from 2001 to 2006. Additionally, $2.5 million was allocated from the Capital Improvement Account, transferred in 2000. A further allocation of $1.5 million was transferred from the Building Fund in 2001. Additionally $1.0 million of the typical allocation to funded depreciation was redirected by the Operating Account to the Renovation Program in 2001.

The Association established the ADA Renovation Program Account within the Operating Division to classify the revenues, expenses, assets and liabilities restricted to the remodeling and asbestos abatement of Association occupied space in the Headquarters Building. Through December 31, 2001, improvements totaling $1,584,373 have been completed.

At December 31, 2001, the Renovation Program Account held $7,969,287 in short-term investment funds.

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. This account transferred $1.5 million to the ADA renovation program account in early 2001. Unspent monies are maintained in a separate short-term investment account to generate interest earnings, which had a balance of $2,099,419 at December 31, 2001.

Technology Fund: During 2000 the Board of Trustees established a Technology Fund to support such activities as implementations and significant upgrades of software and related consulting assistance. These segregated monies are not intended to subsidize normal, ongoing operations or personnel.

Activities approved for the Technology Fund are being underwritten by reserves. An ongoing plan to support future projects has not yet been determined. As of December 31, 2001 the Technology Fund short-term investment account has a balance of $1,765,896.

Subsidiary Operations: In 2001, the for-profit subsidiary generated net after-tax income of $1,389,632, compared with $1,670,594 in 2000. This decrease of $280,962 resulted from reduced sales of the *ADA Guide to Dental Therapeutics*, lower investment income and increased expenses partially offset by higher royalties.

American Dental Real Estate Corporation (ADREC) experienced an after-tax loss of $130,136 for 2001 versus $347,266 in 2000. The improvement in results is a function of other income from insurance reimbursements, an early lease termination payment and less interest expense. While still representing a 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.

After adjusting this loss for such items as depreciation, debt reduction and capital expenditures, ADREC's cash flow loss totals $1,433,916. Of this amount, $1,673,732 represents the principal paydown and prepayment penalty. Therefore a remaining net cash flow surplus exists of $239,816. The Association has committed to funding ADREC's cash flow losses up to $1.7 million annually. In addition to this commitment, principal prepayments begun in 1997 to satisfy ADREC's debt by 2001 instead of the remaining scheduled term ending in 2005. Now that ADREC's debt is repaid, it is expected to generate positive cash flow, although the financial statements may still show a loss because of depreciation.

In 2001, the American Dental Association Health Foundation (ADAHF) exhibited net income of $893,906 compared with earnings of $527,192 in 2000. This increase is largely attributable to the $1 million donation received in 2001 from Dr. Samuel Harris offset by investment losses. ADAHF received a grant from the Association of $2,057,344 in 2001 as compared to $2,257,802 in 2000.

ADA General Fund Operating Account

ADA Operating Results: The 2001 budget approved by the House of Delegates projected a funding deficit of $5,145. Included in this budget was a funding provision of $1,471,605 from the 1999 surplus. Actual financial results stated in a manner consistent with budgetary guidelines indicate that only $39,273 of that 1999 surplus will be needed. A transfer will be made from the Reserve Division Restricted Investment Account to the ADA General Fund in accordance with Board Resolution B-47-2002.

The 2001 financial statements, however, show net income of $757,987. This amount must be restated to conform with budgetary guidelines due to the differing treatment of certain items that are considered as revenues and expenses for budgetary but not for accounting purposes.

A reconciliation of surplus funds to the amount transferred to reserves is shown below.

Net income per 2001 Financial Statements	$757,987
Decreases to net income:	
Funded Depreciation (Note 1)	(454,600)
Renovation Program (Note 1)	(1,000,000)
Pension Funding Adjustment (Note 2)	(749,164)
Carryforwards from 2001 Operations to 2002 (Note 3)	(655,100)
Increases to net income:	
Dividend Declared by ADABEI (Note 4)	1,400,000
2000-2001 Carryforwards Expended (Note 5)	661,604
Funds to be transferred from Reserves to ADA Operations	$(39,273)

Notes.

1. The transfers of monies to the Building Fund and Renovation Program are not expenses in the audited financial statements.
2. Pension expense reflected in the financial statements is less than the amount of contribution calculated by the actuary, due to the different assumptions prescribed by these respective computations. Since the budget reflects the contribution, this incremental amount is meant to restate financial statement net income to reflect the higher contribution.
3. Since these activities are meant to be conducted in 2002, funds will be retained in the operating account.
4. The declaration of dividends is not revenue in the audited financial statements.
5. 2001 spending of 2000 budget monies served to reduce net income in the financial statements. However since these funds were held back from the surplus transfer last year, they should not impact this year's transfer. The Board of Trustees approved the carryforward 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.

It is relevant to note that present and prospective commitments exist for the use of reserve funds.

Variance to Budget: The $39,273 deficit from 2001 represents a favorable variance of $1,432,332 from the funding amount of $1,471,605 budgeted to come from the 1999 surplus. 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.

Annual session registration fees, exhibitor space and conference room rentals and ticket sales below projections from programs in Kansas City	$ (1,778,369)
Salable Materials sales below budget	(403,251)
Increase in interest income due to settlement of long-outstanding IRS receivables	607,781
Testing revenues and accreditation fees above budget	432,049
Dividends declared higher than expected	175,000
Membership dues favorable to budget	370,634
Headquarters Building rental revenue less than budgeted	(328,437)
Miscellaneous income below budget primarily due to overhead recovery from government grants, service income in Health Policy Resources Center and delay in establishing a second shift in Duplicating	(508,747)
All other revenue variances, net unfavorable	(135,199)
Total	$ (1,568,539)

Expenses and Other Items. Major variances between actual and budgeted amounts are shown in the following table.

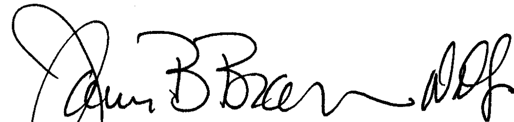
Compensation savings	$ 348,780
Underspending in travel expense	663,660
Savings in printing, publication and marketing costs	490,704
Underspending in office expenses (such as postage, telephone, photocopy, etc.)	275,309
Facility costs under budget	1,060,528
Savings in other expenses, including unspent contingent fund monies	287,874
Underspending in professional services	279,497
Depreciation under budget	141,594
Carryforwards from 2001 to 2002	(655,100)
Remaining expense and other item variances, net favorable	108,025
Total	$ 3,000,871

Conclusion

The financial results discussed above supported a multitude of activities and services to address the varied needs of the profession, the membership and the public.

The Association's finances will be discussed at the Reference Committee on the Budget and Business Matters scheduled for the annual meeting in New Orleans. Any questions can be addressed at that meeting or we can be contacted directly and would be happy to respond to any concerns.

Mark J. Feldman, D.M.D.
Treasurer



James B. Bramson, D.D.S.
Executive Director

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2001 Contingent Fund

Board-Approved Allocations Compared with Actual	Actual Expenses Net		Board Approved Allocations
Administration and Policy			
Executive Director Search Committee	$ 24,295		$ 49,800
Executive Director Committee-Search Firm	23,000		23,000
Council Chairs Participation in Administrative Review	2,522		16,500
Government Affairs			
Gnossos Software	33,011		40,000
Membership			
Task Force to Develop Membership Initiative	9,801		23,100
Affiliate Membership Development Materials	0		19,200
Conference and Meeting Services			
Global Congress	9,129		9,000
Central Administration			
Alliance of the ADA Attendance at ADA Leadership Conference	12,000		12,000
Information Technology			
Fundraising Software	2,600		0
Dental Practice			
Printing of ADA Peer Review Manual	4,705		8,250
Health Policy Resources Center			
Ad Hoc Committee Distribution of Future of Dentistry Report	1,610		3,900
Education			
NERB Study – Oversight Committee	5,448		4,700
Position Paper on Dentistry	6,039		5,000
Predoctoral Education for Pediatric Dentistry	3,000	(A)	2,600
Oversight Committee National Allied Recruitment & Retention	2,932		3,650
Science			
Initial Meeting of Task Force on Evidence Based Dentistry	6,401		9,550
Conference to Finalize Guidelines on Oral Malodor	19,909		24,500
Total Expense Allocation for 2001 Contingent Fund	$ 166,402		$ 254,750

Notes: All Board approved allocations are net of alternative funding and revenue.
(A) Actual expenses of $4,500 were offset by revenues of $1,500.

Notes

Appendix

Notes

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