2005

2005 Annual Reports and Resolutions

American Dental Association

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2005

Annual Reports and Resolutions

146th Annual Session

Philadelphia, Pennsylvania

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Special Note

Copies of *2005 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 and Corporate Relations, Conference and Meeting Services, and Membership and Dental Society Services

Council on ADA Sessions

Council on Communications

Council on Membership

Notes

Council on ADA Sessions

Kattner, Paul F., Illinois, 2005, chair
Conlon, Thomas O., Washington, 2006
Feinberg, Edward, New York, 2006
Frey, John T., Michigan, 2008
Grabill, Laurene A., Pennsylvania, *ex officio**
Hadlock, William A., Louisiana, 2005
Hendrickson, Gregg C., Nevada, 2006, *ex officio*
Hite, D. Stanley, Missouri, 2005
Jordan, John R., Jr., Florida, 2007
Kittredge, Robert L., Massachusetts, 2006
Leighty, Chad R., Indiana, 2007
LoMonaco, Carmine J., New Jersey, 2005
McDougall, Kenneth, North Dakota, 2007
McFadden, Judith A., Pennsylvania, 2005, *ex officio*
Mohme, Edward H., Georgia, 2008
Rader, Charles E., Texas, 2006
Shinbori, Dennis D., California, 2008
Smith, Philip E., South Carolina, 2008
Twesme, A. Ted, Nevada, 2008
Weber, Charles R., Pennsylvania, 2007
Donovan, James P., director

The Strategic Plan of the American Dental Association: The Council on ADA Sessions' mission is to serve ADA members and the worldwide dental community by providing professional, educational and social experiences, which together offer a unique experience. The Council's vision for the future of the annual session is to be the meeting of choice for dentists in the United States and around the world, enhancing the value of membership in the American Dental Association. The sense of community and pride in membership will become clearer and the decision to participate in the annual session will be more compelling. The Council continues to identify action plans to support various goals and objectives of the ADA Strategic Plan, and has established criteria for measuring success and has evaluated the effectives of its activities using those criteria. The Council on ADA Sessions has identified internal and external environmental trends as well as those goals and objectives of the 2002-05 ADA Strategic Plan that are most applicable to the Council's areas of responsibility. The annual session's scientific program and exhibition support Member and Support Services; Practice Support; Image, Ethics and Professionalism; and Information strategic goals. At the same time, the meeting generates significant non-dues revenues for the ADA and therefore also provides financial resources that support additional strategic goals and objectives.

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

145th Annual Session, Orlando, Florida, September 30-October 3, 2004

Orlando, Florida was the site of the ADA's 145th Annual Scientific Session and Technical Exhibition which attracted 32,108 attendees including 8,435 dentists. The Orange County Convention Center was the location for the exhibition, scientific program and meetings of the House of Delegates. The ADA/DENTSPLY Student Clinician program and the ADAF Health Screening Program were also located at the convention center. In the six weeks prior to the annual session, the state of Florida was hit by four hurricanes which impacted many members in and around this region.

ADA Marketplace Exhibition: A total of 1,812 booths were occupied in the exhibit hall rented to 660 companies. The Technical Exhibition had a completely new look and format as the exhibition has been organized into four, easy-to-find, color-coded categories: Over the Counter and Pharmaceutical, Dental Service, Materials and Infection Control, and Instruments and Equipment. This new exhibit hall format is called the ADA Marketplace. Clustering dental products and services into four categories makes it easier for attendees to comparison shop for products, price and services. Exit surveys of dentists visiting the exhibit hall demonstrate that meeting attendees love the categorized format primarily because the organized hall time makes it more convenient for attendees.

The ADA Member Services Pavilion underwent a complete make over. To complement the new Pavilion design, ADA staff also underwent intensive cross-training in an effort to provide better customer service to members

visiting the Pavilion. The ADA Pavilion provides attendees the opportunity to learn first-hand about ADA products and member services.

Other exhibit hall traffic building programs offered in the exhibit hall included:

- Three Marketplace Theatres brought continuing education (CE) directly to the exhibit floor. Tomorrow's Dental Office Today or TDOT was launched in 2004. Programming in the Marketplace theatres supported this initiative.
- A New Product Showcase gave attendees the opportunity to preview new products being introduced on the exhibit floor.
- The free (2nd annual) commemorative lapel pin and a tote bag sponsored by Oral-B Laboratories were distributed at stations located strategically around the exhibit halls.
- ADA Contests – The Golf Challenge was presented by the ADA Seal Program; GlaxoSmithKline, Johnson and Johnson and Omni Oral Pharmaceuticals featured daily prizes and a chance to win a new car.
- The Super Sunday Sweepstakes - The most visible traffic building program, encouraged attendees to visit five participating exhibitors in order to enter the drawing for a trip for two to the 2005 Super Bowl.
- A Power Breakfast featuring breakfast items at participating booths generated additional traffic.

General Sessions and Social Events: The theme of "Discover a World Bursting with Opportunity" was visible in a variety of events designed to heighten a sense of community among the attendees. Members were updated on key ADA accomplishments on behalf of dentistry in 2004 at two general sessions featuring the ADA/Sonicare Distinguished Speaker Series. The keynote addresses were John Major, former Prime Minister of the United Kingdom, and Captain James Lovell, Jr., an astronaut of the Apollo 13 space crew. On Friday October 1, ADA members were treated to a performance by Comedian Bill Cosby which was certainly an occasion to remember. On Saturday, October 2, the ADA made special arrangements for the exclusive use of Universal Studios Florida® from 8:00 p.m. until 12:00 a.m. On Monday, October 4, the Presidential Gala was held honoring ADA President and Mrs. Eugene Sekiguchi. This event took place at the J.W. Marriott Orlando Grande Lakes, generously underwritten by a grant from the Procter & Gamble Company, and featured performances by CIRQUE characters.

Scientific Program: Over 250 courses covering a wide selection of dental and related topics were offered in Orlando during the 2004 ADA annual session. For the first time, all courses required a ticket to attend. This process insured attendees of a seat in the programs and workshops they requested. This process was well received by attendees as it made for a more orderly environment at the meeting.

ADA/DENTSPLY Student Clinician Program: The student program, which celebrated its 45th anniversary at the 2004 annual session, is conducted annually by the Council on ADA Sessions and is financially supported by DENTSPLY International, Inc., York, Pennsylvania.

Outstanding student clinicians representing the 55 accredited dental schools in the United States, including Puerto Rico, presented table clinics for judging on the morning of Saturday, October 2, and were later open for general attendance on Saturday afternoon at The Orange County Convention Center. On Sunday morning, October 3, the winning students presented their clinics.

Winning students in Category I, Clinical Application and Technique were: first place, Rita Bahl, The University of Connecticut School of Dental Medicine; second place, Joseph C. Meng, The University of Iowa College of Dentistry; third place, Sarah J. Carlson, University of Chicago College of Dentistry.

Winning students in Category II, Basic Science and Research were: first place, Stanley Yung C. Liu, The University of California at San Francisco School of Dentistry; second place, Shalin R. Shah, University of Pennsylvania School of Dental Medicine; third place, Ryan P. Savage, University of the Pacific School of Dentistry.

Judges for Category I: Clinical Application and Technique were: Dr. O. Jack Penhall, Greenburg, PA, chair; Dr. John S. Rutkauskas, Chicago, IL; Dr. Steven B. Andreaus, Raliegh, NC; Dr. Alex C. Salinas, San Antonio, TX; Dr. Stephen B. Corbin, Rockville, MD; Dr. Arturo Santiago, Guaynabo, PR; Dr. Keith V. Krell, West Des Moines, IA; Dr. David L. Vorherr, Cincinnati, OH; Dr. Dan G. Middaugh, Seattle, WA; and Dr. Albert Whitehead, Ft. Lauderdale, FL.

Judges for Category II: Basic Science and Research were: Dr. Richard Carlos Tatum, Columbia, MD, chair; Dr. Rahele H. Rezai, Washington, DC; Dr. Robert A. Augsburger, Tulsa, OK; Dr. Wilbur K. Smith, Bel Air, MD; Dr. Susan E. Calderbank, Greenville, PA; Dr. Jon B. Suzuki, Pittsburgh, PA; Dr. Thomas E. Emmering, Bloomingdale, IL; Dr. Angella Tomlinson, Tampa, FL; Dr. Wanda F. Flinn, Gaithersburg, MD; Dr. Thomas Van Dyke, West Roxbury, MA; Dr. Keith L. Kirkwood, Buffalo, NY; Dr. Joel M. White, San Francisco, CA; and Dr. Ronald I. Maitland, New York, NY.

146th Annual Session, Philadelphia, Pennsylvania, October 6-October 9, 2005

Philadelphia, Pennsylvania is the site of the Association's 2005 annual session. The Pennsylvania Convention Center will house most scientific and general audience programs, table clinics, the ADAF Health Screening Program, the exhibition as well as meetings of the House of Delegates. The participation workshops will be held at the Wyndham Hotel. The Prevention Convention, Aging Conference, Women's Conference and selected programs will be held at the nearby Loews Hotel, The Team Building Conference, Men's Conference and selected

other programs will be held at the nearby Philadelphia Courtyard by Marriott.

Technical Exhibition: The ADA Marketplace returns with an improved layout which is designed to circulate attendees through all four categories of the hall. Maximum capacity of the exhibit hall is 1,600 booths. A complete sell out of the exhibition hall is projected. One major change for 2005 is a revised exhibition schedule which extends the exhibit hours on the first day of the meeting. This exhibition schedule will be monitored and measured in an effort to provide several new exhibit hall traffic building programs to help deliver attendees to the exhibit hall.

General Sessions and Social Events: Several activities are planned in Philadelphia to increase members' sense of the dental community and to help facilitate spending time socially with colleagues, staff and family.

Members will have an opportunity to be updated on key ADA activities at general sessions being convened at the Pennsylvania Convention Center on Friday, October 7 and Saturday, October 8. Included in the sessions will be the ADA General Session featuring the Johnson & Johnson Distinguished Speaker Series featuring Colin Powell, the former chair of the Joint Chiefs of Staff of the White House, and Katie Couric, host of the nation's most popular morning news show, NBC Today.

The ADA sponsored evening event will be Peter Nero and the Philly Pops who will perform on Friday, October 7 at 8 p.m. at the Kimmel Center for the Performing Arts.

Scientific Program: The 2005 scientific program offers a wide range of course topics selected to meet the lifelong learning needs of dentists and their professional staff. New courses on the 2005 schedule include: Prevention Convention, New advances in forensic dentistry, Dr. Your Check Has Bounced Again!, Enamel Erosion and Exercise, Nutrition 21st Century Medicine.

The scientific sessions will be held from Thursday through Sunday, with exhibits open Thursday, 12 Noon through Sunday at 1:00 p.m.

In 2005, all courses, both fee and no fee offerings, are ticketed. To attend any course, the individual must present a pre-issued ticket.

Table Clinics: The table clinics will be held on Friday, October 7 from 11:00 a.m. to 2:00 p.m.

ADA/DENTSPLY Student Clinician Program: Two thousand five marks the 46th year of the program. This year in Philadelphia, the students will make their presentations to the public on Saturday, October 8 from 1:00 to 3:00 p.m.

Personnel: Dr. Paul F. Kattner has served as Council chair for the 2004-2005 term, with Dr. D. Stanley Hite serving as program director.

Acknowledgments: The Council wishes to express its appreciation to Dr. Judith A. McFadden, general chair of the 2005 Committee on Local Arrangements, for her assistance in the planning and production of the 2005 meeting, and for her many useful contributions to all of the Council's deliberations during her tenure. The Council also wishes to thank those who capably assisted the Committee's activities related to the 2005 annual session, most importantly the 2005 Committee on Local Arrangements for their valuable assistance in the production of the annual session and they were: Dr. Peter J. Carroll, general co-chair, Dr. Harris N. Colton and Dr. Elaine Stefanowicz, program co-chairs; Dr. Michael D. Cerveris and Dr. Ronald K. Heier, registration co-chairs; Dr. Susan M. Chialastri and Dr. Julia A. Barna, hospitality co-chairs. The Council also expresses its sincere appreciation to the entire Philadelphia Dental Society for their support of this year's ADA annual session. Without the assistance and cooperation of these individuals and organizations, the 2005 annual session would not have been possible.

The Council wishes to recognize those of its members who will be completing their terms on the Council at the conclusion of the 2005 annual session: Dr. William A. Hadlock, Dr. D. Stanley Hite, Dr. Paul F. Kattner and Dr. Carmine J. LoMonaco. The Council also would like to recognize the contributions made by Dr. Roddy N. Feldman, Board of Trustees Liaison, and Dr. Laurene A. Grabill, Committee on the New Dentist Liaison, who served on the Council on ADA Sessions during 2005. The Council will miss all of them and wish them all the best in their future endeavors.

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

Council on Communications

Fiddler, Terry L., Arkansas, 2005, chair
Farinacci, David J., Ohio, 2006, vice chair
Barnes, Brad, Illinois 2007
Bell, Alonzo M., Virginia, 2008
Bement, Naomi L., California, 2008
Cram, Sally J., District of Columbia, 2007
Dodell, David S., Arizona, 2008
Egan, Michael R., Connecticut, 2005
Endel, Dennis W., Wisconsin, 2007
Herwig, Larry D., Texas, 2008
Icyda, Teri-Ross, Florida, 2008
Krische, Matthew F., Kansas, *ex officio**
Powell, Llewellyn, Mississippi, 2008
Roset, Gayle A., Montana, 2006
Shaver, Samantha, Kentucky, 2005
Smail, Douglas B., New York, 2007
Stefanowicz, Elaine, Pennsylvania, 2005
West, Debra S., Nebraska, 2006
Green, Richard, director
Rudy, Mary, interim manager

Mission and Goals: The Council is a primary ADA agency dedicated to promoting and conveying information on oral health issues to the public, Association members and the health care community. In accordance with the ADA *Bylaws,* the Council oversees the development of programs, supports related efforts of the tripartite, and provides recommendations to the Association's policy-making bodies on communications issues, including media relations and the image of dentistry.

The Strategic Plan of the American Dental Association: Using metrics developed in cooperation with the Office of Strategic Planning and Consulting, the Council again charted significant progress in fulfilling goals of the ADA's Strategic Plan.

Goal: Image. The Council discussed the three overarching communications messages that should guide both the Council and the staff in identifying priorities and developing messages, projects and information products, primarily for external audiences. These are: (1) the ADA as the premier source for information about oral health and oral health care; (2) oral health as integral to overall health, and dentistry as a science-based, technologically sophisticated health profession; and (3) the ADA as the premier advocate for the nation's oral health, protecting consumers and, especially, working to improve access for the underserved. The Council believes that these principles should underlie the Council's and staff's thinking and actions regarding external communications.

With that in mind, the metrics for ADA programming targeted to the public are particularly impressive. Some of these projects have relatively large price tags, but it is important to bear in mind the high costs that paid advertising would incur and the fact that these programs constitute the Association's total funding for radio and TV programming for consumers.

- TV Dental Minutes—This weekly show is subscribed to by 240 broadcast stations and 150 cable stations, with 52,000 airings annually in all top-10 markets and 23 of the top 25. In 2005 the show will expand into the Hispanic market, with commitments from Univision, Telemundo and Miami's leading Hispanic TV station. This is the fastest growing population in the country and also the fastest growing broadcast market. The ADA was the first association to produce for high-definition TV and will move Dental Minutes into that format over the next two years. Dental Minutes also are on ADA.org and receive 26,000 hits annually.
- Radio Dental Minutes—This weekly show is picked up by more than 800 stations (up from 400), with 57,000 annual airings in all top-25 markets. The growth of satellite radio has helped immensely as these new stations need programming. The radio Dental Minute is also expanding into the Hispanic market.
- TV public service announcements—Metrics show more than 25,000 annual broadcasts in all top-100 markets, including award-winning Dudley the Dinosaur public service announcements (PSAs) in all 212 broadcast markets nationwide. Dudley was the first bi-lingual PSA campaign for children in the United States. The ADA's PSAs converted to digital format years ago.
- Video news releases/satellite media tours—Coverage from the ADA's video news releases (VNRs) and satellite media tours (SMTs) consistently reaches the top 10 markets. The Give Kids A Smile SMT was

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

live to 20 outlets. These vehicles are vital to promoting ADA messages and reaching the broadcast marketplace with timely news stories such as breakthroughs in technology and oral health care. Recent Back-to-School campaigns have been a big hit and are now annual. The biggest trend in news broadcasting in recent years is the growth of the morning news block, which is viewed by more Americans than nightly news. The SMTs now target the morning block and are very successful.

The Council again wishes to acknowledge the vital contribution of the ADA's national expert spokespersons and consumer advisors, who frequently make themselves available on very short notice and represent the profession effectively in a variety of news media. The image of the Association and the profession are stronger because of the commitment of these volunteers. Significant coverage resulting from contributions of spokespersons and consumer advisors included top-tier media such as *The New York Times, The Wall Street Journal, USA Today, Good Housekeeping, Business Week* and CNN. Goals for 2005 include identifying additional national spokesperson candidates to meet the ADA's goals for diversity and availability to major markets.

Utilization of Web-based technology has resulted in an additional 1,150 media outlets receiving ADA news releases and interactive media kits.

Goals: Information, Member and Support Services, Practice Support. Metrics for ADA.org traffic show unique visits to the site in 2004 increased 31% over 2003. ADA.org is an increasingly important communication vehicle and face of the ADA.

Emerging Issues and Trends:

ADA Seal of Acceptance. The Council is concerned about how the image of the ADA might be affected by the changes in the ADA Seal of Acceptance Program authorized by the 2004 ADA House of Delegates. At its January 2005 meeting, the Council unanimously resolved to monitor and offer to assist in developing changes to the program and to assist, as requested by the Division of Scientific Affairs, with review and appropriate revision of the proposed member survey on the over-the-counter component of the program.

Access to Care. The Council is also concerned about how the ADA's public actions and policies regarding access to care might affect the image of the ADA among policymakers, the public and members of the profession. At its January 2005 meeting, the Council unanimously resolved to request that officers and members of the Board of Trustees consider the need to include appropriate staff or volunteers who can contribute a communications perspective to ADA task forces or other entities that address access-to-care issues, including but not limited to scope of practice of dental auxiliaries and the dentist workforce. The Council also unanimously resolved that the chair appoint a workgroup to monitor developments in these areas and recommend appropriate actions to the Council.

Possible Links Between Oral and Systemic Health. The Council wants the ADA to be in the strongest scientifically supportable position to guide the public and the profession in assessing the degree to which oral and systemic health may be linked. At its January 2005 meeting, the Council resolved unanimously to request that the Council on Scientific Affairs take steps to resolve ambiguities and inconsistencies in the many messages on this issue.

At its June 2004 meeting, following a presentation on knowledge-based governance, the Council held a strategic discussion and developed the following goal: through a communications strategy, increase the number of health care providers who routinely devote time in their consultations with pregnant women or women of child-bearing age to discuss the relationship between oral health and the overall health of a woman and her child.

Give Kids A Smile: After carefully considering various alternatives, the Council recommended to the 2004 ADA House of Delegates that Give Kids A Smile continue to take place in February in conjunction with National Children's Dental Health Month. The Council is grateful to the House for accepting this recommendation.

More than 40,000 volunteers—including nearly 11,000 dentists—participated in the 2005 GKAS event and delivered free care to more than half a million children. Particularly gratifying in the media coverage of GKAS this year was the number of stories that went beyond the event itself to emphasize the ongoing problem of too many children who are not receiving necessary dental care.

Awards: The Council presented a 2004 Dental Editor Service Award to Dr. Harvey S. Nisselson for 15 years of service to the New Jersey Dental Association. The Council also selected the Florida Dental Association as recipient of the 2004 Golden Apple Web Site Award and the Massachusetts Dental Society and the Memphis Dental Society as recipients of 2004 Golden Apple Awards for Excellence in Dental Health Promotion to the Public. Nominations for 2005 awards in these categories will be considered at the Council's June meeting.

Meetings: The Council met in the ADA Headquarters Building on January 14-15, 2005, with a second meeting scheduled for June 17-18.

Personnel: The Council expresses appreciation to retiring members Dr. Terry L. Fiddler, Dr. Michael R. Egan, Dr. Samantha Shaver and Dr. Elaine Stefanowicz. The Council is grateful to Dr. Fiddler for his spirited leadership end humor. The Council also wishes to thank Dr. Joel F. Glover, Fourteenth District trustee, for his commitment and support as the Board of Trustees' liaison to the Council.

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

Notes

Council on Membership

Epel, Lidia M., New York, 2005, chair
Cohlmia, Raymond A., Oklahoma, 2006, vice chair
Baldassarre, Pamela Z., New Hampshire, 2008
Coleman, Brian O., Florida, 2006
Diaz, Walter D., Mississippi, 2008
Doring, Charles A., Maryland, 2007
Eng, Laura M., Minnesota, 2008
Homer, Denny W., Washington, 2006
Kohler, Joseph J., III, Pennsylvania, 2008
Lee, Natasha A., California, *ex officio**
Mollica, Anthony G., Jr., South Carolina, 2007
Peters, Debra, Michigan, 2007
Records, Linda E., Ohio, 2006
Rounds, Norman K., Utah, 2005
Sauer, Edward H., Texas, 2005
Shapiro, Elizabeth A., Illinois, 2005
Weinand, Kenneth J., Missouri, 2008
Williams, John D., California, 2007
Toyama, Wendy-Jo, director
Yancy, Phyllis A., manager

The Strategic Plan of the American Dental Association: At its February 2005 meeting, the Council conducted a strategic planning session and discussed its current initiatives, the continued viability and impact of current initiatives and associated expenses. Specific goals related to actions that support membership growth include increasing membership in target markets, such as federal dentists, new dentists and diverse dentists; membership and revenues growth as a result of continued Tripartite Grassroots Membership Initiative (TGMI) and greater effectiveness with reaching target markets through ADA participation in dental society meetings; among others. The Council developed criteria for measuring the effectiveness of its programs and identified activities aligned to the Strategic Plan. The Council will continue to develop metrics and any new action items with the appropriate link to the current 2002-2005 Strategic Plan for consideration by the Board's Strategic Planning Committee.

Membership Update: For three consecutive years, the ADA has experienced membership growth, after a decade of membership stagnation or decline. Since the TGMI was launched in 2001, the ADA has experienced a net gain of 8,448 active, licensed members and achieved a 71.4% membership market share in 2004, the highest since 1999. Moving forward the key to continued growth will be to institutionalize the business strategy underlying the TGMI: one-to-one personal outreach.

The ADA has made significant gains in its pursuit of 75% membership market share and will continue to strive to reach 75% membership market share after 2005. Leadership support, volunteer involvement and recognition will be critical to success. The Council continues to work on developing shared goals at all three levels of the tripartite, increasing accountability for outreach and retention efforts. Moving forward, the success of the TGMI will be dependent on the ability of the ADA to identify and address tripartite issues that pose challenges to gaining and keeping members.

The Council on Membership is undertaking a membership study to take a broad look at membership; considering various dental perspectives as it considers membership categories, dues, privileges and representation. The goals of the membership study will be to reframe the ADA *Constitution and Bylaws*, focusing on Chapter I membership issues, while considering future trends in dentistry and to ensure that the ADA continues to meet the intent of its mission in the evolving oral health environment. The emergence of a new generation of dentists, the role of the dental team, increasing numbers of internationally trained dentists as educators in U.S. dental schools, the changing dynamics in the industry as practice modalities become more diverse, increases in part-time practitioners and the aging of the workforce are all trends being considered in these discussions and contribute to the dialogue of how broadly the ADA wishes to define membership.

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

Table 1

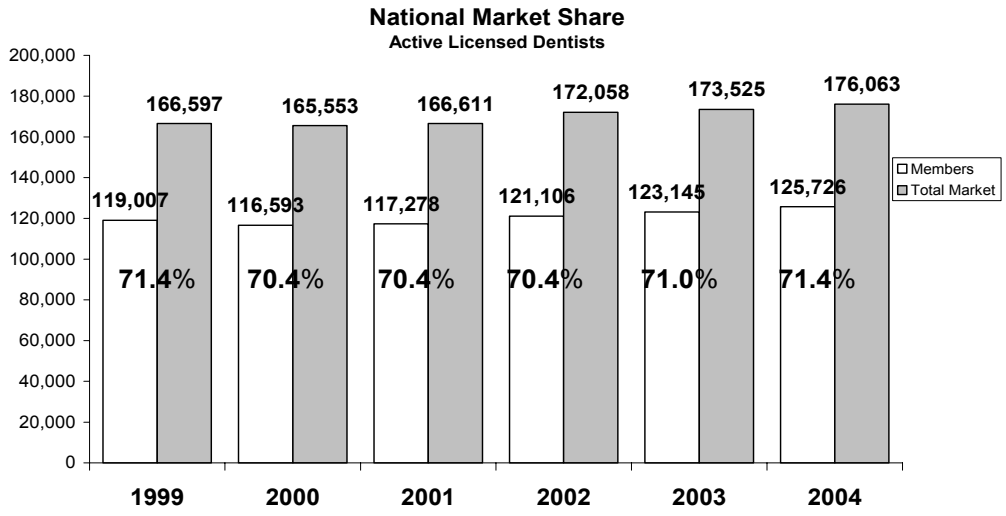


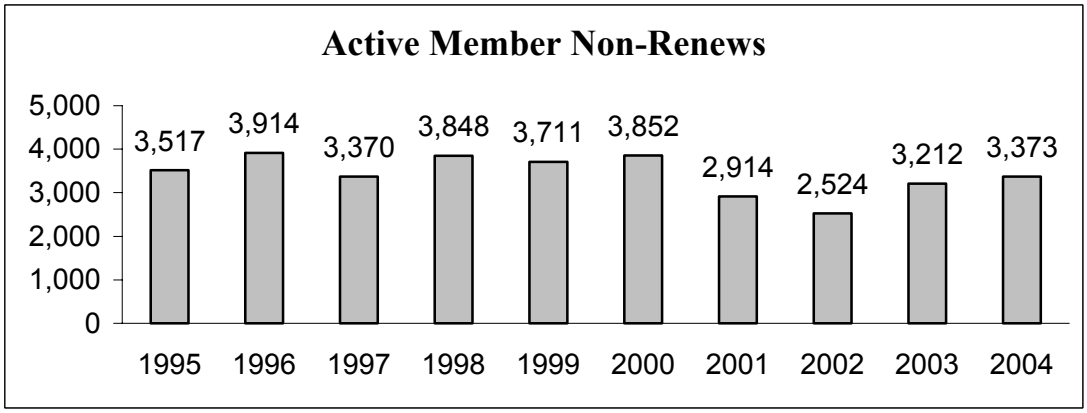
Table 2

Comparison of Members-Active Licensed Dentists
By Target Market
Year-End 2003
with Year-End 2004

Target Group	Increase+/ Decrease- in 2004 Members	2003 Market Share Percentage	2004 Market Share Percentage	Increase+/ Decrease- in Market 2004/2003
Women Dentists	1,586	63.4	63.8	2,291
All Faculty	1,030	74.1	74	1,407
Full-time Faculty	-65	67.9	69.2	-143
General Practitioners	1,716	68.2	68.7	1,379
Specialists	865	82.7	82.4	1,159
Federal Dental Service	62	57	59.8	-116
Foreign Trained Dentists	271	50.5	51.2	420
Minority Dentists	329	55.7	54.5	1,192
New Dentists	1,497	66.1	68.3	955

**Target markets overlap and should not be added together.*

Table 3



In response to Resolutions 14-2004 (*Trans*.2004:297) and 11H-2004 (*Trans*.2004:296), both faculty membership and retired dentists with limited income will be closely examined as part of the membership study. In 2005, the Council undertook research into the needs and perspectives of dental educators to facilitate this discussion, completing both a focus group and the 2005 Dental Educator Web Survey. Due to the scope of the membership study, it is anticipated that the study will take at least two years and will not be completed before the 2005 House of Delegates meets.

Further, depending on the resulting recommendations, the ADA may also need to examine the attractiveness of benefit offerings to all membership segments and whether these are the appropriate mix of products and services to attract and keep members, particularly as the Association strives to be more inclusive. The 2005 Member Participation Survey, which is currently underway, will examine the relationship between utilization of ADA products and services and member loyalty for specific subgroups of members, as well as offer insight into potential new products and services. The findings will assist the ADA Board of Trustees and councils as it oversees membership activities.

Additionally, the Council has evaluated the 2003 Nonmember Needs and Opinion Survey and the 2004 Member Needs and Opinion Survey along with other research as part of its overall membership planning, and has updated its annual membership and student marketing plans accordingly.

End-of-Year 2004 Membership Statistics: The aggregate number of active licensed members increased by 2,581 from 123,145 at the end of 2003, to 125,726 at the end of 2004. This membership increase includes both first-time members and previous members who had been reinstated into membership. The actual number of new and reinstated active members in 2004 is 4,007. The number of new and reinstated members is higher than the aggregate increase in members because some members retired, were deceased, or did not renew their membership.

Table 1 illustrates the six-year membership trend. From 1999-2004, there was an increase of 6,719 active, licensed members and the market increased by 9,466 over the same period.

Table 2 highlights the changes in the market share for key target markets, when comparing year-end 2003 with year-end 2004. As in 2003, the size of the market for all target markets grew except for full-time faculty; a similar trend was noted for the number of members in the target markets. Likewise, the ADA experienced membership increases in all target markets except full-time faculty. However, full-time faculty, women, federal dentists, internationally (foreign) trained dentists and new dentists experienced market share increases.

Market share improvements are due to both recruitment and retention initiatives at all levels of the tripartite. Compared to many associations, the ADA enjoys a very strong retention rate. In 2004, only 3.2% of active ADA members failed to renew their membership, slightly higher than last year. As the Association becomes more successful in convincing nonmember dentists to try ADA membership, a focus on retention will become increasingly important. Prompt follow-up with every lapsing member—by all three levels of the tripartite if feasible—is needed to facilitate retention.

Table 3 shows the number of active members who did not renew their membership each year for the last ten years. Many of the dentists who lapse in one year are subsequently reinstated, so the yearly number of nonrenews should not be added together. The active member non-renew number is used to calculate the annual retention rate for the ADA.

Tripartite Grassroots Membership Initiative (TGMI): The goal to reach 75% market share by 2005 is an ambitious goal for the ADA. The Council continues to direct and monitor the TGMI, a critical tripartite membership recruitment and retention strategy that was launched in 2001 to reach that goal. It is clear that there is still much work to be done in order to reach 75%, particularly in lagging categories. The ADA should continue to strive to reach 75% beyond the year 2005. It must escalate outreach to groups and individual dentists that have been traditionally underrepresented in organized dentistry. The Council continues to develop targeted resources to promote inclusion and has requested that dental societies share successful strategies they have used with the Council to encourage increased outreach with these segments.

The Council has determined that greater lead generation of potential members, incentives for outreach, increased leader involvement and a focus on retention will need to be part of the TGMI as it continues beyond 2005.

While the TGMI has been successful in focusing the spotlight on membership and on increasing the level of outreach throughout the tripartite, much more support is needed to encourage members to talk with nonmembers about membership. TGMI volunteer ranks increased 32% and now number more than 1,000 volunteers. This number must continue to grow to be more effective. The 2004 Member Needs and Opinions Survey confirms that there is room for growth; 30% of member dentists indicated that they would be willing to become TGMI volunteers.

One key challenge to effective one-to-one outreach is preparation of the volunteers. While asking dentists to reach out to peers is a simple tactic, the Council learned that it is very challenging for volunteers for a number of reasons. For example, the lack of time; hesitancy to ask nonmembers to join; or difficulty articulating member value in a meaningful way. Of the 47 constituents in the TGMI, only 27 have held the Field Representative Workshop, an outreach training. Feedback from TGMI volunteers indicates that the training is useful in preparing them to reach out to nonmembers. TGMI states that have not conducted the training will be encouraged to offer the TGMI Field Representative Workshop or any of the four modules (retention,

cultural proficiency, leadership and dental student conversion) to their volunteers. TGMI resources are being updated to continue to assist dental societies with member outreach. New targeted brochures for faculty, new dentists, women dentists and those dentists who practice in urban settings were produced for targeted outreach. Membership market share tends to be lower in constituents with large, urban centers and face unique membership recruitment challenges.

The 2005 ADA annual session is being held in Philadelphia and creates a unique opportunity to appeal to nonmember dentists. Twenty-five percent of non-member dentists (more than 12,000) live within five hours of Philadelphia. This year, the nonmember rate for the ADA annual session is reduced to $75 with a goal of attracting nonmembers to the ADA annual session so that they can sample ADA benefits. The Councils on ADA Sessions and Membership are collaborating to present special nonmember events with a goal of increasing nonmember attendance. The results of the 2005 ADA annual session efforts will be evaluated for future meetings. With TGMI outreach at the local dental societies before and after the ADA annual session, it is hoped that many of the nonmember attendees will decide to join the ADA.

Going forward, it will be important for the TGMI to continue to increase its volunteer ranks and build awareness amongst both members and prospective members and to maintain momentum. Recent nonmember research indicates that 29.5% of nonmembers are aware of the ADA efforts to increase membership and 3.6% report being contacted by a TGMI volunteer with another 7.1% not sure if they were contacted. Among members, awareness is much higher, at 54.4%. The immediate impact of personal contact may be understated, since it often takes multiple messages about the value of ADA membership before a nonmember completes an application. Positive interaction with members may be coupled with invitations to join through direct mail or other sources and result in conversion to membership. Theoretically, if the 1,000 current TGMI field representatives contacted 50 (four per month) nonmembers in 2004 and 2005 to join, the membership gap could be closed. However, nonmember dentists are not distributed evenly across the country. For example, six states with large urban centers comprise nearly 42.2% of nonmembers – California, New York, Texas, Florida, Illinois and Pennsylvania.

The Council continues to encourage the tripartite to streamline the membership approval process. In order to ensure that applicants from states who do not complete the membership process in the recommended 60 days, the 2004 House of Delegates adopted a resolution to provide interim services to applicants so that this critical group is able to enjoy a limited amount of ADA products and services immediately (access to member content on ADA.org, ability to purchase ADA Catalog items at a member rate and the receipt of *JADA* and *ADA News*).

As new members are added, tripartite collaboration will continue to be critical. Efforts to work with constituent and component societies to find new ways to reach out and welcome new dentists will be increasingly important as TGMI engagement and planning moves past 2005. Similarly, the ADA will continue to strengthen its brand within the dental profession and further integrate its membership value messages across its departments and divisions to more effectively convey the value of membership. Continued focus on customer service and retention will be important.

Conversion of dental students to active membership upon graduation continues to be a key objective for the tripartite. At end-of-year 2004, 68.2% of the 2003 dental school graduates had converted to membership, an increase of more than eight percentage points when compared to the class of 2002 at end-of-year 2003 (59.95%). The number of tripartite members among new graduates increased 18% (from 1,902 for the class of 2002 at end-of-year 2003 to 2,253 for the class of 2003 at end-of-year 2004). At the same time, the number of non-transferred new graduates (those who continue to show a constituent society of "DS" for dental school) dropped 33% (from 1,216 for the class of 2002 at end-of-year 2003 to 811 for the class of 2003 at end-of-year 2004). The increase was comprised of tripartite members. Direct ADA members through direct graduate student membership and federal dental service membership remained at the same high rate.

The expansion of the ADA reduced dues program as of January 1, 2004, to incorporate a year at $0 dues is sure to have played a role in the enhanced dental conversion rate. By end-of-year 2004, there were 3,395 dentists who paid the $0 rate; this includes both 2003 dental school graduates and dentists who deferred entry into the reduced dues program by maintaining graduate student membership during an advanced dental education program. As of the end of April 2005, 2,838 dentists paid the $0 dues rate for 2005 membership.

The expansion of the ADA reduced dues program does have a financial impact on the ADA. In 2004, this can be estimated at $397,215 of revenues forgone, if it is assumed that all 3,395 dentists who paid the $0 rate would have become members at the previous rate and paid $117. However, as noted above, it is anticipated that the availability of the $0 rate increased participation in the ADA reduced dues program and ADA membership overall. If membership at the first-year-out rate had maintained the same lower level of end-of-year 2003, the revenue foregone would only be $318,240.

Early indications for the class of 2004 are positive. As of April 30, 2005, there are 2,577 members of the class of 2004 (or 57.4%) who have been transferred into an appropriate constituent dental society for tripartite or direct membership. One new tactic undertaken for the class of 2004 was the utilization of direct mail to the non-transferred new graduates. These new graduates received a New Graduate Information Form mailing in December 2004, requesting updated occupation and contact information, as well as information about their

intention to apply for ADA membership. Each new graduate received a follow-up mailing from the ADA encouraging them to apply for membership, and prospective tripartite members' forms were distributed to the appropriate constituent society for follow-up as well.

New in 2005 is the utilization of new technology to more efficiently request post-graduation practice plans and contact information from the class of 2005 via the Web in addition to a series of mailings. This has increased response rates and should assist the ADA and the tripartite dental societies in better identifying and crafting appropriate communications to new graduates. In addition, a "family" of new brochures highlighting member value messages just for new graduates in various membership categories will be used on an ongoing basis to provide more timely recruitment opportunities to new graduates with the anticipated impact of a further improvement in the conversion rate.

Target Market Trends:

Affiliate Membership (Non-U.S. dentists practicing outside the United States). The ADA's strategy of partnering with dental associations around the globe has resulted in 30 members through the British Dental Association at end-of-year 2004, and the Association will be entering discussions with other dental associations regarding a similar arrangement. However, the number of affiliate members overall has been on a downward trend despite continued direct mail and Internet recruitment. It is anticipated that the FDI World Dental Federation meeting in Montreal, Canada in August 2005 will be an excellent opportunity for affiliate member recruitment and the ADA will have an enhanced presence at that meeting.

One key barrier to recruitment of affiliate members is uncertainty related to dues; critical recruitment opportunities occur in the early fall, prior to when the ADA House of Delegates sets the dues rates for active members. Since affiliate members pay 50% of active dues/assessment, recruitment messages cannot give a firm dues rate for the following year. A second barrier is the high rate of dues for non-U.S. dentists, in 2005, it is $233. Affiliate members receive few benefits for their dues dollar, which impacts the perceived value of membership. In addition, in many countries outside the U.S., $233 is the equivalent of several months' income. The Council will be addressing these barriers, as well as identifying opportunities to enhance the value of membership to potential affiliate members.

Diverse (Minority) Dentists/54.5% Market Share. There is increasing diversity in dental school enrollment, and it is anticipated that the improvement of dental student conversion should also have a positive affect on the minority dentist market share overall. Research shows that even ethnically and racially diverse long-time nonmembers are open to ADA membership. However, membership participation for minority dentists has remained flat around 55%.

Resources for outreach through the TGMI to dentists of diverse backgrounds have been enhanced, and focus on recruitment in areas where large numbers of these potential members practice could be fruitful. As of end-of-year 2004, 50% of nonmember minority dentists practice in the following six states/commonwealths: California, Puerto Rico, Texas, Maryland, Florida and Illinois.

Federal Dentists/59.8% Market Share. Federal dentist membership market share has continued to grow, increasing to 59.8% by end-of-year 2004. Enhancing member communications and demonstrating the value and relevance of membership are the keys to the membership recruitment and retention strategy for this highly mobile group. With the support and advice of the Federal Dental Services (FDS) Membership Advisory Group, which has one representative from the Army, Air Force, Navy, U.S. Public Health Service and Veterans Administration, the ADA has enhanced the FDS Web site on ADA.org and improved electronic communications to federal dentists. In addition, for the first time at the 2005 annual session in Philadelphia, the ADA will offer an educational track for federal dentists.

Graduate Students/72.3% Market Share. In the last three years, the ADA has encouraged tripartite membership for graduate students. This group's mobility, and the fact that many dentists trained outside the United States come to this country to pursue advanced dental education, makes communication a challenge. In addition, the ADA has little insight into graduate students' needs and how to make membership more valuable. To address this, a Graduate Student Advisory Group was formed. Made up of eight graduate student members, both direct and tripartite, the Advisory Group met for the first time in April 2005 and provided feedback on member benefits, recruitment opportunities and perceptions of organized dentistry.

Response to Assignments from the 2004 House of Delegates:

Dues Reduction for Full-time Faculty. Resolution 11H-2004 regarding the issue of a reduction in faculty dues was referred to the Council as part of its membership study with a report to the 2006 House of Delegates or 2005 House of Delegates if the study is complete (*Trans.*2004:296). The Council is conducting qualitative and quantitative research with faculty to include in its discussion. The issue is being considered as it undertakes the membership study, outlined earlier in this report.

Amendment of ADA Bylaws Regarding Dues for Retired Members. Resolution 14-2004 regarding the issue of retired dues was referred to the Council on Membership as part of the membership study with a report to the 2006 House of Delegates (*Trans.*2004: 297). The issue is being considered as it undertakes the membership study outlined earlier in this report.

Interim Services for Applicants. In 2004, the Council on Membership advanced an ADA *Bylaws* change that would allow applicants access to interim services. The 2004 House of Delegates adopted Resolution 17H-2004 (*Trans.*2004:294) that allows applicants to receive interim services (*JADA* and *ADA News*, ADA Catalog items at member rates, and access to ADA.org member-only content) for a period of up to six months.

As anticipated in its supplemental report to the 2004 House of Delegates, the Council in 2005 studied the feasibility and implications of limiting receipt of interim services to one-time and offers the following resolution:

1. Resolved, that Chapter I. MEMBERSHIP of the ADA *Bylaws*, Section 60. INTERIM SERVICES, be amended in the first sentence by striking the word "an" and adding in its place the words and punctuation "a one-time," so the amended section reads as follows (new language underscored, deletion stricken through):

> Section 60. INTERIM SERVICES FOR APPLICANTS. A dentist who has submitted a complete application for active membership in this Association and the appropriate constituent and component societies, if such exist, may on ~~an~~ a one-time, interim basis: receive complimentary copies of the *Journal of the American Dental Association* and the *ADA News*, have access to the ADA.org member-only content areas and purchase items at a member rate through the ADA Catalog. Such interim services shall terminate when the membership application has been processed or within six (6) months of the application submission, whichever is sooner. Applicants shall have no right of appeal from a denial of membership in the Association.

Meetings: The Council met at the ADA Headquarters Building on February 4-5, 2005 and again on June 3-4, 2005. Dr. Ronald B. Gross, trustee, Third District, serves as the Board of Trustees' liaison to the Council.

Personnel: At its June 2004 meeting, the Council nominated Dr. Lidia M. Epel, chair and elected Dr. Raymond A. Cohlmia, vice chair for 2004-2005. At the close of the 2005 annual session, the terms of four highly regarded members of the Council will end: Dr. Lidia M. Epel, 2001-2005, who served as chair of the Council for 2004-2005; Dr. Norman K. Rounds, 2001-2005, who served as chair of the Subcommittee on Marketing, Communications and Benefits Issues; Dr. Edward H. Sauer, 2001-2005, who served as chair of the Subcommittee on Target Marketing Issues; and Dr. Elizabeth A. Shapiro, 2001-2005, who served as chair of the Subcommittee on Tripartite Membership Issues. The Council wishes to acknowledge these individuals for their thoughtful and determined leadership and for the many contributions they made during their years on the Council.

Summary of Resolutions

1. Resolved, that Chapter I. MEMBERSHIP of the ADA *Bylaws*, Section 60. INTERIM SERVICES, be amended in the first sentence by striking the word "an" and adding in its place the words and punctuation "a one-time," so the amended section reads as follows (new language underscored, deletion stricken through):

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Division of Dental Practice

Council on Access, Prevention and Interprofessional Relations

Council on Dental Benefit Programs

Council on Dental Practice

Notes

Council on Access, Prevention and Interprofessional Relations

Lauf, Robert C., North Dakota, 2005, chair
Barsley, Robert E., Louisiana, 2006, vice chair
Antonelli, Morris, Maryland, 2008
Beauchamp, K. Jean, Tennessee, 2006
Bordenave-Bishop, Susan, Illinois, 2008
Filanova, Vincent, New York, 2007
Flaherty, Kevin T., Wisconsin, 2005, American Medical Association
Griffin, Morris H., North Carolina, 2006
Holm, Steven J., Indiana, 2008
Hooker, William J., Arizona, 2005
Howard, Lisa P., Maine, 2007
Low, Samuel B., Florida, 2008
Maddox, Brandon, Illinois, *ex officio**
McCaslin, Alston Jones, VI, Georgia, 2008
McLellan, Thomas S., Michigan, 2005
Miller, Rodney E., Sr., U.S. Virgin Islands, American Hospital Association
Robinson, Lindsey A., California, 2005
Siegel, Philip T., Pennsylvania, 2007
Spradley, Larry W., Texas, 2006
Windell, Henry C., Oregon, 2007
Klyop, John S., director
Jasek, Jane F., manager
McGinley, Jane S., manager
Muraoka, Sharon G., manager

The Strategic Plan of the American Dental Association: The Council's program activities support objectives in each of the five goals of the *ADA Strategic Plan: 2002-2005*: Advocacy; Image, Ethics and Professionalism; Information; Member and Support Services and Practice Support. Each year the Council establishes criteria for measuring the effectiveness of its activities and then uses these criteria to evaluate the success of its program activities and the direction of future activities. When program activities do not achieve the goals set, these activities are evaluated and either the criteria are adjusted or the program activity is discontinued, as appropriate.

Interprofessional Relations

Focus: Interprofessional Relations activities fulfill the Council's mission by maintaining liaison with a variety of health care organizations in interdisciplinary care settings, as well as fostering dental/medical cooperation. Across its three focus areas, the Council liaises with over 45 organizations in this capacity. 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.

Emerging Trends—Relationship Between Oral Health and Systemic Health: Emerging research continues to suggest there may be a link between oral health and systemic health, as well as the impact of oral health on quality of life. Dental caries is caused by bacterial infection and is the single most common chronic childhood disease. As this link between oral and systemic disease unfolds, it will be more important than ever for dentists and physicians to work together on behalf of their patients. To address these issues, the Council has engaged in the following activities.

Oral Health Care Series. The *Oral Health Care Series* consists of nine monographs describing treatment of oral health in patients with complex medical conditions. Through its Oral Health Care Series Committee, the Council is continuing to update and develop new monographs. Four volumes regarding women's oral health, cancer therapy, cardiovascular disease and HIV/AIDS are in various stages of production and scheduled for publication in 2005. A document on renal disease will begin development this year.

American College of Physicians. The Council recognized the need to enhance relationships with physician colleagues. One strategy is to make presentations at targeted meetings to emphasize the role of oral health in addressing overall health, particularly in patients with complex medical conditions. A proposal was submitted and approved to present at the 2005 annual

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

meeting of the American College of Physicians. Dr. Peter Hurst (Council consultant, Illinois) gave this successful presentation to a capacity crowd of 200-300 internists who chose to attend this course among other competing concurrent sessions. Future similar opportunities will be pursued.

Emerging Trends—Interprofessional Relations: The Council continues to respond to requests from members regarding alternative careers to private practice, assist with workforce issues, respond to hospital dentistry issues, address proposals by the American Medical Association and review and comment on proposed standards and initiatives of the Joint Commission on Accreditation of Healthcare Organizations.

Alternative Dental Career Information. The Council provides information and guidance to dentists who are interested in pursuing a nonclinical or nontraditional dental career. The *Alternative Dental Careers Packet* includes information on career guidance, Internet resources, the U.S. Public Health Service, academic programs and other dental industry information. The *Packet* is available from the Council office. Since the initiation of this service, over 3,000 *Packets* have been distributed and technical assistance has been provided to numerous telephone and e-mail requests. Additionally, Council staff responds to an increasing number of requests regarding health professional shortage areas.

Hospital Dentistry Issues. The Council monitors and responds to problems related to medical staff membership, credentialing and privileges. The Council monitors the activities of the Organized Medical Staff Section of the American Medical Association in this regard. Dr. Robert Lauf was the ADA's Official Observer to the Annual Meeting of the American Hospital Association. The Council's initial foray into strategic sessions was the topic: Medical/Dental Interface to Promote Oral Health. 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 ADA'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 to study trends in the severity of these issues.

American Medical Association. Dr. David Whiston (Virginia) was the Official Observer to the 2004 Annual and Interim Meetings of the American Medical Association (AMA). The Council worked closely with the Division of Science regarding a potentially troublesome reference to mercury and dental amalgam in a report of the AMA Council on Scientific Affairs to the AMA House of Delegates. The subject of the report was the medical and public health issues involving mercury and fish consumption, but a background statement had the potential to be misleading. This was brought to the attention of the AMA Council on Scientific Affairs and mutual discussion ensued regarding the distinction between elemental mercury and methylmercury, which is the primary source of health concern. Fundamentally, the AMA and ADA are in agreement on the safety of dental amalgam. Both councils agree that a vehicle for routine sharing of scientific information of concern to both professions is beneficial. Additionally, scope of practice issues continue to be raised at the AMA House of Delegates. Although there were no specific references to dentistry this year, it will be important to remain vigilant on this front.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO). During this past year, the JCAHO focused on the tenuous relationships between medical staffs, hospital administration and governing bodies. The JCAHO discussed medical staff issues through its Leadership Accountabilities Task Force, Credentialing and Privileging Task Force and Hospital Advisory Council, as well as through its Professional and Technical Advisory Committees. The ADA participated in these discussions and underscored the fact that dentists participate as active members of the medical staff and that credentialing and privileging decisions need to be based on the same criteria as any other member. These include education, training, experience and clinical competence. The ADA also stressed that appropriately trained dentists are eligible for the privilege of doing histories and physicals, with a specific note regarding oral and maxillofacial surgeons.

Emerging Trends—Patient Safety: Patient safety has been a cornerstone of the delivery of oral health care, including being incorporated in the Dentist's Pledge (*Trans.*1991:598). New emphasis was placed upon patient safety when the Institute of Medicine (IOM) published its report *To Err is Human: Building a Safer Health System* in late 1999 and the follow-up report *Crossing the Quality Chasm: A New Health System for the 21st Century* in 2001. Since that time, public policy has intensified on safety in health care, particularly in light of the five-year anniversary of the initial IOM report. The following Council activities are pertinent to this issue.

Medical Abbreviations. As part of their National Patient Safety Goals, which all accredited organizations must be in compliance with, the JCAHO issued a goal to improve the effectiveness of communication among caregivers. One of the requirements of this goal is to standardize a set of abbreviations that are not to be used throughout the organization. It was decided to focus on abbreviations not to use because of the enormous number of abbreviations, in general. This caused a great deal of concern upon implementation in the field and JCAHO convened a Summit on Medical Abbreviations in November 2004. The ADA was one of the co-conveners of this summit. Representatives of more than 50 professional societies, associations and other groups came together to reach consensus on the scope and implications of medical errors related to the misuse and misinterpretation of abbreviations, acronyms and symbols

and to find reasonable solutions. A field review of these recommendations was widely distributed and will be used to move this issue forward at the JCAHO. For more information on the National Patient Safety Goals, including medical abbreviations, visit www.jcaho.org.

Council Strategic Session. The Council devoted its March Strategic Session to the mega issue "Patient Safety: A Way of Practice." Four panel members and a facilitator engaged the Council in a discussion of patient safety issues of significance to oral health practice. The four standard questions for strategic sessions were addressed:

1. What do we know of member, the profession and public needs and wants today related to this?
2. What do we know about the current realities of the environment that is relevant to this issue?
3. What do we know about the capacity and strategic position of our Association that would affect any decisions?
4. What are the future implications of our choices today? (What do we need to have in place to ensure the future we envision or to guard against a future we won't like?)

Bioterrorism. Council staff continues to serve on the ADA Bioterrorism Workgroup. Staff works with the Chief Policy Advisor and the Department of Electronic Communications staff to update the ADA's Web page on Bioterrorism. Find information on this topic by searching "bioterrorism" on ADA.org.

Patient Safety and Quality of Care. In the IOM's first report, it was concluded that tens of thousands of Americans die each year from health care related errors, and hundreds of thousands suffer or barely escape from nonfatal injuries. As disturbing as that is, it reflects only a small part of the unfolding story of quality in American health care. The Council proposed, and the ADA House of Delegates approved, policy on patient safety in response to these emerging concerns (*Trans.*2001:429). This year, the Council re-examined these issues and proposes enhancing ADA policy by supporting a portion of the IOM report, *Crossing the Quality Chasm,* thereby embracing the shared agenda of the IOM's six aims for improvement to address key dimensions in which today's health care system functions. Recognizing the importance of this issue, the Council recommends adoption of the following resolution. This resolution supports the ADA Strategic Plan Goal Image, Ethics and Professionalism.

2. Resolved, that it is the ADA's position that health care should be:

- *safe*—avoiding injuries to patients from the care that is intended to help them
- *effective*—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively)
- *patient-centered*—providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions
- *timely*—reducing waits and sometimes harmful delays for both those who receive and those who give care
- *efficient*—avoiding waste, including waste of equipment, supplies, ideas and energy
- *equitable*—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status

Access and Community Health

Focus: Access to oral health care is an ongoing key issue for dentistry from the clinical, community and regulatory perspectives. The Council directs nongovernmental advocacy activities for the ADA and is the conduit for numerous interagency access to care initiatives.

Emerging Trends—Access to Care: Over the past year, the Council noted several trends demonstrating dentistry's commitment to access to care: an increased number of e-mail and telephone requests for information on building community partnerships and reaching special underserved groups (e.g., families of reserve military serving in Iraq); efficiencies in use of Web-based information on access to care, including the Council's new access content site on ADA.org; and increased requests related to access to care for older Americans, as a result of the 2005 GlaxoSmithKline/ADA Foundation/ADA Access to Oral Health Care for Older Adults Grants Program. The following Council activities are access-related.

New ADA.org Content Page. The Council worked with the Division of Communications to develop a new access content page in the Dental Topics section of ADA.org. The goal was to create an electronic clearinghouse of news articles, access program Web site links and frequently-cited articles in *The Journal of the American Dental Association*. This page's content is dynamic, for example the Council is working on a "Featured Access Program of the Month" section, which it will be debuting this year.

Access White Paper. The Council served as the distribution point for the 2004 ADA access white paper, *State and Community Models for Improving Access to Dental Care for the Underserved—A White Paper,* spearheaded by President Richard Haught and reviewed by the 2004 ADA House of Delegates. Searching ADA.org for "white paper" locates the electronic copy. The Council mailed hard copies to all state society presidents and executive directors, as well as almost 350 copies to other individuals and organizations. The Council also facilitated *ADA News* and "Executive Director's Update" notices.

Resolution 73H-2004—White Paper on Dental Care Needs of Aging U.S Populations. Resolution 73H-2004 (*Trans*.2004:300) directed that the ADA Board of Trustees appoint a task group to explore the challenges in rendering comprehensive dental care to the U.S. aging population, giving special attention to identifying varying needs based on the variety of resident situations. The resolution also directed that a white paper be produced for the 2006 ADA House of Delegates and that a status report be provided for the 2005 House of Delegates. This status report will be provided in a supplemental report to the House of Delegates.

The Task Force on Elder Care was appointed by President Haught and held its initial meeting on January 21, 2005. In an attempt to understand all aspects of the emerging needs of this population, outside organizations were invited to provide written input on oral health access challenges of older Americans. At its second meeting held on July 21, select organizations were invited to present to the Task Force. The workgroup held a preliminary discussion about how to frame the white paper and its recommendations.

National Foundation of Dentistry for the Handicapped (NFDH). Liaison with the NFDH helped publicize the Donated Dental Services (DDS) national program and state programs in 34 jurisdictions. During 2003-04, 11,571 dentists donated $12.2 million dollars of care to 5,664 disabled, vulnerable individuals through NFDH's DDS programs. There are about 13,000 individuals on waiting lists in both state DDS programs and the national program. NFDH has pledged to work with the Council to identify specific geographic areas with dire volunteer shortages to better target dentist recruitment.

Collaborative Grant Program. Membership value was greatly enhanced this year when the Council supported a partnership between the ADA Foundation (ADAF), the ADA and GlaxoSmithKline Consumer Health Care, which awarded a total of $225,000 in grants to six programs that enhance access to care for semi-dependent older Americans. Dr. Robert Lauf, Council chair, and Ms. Jane Jasek, Council staff, served on the advisory committee

Head Start Forum. In October 2004 the Council hosted a small forum of ADA and Head Start representatives to address strategies to enhance education, prevention and access to oral health care for children enrolled in Head Start programs. The meeting was funded by the U.S. Health Resources and Services Administration's Maternal and Child Health (MCH) Bureau. A meeting report may be accessed on the Internet at www.mchoralhealth.org. The Council is investigating initiatives to support dental continuing education for the care of very young children as suggested by this forum group, along with possible MCH funding support.

Emerging Trends—Community Health Activities: The Council fields an ever increasing number of requests related to community health activities that complement clinical dental care services. This year's issues of interest to the membership are summarized below.

Pouring Rights Contracts and Marketing of Soft Drinks to Children. The Council examines community health trends to carry out the intent of the ADA's policy opposing school soft drink pouring rights and marketing contracts. The Council partnered this year with the Division of Government Affairs to expand the ADA's public advocacy efforts with federal agencies and Congress to limit target marketing of non-nutritious beverages and foods to children. Council staff continues to respond to numerous e-mail and telephone requests from dentists on the issue of school soft drink pouring rights contracts.

Family Violence Awareness. Increasing awareness within dentistry about recognition and appropriate reporting of suspected violence continues as a key initiative for the Council. To position dentistry within the greater health care arena striving to foster interdisciplinary awareness, the ADA, via the Council, participates as a co-chair organization for the biannual National Conference on Health Care and Domestic Violence sponsored by the Family Violence Prevention Fund (FVPF). Dr. Lynn Douglas Mouden (Council consultant, Arkansas) and staff attended the October 2004 conference, which drew a multidisciplinary audience of about 600 individuals. Approximately 50 dentists and dental hygienists attended, more than doubling 2002 dental attendees. Dr. Mouden also provided input into a new FVPF Web-based resource for dental professionals entitled "Enhancing Dental Professionals' Response to Domestic Violence," which can be accessed at www.endabuse.org.

This year, the Council provided support, in principle, to a potential continuing education (CE) program, which may receive corporate funding. The CE program would educate and update dental professionals in recognizing signs of family violence in the course of their daily practice, and provide state specific resources for follow up, support and referral of suspected victims. A California-based program has been operating for a year. The California Dental Association (CDA) and its Foundation have offered this program as a model, to fine-tune as necessary based on member and legal needs, for expansion to other states. The ADA and the ADAF received a draft proposal in 2005 from the CDA Foundation in conjunction with the National Association of Dental Plans Foundation. The proposal outlines a partnership, suggests pilot training sites and projects a budget, which the Council and the ADAF are deliberating.

Emerging Trends—Public Recognition of Dentists' Altruism: The Council continues to note that, in addition to their heartfelt motivation to help others, members and societies are promoting donated dental care as a public relations opportunity to get dentistry's oral health messages in front of policy-makers and opinion leaders. Public officials and advocacy groups are typically unaware of the breadth of dentistry's altruism. Knowledge of dentistry's community outreach is

influential in getting nondental advocates to help affect change in poorly administered and funded public dental programs. That is why the Council devotes time and resources to public recognition of member and stakeholder efforts to get oral health care to vulnerable populations by sponsoring four award programs. Winners of the Access Recognition Award, Community Preventive Dentistry Award, Geriatric Oral Health Care Award and Council's Choice Award were featured in the November 15, 2004, and February 21 and April 4, 2005, issues of the *ADA News.*

Fluoridation and Preventive Health Activities

Focus: Community water fluoridation is the cornerstone of the ADA's preventive health efforts. The Council serves as the focal point for fluoridation technical assistance and acts as a resource to the profession, public health officials and other external organizations. In addition, the Council supports activities in the areas of oral cancer prevention, tobacco use prevention and cessation, dental sealants, early childhood caries and nutrition.

Emerging Trends—Community Water Fluoridation: Member requests for fluoridation technical assistance by phone, e-mail and fax continue to increase. In the past, fluoridation activities were focused solely on the initiation of fluoridation. Today, those opposed to fluoridation also focus on discontinuing fluoridation—in some cases in communities that have been fluoridated for over 50 years. In these fluoridation cessation efforts, those opposed to fluoridation frequently target water plant personnel as initial points of entry into communities.

Fluoridation Technical Assistance Materials. The development of new resources and revision of existing items is based in part on trends in members' requests for assistance. In 2004, the Council provided educational materials and assisted active campaigns to initiate or retain fluoridation in 35 states. During the past year, on-site assistance was provided to Arkansas, Colorado and New Jersey. Articles concerning fluoridation issues and campaigns were printed throughout the year in *ADA News* and in the ADA's *State Legislative Report*.

In consultation with the Division of Legal Affairs and the Department of State Government Affairs, the Council developed "Fluoridation Ordinance—Suggested Elements." The elements, which can provide a starting point for communities in their efforts to secure fluoridation, are posted on ADA.org.

The revision of the ADA's premier fluoridation resource, *Fluoridation Facts*, continued throughout the year. The revised booklet was released as part of the National Fluoridation Symposium in July 2005.

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 fluoridation education materials. This year's annual NFAC meeting was held on July 13 and 16, in conjunction with the National Fluoridation Symposium.

Fluoridation Legal Activity and Legislative Challenges. Legal activity and legislative challenges regarding fluoridation increased significantly in the past year. Lawsuits regarding fluoridation were active in California (Escondido and Watsonville). The suit in Escondido differs from most recent cases as it was expected to reach the scientific merits of fluoridation. In late 2004, the judge dismissed the case stating that the state clearly has a legitimate interest in protecting dental health and fluoridation of the water supply is widely used to accomplish that interest. The plaintiffs have appealed the ruling. The suit in Watsonville raised the question of whether a municipal law, in particular a "pure water" bill, could preclude fluoridation when state law requires fluoridation under specified circumstances. The Superior Court has ruled in favor of the state law; this case is also on appeal. On the legislative front, an increasing number of states and communities saw the introduction of "pure water" or "water quality" bills expressly designed to prohibit fluoridation. While no state has adopted such legislation, five communities in California, Hawaii, Utah and most recently Michigan (Mt. Pleasant) have passed this type of city ordinance. Those opposed to fluoridation continue to increase their efforts to pursue their agenda in the courts and legislatures. The Council has worked closely with the Division of Legal Affairs and the Department of State Government Affairs in providing assistance to members and constituent dental societies.

National Fluoridation Symposium 2005. As part of the 60th anniversary celebration of community water fluoridation, the ADA, in conjunction with the Centers for Disease Control and Prevention and numerous sponsors, hosted the National Fluoridation Symposium 2005 in Chicago on July 13-16. The goal of the symposium was to recognize the impact that water fluoridation has had on improved oral health and, in turn, general health by preventing tooth decay nationwide. This symposium, which was open to the public, was designed to (1) facilitate the update and transfer of current science surrounding fluoridation; (2) allow for sharing of legislative and legal strategies as they relate to fluoridation; (3) establish a national fluoridation dialogue and (4) refocus efforts on securing water fluoridation for U.S. communities.

Federal Fluoride Panel. As part of its established review process, the Environmental Protection Agency (EPA) has asked the National Research Council (NRC) to update its risk assessment on fluoride. A panel was created to review data and make recommendations to the

EPA regarding its standards for the maximum level of fluoride in water. In conjunction with the Division of Government Affairs and the Council on Scientific Affairs, the Council has monitored the panel's activities and acted as a resource to the two dentists on the panel. While the NRC report release has been delayed several times, it is now scheduled for release in early 2006. The Council is planning to collaborate with other ADA agencies and external organizations to prepare for the report which is anticipated to receive significant press coverage.

Emerging Trends—Tobacco/Oral Cancer: The issue of "harm reduction" strategies for tobacco users and as a public health measure has polarized members of the health community. Additionally, a number of organizations and agencies offer information and activities focused on oral cancer and early detection of oral cancer, but there does not appear to be a unified national effort to raise public awareness and change dentists' behavior in this area.

Tobacco Issues. On an ongoing basis, the Council identifies opportunities for involving the ADA with activities designed to support Association policy relating to tobacco use prevention and tobacco use cessation counseling. Recognizing the extraordinary opportunity for synergy when the 13th World Conference on Tobacco OR Health will be held in conjunction with the 19th International Cancer Conference in Washington, DC in 2006, the Council has requested the ADA support the Conference. Participation in this highly visible international tobacco prevention activity could bring increased synergy with other organizations active in tobacco use prevention and cessation efforts as well as focus attention on the ADA as a national leader in this prevention area.

Oral Cancer Prevention Grant. In August 2002, the ADA received a five-year, $1.2 million grant from the National Cancer Institute to develop and present an all-day continuing education program focusing on early detection of oral cancer and tobacco use cessation to dentists across the country. In conjunction with dental society and dental school co-sponsors, the program, "DENTIST SAVES PATIENT'S LIFE! Early Oral Cancer Detection and Tobacco Use Cessation," has been held in 45 locations across the United States. Courses held have received excellent evaluations. Course presentations will continue through the end of 2006.

Emerging Trends—Oral Health Literacy/Cultural Awareness: It is estimated that approximately half (90 million) of all American adults lack adequate health literacy skills. However, improving health literacy is only part of successful communication. In order to effectively communicate information about oral health to culturally diverse populations, it is necessary to communicate in a comprehensible, concise, culturally and linguistically appropriate manner. At the 2004 House of Delegates, the ADA adopted Resolution 51H-2004, Urging Promotion of Oral Health Literacy (*Trans.*2004:306), which in part addressed the need for review of ADA's current policies on oral health literacy and education to see if an update of policies is appropriate and called for the development of a definition of oral health literacy to be considered by the 2005 House of Delegates. In response to this resolution, the Council reviewed existing policy on these topics and recommended that no update is needed at this time. However, given oral health literacy is in its initial stages at the ADA, the Council will continue to develop programs, activities and additional policy as needed. Additionally, the Council adopted a definition of oral health literacy that was shared with the Council on Communications, the Council on Dental Practice and the Council on Dental Education and Licensure prior to its submission to the 2005 House of Delegates. The Council recommends that the following resolution be adopted. This resolution supports the ADA Strategic Plan Goal Information.

3. Resolved, that it is the ADA's position that oral health literacy is the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate oral health decisions.

Additionally, a new content area for dental professionals has been created on ADA.org regarding oral health literacy and cultural awareness which includes reproducible "patient pages" to assist dentists to facilitate patient education and communication in a culturally and linguistically appropriate manner.

Emerging Trends—Nutrition: With the release of *Dietary Guidelines for Americans 2005* in early 2005, the public refocused its attention on the obesity epidemic.

In an effort to position the ADA as a credible and accessible source on oral health issues for the public and governmental agencies, the Council was challenged to look at possible new action steps that the ADA might take to become more involved in national advocacy activity related to nutrition and health promotion especially in regard to its opposition of school pouring rights contracts. Building on the newly formed ADA liaison with the National Alliance for Nutrition and Activity (NANA), a nongovernmental nutrition advocacy group that promotes the importance of healthy eating, physical activity and obesity control to Congress and federal agencies, the Council has taken the opportunity to provide ADA policy statements and consumer education pieces to support the liaison with NANA. The ADA also maintains a liaison with the National Coordinating Committee on School Health and Safety which is made up of a number of governmental and nongovernmental agencies. Communication with both federal agencies and advocacy groups that lobby those agencies appears to be a balanced approach to positioning the ADA as a national resource for information consistent with its nutrition and oral health policies.

Emerging Trends—Other Prevention Issues: The role of physicians in providing dental care to children, the use of fluoride varnish, the use of sealants, reimbursement and

workforce issues continue to be important to dentistry in any discussion of the prevention of caries. The Council is aware of these evolving issues. While there is no established mechanism to track the programs related to the first dental visit for children, the application of fluoride varnish and sealant programs, the Council receives periodic reports on innovative programs. The Council continues to monitor these programs especially those involving nondentist providers.

Early Childhood Caries. The Council is working toward objectives outlined in its three-year plan for early childhood caries (ECC) prevention, including professional and public education activities. Of particular importance is keeping current with the public health science and collaborating with other ADA 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. A discussion of the prevention and treatment of ECC often develops into a discussion regarding the role of physicians providing dental care to children, the use of fluoride varnish, reimbursement and workforce issues. The Council is aware of these evolving issues and attempts to track the evolution of programs related to first visit for children and the application of fluoride varnish. It should be noted that these topics reach across all three primary Council focus areas—access, prevention and interprofessional relations.

Meetings: The Council met in the ADA Headquarters Building on September 10-11, 2004, and March 11-12, 2005. The Council is scheduled to meet again September 9-10, 2005. Dr. Jeanne P. Strathearn, trustee, First District, serves as the Board of Trustees' liaison to the Council.

Personnel: The close of the 2005 annual session brings to an end the terms of four valued members of the Council: Dr. William J. Hooker, Dr. Robert C. Lauf, Dr. Thomas S. McLellan and Dr. Lindsey A. Robinson. These members have given unselfishly of their time and energy on behalf of the profession. The Council acknowledges their efforts with great appreciation.

Summary of Resolutions

2. Resolved, that it is the ADA's position that health care should be:

- *safe*—avoiding injuries to patients from the care that is intended to help them
- *effective*—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively)
- *patient-centered*—providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions
- *timely*—reducing waits and sometimes harmful delays for both those who receive and those who give care
- *efficient*—avoiding waste, including waste of equipment, supplies, ideas and energy
- *equitable*—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status

3. Resolved, that it is the ADA's position that oral health literacy is the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate oral health decisions.

Council on Dental Benefit Programs

Hall, Glen D., Texas, 2005, chair
Greenblatt, Charles L., Jr., Tennessee, 2005, vice chair
Bishop, Deborah S., Alabama, 2008
Buchheister, John S., Michigan, 2007
Faiella, Robert A., Massachusetts, 2008
Friedel, Alan E., Florida, 2007
Herman, Richard P., New York, 2006
Hogg, Steven W., Oklahoma, 2006
Jacobs, Thomas A., California, 2005
Jaworski, Stephen J., Pennsylvania, 2008
Kampfe, Mark I., Iowa, 2006
Mercer, James E., South Carolina, 2006
Mooney, John T., Idaho, 2008
Nicholas, Dean P., Illinois, 2005
Rempell, Jeffrey H., New Jersey, 2008
Schripsema, Thomas J., New Mexico, 2007
Simpson, Stephen P., Ohio, 2007
Marshall, James Y., director
Ellek, Donalda, manager
McHugh, Dennis, manager
Pokorny, Frank, manager

The Strategic Plan of the American Dental Association: The Council's activities are consistent with and continue to support the *ADA Strategic Plan: 2002-2005*, primarily Strategic Plan Goals of Advocacy; Image, Ethics and Professionalism; Information; Member and Support Services; and Practice Support. The Council annually reviews its Strategic Plan metrics to assure that its activities and programs remain effective and relevant.

Emerging Issues: Emerging issues are discussed at each Council meeting. Recent topics include promoting SNODENT as a clinical recordkeeping and research code set owned and maintained by the ADA; HIPAA electronic transaction activity (e.g., enumeration of teeth on professional claims; diagnostic code data elements; HCPCS modifiers) that could affect the unique standing of the dental claim; innovative dental benefit plan designs such as variations to direct reimbursement plans and the growth of voluntary referral type plans; the standardization of dental plan credentialing efforts as a means to simplify this process for dentists; and the application of "pay for performance."

"Pay for performance" is a concept that is emerging in the health care industry to achieve the interrelated goals of quality of care and cost control. Pay for performance refers to reimbursement or payment schemes that link reimbursement to a measure of individual, group or organizational performance. In attempting to apply this concept to the health care industry, the Centers for Medicare and Medicaid Services (CMS) has developed a demonstration project that links reimbursement to improvements in quality of care and efficiency of health care delivery. Similarly, some insurance companies have also begun to link reimbursement of providers to quality improvement. Several health care provider organizations have developed principles to guide the development and application of pay for performance programs and have participated in the development of guidelines and criteria used in some of the programs. The Council will continue to monitor pay for performance programs and their ramifications for the dental profession.

Dental Codes Standards and Administration:

Code on Dental Procedures and Nomenclature. Requests for changes to the *Code* are addressed through an entity known as the Code Revision Committee (CRC). The CRC was established under a settlement agreement that resolved litigation between the ADA and the Delta Dental Plans Association (DDPA) and is supported administratively by Council staff. This year the National Association of Dental Plans (NADP) was added to the CRC's payer panel, joining representatives of America's Health Insurance Plans (AHIP), Blue Cross and Blue Shield Association (BCBSA), CMS, DDPA and a national purchaser of dental benefits representative. An additional ADA representative was appointed by President Richard Haught to maintain the balance between payers and the ADA representatives.

The current review and revision process, which leads to the next version of the *Code* that will be effective on January 1, 2007, is underway with the first two of three scheduled CRC meetings convening in February and August 2005. These two meetings addressed over 100 requested changes. Additionally, the CRC formed an ad hoc committee to study the issue of procedure code modifiers.

CDT Manual. The current manual, titled *CDT-2005*, has a new feature, a postage-paid comment card that

enables member feedback on content and suggested changes for the next manual. These comments have been analyzed by the Council which is recommending that changes be made to the manual making it more useful to members and their staffs. Changes will be incorporated into the manual's next edition, "CDT-2007."

Code Workshop. This workshop presentation, sponsored and funded by the constituent dental societies, provides information on changes to the *Code* that became effective on January 1, 2005. Members of the Subcommittee on the *Code* have delivered the presentation at 21 constituent or component dental society sponsored sessions. The Council plans to offer the *Code* workshop at the ADA annual session in even numbered years to coincide with the introduction of new codes in odd numbered years. A workshop is planned for the 2006 annual session in Las Vegas.

Dental Claim Form. On January 1, 2005, the current version of the ADA's Dental Claim Form (paper) was published with an enhanced set of completion instructions incorporated into a special section of *CDT-2005*. The paper form's data content and format remains unchanged and is consistent with the HIPAA standard electronic claim format in accordance with Resolution 100H-2001 (*Trans*.2001:434). The Council continues to monitor data content of the HIPAA standard dental claim transaction and feedback from members on the paper form. Preparations have begun for the review and revision process that will lead to the next generation of the ADA Dental Claim Form, which will include formal outreach to third-party payers and practice management system vendors.

Dental Content Committee. The ADA's Dental Content Committee (DeCC), housed administratively within the Council, meets annually in December at the ADA Headquarters Building. It last met on December 2, 2004, and is scheduled to meet again on December 9, 2005. There are five ADA voting members on the DeCC as well as five from individual third-party payer organizations and three from other health care "general interest" organizations. The DeCC has entered its sixth year of review and action on requested changes to data elements found in HIPAA standard electronic transactions (e.g., the dental claim). To date the DeCC has addressed in excess of 1,000 requested changes, doing the majority of its work via monthly conference calls.

In 2005 two of the ADA's DeCC appointees began their participation in the ANSI ASC X12 (American National Standards Institute Accredited Standards Committee X12) meetings to facilitate action on requested changes to HIPAA transactions. The DeCC also established a workgroup for a new initiative that will identify "minimum data sets" for various types of dental claims.

Dental Benefit Information Service: The Dental Benefit Information Service (DBIS) within the Council serves as the authority and primary resource at the ADA for dental plan sponsors and patients in need of assistance in designing effective dental benefit plans and for promoting direct reimbursement (DR) through the national DR advertising campaign.

DR Report to Board of Trustees. At the Board's request, the Council prepared a report on the status of the ADA's DR program, which included a critical evaluation of the program as well as future recommendations. The report was presented to the Board at its April 2005 meeting and included components of a business plan developed by the Council aimed at improving the DR campaign's performance in 2005. Key components of the business plan include education of the membership, national broker meetings, meetings with major consulting firms, the return of the promotional co-op program and mailings to Dental Trade Alliance members.

An additional recommendation for the future was proposed in the report. The Council is studying the feasibility and advisability of the ADA forming a third-party administrator (TPA) to pay dental claims for employers using DR plans and to generate revenue from the TPA activities. The Council proposed using current 2005 campaign funds for the study and would like to see results from the study before the end of the year. The Council will provide a supplemental report to the 2005 House of Delegates with updated DR marketing campaign results.

National Dental Benefits Conference 2005. The National Dental Benefits Conference 2005 (formerly DR Days) is scheduled for August 12-13, 2005, with a "first-time attendee" session on Thursday, August 11. The name of the Conference was changed to more accurately reflect its scope, which has been expanded to include general dental benefit issues. The Council believed that a broader Conference program would be more beneficial to member dental societies. It is expected that approximately 150 people will participate in the Conference. Attendees typically include insurance brokers, consultants, TPAs, constituent and component dental society staff, and dentists and their staff 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. This year's topics include outcomes data from DR plans, dental benefits trends, successful constituent DR promotions, health savings accounts and DR and an update on what employers are looking for in dental benefit plans. In addition, representatives and consultants from the dental benefits industry will lead discussions and give presentations on issues related to third-party payers.

Direct Reimbursement Campaign—Overview: Through research and broker feedback, the target market for the campaign has been streamlined to focus on HR benefits decision-makers and insurance brokers. The print and direct mail components of the campaign have been refined to reflect this change and continue to be the most cost effective and efficient advertising vehicles for

reaching these target markets. Extensive online advertising is also being utilized based on successful testing during the first and second quarters of 2005.

Direct Reimbursement Campaign—Print Advertising. To be more effective and focused on the best DR audiences in future years, the number of publications used for print advertising has been reduced from 16 in the 2005 media schedule to six. Insertions have been reduced from 80 to 32. Two publications have been selected from each of the three primary print categories: HR, broker and business publications. These changes were made based upon a thorough analysis of the number and quality of responses or leads generated by each publication. The quality of a lead is determined by the size of the employee group involved and the level of interest in offering a dental benefit.

Direct Reimbursement Campaign—Direct Mail. In 2005, a total of 48 constituent societies continued to participate in the direct-mail campaign. These constituents chose to participate 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 the ability to follow-up on leads generated by the campaign, as well as reporting any successful DR plan implementations to the ADA.

DBIS Communications. To ensure consistency and ongoing communications with participating campaign states, DBIS staff is in regular contact with the DR staff of constituent dental societies participating in the DR campaign. One of the communication pieces used in this effort, *Direct Reimbursement News,* is now being sent electronically to constituent and component society executive directors, presidents, DR contacts and brokers involved in DR promotion. The newsletter's focus has been expanded to provide stories on general dental benefits issues and a new name reflecting this change will be considered for the newsletter.

DBIS staff routinely suggests story ideas on dental benefits topics to editors of publications and staff will author such stories whenever possible. Three articles on DR appeared in the following publications: *Health Insurance Underwriter, Business Courier* and *Managed Dental Care.* In addition, Council staff will be sending a sample DR news article to state dental societies that they can publish, thereby increasing awareness of DR promotions among members.

Incentives for Companies Providing Goods and Services to the Dental Community. In response to Resolution 15H-2004 (*Trans*.2004:307), the Council, in cooperation with the Council on ADA Sessions, is considering a program to provide special recognition to dental products and services companies that offer dentist and patient friendly dental plans for their employees. Potential incentives and recognition, at the annual session, include special exhibit hall signage, special badge ribbons, favorable ad placement in program, recognition in "Shuttlevision" programs on buses, hotel in-room messaging, use of a special icon and special acknowledgment in *JADA*.

DR Broker Issues. The Consumer Directed Benefit Association (CDBA) is an independent organization of brokers and TPAs involved in the promotion of DR dental plans. An agreement was reached with the CDBA in which CDBA members will be available to follow-up on leads generated from states that have had limited success in implementing DR plans. This will help assure follow-up on leads generated and will increase the likelihood of implementing plans in these states. Brokers are the key to implementing DR plans and staff continues to seek their input and is looking to expand this relationship with brokers on a national level.

Third-Party Issues: The Council and staff continue to meet regularly with individual third-party payers or national payer organizations. The Council Chair, senior management and Council staff met with the leadership of the National Association of Dental Plans (NADP) on January 5, 2005, and with Delta Dental Plans Association (DDPA) on February 9, 2005. Staff has had additional meetings with representatives from DDPA during the first half of 2005 and representatives of NADP met with the Council during its April 2005 meeting. Topics discussed at these meetings included dental trends, evidence-based dentistry, SNODENT, the *Code on Dental Procedures and Nomenclature*, the dental claim form, speakers at annual session, ADA treatment guidelines, licensure of dental consultants, plan policies and administration, and utilization review.

The Council staff maintains a log of member calls regarding third-party carrier concerns. A quarterly summary of the nature of these calls is provided to the Council. The issues that generate the most calls include problematic explanation of benefits language, utilization review, downcoding, bundling and delayed payment concerns.

At the request of the Third-Party Issues Subcommittee, the Council, at its April 2005 meeting, reviewed current ADA policy on audits of private dental offices by third-party payers (*Trans*.1990:540) and suggested changes to this policy that more clearly advise dentists in the event of a third party audit. The Council, therefore, recommends adoption of the following resolution. This resolution supports the ADA Strategic Plan Goal Advocacy.

4. Resolved, that the policy, Audits of Private Dental Offices by Third-Party Payers (*Trans.*1990:540), be amended in the second resolving clause by deleting the statement: "if the audit of dental records appears to go beyond the scope of the audit procedure outlined in the contract, the dentist should immediately seek the advice of his or her legal counsel"; and replacing it with the following: "and in the event of an audit, the dentist is encouraged to obtain a written description of the audit procedures and should seek the advice of his or her legal counsel," and be it further

Resolved, that a new third resolving clause be added to the policy to read as follows:

Resolved, that dentists should consider their potential legal liability under applicable state and federal privacy laws in consultation with their attorneys when negotiating contracts that oblige them to allow third-party payer audits of the practices.

The Council further recommended that the Board of Trustees ask the ADA Division of Legal Affairs to undertake a thorough review of third-party payer audit practices that include provisions for extrapolating the results of a limited record audit to un-audited records and to make refund demands based on such extrapolations and that legal action be considered if appropriate, following this review.

Supporting Constituents with Third-Party Payer Issues. In response to Resolution 52H-2004 (*Trans*.2004:307), which directs the appropriate ADA agencies to solicit information regarding third-party payer problems from all tripartite data sources to use this information to identify and quantify trends in the industry, the Council sent a letter to constituent dental societies asking them to share information regarding carriers and specific problems associated with those carriers. The Council is preparing a third-party complaint form for members to be placed on the ADA Web site to record and track problems members are having with carriers around the country.

In addition, the Council is developing a standardized dental insurance benefit disclosure document for employers to use when reviewing and comparing dental plans they are considering for their employees. This is in response to Resolution 81H-2004. A supplemental report on this project will be provided to the 2005 House of Delegates.

Contract Analysis Service: Since its inception in 1987, the Contract Analysis Service has received and analyzed approximately 3,660 dental provider contracts. The Service is operated out of the ADA's Legal Division. In 2004, 90 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 of a provider contract. As expected, most members continue to submit their requests through the state and local societies and avoid the $50 charge.

The Service responds frequently to telephone inquiries from members about dental provider contracting issues and offers programs and written information on such matters. For example, in 2004 the Service's director gave a presentation on legal issues to consider when entering and terminating provider contracts to the Tri-County Dental Society's New Professional Committee in Loma Linda, California. The Service also issued an updated version of "What Every Dentist Should Know Before Signing a Dental Provider Contract." 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 2004, the Service continued to play a role in educating ADA members about the HIPAA privacy and security regulations, and the effect of these regulations on provider contracting as well as other dental practice issues. Furthermore, the Service's director has worked with the Council's attorney in the Division of Legal Affairs to provide analyses of HIPAA business associate agreements between member dentists and practice management software vendors.

Office of Quality Assessment and Improvement:

*Subcommittee on Quality Assessment and Improvement***.** The Council's Subcommittee on Quality Assessment and Improvement monitors and analyzes policy and initiatives that relate to the concept, implementation or assessment of the quality of health care; and oversees the structure and function of the peer review system. The Subcommittee includes members of the Council on Dental Benefit Programs and, because the subject of quality of care intersects with the interests of many ADA agencies, includes representatives from the Council on Dental Practice, the Council on Dental Education and Licensure and the Council on Government Affairs. The Subcommittee met on February 11, 2005.

The National Committee on Quality Assurance (NCQA) is a national accreditation body for health care benefit plans, particularly managed care and preferred provider organizations. As part of the accreditation process, the quality of care is monitored using a measurement instrument called HEDIS (Health Employer Data Information Set). The data set includes an oral health measure, the annual dental visit, which is applied to the pediatric population covered under Medicaid contracts of managed care plans. The annual dental visit criteria had measured the percentage of enrolled members ages 4-21 who were continuously enrolled in the plan during the measurement year and who had at least one dental visit during the measurement year. The revision expanded the criteria to include two- and three-year olds. The Subcommittee reviewed the criteria and provided favorable comment on the revised criteria to the NCQA on behalf of the American Dental Association.

Dental Practice Parameters. The ADA's Dental Practice Parameters are reviewed each year for possible edits or updating by the Dental Practice Parameters Committee (DPPC). The DPPC 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. Policy issues, related to the development and use of parameters, guidelines and standards are also monitored by the DPPC for possible action. The DPPC added a list of additional resources for oral health care guidelines and parameters to the ADA's dental practice parameters online site.

Evidence-based Dentistry (EBD). The Council is participating in the ADA's efforts to advance the development and use of EBD. A representative of the Council is a member of the EBD Advisory Committee. The Council has noted that it can contribute substantially to the mission and goals of the EBD project, particularly in advocating the appropriate use of systematic reviews to communities of interest such as the dental insurance industry. The Council initiated discussion of mechanisms by which it can provide input on the application of data and timely assistance in developing the conclusions or guidance from evidence-based studies.

Peer Review Structure and Process. The American Dental Association's peer review program, which is implemented by constituent and component dental societies, is a means of efficiently settling disputes between a dentist and a patient or a dentist and third-party payer. The Subcommittee on Quality Assessment and Improvement continually reviews and updates the Association's recommendations on the structure and process of peer review. Recognizing that its recommendation that attorneys be excluded from the peer review process may threaten legal immunity protection offered by the Health Care Quality Improvement Act of 1986, the Council mailed constituent and component societies a notice of this possibility and encouraged them to carefully review sources of legal immunity, such as state legislation and their insurance coverage, to ascertain the extent of protection for its peer review activities.

Peer Review and Mediation Workshops. The Council conducted four peer review workshops and two mediation workshops in 2005. The workshops are offered by the Association free of charge to constituent dental societies and are provided at the request of the constituent dental society. Constituent dental societies are encouraged to host a peer review workshop at least once every five years or more often, if necessary.

National Peer Review Reporting System Survey. The biennial peer review reporting system survey was conducted in 2004 and the results are available from the ADA's Survey Center. Data on the structure and process of the peer review system and the source and disposition of peer review cases is gathered from surveys mailed to constituent dental societies. In 2003, 39 constituent dental societies returned completed surveys. In total, across the 39 respondent constituent dental societies, 2,812 peer review cases were initiated, 1,864 cases were opened, and 1,644 cases were resolved.

Response to Assignments from the 2004 House of Delegates

Incentives for Companies Providing Goods and Services to the Dental Community. Resolution 15H-2004 (*Trans*.2004:307) called on the appropriate agencies of the ADA to develop and offer incentives and recognition to dental product and service companies that provide patient and dentist friendly dental benefit plans to their employees. The Council is gathering benefit plan design information from various dental industry employers in order to properly administer the proposed incentive/recognition program.

Dental Insurance Right to Know Standardized Plan Description. Resolution 81H-2004 (*Trans*.2004:300) directs that the appropriate ADA agency explore the development of a standard dental insurance benefit disclosure document to better inform plan purchasers and end users and that a report on findings and recommendations be presented to the 2005 House of Delegates. A supplemental report on Resolution 81H will be provided to the House of Delegates.

Annual Report on Dental Diagnostic Codes and Dental Procedure Code Modifiers. Resolution 91H-2004 (*Trans*.2004:307) directs that the appropriate ADA agency provide an annual report to the House of Delegates on the status of SNODENT and procedure code modifiers. A supplemental report will be presented to the 2005 House of Delegates that will address progress on the strategic actions concerning dental diagnostic coding (e.g., SNODENT), under the Council's plan as approved by the Board of Trustees, and will also include preliminary CRC findings on procedure modifiers, reflecting the strategy and tactics recommended by the Council and approved by the Board.

Amendment of Policy on Insurance Benefits for Posterior Direct Resin Restorations. Resolution 95-2004 (*Trans*.2004:332), to amend existing ADA policy on insurance benefits for posterior direct resin restorations, was referred to the appropriate ADA agency for study and report to the 2005 House of Delegates. The Council considered the merits of Resolution 32H-2003 (*Trans*.2003:362) and the amendment proposed in Resolution 95-2004. It concluded that, indeed, the inclusion of a reimbursement recommendation in this policy may have an unintended and negative impact on some dentists. However, deleting the reference to reimbursement in the original policy as proposed renders the resulting policy statement to be unnecessary since determination of the appropriateness of a clinical dental procedure is typically not a matter for action by the House of Delegates. Consequently, the Council recommends that Resolution 95-2004 not be adopted and that Resolution 32H-2003 (*Trans*.2003:362) be rescinded.

5. Resolved, that Resolution 32H-2003 (*Trans*.2003: 362), Insurance Benefits for Posterior Direct Resin Restorations, be rescinded.

Meetings: The Council met in the ADA Headquarters Building on November 5-7, 2004 and April 8-10, 2005. It is scheduled to meet again November 4-6, 2005. Dr. Perry K. Tuneberg, Eighth District trustee, served as the Board of Trustees' liaison to the Council.

Chair and Vice Chair: Dr. James E. Mercer was nominated as chair of the Council for the 2005-2006 term at the April 2005 meeting. Dr. Richard P. Herman was elected vice chair of the Council for the 2005-2006 term at the April 2005 meeting.

Personnel: The close of the 2005 annual session brings to an end the terms of five valued members of the Council: Dr. Charles L. Greenblatt, Jr., Dr. Glen D. Hall, Dr. Thomas A. Jacobs and Dr. Dean P. Nicholas. 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, Dr. John Buchheister, representing the Ninth District, resigned from the Council in March 2005. The Council extends its thanks and best wishes to Dr. Buchheister as well.

Summary of Resolutions

4. Resolved, that the policy, Audits of Private Dental Offices by Third-Party Payers (*Trans.*1990:540), be amended in the second resolving clause by deleting the statement: "if the audit of dental records appears to go beyond the scope of the audit procedure outlined in the contract, the dentist should immediately seek the advice of his or her legal counsel"; and replacing it with the following: "and in the event of an audit, the dentist is encouraged to obtain a written description of the audit procedures and should seek the advice of his or her legal counsel," and be it further
Resolved, that a new third resolving clause be added to the policy to read as follows:

> **Resolved,** that dentists should consider their potential legal liability under applicable state and federal privacy laws in consultation with their attorneys when negotiating contracts that oblige them to allow third-party payer audits of the practices.

5. Resolved, that Resolution 32H-2003 (*Trans.*2003: 362), Insurance Benefits for Posterior Direct Resin Restorations, be rescinded.

Council on Dental Practice

Stuart, Michael L., Texas, 2005, chair
Berryman, Richard A., New Hampshire, 2005
Burk, James R., New York, 2006
Carney, Kerry K., California, 2008
Drumm, John W., District of Columbia, 2005
Howard, H. Fred, Kentucky, 2008
Hunt, Richard F., North Carolina, 2007
Isbell, Gordon R., III, Alabama, 2006
Jankowski, Richard L., Michigan, 2006
Kyger, Billie Sue, Ohio, 2007
Maletta, John A., Iowa, 2008
McConathy, Jennifer, New Hampshire, *ex officio**
Shaw, Robert R., Washington, 2008
Steinberg, Teri, Illinois, 2007
Talley, Robert H., Nevada, 2006
Tilton, Jon W., Kansas, 2007
Tully, John J., Pennsylvania, 2005
Winker, Wade G., Florida, 2008
Luther, John R., director
Collins, Donald, senior manager
Dietrich, Joan M., manager
Keating, Linda E., manager

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 2004 and the projections for 2005 were reviewed by the Council.

Emerging Issues and Trends: The Council continues to address several issues raised in the Future of Dentistry Report, specifically concerning future dental practice management and uses for information technology in the dental practice. The Council's new Subcommittee C was created to address emerging issues and bring them to the Council for discussion and action as appropriate. Topics being considered include electronic claim management and tracking, electronic funds transfers from payers to dentists and a variety of issues affecting the dental laboratory industry including off-shore production. The Subcommittee is working collaboratively with the Standards Committee on Dental Informatics to develop content for the model electronic dental laboratory slip. The Subcommittee is also working collaboratively with the Council on Scientific Affairs to disseminate information to member dentists about the links between oral and systemic disease. The Subcommittee has initiated an outreach program to dentists in the Army Reserves thanking them for their service and commitment to their Country. Lastly, the Council is in the process of creating a publication explaining the impact and effects on oral health of the "top 25" over-the-counter vitamin supplements, an idea initiated by Subcommittee C.

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

Council Activities

SUCCESS 2004-2005: Completing its 22nd successful year of operation, the SUCCESS Program continues to be a vital program with the goal of providing quality information on starting a dental practice to junior, senior and graduate dental students who will be entering practice in the near future. Responses from corporate sponsors, dental students, dental schools and organized dentistry continue to be extremely positive.

The program conveyed business training information to students in two ways. First, the Association's publication, *Starting Your Dental Practice: A Complete Guide*, was distributed to almost 4,500 senior dental students during the year. The publication is a comprehensive 152-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, HIPAA compliance and several other sections on office practice management. Corporate sponsorship is appropriately recognized in this publication.

Second, a one-day practice management seminar was presented to 24 dental schools in 2004-2005. This concentrated seminar covers such topics as: life after dental school; practice options; associateships; the office dental team; practice by the numbers (accounting information); basics of dental benefit plans; practice purchase; managing money and practice financing; HIPAA compliance 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.

The Council continued to cosponsor the half-day seminar, "An Ethical Perspective to Starting Your Dental Practice," presented by a dentist-speaker from the Council on Ethics, Bylaws and Judicial Affairs (CEBJA). A pilot program was presented in conjunction with CEBJA which combined the dental practice management and ethics program into one in October 2004.

Corporate Sponsors. The following corporate sponsors made a significant financial contribution to the SUCCESS Program: ADA Insurance Plans; A-dec, Inc.; the Axa Equitable Life Insurance Company; The CNA Insurance Companies and Brown & Brown Insurance; Collegiate Funding Services (CFS); DENTSPLY International; Matsco; Patterson Dental Supply, Inc.; Pfizer Consumer Healthcare Division, Pfizer Inc.; Procter & Gamble Company; Sullivan-Schein, A Henry Schein Company; and the Sunstar Butler Company.

Seminar Site Selection. The following dental schools hosted the SUCCESS seminar for the 2004-2005 program year: Tufts University; University of Kentucky; University of Louisville; University of Nevada Las Vegas; University of Pennsylvania; Southern Illinois University; Virginia Commonwealth University; Medical College of Georgia; Howard University; University of Connecticut; Case School of Dental Medicine; Nova Southeastern University; University of Medicine & Dentistry New Jersey Dental School; Boston University; University of Michigan/University of Detroit Mercy; University of Oklahoma; University of Southern California; University of the Pacific/Arthur Dugoni School of Dentistry; Temple University; Creighton University; University of California at Los Angeles; University of Puerto Rico and University of Pittsburgh.

The dental student attendees rated the overall SUCCESS Program for 2004-2005 an average of above 4.5 on a 1.0 to 5.0 scale of excellence.

Seminar Presenters. Two dentists selected from the Council's list of consultants presented each seminar. Presenters were evaluated using a student feedback questionnaire and the average numerical score received was above 4.5 on a five-point scale, five being excellent.

SUCCESS Program Revisions. Each year the SUCCESS Program is reviewed in light of the changing dental practice environment and student needs. An ad hoc committee, appointed by the Council Chair, reviewed proposed program material changes via two conference calls in June 2004. Subsequently, the SUCCESS Manual was updated this past year. A more comprehensive review of the program is underway, with anticipated significant updates in 2006.

Directory of Dental Practice Management Consultants and the Directory of Dental Practice Appraisers and Brokers: These CDP directories were converted to online publications during 2004. They are now freely available to members on ADA.org. In addition, appraisers, brokers and practice management consultants who wish to list themselves in either publication can use the same online environment to apply for a listing in the publication, describe their services or activities, and then pay the required payment.

Preventive Services for the Very Young: The Council created a subcommittee on this topic that met via telephone conference call. The purpose of the call was to review portions of Board Report 19 to the 2004 House of Delegates, Physicians Providing Dental Services (*Supplement* 2004:4024), which deals with preventive services to the very young.

Resolutions B-62-2004 and B-64-2004 (*Supplement* 2004:4033) from Board Report 19 concerned the Committee. These resolutions read as follows.

> **B-62-2004. Resolved,** that the Council on Dental Practice consider the practice management implications of providing preventive services for very young patients and make information available to dentists on this subject.
>
> **B-64-2004. Resolved,** that the Council on Scientific Affairs and the Council on Dental Practice develop a caries risk assessment protocol, with the appropriate forms, for evaluating the risk individual patients have for caries.

Previously, in a report to the Board, the Council gave the following comments regarding these resolutions: "The dental profession's commitment to addressing the issue of unmet dental care must be clearly articulated." "The health and welfare of the public are paramount considerations." "Dental services, e.g., fluoride varnish, provided by medical personnel must be scientifically proven and provided only after proper training." "Patients receiving any form of dental evaluation or treatment by medical personnel should be referred to a dentist for comprehensive diagnosis and treatment planning." "Compensation for the same services provided by a dentist or a physician should be equivalent."

As a follow-up to these comments and at the recommendation of the subcommittee, the Council at its May 2005 meeting urged that ADA publications on childhood oral health should contain photos of infants and provide parents with information on how they could better care for a child's teeth; limit the consumption of fruit drinks; and provide parents with information on what they and their child might expect on a first visit.

The subcommittee is reviewing existing risk assessment programs and will make a recommendation to the Board of Trustees concerning development of our own program in the coming year.

The Council believes that the key to successful referral relationships between physicians and dentists is in good bi-directional communications and that a standardized risk assessment tool needs developing or adopting from other

sources that would enable medical personnel to make appropriate referrals to dentists.

Dental Team Advisory Panel (DTAP): The Council's Dental Team Advisory Panel (DTAP) for 2005 includes the following members: Dr. Richard F. Hunt, chair, North Carolina; clinical assistants – Ms. Agnes Bouc Gesch, CDA, Nebraska; and Ms. Susan Price, Florida; business managers – Ms. Francine Bergeron, Connecticut and Ms. Beverly Schultz, New Hampshire; dental hygienists – Ms. Lisa Bell, RDH, Virginia; and Ms. Debra Edinger, RDH, CDA, Florida; and dental laboratory technicians – Ms. Elizabeth Curran, CDT, Arizona; and Mr. Tim Sweeney, CDT, Nebraska. The DTAP met on March 11, 2005, at the ADA Headquarters Building in Chicago. The Panel offered comments, through the Council, to the Council on Dental Education and Licensure (CDEL) on career materials for dental laboratory technicians (DLTs) and discussed a variety of topics, including: recruitment and training of DLTs; retention and training of DLTs; retention and motivation of dental team members; dental team recognition activities; publications for team members; and the annual Team Building Conference.

Team Building Conference: The Councils on Dental Practice and ADA Sessions cosponsored the Team Building Conference IX on September 30-October 1 at the 2004 ADA annual session held in Orlando.

Attendees overwhelmingly agreed that the 2004 Conference met their expectations and that they would recommend other teams attend, as reported in the post-Conference evaluation forms. Speakers' ratings averaged 4.8 on a five-point scale. This year's Conference, "Bringing Out the Best in Your Team," will take place October 6-7 in Philadelphia.

Liaison with the American Dental Hygienists' Association (ADHA): The ADHA sent representatives to the Council meeting held November 18-20, 2004.

One of the main topics of the presentation was ADHA's recent promotion of the Concept of a new hygienist category of "advanced dental hygiene practitioner (ADHP)."

According to ADHA, this category is not a new concept, but is similar to models used by other health practitioners. ADHA representatives stated that ADHA expects the ADHP to function in public health programs only, and therefore, does not pose a threat to dentists in private practice. The ADHA is planning to form an advisory board of stakeholders in 2005 to help in development of the concept.

Council staff attended the ADHA's 82nd Annual Session held in Las Vegas on June 24-28, 2005.

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 2005 DARW, March 6-12, was cosponsored by the Canadian Dental Association and the Canadian Dental Assistants Association. Awards in each of four categories are given to dental offices, dental assisting schools, associations and other organizations that utilize creative, innovative ways of celebrating DARW. Participation in the DARW promotion increased this year due to Sullivan-Schein, a Henry Schein Company, including a blurb in its February newsletter mailed to over 100,000 dental offices.

Ms. Jennifer Blake, ADAA past president and director, Education, made an appearance at the May 2005 Council meeting to discuss current cooperative projects, as well as the potential for joint ADAA/ADA projects. Issues discussed included ADAA presentations at ADA conferences, such as the Team Building Conference and the New Dentists' Conference, roundtable presentations at the 2006 ADA annual session and possible registry of continuing education hours for assistants. Council staff attended the ADAA's annual session held in Washington, DC, July 14-16, 2005.

Dr. Richard L. Hunt is serving his first year of a three-year term as a representative to the Dental Assisting National Board (DANB).

Liaison with the Dental Laboratory Industry: The Council continues to maintain formal liaison activities with the dental laboratory industry. Ms. Ricki Braswell, co executive director, National Association of Dental Laboratories (NADL), made a presentation to the Council at its May 2005 meeting.

The NADL suggested an amendment to the ADA policy related to regulation of dental laboratories. The amendment removes language that stands in opposition to regulation of dental technicians.

The Council agrees that removal of this language serves to strengthen the statement's emphasis on state rights regarding regulation of dental laboratory technicians. Still remaining as policy is the subsequent statement in support of any regulation or licensure of dental laboratories being under the auspices of the state board of dentistry.

Therefore, the Council recommends that the House of Delegates adopt the following resolution. This resolution supports the ADA Strategic Plan Goal of Practice Support.

6. Resolved, that the Statement on Prosthetic Care and Dental Laboratories (*Trans*.1990:543; 1996:623; 1999:932; 2000:454; 2003:365) be amended by deleting the following sentence under the section Regulation of Laboratories which reads: As the dental laboratories do not shoulder the ultimate responsibility for the public's welfare, the Association believes that licensure of dental laboratories is not warranted.

Ongoing issues of concern with the dental laboratory industry have not changed and include: recruitment and retention of qualified people to the field of dental laboratory technology; the declining number of accredited training programs for CDTs; lack of a recognized level of competency for dental laboratory technicians; and current trends in the field of dental laboratory technology. Current trends include the increasing use of offshore/foreign laboratories coupled with greater demand for cosmetic

treatments and prosthetics. The NADL pointed out that dental laboratories, especially those that import products, are increasingly coming under the scrutiny of the U.S. Customs and Border Protection and the U.S. Food and Drug Administration (FDA).

The Council annually implements Resolution 28H-1987 (*Trans*.1997:682) regarding recognition for certified dental technicians (CDT). With assistance from the National Association of Dental Laboratories (NADL), the Association individually recognizes each certified dental technician who reached his or her 25th anniversary working in the dental laboratory industry. NADL provides the Council with these names. This past year, 68 CDTs celebrating their 25th anniversary and 16 celebrating their 35th anniversary of receiving their certification were given a recognition certificate and memo from the ADA President. At its May 2005 meeting, the Council extended this to recognizing CDTs on their 45th and 50th anniversary of certification.

Dr. Robert Talley of the Council is serving his first year in a three-year term as trustee of the National Board of Certification in Dental Laboratory Technology (NBC).

Council Publications: The Department of Salable Materials assisted the Council with the development and promotion of its publications. Council staff works closely with other ADA departments as well in the promotion of its publications through various communications with members. New publications include *Protecting Your Dental Office From Fraud and Embezzlement* (in conjunction with the Division of Legal Affairs) and *Smart Hiring: A Guide for the Dental Office.* Revised publications include *Employee Office Manual: A Guide for the Dental Practice and Practice Options for the New Dentist: A How-To Guide*.

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." This is done by collecting and analyzing information about such topics as mental health and substance use disorders among dentists, monitoring issues and developments in the larger professional health community, designing educational programs and forwarding recommendations to the Council for its action. Resources are available to assist constituent society well-being programs in reaching out to individual dentists.

The annual survey of dentist assistance programs was completed; 39 states responded to a faxed questionnaire. The findings are consistent with those of the past several years, that the greatest numbers of troubled dentists are served in those states where the dental society takes the most active role. There are two states where no assistance services (through the dental society or the licensing board) are available to dentists, and eight states where assistance program services are made available to dentists by programs with no relationship with the dental society. Complete survey results may be obtained on ADA.org or by contacting the Council office.

The *Dentist Well-Being Programs Handbook* was completed, distributed to each constituent dental society, and posted in its entirety on ADA.org. This publication is designed to provide guidance for dental societies in supporting troubled dentists, whether the dental society administers its own program or works in collaboration with some outside agency.

Analysis of data from the 2003 Dentist Well-Being Survey was completed and a report prepared by the ADA Survey Center. The findings of this survey are rich and complex. The survey population was equally divided between four demographic groups—men under 40, men 40 and older, women under 40 and women 40 and older. A report delineating the findings from each demographic group is being prepared for the Board's information. With input from the Dentist Well-Being Advisory Committee, the Council has identified three priority issues from the survey: alcohol abuse, women's issues and depression. The full report may be obtained by contacting the Survey Center at ext. 2568.

The 2004 Golden Apple for Excellence in Well-Being Activities was awarded to the Pennsylvania Dental Association (PDA). The PDA has established an effective working relationship with the Physicians Health Program of the PA Medical Society; it has a cadre of dentist well-being volunteers, and with these combined efforts, a significant number of dentists have received services.

The 11th National Institute on Dentist Well-Being, titled "Keeping the Life in Your Life's Work," will be held September 15-17, 2005, at ADA Headquarters in Chicago. One program track is devoted to personal growth issues, with innovative programming on topics such as performance coaching and "The Seven Habits of Highly Effective Families." Sessions for professionals and volunteers who assist troubled dentists will be facilitated by a number of nationally known experts. A panel of volunteers from the two Golden Apple recipient states will talk about "What Makes a Great Program."

Staff represented the ADA, and served as faculty, at the 2004 Dental Section of the University of Utah School on Alcoholism and Other Drug Dependencies. This is an ongoing activity, with annual review by the Council. The manager has also represented the ADA at the annual meeting of the Federation of State Physician Health Programs (FSPHP). Association presence at this meeting is particularly important because FSPHP programs provide services to dentists in 23 states.

The Council's Dentist Well-Being Advisory Committee (DWAC) met at the ADA Headquarters Building in March. Its members are: Dr. John Drumm, chair, Washington; Dr. Stephen Abel, FL; Dr. Ioanna Mentzelopoulou, NY; Dr. Mary E. Martin, OK; Dr. Wade G. Winker, FL; Dr. William Corcoran, NE; Dr. John Bauman, CO; and Dr. James Reilly, MA. S. Richard Lavine, M.D., CA, is the Council's psychiatric consultant. Mrs. Doris Cunningham, NC, is a liaison member from the Alliance of the American Dental Association.

ADA Policy Recommendations: Upon recommendation of the DWAC, the Council reviewed the Association's policies on Chemical Dependency and Well-Being issues.

This review resulted in recommendations for new policies and revision of existing policies.

The Council reviewed the Association's policy on Guiding Principles for Dentist Well-Being Programs (*Trans.*1996:693); ADA Policy Statement on Provision of Dental Care for Patients Who Are or Have Been Chemically Dependent (*Trans.*1989:556; 1991:619); and ADA Policy Statement on Chemical Dependency (*Trans.*1986:519).

As part of the Council's review process, policy statements and other documents from the American Medical Association, the American Society of Addiction Medicine, the American Academy of Pediatrics, the Drug Enforcement Administration, and the Federation of State Physician Health Programs were reviewed. The intent in consulting the policies of these other organizations was to assure the Council and the House that the proposed policies contained within this report are consistent with other recognized practices.

The Council was mindful of its role in encouraging health and wellness among dentists. An additional consideration is that of providing guidance for dentists in the exercise of their professional judgment and minimizing legal exposure in treating patients with substance use disorders.

This review resulted in recommendations for two proposed new policies, further development of the topics addressed in existing policies and rescission of those existing policies.

Dentist Health and Wellness. This proposed new policy was modeled after a statement on "Physician Health and Wellness" contained in the *Code of Ethics* of the American Medical Association. The Council recognized growing public awareness of the importance of professional health, coupled with its concern about the aging of the dental workforce. The proposed policy addresses the dentist's role in personal health and protection of the practice as well as ways organized dentistry can assist its members in this area. The Council, therefore, recommends the adoption of the following resolution. This resolution supports ADA Strategic Plan Goal of Practice Support.

7. Resolved, that the following ADA Statement on Dentist Health and Wellness be adopted.

Statement on Dentist Health and Wellness

To preserve the quality of their performance and advance the welfare of patients, dentists are encouraged to maintain their health and wellness, construed broadly as preventing or treating acute or chronic diseases, including mental illness, addictive disorders, disabilities and occupational stress. When health or wellness is compromised, so may be the safety and effectiveness of the dental care provided. When failing physical or mental health reaches the point of interfering with a dentist's ability to engage safely in professional activities, the dentist is said to be impaired.

In addition to maintaining healthy lifestyle habits, every dentist is encouraged to have a personal physician whose objectivity is not compromised. Impaired dentists whose health or wellness is compromised are urged to take measures to mitigate the problem, seek appropriate help as necessary and engage in an honest self-assessment of their ability to continue practicing.

Dentists are encouraged to participate in the ADA's Health Screening Program when they attend annual session, both to assist them in monitoring key indicators of personal health and to contribute to the body of knowledge about dentist health and well-being.

Dentists are strongly encouraged to have adequate disability and overhead protection insurance coverage which they review on a regular basis.

The ADA and/or its constituent and component societies, as appropriate, are encouraged to assist their members in being able to provide safe and effective care by:

- promoting health and wellness among dentists
- supporting peers in identifying dentists in need of help
- intervening promptly when the health or wellness of a colleague appears to have become compromised, including the offer of encouragement, coverage or referral to a dentist well-being program
- encouraging the development of mutual aid agreements among dentists, for practice coverage in the event of serious illness
- establishing or cooperating with dentist (or multidisciplinary) well-being programs that provide a supportive environment to maintain and restore health and wellness
- establishing mechanisms to assure that impaired dentists promptly cease practice
- reporting impaired dentists who continue to practice, despite reasonable offers of assistance, to appropriate bodies as required by law and/or ethical obligations
- supporting recovered colleagues when they resume patient care

The Use of Opioids in the Treatment of Dental Pain. Because of the extent of problems associated with the abuse of controlled substances, particularly opioids, federal agencies have stepped up their scrutiny of licensees who prescribe these medications.

Dentists may prescribe opioids for the treatment of acute and chronic dental pain. Their prescribing practices are subject to review by outside agencies. Dentists are at risk to be targeted by patients seeking to obtain these drugs. In addition, opioids are a common drug of choice for dentists with substance use disorders. Guidelines for the prescription of opioids have been written for physicians and the Council believes that similar guidance may be helpful for dentists. The Council, therefore,

recommends the adoption of the following resolution. This resolution supports the ADA Strategic Plan Goal of Practice Support.

8. Resolved, that the following ADA Statement on the Use of Opioids in the Treatment of Dental Pain be adopted.

Statement on the Use of Opioids in the Treatment of Dental Pain

1. The ADA encourages continuing education about the appropriate use of opioid pain medications in order to promote both responsible prescribing practices and limit instances of abuse and diversion.
2. Dentists who prescribe opioids for treatment of dental pain are encouraged to be mindful of and have respect for their inherent abuse potential.
3. Dentists who prescribe opioids for treatment of dental pain are also encouraged to periodically review their compliance with Drug Enforcement Administration recommendations and regulations.
4. Dentists are encouraged to recognize their responsibility for ensuring that prescription pain medications are available to the patients who need them, for preventing these drugs from becoming a source of harm or abuse and for understanding the special issues in pain management for patients already opiate dependent.
5. Dentists who are practicing in good faith and who use professional judgment regarding the prescription of opioids for the treatment of pain should not be held responsible for the willful and deceptive behavior of patients who successfully obtain opioids for non-dental purposes.
6. Appropriate education in addictive disease and pain management should be provided as part of the core curriculum at all dental schools.

Policy Statement on Chemical Dependency. The Council believes that the ADA's current Policy Statement on Chemical Dependency (*Trans.*1986:519) is outdated and too broad in scope and that each topic addressed in this policy statement, i.e., the nature of addictive illness, assistance to affected dental family members, dental education, constituent society chemical dependency committees and their state boards of registration, and research in chemical dependency, warrants further development in their own policy statements. Therefore, the Council recommends adoption of the following resolution.

9. Resolved, that Resolution 64H-1986 (*Trans.*1986: 519), ADA Policy Statement on Chemical Dependency, be rescinded.

The following proposed new policy statements—Alcoholism and Other Substance Use Disorders; Substance Use Among Dentists; and Substance Use Among Dental Students—address three of the topics in Resolution 64H-1986.

Alcoholism and Other Substance Use Disorders. This proposed new policy statement replaces the ADA's policy related to substance use disorders as diseases, using current terminology. The Council, therefore, recommends adoption of the following resolution. This resolution supports ADA Strategic Plan Goal Practice Support.

10. Resolved, that the following ADA Statement on Alcoholism and Other Substance Use Disorders be adopted.

Statement on Alcoholism and Other Substance Use Disorders

1. The ADA recognizes that alcoholism and other substance use disorders are primary, chronic, and often progressive diseases that ultimately affect every aspect of health, including oral health.
2. The ADA recognizes the need for research on the oral health implications of chronic alcohol, tobacco and/or other drug use.
3. The ADA recognizes the need for research on substance use disorders among dentists, dental and dental hygiene students, and dental team members.

Substance Abuse Among Dentists. The prevalence of substance use disorders among dentists as a group is comparable to that in the general population. Substance use disorders are treatable illnesses; rates of recovery are much higher in licensed health professionals than in the general population, due in large part to specialized treatment, long-term monitoring and strong desire to maintain the license to practice. Active substance use disorder, however, can cause professional impairment, threatening the well-being of patients and of the practice itself. The Council, therefore, recommends adoption of the following resolution. This resolution supports the ADA Strategic Goal of Practice Support.

11. Resolved, that the following ADA Statement on Substance Abuse Among Dentists be adopted.

Statement on Substance Abuse Among Dentists

1. Dentists who use alcohol are urged to do so appropriately. Dentists are also urged to use prescription medications only as prescribed by an appropriate, licensed healthcare professional and to avoid the use of illegal substances.
2. Colleagues, dental team members, and the dentists' family members, are urged to seek assistance and intervention when they believe a dentist is impaired.
3. Early intervention is strongly encouraged.
4. Dentists with addictive illness are urged to seek adequate treatment and participate in long-term monitoring protocols to maximize their likelihood of sustained recovery.

5. Impaired dentists who continue to practice, despite reasonable offers of assistance, may be reported to appropriate bodies as required by law and/or ethical obligations.
6. Dentists in full remission from addictive illness should not be discriminated against in the areas of professional licensure, clinical privileges, or inclusion in dental benefit network and provider panels solely due to the diagnosis and recovery from that illness.
7. The ADA encourages additional research in the area of dentist impairment and the factors of successful recovery.

Substance Use Among Dental Students. The following proposed new policy reflects awareness of the vulnerability of young people in the natural development of substance use disorders and calls attention to the Association's role in transmitting professional norms and behaviors to its future practitioners. Therefore, the Council recommends adoption of the following resolution. This resolution supports the ADA Strategic Goal of Practice Support.

12. Resolved, that the following ADA Statement on Substance Use Among Dental Students be adopted.

Statement on Substance Use Among Dental Students

1. The ADA supports educational programs for dental students that address professional impairment associated with substance abuse.
2. Dental students who use alcohol should strive to do so appropriately. Dental students are also urged to use prescription medications only when prescribed by an appropriate, licensed healthcare professional and to avoid the use of illegal substances.
3. Dental school administration and faculty are encouraged to promptly intervene once aware of inappropriate substance use by a student.
4. Dental schools are strongly encouraged to support a student's referral to an addiction treatment program, if appropriate, and indicated by a thorough evaluation, prior to making disciplinary decisions.
5. Dental schools are encouraged to support only the appropriate use of alcohol on their premises or at their functions or by faculty when with students in social settings.

Rescission of Policy Statement on Provision of Dental Care for Patients Who Are or Have Been Chemically Dependent. Current ADA policy on dental treatment of patients with substance use disorders is outdated and does not reflect research findings on the effectiveness of brief intervention by healthcare providers. Therefore, the Council recommends adoption of the following resolution.

13. Resolved, that Resolutions 17H-1989 (*Trans.*1989: 556) and 72H-1991 (*Trans.*1991:619), ADA Policy Statement on Provision of Dental Care for Patients Who Are or Have Been Chemically Dependent, be rescinded.

Proposed Policies Related to Substance Use by Pregnant Women, Adolescents and Children. The Council recommends that the House consider a general policy as well as one related to pregnant women and to children and adolescents. These proposed new policies all recognize the importance of the dentist as a member of the broader healthcare team, as well as the importance patients ascribe to dentists' recommendations. Therefore, the Council recommends adoption of the following resolution. This resolution supports ADA Strategic Goal Practice Support.

14. Resolved, that the following ADA Statement on Provision of Dental Treatment of Patients with Substance Use Disorders be adopted.

Statement on Provision of Dental Treatment for Patients with Substance Use Disorders

1. Dentists are urged to be aware of each patient's substance use history, and to take this into consideration when planning treatment and prescribing medications.
2. Dentists are encouraged to be knowledgeable about substance use disorders—both active and in remission—in order to safely prescribe controlled substances and other medications to patients with these disorders.
3. Dentists should draw upon their professional judgment in advising patients who are heavy drinkers to cut back, or the users of illegal drugs to stop.
4. Dentists may want to be familiar with their community's treatment resources for patients with substance use disorders and be able to make referrals when indicated.
5. Dentists are encouraged to seek consultation with the patient's physician, when the patient has a history of alcoholism or other substance use disorder.
6. Dentists are urged to be current in their knowledge of pharmacology, including content related to drugs of abuse; recognition of contraindications to the delivery of local anesthetics; safe prescribing practices for patients with substance use disorders—both active and in remission—and management of patient emergencies that may result from unforeseen drug interactions.
7. Dentists are obliged to protect patient confidentiality of substance abuse treatment information, in accordance with applicable state and federal law.

The following proposed new policy reflects current understanding of the implications of maternal substance

use and the role dentists play as healthcare providers to women in the midst of childbearing and childrearing. Therefore, the Council recommends adoption of the following resolution. This resolution supports the ADA Strategic Goal of Practice Support.

15. Resolved, that the following ADA Statement on Alcohol and Other Substance Use by Pregnant and Postpartum Patients be adopted.

Statement on Alcohol and Other Substance Use by Pregnant and Postpartum Patients

1. Dentists are encouraged to inquire about pregnant or postpartum patients' history of alcohol and other drug use, including nicotine.
2. As healthcare professionals, dentists are encouraged to advise these patients to avoid the use of these substances and to urge them to disclose any such use to their primary care providers.
3. Dentists who become aware of postpartum patients' resumption of tobacco or illegal drug use, or excessive alcohol intake, are encouraged to recommend that the patient stop these behaviors. The dentist is encouraged to be prepared to inform the woman of treatment resources, if indicated.

The following proposed new policy related to child and adolescent patients is forwarded in response to dentist requests to the Dentist Well-Being Program of the Council on Dental Practice, for guidance in this area as well as the societal problem of young people's access to a variety of drugs of abuse. Therefore, the Council recommends adoption of the following resolution. This resolution supports the ADA Strategic Goal of Practice Support.

16. Resolved, that the following Guidelines Related to Alcohol, Nicotine, and/or Drug Use by Child or Adolescent Patients be adopted.

Guidelines Related to Alcohol, Nicotine, and/or Drug Use by Child or Adolescent Patients

1. Dentists are urged to be knowledgeable about the oral manifestations of nicotine and drug use in adolescents.
2. Dentists are encouraged to know their state laws related to confidentiality of health services for adolescents and to understand the circumstances that would allow, prevent or obligate the dentist to communicate information regarding substance use to a parent.
3. Dentists are encouraged to take the opportunity to reinforce good health habits by complimenting young patients who refrain from using tobacco, drinking alcohol or using illegal drugs.
4. A dentist who becomes aware of a young patient's tobacco use is encouraged to take the opportunity to ask about it, provide tobacco cessation counseling and to offer information on treatment resources.
5. Dentists may want to consider having age-appropriate anti-tobacco literature available in their offices for their young patients.
6. Dentists who become aware of a young patient's alcohol or illegal drug use (either directly or through a report to a team member), are encouraged to express concern about this behavior and encourage the patient to discontinue the drug or alcohol use.
7. A dentist who becomes aware that a parent is supplying illegal substances to a young patient, may be subject to mandatory reporting under child abuse regulations.

Dentist Well-Being Activities at the State Level. The "Guiding Principles for Dentist Well-Being Programs" were adopted as policy at the 1996 meeting of the House of Delegates (*Trans.*1996:693). Its language was borrowed from a similar resolution adopted by the American Bar Association and the reference to "the judiciary" in its text is inappropriate to dentistry. In addition, there have been a number of changes in the way assistance services are delivered to dentists, so that this policy is outdated. The Council, therefore, recommends adoption of the following resolution. This resolution supports the ADA Strategic Goal of Practice Support.

17. Resolved, that the ADA supports efforts by constituent and component dental societies in the development, maintenance, and collaboration with effective programs to identify and assist those dentists and dental students affected by conditions which potentially impair their ability to practice dentistry, and be it further **Resolved,** that constituent and/or component dental societies be urged to adopt the following Guiding Principles for Dentist Well-Being Activities at the State Level.

Guiding Principles for Dentist Well-Being Activities at the State Level

1. Constituent dental societies are encouraged to have some level of involvement in services for dentists affected by conditions which potentially or actually impair their ability to practice dentistry.
2. State-level programs to prevent and intervene in dentist and dental team member impairment should be strengthened, supported and well publicized as the most humane and effective method of protecting the interests of the public and of dental professionals.
3. Dental societies should be advocates for dentists to have the same rights of privacy and confidentiality of personal medical information as other persons.
4. Those dental societies that administer dentist well-being programs are urged to maintain a strong working relationship with their state boards

of dentistry and with the ADA's Dentist Well-Being Program.

5. The dental society should ensure that those who serve as dentist peer assistance volunteers are provided immunity from civil liability, except for willful or wanton acts.
6. The dental society should also ensure that those who serve as dentist peer assistance volunteers are appropriately trained and supervised in these activities.
7. Dental societies in states where services are provided to dentists by multidisciplinary or physician health programs are urged to develop strong relationships with those programs, in order to:

    a. educate service providers about the particular needs of dentists and the dynamics of dental practice
    b. assist providers in outreach to dentists in need of assistance
    c. support dentists and families if treatment is necessary
    d. assist program providers in developing monitoring contracts appropriate to individual dentist's practice situations
    e. assist program providers in advocating for program participants with the dental board or licensing agency

8. Constituent and component dental societies are strongly encouraged to offer continuing education programs on the prevention, recognition and treatment of professional impairment.
9. Dental societies are encouraged to support well-being volunteer liaison activities to their dental schools

and be it further
Resolved, that Resolution 18H-1996 (*Trans.*1996:693), Guiding Principles for Dentist Well-Being Programs, be rescinded.

Ergonomics and Disability Support Services Program: The Ergonomics and Disability Support Advisory Committee (EDSAC) is chaired by CDP member, Dr. Richard L. Jankowski. Other members include, Dr. Teri Steinberg (CDP), Dr. David Ahearn, Dr. Connie M. Verhagen, Dr. Jack Gotcher (CSA), Mr. Scott W. Smith and William J. Sullivan, MD.

The Council will present a program on Ergonomics at the 2005 ADA annual session. A presenter from OSHA will also appear on the program to describe OSHA's Alliance Program with industries and OSHA policy.

During the past year, the EDSAC completed a paper on ergonomics that explains basic principles. The full paper is available at the ergonomics Web site at ADA.org and is called, *An Introduction to Ergonomics: Risk Factors, MSDs, Approaches and Interventions.* In addition, the EDSAC completed a survey of the status of ergonomics education and training in dental schools, dental hygiene programs, dental assisting programs and in schools of dental laboratory technology. Over 500 institutions were surveyed about their ergonomics program with a response rate of 62%. Conclusions from the final analysis of the data may be used by the Council to make recommendations to the appropriate agency about ergonomics education and training in dental schools and in allied dental training institutions. The Council also accepted the EDSAC recommendation to ask the Council on Scientific Affairs to consider reviewing the scientific validity of the ADA Health Screening's Carpal Tunnel Syndrome data collection method during annual session.

Meetings: The Council on Dental Practice met in the Association Headquarters Building on November 18-19, 2004, and May 19-21, 2005. Dr. John S. Findley, Fifteenth District trustee, serves as the Board of Trustees' liaison to the Council.

Personnel: At the May 2005 meeting of the Council, Dr. Gordon Isbell was unanimously nominated as chair for 2005-2006. The 2005 ADA annual session will mark the retirement from the Council of Dr. Michael L. Stuart, chair, Dr. John W. Drumm, Dr. Richard A. Berryman, and Dr. John J. Tully. The Council wishes to express its appreciation to these individuals for their thoughtful, determined leadership and for the many contributions during their tenure. Dr. John R. Luther was appointed director of the Council in March 2005. The senior manager of the Council, Dr. Donald Collins, retired in June 2005.

The ADA Seminar Series and Dental Practice Marketing activities and its two staff members were relocated to the new Association agency, Center for Continuing Education and Lifelong Learning, whose director is Ms. Marsha Hawk.

Summary of Resolutions

6. Resolved, that the Statement on Prosthetic Care and Dental Laboratories (*Trans.*1990:543; 1996:623; 1999:932; 2000:454; 2003:365) be amended by deleting the following sentence under the section Regulation of Laboratories which reads: As the dental laboratories do not shoulder the ultimate responsibility for the public's welfare, the Association believes that licensure of dental laboratories is not warranted.

7. Resolved, that the following ADA Statement on Dentist Health and Wellness be adopted.

Statement on Dentist Health and Wellness

To preserve the quality of their performance and advance the welfare of patients, dentists are encouraged to maintain their health and wellness, construed broadly as preventing or treating acute or chronic diseases, including mental illness, addictive disorders, disabilities and occupational stress. When health or wellness is compromised, so may be the

safety and effectiveness of the dental care provided. When failing physical or mental health reaches the point of interfering with a dentist's ability to engage safely in professional activities, the dentist is said to be impaired.

In addition to maintaining healthy lifestyle habits, every dentist is encouraged to have a personal physician whose objectivity is not compromised. Impaired dentists whose health or wellness is compromised are urged to take measures to mitigate the problem, seek appropriate help as necessary and engage in an honest self-assessment of their ability to continue practicing.

Dentists are encouraged to participate in the ADA's Health Screening Program when they attend annual session, both to assist them in monitoring key indicators of personal health and to contribute to the body of knowledge about dentist health and well-being.

Dentists are strongly encouraged to have adequate disability and overhead protection insurance coverage which they review on a regular basis.

The ADA and/or its constituent and component societies, as appropriate, are encouraged to assist their members in being able to provide safe and effective care by:

- promoting health and wellness among dentists
- supporting peers in identifying dentists in need of help
- intervening promptly when the health or wellness of a colleague appears to have become compromised, including the offer of encouragement, coverage or referral to a dentist well-being program
- encouraging the development of mutual aid agreements among dentists, for practice coverage in the event of serious illness
- establishing or cooperating with dentist (or multidisciplinary) well-being programs that provide a supportive environment to maintain and restore health and wellness
- establishing mechanisms to assure that impaired dentists promptly cease practice
- reporting impaired dentists who continue to practice, despite reasonable offers of assistance, to appropriate bodies as required by law and/or ethical obligations
- supporting recovered colleagues when they resume patient care

8. Resolved, that the following ADA Statement on the Use of Opioids in the Treatment of Dental Pain be adopted.

Statement on the Use of Opioids in the Treatment of Dental Pain

1. The ADA encourages continuing education about the appropriate use of opioid pain medications in order to promote both responsible prescribing practices and limit instances of abuse and diversion.
2. Dentists who prescribe opioids for treatment of dental pain are encouraged to be mindful of and have respect for their inherent abuse potential.
3. Dentists who prescribe opioids for treatment of dental pain are also encouraged to periodically review their compliance with Drug Enforcement Administration recommendations and regulations.
4. Dentists are encouraged to recognize their responsibility for ensuring that prescription pain medications are available to the patients who need them, for preventing these drugs from becoming a source of harm or abuse and for understanding the special issues in pain management for patients already opiate dependent.
5. Dentists who are practicing in good faith and who use professional judgment regarding the prescription of opioids for the treatment of pain should not be held responsible for the willful and deceptive behavior of patients who successfully obtain opioids for non-dental purposes.
6. Appropriate education in addictive disease and pain management should be provided as part of the core curriculum at all dental schools.

9. Resolved, that Resolution 64H-1986 (*Trans.*1986: 519), ADA Policy Statement on Chemical Dependency, be rescinded.

10. Resolved, that the following ADA Statement on Alcoholism and Other Substance Use Disorders be adopted.

Statement on Alcoholism and Other Substance Use Disorders

1. The ADA recognizes that alcoholism and other substance use disorders are primary, chronic, and often progressive diseases that ultimately affect every aspect of health, including oral health.
2. The ADA recognizes the need for research on the oral health implications of chronic alcohol, tobacco and/or other drug use.
3. The ADA recognizes the need for research on substance use disorders among dentists, dental and dental hygiene students, and dental team members.

11. Resolved, that the following ADA Statement on Substance Abuse Among Dentists be adopted.

Statement on Substance Abuse Among Dentists

1. Dentists who use alcohol are urged to do so appropriately. Dentists are also urged to use prescription medications only as prescribed by an appropriate, licensed healthcare professional and to avoid the use of illegal substances.

2. Colleagues, dental team members, and the dentists' family members, are urged to seek assistance and intervention when they believe a dentist is impaired.
3. Early intervention is strongly encouraged.
4. Dentists with addictive illness are urged to seek adequate treatment and participate in long-term monitoring protocols to maximize their likelihood of sustained recovery.
5. Impaired dentists who continue to practice, despite reasonable offers of assistance, may be reported to appropriate bodies as required by law and/or ethical obligations.
6. Dentists in full remission from addictive illness should not be discriminated against in the areas of professional licensure, clinical privileges, or inclusion in dental benefit network and provider panels solely due to the diagnosis and recovery from that illness.
7. The ADA encourages additional research in the area of dentist impairment and the factors of successful recovery.

12. Resolved, that the following ADA Statement on Substance Use Among Dental Students be adopted.

Statement on Substance Use Among Dental Students

1. The ADA supports educational programs for dental students that address professional impairment associated with substance abuse.
2. Dental students who use alcohol should strive to do so appropriately. Dental students are also urged to use prescription medications only when prescribed by an appropriate, licensed healthcare professional and to avoid the use of illegal substances.
3. Dental school administration and faculty are encouraged to promptly intervene once aware of inappropriate substance use by a student.
4. Dental schools are strongly encouraged to support a student's referral to an addiction treatment program, if appropriate, and indicated by a thorough evaluation, prior to making disciplinary decisions.
5. Dental schools are encouraged to support only the appropriate use of alcohol on their premises or at their functions or by faculty when with students in social settings.

13. Resolved, that Resolutions 17H-1989 (*Trans.*1989:556) and 72H-1991 (*Trans.*1991:619), ADA Policy Statement on Provision of Dental Care for Patients Who Are or Have Been Chemically Dependent, be rescinded.

14. Resolved, that the following ADA Statement on Provision of Dental Treatment of Patients with Substance Use Disorders be adopted.

Statement on Provision of Dental Treatment for Patients with Substance Use Disorders

1. Dentists are urged to be aware of each patient's substance use history, and to take this into consideration when planning treatment and prescribing medications.
2. Dentists are encouraged to be knowledgeable about substance use disorders—both active and in remission—in order to safely prescribe controlled substances and other medications to patients with these disorders.
3. Dentists should draw upon their professional judgment in advising patients who are heavy drinkers to cut back, or the users of illegal drugs to stop.
4. Dentists may want to be familiar with their community's treatment resources for patients with substance use disorders and be able to make referrals when indicated.
5. Dentists are encouraged to seek consultation with the patient's physician, when the patient has a history of alcoholism or other substance use disorder.
6. Dentists are urged to be current in their knowledge of pharmacology, including content related to drugs of abuse; recognition of contraindications to the delivery of local anesthetics; safe prescribing practices for patients with substance use disorders—both active and in remission—and management of patient emergencies that may result from unforeseen drug interactions.
7. Dentists are obliged to protect patient confidentiality of substance abuse treatment information, in accordance with applicable state and federal law.

15. Resolved, that the following ADA Statement on Alcohol and Other Substance Use by Pregnant and Postpartum Patients be adopted.

Statement on Alcohol and Other Substance Use by Pregnant and Postpartum Patients

1. Dentists are encouraged to inquire about pregnant or postpartum patients' history of alcohol and other drug use, including nicotine.
2. As healthcare professionals, dentists are encouraged to advise these patients to avoid the use of these substances and to urge them to disclose any such use to their primary care providers.
3. Dentists who become aware of postpartum patients' resumption of tobacco or illegal drug use, or excessive alcohol intake, are encouraged to recommend that the patient stop these behaviors. The dentist is encouraged to be prepared to inform the woman of treatment resources, if indicated.

16. Resolved, that the following Guidelines Related to Alcohol, Nicotine, and/or Drug Use by Child or Adolescent Patients be adopted.

Guidelines Related to Alcohol, Nicotine, and/or Drug Use by Child or Adolescent Patients

1. Dentists are urged to be knowledgeable about the oral manifestations of nicotine and drug use in adolescents.
2. Dentists are encouraged to know their state laws related to confidentiality of health services for adolescents and to understand the circumstances that would allow, prevent or obligate the dentist to communicate information regarding substance use to a parent.
3. Dentists are encouraged to take the opportunity to reinforce good health habits by complimenting young patients who refrain from using tobacco, drinking alcohol or using illegal drugs.
4. A dentist who becomes aware of a young patient's tobacco use is encouraged to take the opportunity to ask about it, provide tobacco cessation counseling and to offer information on treatment resources.
5. Dentists may want to consider having age-appropriate anti-tobacco literature available in their offices for their young patients.
6. Dentists who become aware of a young patient's alcohol or illegal drug use (either directly or through a report to a team member), are encouraged to express concern about this behavior and encourage the patient to discontinue the drug or alcohol use.
7. A dentist who becomes aware that a parent is supplying illegal substances to a young patient, may be subject to mandatory reporting under child abuse regulations.

17. Resolved, that the ADA supports efforts by constituent and component dental societies in the development, maintenance, and collaboration with effective programs to identify and assist those dentists and dental students affected by conditions which potentially impair their ability to practice dentistry, and be it further **Resolved,** that constituent and/or component dental societies be urged to adopt the following Guiding Principles for Dentist Well-Being Activities at the State Level.

Guiding Principles for Dentist Well-Being Activities at the State Level

1. Constituent dental societies are encouraged to have some level of involvement in services for dentists affected by conditions which potentially or actually impair their ability to practice dentistry.
2. State-level programs to prevent and intervene in dentist and dental team member impairment should be strengthened, supported and well publicized as the most humane and effective method of protecting the interests of the public and of dental professionals.
3. Dental societies should be advocates for dentists to have the same rights of privacy and confidentiality of personal medical information as other persons.
4. Those dental societies that administer dentist well-being programs are urged to maintain a strong working relationship with their state boards of dentistry and with the ADA's Dentist Well-Being Program.
5. The dental society should ensure that those who serve as dentist peer assistance volunteers are provided immunity from civil liability, except for willful or wanton acts.
6. The dental society should also ensure that those who serve as dentist peer assistance volunteers are appropriately trained and supervised in these activities.
7. Dental societies in states where services are provided to dentists by multidisciplinary or physician health programs are urged to develop strong relationships with those programs, in order to:

    a. educate service providers about the particular needs of dentists and the dynamics of dental practice
    b. assist providers in outreach to dentists in need of assistance
    c. support dentists and families if treatment is necessary
    d. assist program providers in developing monitoring contracts appropriate to individual dentist's practice situations
    e. assist program providers in advocating for program participants with the dental board or licensing agency

8. Constituent and component dental societies are strongly encouraged to offer continuing education programs on the prevention, recognition and treatment of professional impairment.
9. Dental societies are encouraged to support well-being volunteer liaison activities to their dental schools

and be it further
Resolved, that Resolution 18H-1996 (*Trans.*1996:693), Guiding Principles for Dentist Well-Being Programs, be rescinded.

Notes

Division of Education

Commission on Dental Accreditation

Council on Dental Education and Licensure

Joint Commission on National Dental Examinations

Notes

Commission on Dental Accreditation

Robbins, Morris L., Tennessee, 2006, chair, American Dental Association
Cole, James R., II, New Mexico, 2007, vice chair, American Association of Dental Examiners
Adair, Steven M., Georgia, 2007, American Academy of Pediatric Dentistry
Boyle, Ann M., Illinois, 2007, American Dental Education Association
Braun, Thomas W., Pennsylvania, 2005, American Association of Oral and Maxillofacial Surgeons
Byrd, Lanier, Texas, 2005, Public Member
Caton, Jack G., Jr., New York, 2006, American Academy of Periodontology
Dolan, Teresa A., Florida, 2008, American Association of Public Health Dentistry
Feldman, Cecile A., New Jersey, 2008, American Dental Education Association
Gillespie, M. Joan, Virginia, 2007, American Dental Association
Graham, Bruce S., Illinois, 2005, American Dental Education Association
Harrison, James, Ohio, 2005, American Dental Education Association and American Student Dental Association
Hutter, Jeffrey W., Massachusetts, 2008, American Association of Endodontists
Johnson, Ronald, Texas, 2006, American Dental Education Association
McKay, Kay J., Arizona, 2007, Public Member
McPherron, Sharon, Missouri, 2008, Public Member
Melrose, Raymond J., California, 2006, American Academy of Oral and Maxillofacial Pathology
Meyerowitz, Cyril, New York, 2005, American Association of Hospital Dentists and American Dental Education Association
Nimmo, Arthur, Florida, 2005, American College of Prosthodontists
Pick, Samuel E., Nevada, 2006, American Association of Dental Examiners
Potter, Brad J., Georgia, 2007, American Academy of Oral and Maxillofacial Radiology
Roberts, Matthew B., Texas, 2008, American Dental Association
Robinson, Thomas H., California, 2006, Public Member
Simonian, Roger B., California, 2005, American Dental Association
Smith, Richard D., West Virginia, 2008, American Association of Dental Examiners
Sullivan, Diana Macalus, Minnesota, 2008, American Dental Assistants Association
Tatum, Richard Carlos, Maryland, 2005, American Association of Dental Examiners
Vaden, James L., Tennessee, 2007, American Association of Orthodontists
Wilson, James W., II, California, 2005, National Association of Dental Laboratories
Zinser, Nancy C., Florida, 2007, American Dental Hygienists' Association
Hart, Karen M., director
Monehen, Rosemary, senior manager
Horan, Catherine A., manager
Podolski, Sally, manager
Soeldner, Peggy, manager
Tooks, Sherin, manager
Welling, Gwendolyn, manager

Strategic Planning and Assessing Outcomes: The Commission has developed goals, objectives, action plans and evaluation mechanisms reflective of its Mission Statement. The Commission conducted its first Mega Issue Discussion in January 2005; the topic was international dental education and accreditation. The Commission and its Standing Committee on Outcomes Assessment (OA) spend considerable time on operational effectiveness activities and strategic planning. The OA Committee has the responsibility of monitoring the Commission's Operational Effectiveness Assessment Plan, reporting its findings and making recommendations to the Commission.

Summary of Accreditation Actions: The Commission's accreditation actions from July 2004 through January 2005 are summarized in Table 1. At the July 2004 and January 2005 meetings, a total of 474 accreditation actions were taken. These actions were based on site visit reports, progress reports and other information 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. During this time, two dental (DDS/DMD) programs, 12 dental hygiene programs, 2 dental assisting programs, 11 advanced specialty programs and eight postdoctoral general dentistry programs held the accreditation status of Initial Accreditation. As indicated in Table 2, the total number of educational programs accredited is 1,341. This represents an increase of four programs from the previous reporting period. Of the 1,341 accredited programs, 48

(3.6%) hold the status of "Initial Accreditation" (formerly termed "Accreditation Eligible" or "Preliminary Provisional Approval"). One thousand two hundred and forty-four programs (92.8%) are in compliance with all requirements and have been awarded "Approval *Without* Reporting Requirements." During this reporting period, 49 programs (3.7%) were found to have deficiencies or areas of noncompliance and hold the status of "Approval *With* Reporting Requirements." Each of the 49 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. The Commission also investigated five complaints against programs during this time.

During this reporting period, no programs were denied initial accreditation or had their accreditation withdrawn. 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 24 programs (mostly advanced education in general dentistry programs) voluntarily closed, thus discontinuing their participation in the Commission's accreditation program.

Table 1. Accreditation Actions: Two Meetings—July 2004 and January 2005

		Advanced Education					
	Dental	Specialty	General	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Accreditation Eligible							0
Preliminary Provisional Approval			1				1
Initial Accreditation	2	11	8	2	12		35
Approval (without reporting req.)	10	116	61	47	70	4	308
Approval (with reporting req.)	2	25	14	28	33	4	106
Accreditation Denied							0
Discontinued Programs		5	17		1	1	24
Accreditation Withdrawn							0
Decision Appealed							0
Number of Accreditation Actions	14	157	101	77	116	9	474

Table 2. Number of Accredited Programs—January 2005

		Advanced Education					
	Dental	Specialty	General	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Initial Accreditation	2	18	9	2	13		44
Preliminary Provisional Approval Initial Accreditation		1	3				4
Approval (without reporting req.)	53	402	268	246	254	21	1,244
Approval (with reporting req.)	1	10	7	17	12	2	49
Number of Accredited Programs	56	431	287	265	279	23	1,341

Trends: The Commission's 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. To support informed decision-making, the Commission monitors trends in the dental education and practice arenas, as well as in higher education. During this reporting period, the Commission, the discipline-specific review committees, the Standing Committee on Outcomes Assessment, and ad hoc committees considered the following trends and topics:

- proposed new and/or revised accreditation standards for all disciplines
- validity and reliability studies on accreditation standards
- frequency of citings of program non-compliance with current accreditation standards
- activities of the Commission on Dental Accreditation of Canada and Mexican National Council on Dental Education
- report by the Institute of Medicine, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*

- requests from advanced dental specialty programs to increase enrollment
- requests to accredit advanced training programs in the general dentistry areas of dental anesthesiology and oral medicine
- international dental education and consultation activities
- actions taken by the 2004 ADA House of Delegates
- Presidential Committee's study of the Commission and the Commission's study on the structure and function of its review committees
- reauthorization of the Higher Education Act of 1965

The remainder of this report highlights some of the important topics considered by the Commission this year.

Proposed Revisions to the Accreditation Standards: Since August 2003, the Commission has been reviewing its accreditation standards for all disciplines, policies and procedures to ensure that they adequately address the potential impact of non-traditional funding methods on the integrity of accredited programs. A number of standards revisions related to institutional effectiveness, financial support, admissions and student services also are under consideration. In July 2004, the Commission directed that several proposed standards be forwarded to the communities of interest for review and comment. Hearings on the proposed standards revisions were conducted at the October 2004 ADA and March 2005 American Dental Education Association (ADEA) meetings. Written comment was received through May 15, 2005. The Review Committees and Commission will review the comments at the July 2005 meetings. Any new and/or revised standards will be reported to all of the communities of interest.

Proposed revisions to the accreditation standards for allied dental education programs, and advanced specialty education programs in endodontics, oral and maxillofacial surgery, pediatric dentistry, and prosthodontics are under consideration. The Commission has circulated to the communities of interest all proposed revisions to the accreditation standards for these programs. Proposed revisions are transmitted to the communities of interest via Commission meeting minutes, are available from Commission offices and are posted on ADA.org. Open hearings on proposed revisions are conducted routinely at the annual meetings of the ADA and ADEA. The next hearing will be held during the October 2005 ADA Annual Session in Philadelphia, Pennsylvania.

Validity and Reliability Studies: Such studies are conducted periodically in accord with good accreditation practice and requirements of the United States Department of Education. The purpose is to determine if the standards continue to be appropriate for the discipline. The Commission seeks input from the broad communities of interest (dental educators, general and specialty practitioners, state boards, national dental organizations, certifying boards and the public) to ensure the currency and relevancy of the standards. The studies on the accreditation standards for dental education (DDS/DMD programs) as well as the standards for dental assisting, dental hygiene and dental laboratory technology education programs are being conducted in 2005. Validity and reliability studies on the accreditation standards for the nine advanced specialty education disciplines will be conducted in 2006.

Revised Policies: The Commission develops, publishes and periodically reviews policies and procedures that guide the accreditation process. The *Evaluation Policies and Procedures* manual is available on ADA.org. During this reporting period, the Commission revised its Public Disclosure and Confidentiality Policy, the Reminder of Confidentiality Policy and the Agreement of Confidentiality. The revisions address provisions regarding protected patient health information.

New Policy: In July 2004, the Commission adopted a new policy, Request to Establish a Process of Accreditation for Programs in Areas of Advanced Training in General Dentistry, and revised its policies on programmatic advertising and student recruitment. In adopting the new policy, the Commission considered comments regarding the proposed revisions to the Eligibility Criteria for the Initiation of an Accreditation Program in a New Dental Education Discipline (first adopted in August 2002) from the communities of interest, as well as a report from the Outcomes Assessment Committee and recommendations from the Postdoctoral General Dentistry Review Committee. Upon adoption of the new policy, the Commission rescinded the 2002 policy, Eligibility Criteria for the Initiation of an Accreditation Program in a New Dental Education Discipline. Additional information on this initiative is reported elsewhere in this report in response to resolutions by the 2004 ADA House of Delegates.

Ensuring Integrity in the Commission's Operations: As a result of its investigation of a complaint against the Commission by the American Association of Orthodontists and its findings of irregularities in the review process committed by the Orthodontics and Dentofacial Orthopedics Review Committee, the United States Department of Education (USDE) requested that the Commission consider additional procedures to ensure the integrity of the review committee process and due process to every program.

In January 2005, the Ad Hoc Committee on the Structure and Function of Review Committees reported its progress to the Commission, noting that the current number and types of committees are appropriate, but that the composition of the committees should be revised to include a broader representation of the dental profession and the public and that training activities for all review committee members must be enhanced. The Ad Hoc Committee will report its conclusions and recommendations to the Commission in July 2005.

Commission on Dental Accreditation of Canada: A reciprocal 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. Each commission recognizes the accreditation of educational programs in specified categories accredited by the other agency.

In 2004, the CDAC requested that the Commission consider extending the agreement to include CDAC, two-year, non-degree programs for graduates of non-accredited (international) dental education programs, i.e., "qualifying programs." At that time, the Commission concluded that the agreement could not be extended to include the CDAC qualifying programs since the Commission did not have a similar process in place to accredit non-degree dental education programs for international dentists.

During this reporting period, the Commission studied the need and feasibility of accrediting two-year certificate programs in the United States and approved a process for initiating accreditation of U.S. dental school sponsored two-year certificate programs for graduates of international dental schools. In February 2005, Commission representatives participated on a CDAC site visit to a Canadian qualifying program to learn more about their two-year programs.

The Commission will continue to refine the preliminary draft of the Accreditation Standards of Two-Year Certificate Programs for International Graduates. In doing so, the Commission will compare the draft standards to the CDAC's Accreditation Requirements for Qualifying Programs for Graduates of Non-Accredited Educational Programs in Dentistry. It is anticipated that a draft document will be circulated to the Commission's community of interest following its July 2005 meeting. Hearings on the proposed standards will be conducted at the ADA and ADEA annual sessions.

The CDAC has appointed a task force to explore reciprocal agreements between CDAC and other international accrediting agencies for the accreditation of predoctoral dental education and dental specialty education programs.

Representatives of the U.S., Canadian, Australian/New Zealand dental education and accreditation systems met during the IADR/AADR annual meetings in March 2005 in Baltimore. All representatives agreed to further explore the possible establishment of a reciprocal agreement among the three dental accreditation agencies.

Mexican National Council on Dental Education: Representatives of the Mexican National Council on Dental Education (MNCDE) continue to attend Commission meetings. The Commission and MNCDE representatives continue to believe considerable revision to the Mexican Predoctoral Accreditation Guidelines and Procedures would be needed to achieve comparability with the Commission and CDAC accreditation standards. A reciprocal agreement between the agencies is premature. At this time, the Commission has expressed its willingness to continue to offer assistance to the MNCDE, as they have requested.

Response to Assignments from the 2004 House of Delegates:

Encouraging U.S. Dental Schools to Provide Education in Caries. The second resolving clause of Resolution 30H-2004 (*Trans.*2004:301) encouraged the Commission on Dental Accreditation to include education and experience in providing caries preventive treatment for infants and young children in the Accreditation Standards for Dental Education Programs. The Commission and its Review Committee on Predoctoral Dental Education considered the resolution in January 2005 and determined that further consideration of the resolution should be done as part of the regularly-scheduled 2005 Validity and Reliability Study of the Accreditation Standards for Dental Education Programs. Results of this study will be reported to the communities of interest, including the House of Delegates.

Activities of the International Accreditation Workgroup. Resolution 41H-2004 (*Trans*.2004:320) urged the Commission to make available fee-based consulting services and evaluation to international dental schools and to submit with its 2006 budget a plan showing how the international consultation and evaluation program will become self-sufficient within three years of implementation and recover start-up costs within six years. The resolution also recommended that an ad hoc committee composed of Commissioners and ADA Board of Trustees members be appointed to continue to give input on this new activity.

In response the resolution, an ad hoc committee was appointed to continue the dialogue regarding international consultation and evaluation activities. Dr. Robert M. Brandjord and Dr. Roddy N. Feldman were appointed from the ADA Board of Trustees. Dr. James R. Cole and Dr. Raymond J. Melrose were appointed to represent the Commission. Dr. Cole chairs the Committee. The Ad Hoc Committee met on December 8, 2004, and March 10, 2005. The Committee reviewed Board Report 21 (*Supplement* 2004:5038) and House Resolution 41H-2004.

Acknowledging that the House removed "accreditation" and substituted "evaluation," the Committee and Commission are discussing possible definitions for "consultation" and "evaluation." Whether international dental schools will be interested in Commission-sponsored consultation and evaluation services if accreditation is not available to them is also being debated. A survey of international dental schools is being conducted to learn more about their interests in consultation, evaluation and accreditation services by the Commission. The Center for International Development and Affairs will assist in the conduct of this survey. Information from the survey of international dental schools will support the development of the business plan. A progress report on these activities will be considered by the Commission on Dental Accreditation at its July 2005 meeting and at the ADA Board of Trustees' August 2005 meeting. Actions taken during these meetings will be reported to the House of Delegates.

Accreditation of Programs in Areas of Advanced Training in General Dentistry. Resolution 72 (*Trans.*2004:317) was referred to the Commission for study and report to the 2005 House of Delegates. It urged the Commission to modify its *Rules* to ensure the accreditation of only those dental and dental-related educational programs whose areas of general dentistry are recognized by the ADA through the Council on Dental Education and Licensure. The Commission noted after thorough discussion that recognition of general dentistry areas is not currently part of the CDEL's *Bylaws* duties and concluded that a modification of Commission *Rules* would not be appropriate at this time.

The Commission also considered Resolution 84H-2004 (*Trans.*2004:318) which urged the Commission to postpone action on any requests to establish an accreditation program in any areas of advanced training in general dentistry until the 2005 House of Delegates. The policy, "Request to Establish a Process of Accreditation for Programs in Areas of Advanced Training in General Dentistry" was adopted by the Commission in July 2004 (*Supplement* 2004:5053). At that time, the Commission believed that the additional input from the communities of interest over the previous year was invaluable. The suggestions for rewording the policy were positive and clarified the intent to focus on full-time programs in non-specialty general dentistry education areas. Following the July 2004 meeting, the Commission received two renewed requests to establish accreditation processes.

At the January 2005 meeting, the Commission concluded that it should proceed with consideration of the applications since it has provided sufficient opportunity for comment from the communities of interest, made appropriate revisions based on the input received, and carefully considered the matter since it first received the requests in January 2001. Accordingly, the Commission considered requests to establish a process of accreditation for full-time programs in the advanced general dentistry areas of dental anesthesiology and oral medicine. The Commission determined that accreditation processes for programs in these areas of general dentistry should be established and directed that two ad hoc committees be appointed to draft accreditation standards. The ad hoc committees will report their progress at the Commission's July 2005 meeting.

Dental Assisting Program Accreditation. Resolution 82-2004 (*Trans.*2004:318) was referred to the Commission for study and report to the 2005 House of Delegates. The resolution requested the Commission to study the feasibility of accrediting high school and vocational dental assisting programs. The Commission and its Review Committee on Dental Assisting Education reviewed the resolution in January 2005 and determined that further consideration should be done as part of the regularly scheduled 2005 Validity and Reliability Study of the Accreditation Standards for Dental Assisting Education Programs. Results of this study will be reported to the communities of interest, including the House of Delegates.

Meetings: The Commission conducted meetings on July 30, 2004, and January 28, 2005, at ADA Headquarters. The Commission's discipline-specific review committees met prior to these meetings. Approximately 70% of the review committees conducted business via teleconferencing. Reports, meeting minutes, the Commission newsletter Communications Update and important communications to the communities of interest were disseminated via e-mail and online at ADA.org. This increased use of electronic communications has allowed the Commission to expedite business and decrease mailing and copying costs.

Board of Trustees' liaisons Dr. Michael E. Biermann, trustee, Eleventh District, and Dr. Zack D. Studstill, trustee, Fifth District, attended the July 2004 and January 2005 meetings, respectively. The next meeting of the Commission is July 29, 2005.

Acknowledgments: The Commission acknowledges with appreciation the many significant contributions made by those members who will complete their terms in 2005: Dr. Thomas W. Braun, Dr. Lanier Byrd, Dr. Bruce Graham, Dr. James Harrison, Dr. Cyril Meyerowitz, Dr. Arthur Nimmo, Dr. Roger B. Simonian, Dr. Richard Carlos Tatum and Mr. James W. Wilson, II.

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

Council on Dental Education and Licensure

Wood, Roger E., Virginia, 2005, chair, American Dental Association
Houfek, Scott W., Wyoming, 2005, vice chair, American Association of Dental Examiners
Comer, Robert W., Georgia, 2005, American Dental Education Association
Dahl, Eva C., Wisconsin, 2007, American Dental Association
Giorgio, Douglas J., Jr., Georgia, 2005, American Dental Association
Himmelberger, Linda K., Pennsylvania, 2007, American Dental Association
Kiesling, Roger L., Montana, 2008, American Dental Association
Lemmo, Ronald, Ohio, 2008, American Dental Association
Maggio, Frank A., Illinois, 2008, American Association of Dental Examiners
McDonnell, Stephen R., Minnesota, 2006, American Dental Association
Ozgul, Ender S., Texas, 2005, *ex officio**
Reinhardt, John W., Nebraska, 2007, American Dental Education Association
Robinson, Peter J., Connecticut, 2006, American Dental Education Association
Schonfeld, Steven E., California, 2006, American Dental Association
Shampaine, Guy, Maryland, 2007, American Association of Dental Examiners
Sims, Paul G., Montana, 2006, American Association of Dental Examiners
Young, Stephen K., Oklahoma, 2008, American Dental Education 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 ADA Headquarters Building on November 11-12, 2004, and April 28-29, 2005. Dr. G. Kirk Gleason, Second District, serves as the Board of Trustees' liaison to the Council.

The Strategic Plan of the American Dental Association: In accordance with its mission statement and *Bylaws* duties, the Council continued to develop its action plans, strategies and metrics associated with implementation of specific objectives under each goal of the *ADA Strategic Plan: 2002-2005*. The Council's new activities and key accomplishments for 2005 are highlighted in this report, including, promotion of careers in dentistry, development of resources to prepare dentists for careers in academia, review of the Association's anesthesia policy statement, licensure initiatives and continued improvements to and implementation of the ADA Continuing Education Recognition Program (ADA CERP).

Dental Education

Resources to Prepare Practicing Dentists for Academic Dentistry: Over the past year, the Council in collaboration with the American Dental Education Association (ADEA) investigated ways to prepare dental practitioners to participate in academic dentistry. The Council explored educational opportunities for practitioners and developed a Panel Presentation Workshop scheduled for the 2005 annual session to help practitioners position themselves to apply for teaching positions. A variety of resources will soon be available to members on ADA's and ADEA's Web sites including a List of Frequently Asked Questions for Practitioners and a List of Educational Resources. These resources will be promoted to ADA members through the *ADA News*.

Proposed Plans to Develop a Guide on How to Develop an Accredited Postdoctoral General Dentistry Program: Plans are in place to develop a "how to" guide on developing an accredited postdoctoral general dentistry program. The Guide will be similar to *A Guide for Developing an Accredited Dental Hygiene Education Program* and will be useful to those interested in starting an accredited general practice residency (GPR) or advanced education in general dentistry (AEGD) program. It is anticipated that the Guide will be available for sale in 2006.

Predoctoral Dental Curriculum Study: The American Dental Education Association (ADEA) held a Forum on the Predoctoral Dental Curriculum in October 2004 involving all major stakeholder groups including the ADA. Recommendations were proposed for curricular reform in dental education. As ADEA moves forward to implement these recommendations, an oversight committee called the Commission for Change and Innovation in Dental Education will play a pivotal role in guiding the process. ADEA's Commission for Change will explore innovative ways to change the predoctoral dental curricula to produce dentists for the 21st Century. A member of the Council, Dr. Stephen K. Young, dean, University of Oklahoma, College of Dentistry, represents the ADA on the ADEA Commission for Change. The

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

Commission's first meeting was held May 14, 2005. The timeline for the Commission's work is approximately three years. The Council will continue to closely monitor this activity.

Golden Apple Awards: The Council presented its second Golden Apple Award in 2004 to Dr. Thomas D. Taylor, professor and head of prosthodontics and operative dentistry at the University of Connecticut, School of Dental Medicine, for his outstanding mentoring of dental students interested in academic careers. To help increase awareness of the Council's Golden Apple Award, an article appeared in the February 7 issue of *ADA News* recognizing the mentoring efforts of Dr. Thomas Taylor and Dr. Spencer Redding, the 2003 award winner. The Council will continue to promote its mentoring award(s) in the coming year to encourage and support faculty members who play a critical role in guiding students toward academic careers.

Revised Dental Specialty Definition

Request for Approval of the Revised Definition of Endodontics as Proposed by the American Association of Endodontists: A proposed revised definition of endodontics was submitted to the Council by the American Association of Endodontists (AAE). At its April 2005 meeting, the Council directed that the proposed 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 2005 meeting. Following approval by the Council, the definition will be reported to the House of Delegates and the Council's published list of definitions of *ADA Recognized Dental Specialties* will be revised to incorporate the new definition.

Non-Specialty Interest Areas in General Dentistry

In December 2004, the Board of Trustees adopted Resolution B-121-2004 (*Trans.*2004:272) that directed the Council to develop a proposed process to recognize non-specialty interest areas in general dentistry. The Board made its decision to adopt Resolution B-121 after reviewing key findings from two surveys conducted by the ADA Survey Center in 2004. One survey was mailed to approximately 6,500 professionally active dentists (specialists, general practitioners and dental educators); a second survey was sent electronically to 70 executive directors of national dental organizations, including ADA-recognized dental specialty certifying boards and sponsoring organizations. The surveys included similar questions on how important it is for the ADA to have a process to recognize these dental credentialing organizations and also asked respondents to rate agreement with a series of questions that presented advantages and disadvantages about development of an ADA recognition process. The Board also considered information on the historical background related to the Association's previous consideration on this issue.

The Board's directive to the Council requests that the process to recognize non-specialty interest areas in general dentistry include guidelines for recognition of these non-specialty interest areas, including related formal education and training of one academic year or more and that the proposed guidelines be consistent with the ADA *Principles of Ethics and Code of Professional Conduct*. The resolution also calls for a progress report to the Board at its August 2005 meeting.

In April 2005, the Council considered Resolution B-121-2004, conducted an in-depth strategic discussion on this issue and reviewed extensive background information before identifying how best to implement the Board's directive. The Council directed the appointment of a subcommittee to be comprised of Council members and members from the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) to develop proposed criteria for recognition of non-specialty interest areas in general dentistry practice and education. During previous consideration of this issue, the Council has studied it jointly with CEBJA, due primarily to implications associated with the ADA *Principles of Ethics and Code of Professional Conduct*. Based on the language of the Board's resolution, the Council believed that the rationale remains to again consider jointly undertaking this activity with CEBJA. The Committee will meet over the summer and the Council will report its progress to the Board in August. Additional information regarding this activity will be forwarded to the 2005 House of Delegates in a supplemental report.

Career Recruitment, Resources and Related Activities

Career Resources: As previously reported (*Reports* 2004:54), a primary goal of the Council's national careers campaign and other career initiatives is to attract qualified underrepresented minorities into the dental profession. The wide variety of career resources reaches out to students of all ages and encourages them to start thinking of dental careers early on.

The newest resource is a career video, *Something to Smile About–A Career in Dental Laboratory Technology*. The video was produced with funds raised by the ADA Foundation from dental organizations and corporate sources. The video highlights the creative and highly detailed nature of a career in dental laboratory technology (DLT), and the variety of career options and technology used by dental laboratory technicians. Complimentary copies of the video were sent to constituents and component dental societies, accredited DLT education programs, video sponsors and other related dental groups. The video is also available for purchase along with the Council's other career resources.

Career Mentoring: The grassroots mentoring initiative, a key component of the national careers campaign located at http://www.ada.org/goto/careers, is part of a local effort

to recruit qualified students, especially underrepresented minorities, into dentistry. This initiative involves member dentists as mentors sharing information and providing opportunities for job shadowing. Future plans call for development of a model mentoring project to share with other dental societies. An ADA appreciation reception will be held for the mentor coordinators and dentist mentors at the 2005 annual session in Philadelphia.

Diversity Initiatives: During the past year, the Council's career guidance activities have focused on several diversity initiatives. The Council's Ad Hoc Committee to Attract Qualified Underrepresented Minorities into Dentistry met for the third time in June to focus on expanding the mentoring concept and to consider strategies to develop minority predental clubs. Representatives from the American Student Dental Association the American Dental Education Association and the minority student dental associations—the National Dental Association, the Hispanic Dental Association, and the Society for American Indian Dentists were invited to participate in the meeting and collaborate on these strategies.

Learning for Life *(National Health Career Exploring Program*), a community-based career exploration organization, and the ADA formed a partnership inviting and encouraging state and local dental societies to form alliances with Learning for Life's local offices and establish Careers in Dentistry Explorer Posts. Learning for Life's mission of fostering opportunities for young people from all backgrounds to consider a career in the health professions supports the ADA's commitment to foster diversity in the dental profession.

Dentistry was again represented and promoted through the *Something to Smile About* career resources booth at the 23rd United States Hispanic Leadership Institute Conference held March 10-12 in Chicago. Approximately 23,000 high school students attended. Two ADA interns from Cristo Rey High School in Chicago joined the coordinator of Career Guidance Activities at the ADA career resources booth to help promote careers in dentistry.

As part of an ongoing effort to continually upgrade career-related information online, the Association is developing a new Web site to attract unrepresented minority youth as well as other target audiences toward careers in the dental profession. This Web site will provide convenient access to accurate, upbeat, age-specific information about dentistry. It is anticipated that this Web site will be available by the end of 2005.

A new minority outreach initiative, building on current efforts of the national campaign for dentistry, is included in the Council's proposed 2006 budget. The primary goal of this newest activity is to identify several constituent/component dental societies to assist the Council in developing and/or expanding on local dental society outreach efforts to underrepresented youth acquainting them with opportunities in dentistry. Graduates of the ADA Institute for Diversity in Leadership will be invited to participate as consultants in this outreach activity. The initiative includes on-site visits to targeted dental societies to provide guidance regarding the society's career outreach to underrepresented youth.

Dental Admission Testing Program

The numbers of examinees participating in the DAT Program have increased for the last five years. The number of examinees in 2004 (11,360) represented a 57% 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 45.4% of the examinee pool in 2000 and 47.2% of the pool in 2004. There has been little change in the ethnic distribution of the examinees participating in the program over the five-year period beginning in 2000. During 2004, the percentage of examinees identifying themselves as Asian was 19.7%, and the percentage of White examinees was 53.8%. The percentages of American Indian, Black and Hispanic examinees were approximately 1%, 6% and 6%, respectively.

Average examinee performance has remained stable in recent years. The mean DAT Academic Average for first-time examinees has remained at approximately 17.5, on a measurement scale that ranges from 1 to 30. Average Perceptual Ability Test (PAT) scores for first time examinees have decreased slightly from 17.0 in 2000 to 16.4 in 2004. However, in general, the mean Academic Averages and PAT scores of students who matriculated in dental school have increased slightly from 1999 to 2003.

Dental Admission Testing Program Initiatives and Research Activities: Recently, a number of initiatives have been endorsed by the testing program in its ongoing effort to provide high quality customer service while ensuring the integrity of the testing process. First, in order to guarantee the validity of test scores and the efficiency of test delivery, the method of item presentation will be altered in the near future and research will be conducted on additional modifications to the manner in which tests are delivered to the examinees. Second, in order to support access to the testing program by low income applicants to dental schools, the testing program will be offering and evaluating a partial fee waiver program beginning in 2006. Finally, information for interpreting the DAT scores achieved by minority applicants has been developed as a resource for dental school admission committees.

Traditional research related to the DAT continues in several areas. Among others, 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. Ongoing research has shown that the DAT continues to be the best nationally available predictor of dental school performance. Moreover, recent research has shown that DAT scores are predictive of dental school performance for both majority and minority applicants.

Allied Education

Allied Workforce Models: As previously reported (*Reports* 2004:54), the Council convened an interagency workgroup in September 2004 to prepare for a comprehensive allied dental workforce study in 2005. Because of the complexity and far-reaching implications of this study, as well as related issues that are under review by other Association agencies, the ADA Board of Trustees took action in August 2004 (Board Report 18) to form a Workforce Models Task Force to consolidate all Association activities surrounding allied workforce studies. Subsequently, the Council's workgroup was discontinued and Council member, Dr. Steven Schonfeld, chair of the Council's interagency workgroup, was appointed as an ad hoc Task Force member. The Workforce Models Task Force will present a report and recommendations to the Board of Trustees in August 2005 and to the 2005 House of Delegates.

Licensure

Licensure Related Activities: The Council continues to monitor licensure issues, in particular, freedom of movement, the clinical licensure examination process and the postgraduate year of study as an alternative to the clinical licensure examination.

Freedom of Movement. The number of state dental boards that accept results of more than one state or regional clinical testing agency for initial licensure continues to increase. In 1998, approximately eight states accepted results of more than one clinical examination. In 2005, approximately 30 states accept multiple examination results.

The number of state dental boards that grant licensure by credentials also continues to increase. In 1998, 32 state boards granted licensure by credentials, while in 2005 that number has grown to 45 states plus the District of Columbia and Puerto Rico. Virginia passed a law this year authorizing its dental board to grant licensure by credentials. As soon as rules implementing this law are adopted and put into effect, the total number of states granting licensure by credentials will increase to 46. Hawaii has a community service license law that allows dentists with proper credentials to work in federally qualified health centers, native Hawaiian health centers and post-secondary dental training programs only. The remaining states that do not grant licensure by credentials are Delaware, Florida and South Carolina.

Clinical Licensure Examination Process. In April 2004, the Council on Dental Education and Licensure adopted a recommendation that the Association support the concept that a graduate from a Commission-accredited dental school be able to take a single clinical examination that would have national acceptance. The Council's recommendation was subsequently forwarded to the ADA's Interagency Task Force on Patient-Based Examinations for consideration (*Supplement* 2004:5008). Following the Council's action, the American Association of Dental Examiners convened the American Dental Licensing Examination Committee (ADLEC) to begin the process of developing a single, national clinical examination for dental licensure. The ADLEC incorporated as the American Board of Dental Examiners (ADEX) in early 2005 and ADEX is now an independent agency responsible for development of a clinical licensure examination that will be administered by the existing state and regional testing agencies. According to ADEX, 42 states have indicated that they will accept results of the ADEX examination. As of the writing of this report, national examinations for dentistry and dental hygiene are nearly completed. It is anticipated that these examinations will be ready for implementation for the graduating class of 2006. In a related activity, the 2004 ADA House of Delegates adopted Resolution 23H-2004 (*Trans*.2004: 314) directing the appointment of an ADA National Clinical Licensing Examination Consensus Committee. The Consensus Committee and the ADA Board of Trustees have closely monitored the AADE/ADEX processes. Two members of the Council participated in the Consensus Committee. A response to Resolution 23H-2004 will be provided in a separate report to the House of Delegates.

Alternate Pathways to Licensure. New York, Minnesota and Washington are currently the only states where candidates have the option of taking a clinical exam or completing postgraduate education (PGY-1 as an alternative pathway to licensure) for licensure. Effective in 2007, New York will eliminate the clinical examination requirement and licensure candidates will be required to complete postgraduate education to obtain licensure. In Washington, this option is open only to those individuals who complete an accredited residency program in specified settings.

Resources for International Dentists: Currently, the ADA's primary resource for international dentists who wish to become licensed in the United States is the booklet *U.S. Licensure for International Dentists*. This booklet is available on ADA.org and in hard copy through the Council on Dental Education and Licensure upon request.

It is anticipated that a new resource, *Frequently Asked Questions for the International Dentist* (FAQ), will be placed on ADA.org by summer of 2005. The FAQ is intended to complement *U.S. Licensure for International Dentists* and provide basic information in an easy to read format. A salable resource packet is also in development that is intended to provide guidance to the international dentist about how to prepare for the dental licensure process. It is anticipated that the salable packet will be available by summer 2006. These resources are significant in that they address one of the most frequent areas of inquiry that the ADA currently receives by telephone. These resource materials will free up staff time.

Anesthesiology

Proposed Revisions to the ADA Anesthesia Documents: The Council proposes revisions to the ADA Policy Statement: The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry. These proposed revisions are intended to make the Policy Statement consistent with the ADA's anesthesia guidelines documents; Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists and Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry.

Call for Comments from the Communities of Interest. Following review by the Board of Trustees, the Council circulated the proposed changes to the communities of interest for comment, including the Council on Dental Practice, Council on Scientific Affairs, Council on Government Affairs, Committee on the New Dentist, constituent dental societies, ADA recognized dental specialty certifying boards and sponsoring organizations, dental school deans, state boards of dentistry and selected dental-related organizations. A call for comments also appeared in the January 17, 2005, issue of *ADA News*. The Council received comments from ten individuals, one dental dean and eight dental-related organizations, including the Dental Organization for Conscious Sedation (DOCS). The Council also received comments from over 300 DOCS members in support of the comments submitted by DOCS. The comments received from responders generally supported the proposed changes to the *Policy Statement*. All comments received were taken into consideration in finalizing the proposed changes.

Summary of Proposed Changes. A summary and rationale for each of the proposed changes follows. Each change is listed by the specific section where it appears in the document (e.g., "Introduction"). See Appendices 1 and 2 (pp. 67-71) for the complete policy and the proposed changes. (underline=addition, ~~strikethrough~~=deletion)

Introduction. The Council recommended that the "Introduction" section, first sentence, be amended by inserting "interest and" after the word "continuing" and before the word "expertise" for the purposes of clarification. (Appendix 1, page 67, line 5)

Education. Though the Council recognizes that 1) dentists are aware of their professional responsibility to be lifelong learners, and 2) some states have continuing education requirements for maintaining anesthesia permits, the Council believed that it would be appropriate to add language to this section urging practitioners to regularly participate in continuing education in the area of sedation and anesthesia. (Appendix 1, page 68, lines 10-14)

Risk Management. The Council determined that the first bullet could be clarified by adding language that addresses drug pharmacology, including absorption, distribution, metabolism and excretion. The Council believed that this new language would assist dentists to further understand his/her responsibility in minimizing risk to patients when providing dental anesthesia services. (Appendix 1, page 68, line 24-25)

Additionally, the Council proposed adding a new bullet to provide further clarification to the practitioner. The new bullet contains language related to the definition of titration that is similar to what appears in the Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry and the Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists to ensure that all three of the ADA's anesthesia documents contain consistent language. In the policy statement, the proposed language appears under the section "Risk Management." (Appendix 1, page 68 lines 27-29) In the *Guidelines* documents, the proposed language appears in the "Definitions" sections following the definition of "titration." (Appendix 2, page 70, lines 27-29)

State Regulation. Under this section, the Committee proposed the following revisions. The changes appear in Appendix 1, page 69, lines 3-11.

1. Deletion of the word "permitted" and insertion of the word "allowed" (page 69, line 3) for the purpose of clarification.

2. Deletion of the sentence that urges state boards to regulate dentists' use of conscious sedation, deep sedation and general anesthesia (page 69, lines 4-5) because it is unnecessary since all state boards regulate dentists' use of these modalities.

3. Replacing the word "certify" (page 69, lines 6-7) with "issue permits to" because the term "certify" could be misleading.

4. After the word "the" and before the word "protocol," insert "route of administration, level of sedation" (page 69, line 8) to encourage state boards to give consideration to these important elements in the safe and appropriate delivery of dental anesthesia.

5. After the word "care" (page 69, lines 10-11) insert the words "as outlined here and in the ADA Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists (2003)."

The Council, therefore, proposes the following resolution for consideration. This resolution supports ADA Strategic Goal Practice Support.

18. Resolved, that the ADA Policy Statement: The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry (*Trans.*1999:936), be amended as proposed, and be it further

Resolved, that the definition of "titration" as it appears in the "Definitions" sections of the ADA Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists (*Trans.*2003:368) and the

Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry (*Trans.*2003:368), be amended to read as follows, so that all three ADA anesthesia documents are consistent.

> *titration* – the administration of small incremental doses of a drug until a desired clinical effect is observed.
>
> In accord with this particular definition, the clinical effects of titration of oral medication for the purposes of sedation are unpredictable. Repeated dosing of orally administered sedative agents may result in an alteration of the state of consciousness deeper than the intent of the practitioner. Except in unusual circumstances, the maximum recommended dose of an oral medication should not be exceeded.

Proposed Plans for a 2006 Anesthesia Conference: In conjunction with its review of and proposed changes to the ADA Policy Statement: The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry, the Council determined that all three ADA anesthesia documents warrant further updating to address incorporation of more contemporary terminology, issues related to levels of sedation and addition of a resource list to the documents. The Council believed that revisions of this magnitude would require a consensus building process similar to that which the ADA conducted in 1989. The Council directed that the primary objective of the conference would be for conference participants to make recommendations for use in the comprehensive review and revision of the ADA's anesthesia documents. The conference plans and a resolution requesting financial support for this conference will be presented to the 2005 House of Delegates for consideration in a supplemental report.

ADA Continuing Education Recognition Program

Recognized Provider Statistics: As a result of actions taken in November 2004 and April 2005, currently there are 337 ADA Continuing Education Recognition Program (ADA CERP) recognized providers. Twelve 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. Twelve constituent dental societies, and the American Academy of Oral and Maxillofacial Pathology, the American Association of Endodontists and the American Association of Orthodontists have extended recognition to 105 component societies or affiliates.

Update on Status of Proposed Standards Revisions: The ADA CERP standards and procedures undergo review on a periodic basis to ensure that they remain current. Areas currently under review include commercialism, commercial support and promotional conflict of interest. Feedback on proposed changes to the standards was solicited from the communities of interest, including the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) and ADA CERP recognized CE providers. The Council considered the feedback received and determined that the proposed changes will undergo further study prior to final adoption of revisions.

ADA CERP and AGD PACE Cooperation: As previously reported (*Reports* 2003:65), a joint ADA CERP—AGD PACE Workgroup reviewed the policies and procedures of these parallel programs to identify ways the two recognition programs can more closely align and reduce potential confusion and redundancies. Most recently, recommendations for creating more uniform policies and procedures were favorably received by both the Council and AGD PACE Committee. Both agencies confirmed their continuing commitment to address the differences between the two programs and to continue to cooperate to achieve the goal of reciprocity between the two programs.

As a result of ongoing cooperative efforts over the last few years, substantive differences in the policies and procedures of the two programs have been resolved. For this reason, in April 2005, the Council approved ADA CERP reciprocal recognition of AGD PACE approved providers with the exception of AGD PACE sole providers and single course providers.

Continuing Education Course Listing: Since 1991, the Council has compiled and published the semiannual *CE Course Listing* as a resource for dentists and allied dental personnel. The *CE Course Listing* is posted online in the members-only section of ADA.org. Currently, ADA CERP recognized providers are given access via the Internet to enter and update provider and CE course information and regularly list between 1,000 and 1,500 courses. Due to significantly decreased demand, publication and sale of the print version of the *CE Course Listing* was discontinued in 2005. Members will continue to have access to the *CE Course Listing* online at ADA.org.

ADA CERP Recognition Reapplication: Resolution 42-2004 (*Trans.*2004:313) calls for the Association to streamline the ADA CERP reapplication. The resolution included specific suggestions. The Council considered the issues and concerns related to the application process as described in the background statement accompanying the resolution and focused on identifying new procedures to help ease the burden of participating in ADA CERP. Although changes have already been made to simplify the reapplication process, some providers may not be aware of changes that have been made since their previous application. The Council is supportive of ongoing improvements to the application and reapplication process. As part of its continuing commitment to improve the ADA CERP for all providers, an abbreviated application is being developed for reapplicants completing

recognition terms of three or four years. The abbreviated application will contain fewer questions and will require less documentation to support responses to the questions.

The Council felt that, to maintain the integrity of the program, changes made to the application/reapplication process should apply to all providers and not be limited to certain groups of providers. Also, ADA CERP will continue its longstanding efforts to help providers with the application process through staff consultations, workshops, and by providing samples of good practice to guide providers in establishing operational polices and procedures for their own CE activities.

ADA CERP Recognition for Constituents and Dental Schools: In addressing Resolution 64-2004 (*Trans.*2004:319), the Council felt it was important to respond to each resolving clause. The first resolving clause calls for the ADA to designate all constituent societies and accredited dental schools as ADA CERP recognized providers. The second resolving clause calls for waiving the application fees and annual fee for these providers.

With regard to the first resolving clause, some of the issues of concern have been addressed in the revised application that was implemented in January 2004. Other issues will be addressed by the changes proposed above in response to Resolution 42-2004. All of these changes are intended to ease the burden of participation in the program and to demonstrate the Council's continuing commitment to improve ADA CERP for all providers.

In its consideration of the second resolving clause of the resolution, the Council considered the financial impact of this proposal and reviewed the program's budget information and current provider fees. The ADA CERP is not a profit center for the ADA and when indirect costs are calculated into the program's budget information, this program operates at a deficit. The Council also noted that fee increases for all providers have been nominal and typically account for the cost of inflation.

If dental schools and constituent and component societies are exempted from paying fees, provider revenues will decrease significantly and the deficit for operating the program will increase by over $50,000 annually. This additional cost would have to be assumed by the ADA membership through an increase in ADA member dues or by passing the costs on to the remaining CE providers, many of which are not for-profit entities (related dental organizations, hospitals, military programs, study clubs, etc.). The Council believed that this would not be a practical approach to managing costs associated with the operation of this program.

The Council also believed that the ADA CERP policies should apply equally to all providers. Some providers in those groups addressed in the resolution may not fully meet the standards. The Council found no basis for exempting a select group of providers from demonstrating compliance with the standards, as this would defeat the ADA CERP goal of enhancing the quality of CE available to members.

The Council believed that, without exception, continuing dental education is a revenue generating activity for all CE providers and the nominal fees associated with participation in ADA CERP should be considered part of the cost of doing business and providing quality CE for the dental profession. Based on ADA CERP's continuing commitment to improve ADA CERP for all providers and its intent to be responsive to this resolution, the Council recommended that no further action be taken by the ADA House of Delegates regarding Resolution 64-2004.

Review of ADA Policies

In response to Resolution 15H-1995 (*Trans.*1995:660), the Council reviewed current ADA policies to determine whether any policies were redundant, irrelevant or required modification. Based on this review, the Council recommends the following actions.

Guidelines for Examiner Standardization: The Council determined that this policy is outdated and should be rescinded. The Guidelines are no longer current or relevant since the American Association of Dental Examiners (AADE) developed a new document, Guidance for Clinical Examinations in Dentistry (2003). The new AADE document meets the intent of the 1998 document and includes updated information.

The policy adopted in 1998 reads as follows.

> **36H-1998. Resolved,** that the American Dental Association, in cooperation with other involved agencies and organizations, actively endorse and urge all dental clinical testing agencies and their participating licensing boards to follow the recommendations of the Guidelines for Examiner Standardization (*Supplement* 1998:447), and be it further
> **Resolved,** that the ADA Council on Dental Education and Licensure monitor the utilization of the guidelines by the clinical testing agencies and report annually to the House of Delegates on its findings.

The Council recommends adoption of the following resolution.

19. Resolved, that Resolution 36H-1998 (*Trans.*1998: 713), Guidelines for Examiner Standardization, be rescinded.

Eliminating Use of Human Subjects in Board Examinations: Resolution 64H-2000 (*Trans.*2000:477) supports the elimination of the use of human subjects in the clinical licensure examination process by 2005. Since 2000, the ADA has sponsored two major activities related to this resolution: the Task Force on the Role of Patient-Based Examinations (*Supplement* 2001:5106; *Supplement* 2002:5075; *Supplement* 2003:5023; *Supplement* 2004:5008) and the National Clinical Licensing Examination Consensus Committee (Resolution 23H-2004, *Trans*.2004:314).

To date there are no clinical testing agencies that have completely eliminated the use of human subjects. As previously noted elsewhere in this report, one state (New York), will eliminate the use of a clinical examination entirely in 2007 and instead require completion of a postgraduate residency program for licensure eligibility. The Council considered Resolution 64H-2000 at its April 2005 meeting and discussed the next possible steps that the ADA could take regarding this resolution and its mandate to eliminate the use of patients in the clinical licensure examination process by 2005. Although the mandate has not been achieved, the Council believed the intent of the resolution is still relevant. The Council recommended that the resolution be amended to delete reference to an implementation date in order to extend more flexibility to the clinical testing agencies in achieving the goal of eliminating human subjects from clinical examinations and to change the intent of the resolution to become Association policy rather than a time-defined mandate. The Council also recommended deleting the term "human subjects" and inserting "patients," as this more accurately describes what is intended by the term. ~~Strikethrough~~=deletions and underline=additions.

> **Resolved,** that the Association supports the elimination of the use of ~~human subjects~~ patients in the clinical licensure process ~~by 2005~~, and be it further
> **Resolved**, that the Association transmit this policy to all clinical testing agencies.

Therefore, the Council presents the following resolution for consideration. This resolution supports ADA Strategic Plan Goal Advocacy.

20. Resolved, that Resolution 64H-2000, Elimination of the Use of Human Subjects in Board Examinations (*Trans*.2000:477), be amended in the first resolving clause by deleting the words "by 2005" and be it further **Resolved,** that Resolution 64H-2000 be amended by deleting the words "human subjects" wherever they appear and replacing them with the word "patients," so that the amended policy would read:

> **Resolved,** that the Association supports the elimination of the use of patients in the clinical licensure process, and be it further
> **Resolved**, that the Association transmit this policy to all clinical testing agencies.

Response to Assignments from the 2004 and 2003 House of Delegates

Revision to the *Requirements for Recognition of National Certifying Boards for Dental Specialists:* Resolution 2H-2004 (*Trans*.2004:313) amended the *Requirements* under Organization of Boards, paragraph (1), so that the maximum number of voting certifying board members was increased from nine to 12. In response to this resolution, the dental specialty certifying boards and sponsoring organizations were notified of this change in correspondence dated December 30, 2004, and the revised document was posted on ADA.org.

Encouraging U.S. Dental Schools to Provide Education in Caries Prevention Treatment for Infants and Young Children: Resolution 30H-2004 (*Trans*.2004:300) urges U.S. dental schools to include education and experience in providing caries prevention treatment for infants and young children in their predoctoral program and encourages the Commission on Dental Accreditation to include this in the criteria for dental school accreditation. In response to the resolution, the Council provided this information in correspondence dated December 2004 to constituent and component dental societies, state boards of dentistry, dental deans and dental specialty certifying boards and organizations. The Commission on Dental Accreditation's response to this resolution can be found in the Commission's annual report.

ADA CERP Recognition Reapplication: Actions taken by the Council in response to Resolution 42-2004 (*Trans*.2004:313) are provided under the ADA Continuing Education Recognition Program section of this report.

ADA CERP Recognition for Constituents and Dental Schools: Actions taken by the Council in response to Resolution 64-2004 (*Trans*.2004:319) are provided under the ADA Continuing Education Recognition Program section of this report.

Postgraduate Dental Training Programs in Alaska: Resolution 90H-2004 (*Trans*.2004:293) requested that appropriate ADA agencies investigate the feasibility of using new or existing accredited postgraduate dental training programs in Alaska to address problems faced by Alaska Natives. The Council appointed a subcommittee to consider this resolution with input from the Commission on Dental Accreditation and from the executive director of the Alaska Dental Society. In April 2005, the Council considered the committee's report and concluded that it 1) supports the intent of the resolution and believes that it is feasible for accredited postgraduate education programs to help address access problems faced by Alaskan Natives; however, the Council also believes that efforts to address oral health care access issues in Alaska cannot be solely resolved by increasing the number of postdoctoral general dentistry programs in Alaska; 2) will continue to monitor and support initiatives to develop new and expanded postgraduate education programs in Alaska; and 3) will monitor any proposed changes to postdoctoral education accreditation *Standards* and provide comment as appropriate if the Council believes that proposed changes could be a barrier to development of new or expanded programs in Alaska. It is the Council's opinion that the current accreditation standards do not present any barriers to the development of new or expanded programs in Alaska.

Strategies to Request Specific Funding for Dental Faculty Development: Resolution 84H-2003 (*Trans*.2003:371) directed that the Association develop strategies to be presented to the appropriate agencies requesting specific funding for dental faculty development beginning in fiscal year 2005. In 2004, the Council reported progress on implementation of this resolution (*Reports* 2004:58). The Council, in collaboration with the Council on Government Affairs, will continue to monitor and/or lobby for funding support for the following initiatives:

- National Institute for Dental and Craniofacial Research Request for Application for training clinical researchers and a joint fund with the Library of Medicine to train students for research and teaching careers in informatics;
- Maternal and Child Health Pediatric Dental Training Program;
- Dental Health Provider Shortage Act (S. 2740) addressing how to expand dental services in rural locations (currently being discussed for reintroduction in 2005);
- National Institutes of Health Extramural Loan Repayment Programs;
- Title VII Dental Residency Training Programs; and
- Dental Health Improvement Act addressing dental workforce and access to care needs for dentists and dental hygienists.

Additionally, the Council has requested that the Department of State Government Affairs consider developing a packet of resources for constituent dental societies to use in lobbying for state funding for faculty development. Other funding opportunities include ongoing plans to implement the ADA Foundation's National Campaign for Dental Education and the announcement earlier this year of the ADA Foundation's request for proposals to support students interested in teaching careers.

Personnel: The 2005 annual session will mark the completion of terms of service of four Council members: Dr. Roger E. Wood, Dr. Scott W. Houfek, Dr. Robert W. Comer and Dr. Douglas J. Giorgio, Jr. The Council wishes to express its appreciation to these individuals for their thoughtful, determined leadership and for their many contributions during their tenure.

Summary of Resolutions

18. Resolved, that the ADA Policy Statement: The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry (*Trans.*1999:936), be amended as proposed, and be it further
Resolved, that the definition of "titration" as it appears in the "Definitions" sections of the ADA Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists (*Trans.*2003:368) and the Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry (*Trans.*2003:368), be amended to read as follows, so that all three ADA anesthesia documents are consistent.

> *titration* – the administration of small incremental doses of a drug until a desired clinical effect is observed.
>
> In accord with this particular definition, the clinical effects of titration of oral medication for the purposes of sedation are unpredictable. Repeated dosing of orally administered sedative agents may result in an alteration of the state of consciousness deeper than the intent of the practitioner. Except in unusual circumstances, the maximum recommended dose of an oral medication should not be exceeded.

19. Resolved, that Resolution 36H-1998 (*Trans*.1998: 713), Guidelines for Examiner Standardization, be rescinded.

20. Resolved, that Resolution 64H-2000, Elimination of the Use of Human Subjects in Board Examinations (*Trans*.2000:477), be amended in the first resolving clause by deleting the words "by 2005" and be it further
Resolved, that Resolution 64H-2000 be amended by deleting the words "human subjects" wherever they appear and replacing them with the word "patients," so that the amended policy would read:

> **Resolved,** that the Association supports the elimination of the use of patients in the clinical licensure process, and be it further
> **Resolved**, that the Association transmit this policy to all clinical testing agencies.

Appendix 1

American Dental Association Policy Statement: the Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry (1999)

Introduction

Dentists have had both a historic and specific continuing interest and expertise in providing anesthetic, sedative and other anxiety and pain control procedures for their patients. The effective control of anxiety and pain has been an integral part of dental practice since the early development of the profession. Use of a wide variety of anxiety and pain control techniques has enabled the profession to extend oral health care to millions of individuals who would otherwise remain untreated. Without effective anxiety and pain control, numerous dental procedures are virtually impossible and many patients do not seek needed dental treatment. In addition, both anxiety and pain control techniques are often essential for the management of special patients, young children and the mentally and physically challenged. The use of anxiolytic sedative and anesthetic techniques by appropriately trained dentists in the dental office and other settings continues to have a remarkable record of safety.

Anxiety and pain can be modified by both psychological and pharmacological techniques. In some instances, psychological approaches are sufficient. However, in many instances, pharmacological approaches are required.

Local anesthetics are used to control regional pain. Sedative drugs and techniques may control fear and anxiety, but do not by themselves fully control pain and, thus, are commonly used in conjunction with local anesthetics. General anesthesia provides complete relief from both anxiety and pain.

This policy statement addresses the use of conscious sedation, deep sedation and general anesthesia, as defined in the Association's Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry. These terms refer to the effects upon the central nervous system and should not be confused with any route of drug administration.

The use of conscious sedation, deep sedation and general anesthesia in dentistry is safe and effective when properly administered by trained individuals. The American Dental Association strongly supports the right of appropriately trained dentists to use these modalities for the management of dental patients and is committed to ensuring their safe and effective use.

Education

Dentists who have received appropriate formal education in conscious sedation, deep sedation and general anesthesia are qualified to use these modalities in practice. Training to competency in conscious sedation techniques may be acquired at the predoctoral, postgraduate, graduate, or continuing education level. Dentists who wish to utilize conscious sedation are expected to successfully complete formal training which is structured in accordance with the Association's educational Guidelines, "Part One: Teaching the Comprehensive Control of Anxiety and Pain to the Dental Student" and/or "Part Three: Teaching the Comprehensive Control of Anxiety and Pain in a Continuing Education Program."

The knowledge and skills required for the administration of deep sedation and general anesthesia are beyond the scope of predoctoral and continuing education. Only dentists who have completed an advanced education program structured in accordance with "Part Two: Teaching the Comprehensive Control of Anxiety and Pain at the Advanced Education Level" of the “Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry” or completion of an ADA accredited postdoctoral training program (e.g., oral and maxillofacial surgery) which affords comprehensive and appropriate training necessary to administer and manage deep sedation/general anesthesia, commensurate with the ADA document “The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry” are considered educationally qualified to use deep sedation and general anesthesia in practice.

The dental profession's continued ability to control anxiety and pain effectively is dependent on maintaining a strong educational foundation in the discipline. While many practicing dentists may elect not to use conscious sedation, deep sedation or general anesthesia, it is critical that those who wish to do so have access to adequate training. The Association supports efforts to expand the availability of courses and programs at the predoctoral, advanced and continuing educational levels which are structured in accordance with its educational Guidelines in anxiety and pain control. It urges dental schools to expand opportunities for predoctoral students to receive training and clinical experience in conscious sedation techniques. It urges continuing education sponsors to offer comprehensive courses in accordance with the Guidelines in conscious sedation techniques which include sufficient opportunity for supervised clinical experience to enable participants to achieve competency in these techniques. ~~Finally~~, I~~i~~t urges sponsors of advanced dental education to develop programs at the postgraduate level which are designed to train individuals in conscious sedation, deep sedation and general anesthesia. Finally, it urges dental practitioners to regularly participate in continuing education in the areas of sedation and anesthesia in order to remain current.

The objective of educating dentists to utilize conscious sedation, deep sedation and general anesthesia is to enhance their ability to provide oral health care.

Risk Management

Appropriate educational preparation, while necessary, is not by itself sufficient to ensure safe and effective use of conscious sedation, deep sedation and general anesthesia. There is some degree of risk associated with the use of any drug, even when administered by trained individuals. Dentists who are qualified to utilize conscious sedation, deep sedation and/or general anesthesia have a responsibility to minimize risk to patients undergoing dental treatment by:

- Using only those drugs and techniques with which they are thoroughly familiar, i.e., understand the indications, contraindications, adverse reactions and their management, drug interactions, drug pharmacology including absorption, distribution, metabolism and excretion and proper dosage for the desired effect;
- Understanding that the clinical effects of titration of oral medication for purposes of sedation are unpredictable and may result in an alteration of the state of consciousness deeper than the intent of the practitioner;
- Limiting use of these modalities to patients who require them due to such factors as the extent and type of the operative procedure, psychological need or medical status;
- Conducting comprehensive preoperative evaluation of each patient to include a comprehensive medical history, assessment of current physical and psychological status, age and preference for and past experience with sedation and anesthesia;
- Conducting physiologic and visual monitoring of the patient as needed from onset of anesthesia/sedation through recovery;
- Having available appropriate emergency drugs, equipment and facilities and maintaining competency in their use;
- Maintaining fully documented records of drugs used, dosage, vital signs monitored, adverse reactions, recovery from the anesthetic, and, if applicable, emergency procedures employed;
- Utilizing sufficient support personnel who are properly trained for the functions they are assigned to perform;
- Treating high-risk patients in a setting equipped to provide for their care.

The Association expects that patient safety will be the foremost consideration of dentists who use conscious sedation, deep sedation and/or general anesthesia. Dentists who use these modalities should take all necessary measures to minimize risk to patients.

State Regulation

State dental boards have a responsibility to ensure that only dentists who are properly trained, experienced, and currently competent are ~~permitted~~ allowed to use conscious sedation, deep sedation and general anesthesia within their jurisdictions**.** ~~For this reason, the Association strongly urges state dental boards to regulate dentists' use of these modalities.~~ In addition to identifying educational requirements which are consistent with the Association's Guidelines, state dental boards should evaluate and ~~certify~~ issue permits to dentists who apply to administer conscious sedation, deep sedation and/or general anesthesia to ensure that the route of administration, level of sedation, protocol, procedures, facilities, drugs, equipment and personnel utilization meet acceptable standards for safe and appropriate delivery of anesthesia care, as outlined here and in the *ADA Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists* (2003).

The Association recognizes the existence of office-based ambulatory anesthesia as an integral part of the management of anxiety and pain control for dental patients. It is important that state dental boards be aware that ambulatory anesthesia services, will be increasingly available from well qualified dentists. It is in the best interest of the public and the profession that access to this cost-effective service be widely available.

States introducing regulation of conscious sedation, deep sedation and/or general anesthesia may elect to identify a period of time during which practitioners without the specified educational qualifications may apply and be evaluated for the use of these modalities. These practitioners should have demonstrated competence in the use of the regulated modalities over an extended period of time as determined by the state dental board.

Research

The use of conscious sedation, deep sedation and general anesthesia in dentistry will be significantly affected by research findings and advances in these areas. The Association strongly supports the expansion of both basic and clinical research in anxiety and pain control. It urges institutions and agencies that fund and sponsor research to place a high priority on this type of research, which should include: 1) epidemiological studies which provide data on the number of these procedures performed and on morbidity and mortality rates, 2) clinical studies of drug safety and efficacy, 3) basic research on the development of safer and more effective drugs and techniques, 4) studies on improving patient monitoring, and 5) research on behavioral and other non-pharmacological approaches to anxiety and pain control.

Appendix 2

From: Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists (2003) and Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry (2003)

Definitions

Methods of Anxiety and Pain Control

analgesia - the diminution or elimination of pain.

anxiolysis - the diminution or elimination of anxiety.

local anesthesia - the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

conscious sedation[1] - a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command and that is produced by a pharmacological or non-pharmacological method or a combination thereof.

In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of conscious sedation.

combination inhalation–enteral conscious sedation (combined conscious sedation) - conscious sedation using inhalation and enteral agents.

When the intent is anxiolysis only, and the appropriate dosage of agents is administer-ed, then the definition of enteral and/or combination inhalation-enteral conscious sedation (combined conscious sedation) does not apply.

Nitrous oxide/oxygen when used in combination with sedative agents may produce anxiolysis, conscious or deep sedation or general anesthesia.

titration – the administration of small incremental doses of a drug until a desired clinical effect is observed.

In accord with this particular definition, the clinical effects of titration of oral medication for the purposes of sedation ~~is~~ are unpredictable. Repeated dosing of orally administered sedative agents may result in an alteration of the state of consciousness ~~beyond~~ deeper than the intent of the practitioner. Except in unusual circumstances, the maximum recommended dose of an oral medication should not be exceeded.

deep sedation - an induced state of depressed consciousness accompanied by partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or to respond purposefully to physical stimulation ***or*** verbal command, and is produced by a pharmacological or non-pharmacological method or a combination thereof.

[1] Parenteral conscious sedation may be achieved with the administration of a single agent or by the administration of more than one agent.

general anesthesia - an induced state of unconsciousness accompanied by partial or complete loss of protective reflexes, including the inability to continually maintain an airway independently and respond purposefully to physical stimulation or verbal command, and is produced by a pharmacological or non-pharmacological method or a combination thereof.

Joint Commission on National Dental Examinations

MacNeil, R. Lamont, Connecticut, 2005, chair, American Dental Education Association
Awadalla, Eleanore, Ohio, 2005, vice chair, American Association of Dental Examiners
Ackley, Eva, Florida, 2008, American Association of Dental Examiners
Ambewadikar, Rashmi, New York, 2005, American Student Dental Association
Boltz, Roger H., Colorado, 2006, American Association of Dental Examiners
Higgins, Michael S., Illinois, 2005, American Dental Association
Keeter, Donald K., Oklahoma, 2007, American Dental Association
Little, Lynne Tatum, North Carolina, 2006, American Dental Hygienists' Association
McClellan, Gerald W., Jr., California, 2006, American Dental Association
Panagakos, Fotinos, New Jersey, 2007, American Dental Education Association
Reddy, Michael S., Alabama, 2008, American Dental Education Association
Sand Wall, Darlene, Kentucky, 2008, American Association of Dental Examiners
Schoyer, Nancy, Colorado, 2006, Public Member
Vaughn, Stephen C., Nevada, 2007, American Association of Dental Examiners
Winder, Ronald L., Oklahoma, 2005, American Association of Dental Examiners
Bailey, Robert L., director, Department of Testing Services

Meetings: The Joint Commission on National Dental Examinations met in the Headquarters Building, Chicago, on March 23, 2005. Most of the topics considered by the Joint Commission had been reviewed by one of four committees. The Committees on Administration, Dental Hygiene and Examination Development met on March 22, 2005. The fourth standing committee of the Joint Commission, the Committee on Research and Development, met January 6, 2005.

The annual National Dental Examiners' Advisory Forum, sponsored by the Joint Commission, met in Chicago on the morning of March 22, 2005. Approximately 80 state board representatives, dental examiners, dental hygienists and dental educators attended the Forum. The program included staff updates on examination results and statistics for the National Board Dental Examinations (NBDE) Part I and Part II and the National Board Dental Hygiene Examination (NBDHE). Staff and members of the Joint Commission provided reports on the following topics:

- Reliability of the NBDE and the NBDHE and past and current fail rates;
- An update of test administration issues;
- International education and accreditation issues;
- The Joint Commission's Innovative Dental Assessment (IDEA) Small Grants Program;
- Practice Analysis for the NBDE and the NBDHE;
- The proposed NBDE Part I Comprehensive Examination; and
- The NBDE Part II study of examination length.

Thirty 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.

Trends in the Number of Test Candidates and Pass Rates:

National Board Dental Examinations, Part I. The number of Part I candidates in 2004 (7,731) was down from the prior year (9,589), representing a 19% decrease and a continuing downward trend since the peak in 2002 of 10,509 candidates. The number of candidates from accredited dental schools (4,949) decreased slightly, compared with the previous year, while candidates who graduated from nonaccredited dental schools (2,782) decreased by approximately 37%. Performance of Part I candidates from accredited schools has been fairly stable over the last five years with pass rates averaging between 86% and 90%. Performance of Part I candidates from nonaccredited dental schools was at an overall pass rate at 46%, an improvement over past years where the pass rates averaged approximately 35%.

National Board Dental Examinations, Part II. The number of 2004 Part II candidates from accredited dental schools (4,866) increased slightly (6%) from the previous year. The overall Part II performance of candidates from accredited dental schools was consistent with the previous year, with a pass rate of 90%. The number of candidates from nonaccredited dental schools (1,354) declined significantly (38%) from the previous year. Performance of Part II candidates from nonaccredited dental schools decreased slightly in 2004, and has consistently dropped over the last five years from a pass rate of 61% to the current 52%.

National Board Dental Hygiene Examination. The numbers of candidates taking the dental hygiene examination in 2003 and 2004 reached ten-year highs (6,656 and 6,865, respectively). Performance on the 2004

examination (88% pass rate) remains consistent over the past five years (86-89%).

Pass Rates of Repeating Candidates. As in the past, candidates who failed the examination in 2004 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 approximately 90%, while repeating candidates had a pass rate of approximately 69%. Part II candidates from accredited schools who were taking the examinations for the first time had a pass rate of 93%, while repeating candidates had a pass rate of only 72%.

Graduates of nonaccredited dental schools who were taking Part I for the first time in 2004 had a pass rate of approximately 53%, while repeating candidates from nonaccredited schools had a pass rate of only 41%. Part II candidates from nonaccredited programs who were taking the examination for the first time had a pass rate of 66%, while candidates from nonaccredited schools who were repeating the examination had a pass rate of approximately 36%. Repeating dental hygiene candidates from accredited programs had pass rates significantly lower than first-time candidates. In 2004, the repeating dental hygiene candidates from accredited programs had a pass rate of approximately 38%, while the pass rate for first-time dental hygiene candidates from accredited schools remains stable at approximately 95%. For dental hygiene candidates from non-accredited programs taking the exam for the first time, the pass rate was 33%; for those repeating, the pass rate was only 29%.

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 58 dental test constructors and 18 dental hygiene test constructors to another one-year term and selected ten new dental and three new dental hygiene test constructors.

Endodontics Test Specifications: The Joint Commission approved minor changes in the test specifications for the endodontics component of the NBDE Part II examination. This modification to the endodontics test specifications will be implemented for 2006.

Research and Development Activities:

Results of the Part I Comprehensive Pilot Examination. The Joint Commission at its 2004 meeting reviewed the results of a practice analysis completed for NBDE Part I. One of the findings was that the examination should better reflect the application of foundation knowledge to the practice of clinical dentistry. In order to achieve this, the Commission voted to proceed in 2004 with a pilot of a new Comprehensive Part I examination. The pilot was designed to assess candidates' knowledge and problem solving skills in the traditional basic sciences in a more clinically relevant and interdisciplinary context. In order to enhance the clinical relevance of the exam, 20% of the items were involved in testlets in which the test items in the different disciplines were intermingled in an interdisciplinary assessment context. Testlets consisted of a clinically relevant scenario and a set of multiple-choice items associated with the scenario. The remaining items were traditional stand-alone multiple-choice items.

The pilot was to address at least four key questions. First, would a restructured examination, as operationalized in the pilot, adequately sample from the knowledge and problem solving skills in those basic sciences underlying the successful practice of dentistry? Second, would a restructured Part I be more clinically relevant than the traditional Part I? Third, would the stand-alone and testlet-based items be comparable with regard to difficulty and discrimination? Fourth, would the interdisciplinary structure of the examination prove to be comprehensive in nature?

The pilot was administered to 1,192 students at 32 U.S. dental schools. In addition to completing the pilot, the students responded to a questionnaire designed to elicit their reactions to the pilot. A subset of this sample participated in the July 2004 Part I administration. The subset included 1,059 students, regardless of status, i.e., first time or repeating candidates. The pilot was administered between June 14 and July 8, 2004.

The results of the pilot analysis indicated that the stand-alone items were successful in providing the breadth and depth of sampling from the traditional Part I content domains. The analysis also suggests that the testlets created a more clinically relevant assessment context. In addition, the analysis confirmed that the stand-alone items and testlet-based items were of comparable difficulty and the two item types were comparable with regard to their capacity to discriminate between more and less able students. And finally, the analysis confirmed that the two item types tap different underlying abilities and, therefore, are assessing different abilities.

At its 2005 meeting, the Joint Commission voted to replace the traditional Part I examination with one modeled after the pilot. Specifically, the restructured Part I would involve the following features: 1) a comprehensive format, 2) a single standard score ranging from 49 to 99 for reporting performance with a 75 indicating minimum competence, 3) multiple choice items in the traditional Part I disciplines intermingled throughout the examination, and 4) item types to include approximately 80% stand-alone items and 20% of the items imbedded in testlets that include approximately five multiple-choice items per testlet. Implementation has not yet been determined but third quarter 2006 or later is anticipated.

Computer-based Delivery Methods. The Joint Commission's Committee on Research and Development provided a report to the Joint Commission on its continuing discussion and research into various methods of computerized test delivery. The National Board exams as currently administered in computer test centers are very

close in format to print versions of the same exams. However, information provided by the Committee on Research and Development (R&D) indicates that computer-based testing offers opportunities for a variety of methods for presenting items that may optimize testing efficiency and limit exposure of items. Methods such as Computer Adaptive Testing, Automated Test Assembly and Linear on the Fly Test are among the more complex and interesting approaches available. Following review of information on these and other methods of test delivery, the Joint Commission requested that the R&D Committee continue to study and provide information on these and other approaches to test delivery and item presentation. The Joint Commission approved a recommendation for implementation of the first of several steps in the transition to more sophisticated methods of test delivery.

New Method in Reporting Candidate Results for NBDE Part II. In recent years Part II candidates, regardless of status, have received official score reports that show their comprehensive score, the associated pass/fail status, and performance in each of the disciplines represented on the examination. Reporting on the performance by each discipline is limited however. It is based on raw score information, which is dependent on the performance of a single sample of candidates who took Part II as a print-based examination. The information is provided to candidates in terms of a three-letter reporting system. Specifically, an "H" indicates higher than average performance, an "A" indicates performance at the average, and an "L" indicates lower than average performance. The JCNDE acknowledged that these current classification categories are too broad and do not provide candidates with a full understanding of the extent of their strengths or weaknesses. Both dental schools and candidates have expressed desire for this type of information on performance in specific disciplines.

Therefore, the Joint Commission approved a recommendation to adopt a different method of reporting candidate score results for Part II. The new reporting method will include the number of items in each discipline, the national average correct, and the candidate's number correct. This change in score reporting will assist the candidate in better understanding relative strengths and weaknesses for each discipline. This new manner of reporting scores will begin in 2006.

Study on the Impact of Shortening the NBDE Part II Examination. The Joint Commission reviewed a report from the R&D Committee related to its ongoing studies of the possible reduction in the length of Part II. The Committee has indicated that there are a number of reasons to consider shortening Part II and reducing the number of alternatives for each item. First, it might be possible to present a shorter examination in one day rather than in one and one-half days. This might allow for a savings in testing fees and eliminate difficulties in scheduling consecutive-day testing at computer test centers. Second, reducing test length should reduce possible candidate fatigue. Third, the reduction would lessen item exposure.

A number of studies were conducted by the R&D Committee to determine the impact of shortening the examination on score reliability and content coverage. With regard to reliability, the results indicate that the examination could be reduced from 400 to 300 stand alone items while maintaining a reliability estimate at or above 0.90. This calculation, however, assumes that the number of case-based items of 100 remains constant. The Committee observed that reducing Part II from 500 to 400 items would probably not shorten the examination enough to be delivered in one day on the computer system. With regard to content coverage, the Committee noted that while the practice analysis allows for the distribution of content, it does not suggest how many items are required to adequately cover the content under the current content specifications. There are a number of areas that have only one item assigned. Reducing the number of items proportionately could eliminate these content areas. This means some specific content areas would be randomly included or excluded.

The Joint Commission also reviewed information from studies on limiting the number of item alternatives or options. Currently Part II is constructed with four or five alternatives per item. There is considerable research showing that three-alternative multiple choice items may be just as effective as four- and five-alternative items. The R&D Committee research suggested that by reducing the number of alternatives to three rather than four or five, a shortened test of 400 items could be accommodated in one testing day.

The Joint Commission requested that the R&D Committee conduct further analysis and gather feedback from the communities of interest on the possible impact of shortening the Part II examination and reducing the number of alternatives devoted to each item. The Joint Commission would like to learn more about potential concerns that may be related to the scope of the content covered in a shorter exam.

Progress Report on the Innovative Dental Assessment (IDEA) Methods Research Grant Program: The IDEA grants program was approved by the Joint Commission at its 2004 meeting. The primary purpose for the grant program is to enhance the evaluation of those preparing to practice dentistry or dental hygiene. Expected outcomes include advances in the theory, knowledge or practice of assessment at any point along the continuum from dental education through practice. In particular, assessment methods should be applicable to the evaluation of educational outcomes and competencies for practice relevant to the entry level dental or dental hygiene practitioner. Examples of potential projects are use of testlets or key features items, innovative item formats and technology-enhanced assessment. Pilot and more comprehensive projects are of interest. Collaborative investigations among institutions are encouraged.

The announcement of the program and the start of the first year's funding cycle were made on January 4, 2005. During the second and subsequent years, the announcement of the cycle will be July 1. The first awards will be announced in April 2006.

Examination Administration Issues:

Candidates who Require Retesting for the National Board. The Joint Commission discussed the importance of item security, especially in relation to computerized examinations, and the need for students to have time to remediate between examinations. The Commission also discussed the need to eliminate repeated access to exam content as it relates to preserving examination validity and security.

The Joint Commission determined that it should retain the requirement that as paper-based testing is phased out, a minimum of 90 days be required before a candidate becomes eligible to retest for computerized exams and that the total number of testing opportunities be limited to three per calendar year to allow candidate remediation, limit item exposure, and promote examination security. This requirement will apply to the NBDE Part I and Part II and the NBDHE.

Released Examinations. The Joint Commission discussed the continuing need to have available materials to assist candidates in the preparation of NDBE examinations, such as released examinations. However, the Joint Commission noted that it had been a number of years since the Joint Commission has released examinations no longer in use for testing purposes. Staff explained that logistical issues associated with the transition in administration of both paper-and-pencil and computerized exams have prevented the regular release of National Board Examinations during the past few years. However, in addition to releasing the 2004 Comprehensive Part I Pilot Examination, the Joint Commission will begin to release to the American Student Dental Association, to accredited dental schools, and to dental hygiene programs exams that are no longer in use or compiled groups of expired exam items that have not previously been released. A December 2005 timeframe is anticipated for the first set of items to be released. Many dental schools have requested permission to provide released items to students in electronic format and the Joint Commission has agreed to develop a process to do so in a manner that protects its copyrighted material. Released exams may not be copied or disseminated in any form without the expressed, written permission of the Joint Commission.

Acknowledgments: The Joint Commission acknowledges with appreciation the contributions made by Ms. Rashmi Ambewadikar, Dr. Eleanore Awadalla, Dr. Michael S. Higgins, Dr. R. Lamont MacNeil and Dr. Ronald L. Winder who complete their terms on the Joint Commission this year.

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

Notes

Division of Finance

Council on Members Insurance
and Retirement Programs

Notes

Council on Members Insurance and Retirement Programs

Bethea, Robert P., South Carolina, 2005, chair
Lindsey, H. Jeffrey, Georgia, 2006, vice chair
Axler, Jerrold H., Pennsylvania, 2008
Baker, Gary O., Missouri, 2007
Bocks, Charles R., California, 2007
Brennan, Robert J., Wisconsin, 2006
Brewer, Kevin M., Montana, 2008
Feinberg, Maxine, New Jersey, 2008
Hauer, Michael R., Arizona, 2005
Lastra, Idalia, Florida, 2008
Shapiro, Denise M., Rhode Island, 2005
Shaw, Daniel W., Minnesota, 2006
Simpson, William J., Illinois, 2007
Stewart, Debra G., Texas, 2005
Taylor, Daniel L., Ohio, 2006
Wetzel, Frederick W., New York, 2008
Whitis, Harry W., Arkansas, 2007
Dwyer, David R., director

The Strategic Plan of the American Dental Association: The Council supports the Strategic Plan's goal of providing dentists resources to maximize their clinical practice and management skills as well as their personal well being. It does this by overseeing competitively priced insurance and retirement programs designed to meet the special 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. Because each of these programs and services is available exclusively to Association members, they support the Strategic Plan's membership goals.

ADA Member Group Insurance Programs

The four ADA member group insurance programs are underwritten and administered by the Great-West Life & Annuity Insurance Company. The programs are experience-rated, marketed without the use of agents, and 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. The programs are as follows:

The *Life Insurance Program* is the largest of the member insurance programs. It consists of the Term Life Plan, available to members, their spouse and eligible children, the Term Plus (Universal Life) Plan, available to members only and the Life Insurance Plan for Dental Students.

The *Income Protection Plan* provides long-term disability insurance to members. Monthly benefits of up to $10,000 can be paid when the member is disabled from his/her special area of practice.

The *Office Overhead Expense Plan* will reimburse insured members for up to $25,000 in monthly business expenses when they are totally or partially disabled from their special area of dental practice.

The *MedCASH Insurance Plan* provides cash payments of up to $1,000/day to an insured member or dependent who receives hospital based medical care. Additional cash payments can be provided for insured persons who are diagnosed with certain critical medical conditions.

Participation: Participation in the member insurance plans for the past five years is shown in Table 1. Participation in the insurance plans reflects demographic trends among the membership as well as competitive conditions in the insurance markets. While enrollment in the insurance plans has generally not increased, participants are purchasing larger amounts of coverage.

Financial Experience: Each of the insurance plans is in sound financial condition and has assets in excess of its reserve requirements and other funding liabilities. This has enabled the Council to reduce the cost of coverage for participating members by approving premium credits. Table 2 shows premium credits for each plan during the past year.

Table 1

Program	2000	2001	2002	2003	2004
Member Term Life	62,997	61,588	61,179	60,304	60,894
Spouse Term Life	21,887	21,731	21,507	21,184	20,743
Child Term Life[1]	10,350	10,008	9,674	9,309	8,796
Student Term Life	5,226	4,943	5,856	7,983	9,209
Term Plus Plan	2,287	2,228	2,170	2,129	2,079
Income Protection	20,930	20,302	19,280	19,047	18,580
Student Disability	486	484	465	524	574
Overhead Expense	9,007	8,961	8,880	8,871	8,768
MedCASH	7,234	6,917	6,559	6,377	6,190

[1] This is the number of members who are insuring their children.

Table 2

Program	Payment Date	Credit
Life Insurance Program	1-Jan-04	40%
	1-Jul-04	40%
Income Protection Plan	1-May-04	10%
	1-Nov-04	10%
Office Overhead Expense Plan	1-Feb-04	37%
	1-Aug-04	37%
MedCASH Plan	1-Apr-04	29%
	1-Oct-04	25%

Table 3

Members Retirement Program Assets as of December 31, 2004		
Investment Option	Year-end Assets	Percent of Total
Growth Equity Fund	$283,525,029.54	21.28%
Small Cap Growth Fund	140,371,933.03	10.54%
Equity Index Fund	172,825,081.01	12.97%
Foreign Fund	96,763,006.37	7.26%
Lifecycle Conservative Fund	21,696,171.18	1.63%
Lifecycle Moderate Fund	122,532,279.11	9.20%
Equity Income Fund	30,423,540.96	2.28%
Large Cap Growth Fund	29,908,202.02	2.24%
Small Cap Value Fund	36,013,470.36	2.70%
U.S. Bond Fund	18,322,988.29	1.38%
Money Market Guarantee Account	275,199,984.13	20.66%
5-year Guaranteed Rate Accounts	52,121,328.43	3.68%
3-year Guaranteed Rate Accounts	55,656,175.47	4.18%
Total	$1,332,359,189.90	100.00%

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, Roth IRA or a rollover IRA.

ADA Members Retirement Program: At the end of 2004, 5,903 members were participating in the ADA Members Retirement Program. Members and their employees have a choice of 13 investment funds and accounts. 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. Table 3 shows, as of December 31, 2004, the investment of the Retirement Program's assets.

Change in Investment Vehicle for Equity Index Fund. The Council approved a change in the investment vehicle for the Equity Index Fund effective with the close of business on April 29, 2005. On that date, the assets of the Fund were transferred from the State Street Global Advisors S&P 500 Stock Index Fund to the Vanguard Institutional Index Fund. The primary affect of the change will be to reduce the Fund's expense ratio by .10%.

Replacement of Lifecycle Moderate Fund and Lifecycle Conservative Fund. The Council approved the replacement of the Lifecycle Funds effective with the close of business on April 29, 2005. The Lifecycle Funds were managed by State Street Global Advisors (SSGA). The Lifecycle Moderate Fund was replaced with the Vanguard LifeStrategy Moderate Fund. The Lifecycle Conservative Fund was replaced with the Vanguard LifeStrategy Income Fund. The Council's decision was necessitated by the decision of SSGA to resign as investment manager for the Lifecycle Funds.

The Vanguard LifeStrategy Income Fund has the same investment objective and similar investment strategies as the SSGA Lifecycle Conservative Fund. It seeks to provide current income and some capital appreciation. The Vanguard LifeStrategy Moderate Growth Fund has the same investment objective and similar investment strategies as the SSGA Lifecycle Moderate Fund. It seeks to provide capital appreciation and a low to moderate level of current income.

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 AXA Equitable Life Assurance Society. As of December 31, 2004, there were 2,038 participants in the ADA-endorsed IRA. The total value of their investments was $90.8 million, allocated among 15 investment options. The Association assists Equitable in marketing and administering the ADA-endorsed IRA Program. In exchange for this assistance, Equitable pays the Association a fee that is based upon the amount of assets held in the Program. During 2004, the fee paid to the Association totaled $38,323.40.

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. The Council has now met at least once with each of the insurance companies that underwrite policies for significant numbers of dentists.

The Council is currently conducting a survey of professional liability insurance companies in an effort to obtain profession-wide statistics on the incidence, severity and causes of dental malpractice incidents. The Council hopes this survey will provide information that will assist the profession in understanding the scope of dental malpractice claims in the United States as well as to develop recommendations to assist dentists improve patient care and their ability to defend themselves against unfounded allegations.

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 2004 scientific program was titled "Managing Risk in the Dental Office" and was developed and presented by The Eastern Dentists Insurance Company (EDIC) and the Fortress Insurance Company. It was very favorably received by the members who attended as evidenced by high marks for its content, delivery, visual aids and overall quality. For their efforts in making the 2004 seminar a success, the Council wishes to acknowledge with appreciation Dr. Michael Ragan, risk management consultant for the Fortress Insurance Company, and Mr. Barry Regan, claims manager for the Eastern Dentists Insurance Company.

Acknowledgments

Support for the ADA Foundation: The Council wishes to acknowledge with gratitude the very generous support given the ADA 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.

Personnel: The Council acknowledges with appreciation the many significant contributions made by those members who will complete their terms in 2005: Dr. Robert Bethea, Dr. Michael Hauer, Dr. Denise Shapiro and Dr. Debra Stewart. 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.

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

Notes

Divisions of Government Affairs and Legal Affairs

Council on Ethics, Bylaws and Judicial Affairs

Council on Government Affairs

Notes

Council on Ethics, Bylaws and Judicial Affairs

Jones, Kenneth D., Jr., Ohio, 2005, chair
Antoon, James W., Florida, 2006, vice chair
Asai, Rickland G., Oregon, 2007
Black, Richard C., Texas, 2008
Charlton, Dennis J., Pennsylvania, 2007
Dickey, Keith W., Illinois, 2007
Epstein, Ralph H., New York, 2005
Fontana, Nicholas A., Michigan, 2008
Graeber, John J., New Jersey, 2005
Hutchison, Bruce R., Virginia, 2006
Largent, Beverly A., Kentucky, 2007
Morgan, Stephen S., Utah, 2005
Scott, Marvin M., California, 2006
Smith, James F., Nebraska, 2008
Turkel, Roger M., Rhode Island, 2006
Waugh, W. Scott, Oklahoma, 2008
Wolff, Carol M., Georgia, 2008
Wils, Wendy J., director

The Strategic Plan of the American Dental Association: The Council's activities are consistent with and continue to support the *ADA Strategic Plan: 2002-2005*, primarily the Strategic Plan Goal for Image, Ethics and Professionalism. At its October 2004 meeting, the Council reviewed its current activities and programs, applying metrics to assess their effectiveness and relevancy and considered projections for the ensuing year. At its March 2005 meeting, the Council conducted a strategic discussion to examine its role in fostering ethics and professionalism. To assist in this discussion, the Council invited representatives from the American Medical Association's (AMA) ethics group to share information and perspectives on AMA's ethics organization, structure and resources.

Response to Assignments from the 2004 House of Delegates

Consideration of Code of Ethics Advisory Opinions Regarding Evidence Based Dentistry: Resolution 83H-2004 (*Trans*.2004:322) urged the Council on Ethics, Bylaws and Judicial Affairs, in consultation with the Council on Scientific Affairs and other parties of interest, to develop advisory opinions to the ADA *Principles of Ethics and Code of Professional Conduct* on the appropriate application of Evidence Based Dentistry (EBD) methodology to dental research, with particular emphasis as it relates to "best evidence" conclusions, peer reviewed publications and utilization by entities outside the profession. The resolution also asked the Council to formulate an advisory opinion regarding the ethical use of the term "EBD" in professional announcements and advertisements.

At its October 2004 meeting, the Council heard from representatives in the Division of Science and the Division of Dental Practice on EBD. The proponents of the resolution were also invited to supplement their background to help the Council fully understand their concerns. With assistance from these entities, the Council examined the history of EBD, its clinical application in the practice of dentistry, the existing ADA policies and third parties issues. In February 2005, the Council also sought input from the ADA Advisory Committee on EBD, which is composed of two members from the Council on Scientific Affairs, two expert consultants, a Board of Trustees' liaison, and one representative from each of the following Association Councils: Access, Prevention and Interprofessional Relations; Dental Benefit Programs; Dental Education and Licensure; Dental Practice and Ethics, Bylaws and Judicial Affairs.

As to the first resolving clause, the Council determined that it would not develop the advisory opinions as suggested. The Council notes that existing ADA policy includes a definition of EBD, explains a four-step EBD process, provides a glossary of related terms, and addresses ADA's role in the EBD process (*Trans*.2001: 462). According to this policy, the ADA envisions its role as defining clinical questions, setting protocols for systematic reviews, critically appraising reviews and policies of other organizations and developing mechanisms for translating and disseminating information to the membership. Establishing ethical requirements for research, publications and entities outside the profession in an effort to control the use of EBD methodologies and terms would expand the scope of the ADA *Principles of Ethics and Code of Professional Conduct* into non-traditional areas of research and business. The strength of the ADA *Principles of Ethics and Code of Professional Conduct* is its focus on the clinical practice of dentistry and the dentist-patient relationship. The Council firmly believes this focus should be maintained. The Council is satisfied that the issues raised by this aspect of the

resolution are being addressed by the leadership which ADA is providing through the Advisory Committee on EBD.

With respect to the second resolving clause, the Council decided not to develop or amend an existing advisory opinion in the ADA *Principles of Ethics and Code of Professional Conduct* to address the use of the term EBD in dentists' professional announcements and advertising. The Council concluded that this usage is adequately addressed by the "false and misleading standard" reflected in Advisory Opinion 5.F.2. EXAMPLES OF "FALSE OR MISLEADING." The advisory opinion states:

> The following examples are set forth to provide insight into the meaning of the term "false or misleading in a material respect." These examples are not meant to be all-inclusive. Rather, by restating the concept in alternative language and giving general examples, it is hoped that the membership will gain a better understanding of the term. With this in mind, statements shall be avoided which would: a) contain a material misrepresentation of fact, b) omit a fact necessary to make the statement considered as a whole not materially misleading, c) be intended or be likely to create an unjustified expectation about results the dentist can achieve, and d) contain a material, objective representation, whether express or implied, that the advertised services are superior in quality to those of other dentists, if that representation is not subject to reasonable substantiation.
>
> Subjective statements about the quality of dental services can also raise ethical concerns. In particular, statements of opinion may be misleading if they are not honestly held, if they misrepresent the qualifications of the holder, or the basis of the opinion, or if the patient reasonably interprets them as implied statements of fact. Such statements will be evaluated on a case by case basis, considering how patients are likely to respond to the impression made by the advertisement as a whole. The fundamental issue is whether the advertisement, taken as a whole, is false or misleading in a material respect.

Annual Revisions of the ADA *Constitution and Bylaws* and ADA *Principles of Ethics and Code of Professional Conduct*: The current editions of the ADA *Constitution and Bylaws* and the ADA *Principles of Ethics and Code of Professional Conduct*, revised to January 1, 2005, reflect amendments that were approved by the 2004 House of Delegates.

Emerging Issues/Trends in Ethics

Best Dentists Lists: Under this section, the Council is proposing to the House of Delegates consideration of a new ADA policy. The Council is aware that various third party media sources, such as news programs, practice management groups, newspapers and magazines, are publishing national, state or community lists and directories depicting select practitioners as "top dentists" or "best dentists." An Internet search for the term "best dentists" on October 19, 2004, produced about 169,652 hits. Below are some URLs which are representative of the types of lists currently being published:

http://www.washingtonian.com/health/dentists_list.html
http://www.bestdentists.com/
http://www.1800bestdds.com/?src=overture
http://www.uiowa.edu/~ournews/2004/august/082004best-dentists.html
http://www.thebestdentistsinam.com/index.asp

The lists are commonly compiled using subjective selection criteria, such as opinion polls of dentists and other professionals in a community, without solicitation to, or *quid pro quo* from, the dentists selected for the lists. In the polling process dentist-respondents are commonly asked to "name the dentists they would send a member of their own family to." The dentists who receive the highest number of votes in a specific category of practice or a recognized specialty are named in the listing. It appears that some third parties attempt to use their lists and directories as a revenue source from the dentists selected for the listings. One company, which publishes directories for not only best dentists, but also best lawyers and best physicians, spoke with the Council at its October 2004 meeting. This company advised the Council that dentists are not required or allowed to pay a fee to be listed and that the purchase of products, such as a directory book, a plaque, or an online link, had no impact on the company's inclusion process. Additionally, the Council is aware that some individual dentists are referencing their inclusion in best dentists listings when they advertise their dental practices.

As to the individual member-dentist, the Council believes that statements made in advertisements about the listings are addressed by Advisory Opinion 5.F.2. EXAMPLES OF "FALSE OR MISLEADING," paragraph "d" of the ADA *Principles of Ethics and Code of Professional Conduct*. Accordingly, these representations would be evaluated on a case-by-case basis, considering how patients are likely to respond to the impression made by the advertisement as a whole. Members who choose to participate in such listings are also advised to ensure such action does not run afoul of applicable state law.

As to the third parties, the Council acknowledges that ADA's jurisdiction is limited to the review of member-dentists' conduct. Nonetheless, the Council strongly believes that the public, at a minimum, would benefit from knowing the selection criteria so the listing can be assessed in an appropriate perspective. In its study of this subject, the Council examined policy adopted by the American Medical Association on best physicians. It calls for third parties to disclose their selection criteria.

Because disclosure will help the public, the Council recommends adoption of the following resolution:

21. Resolved, that American Dental Association policy is that any published lists of "best dentists" should incorporate a full disclosure of the selection criteria, including, but not limited to, any direct or indirect financial arrangements.

Access to Care: At its October 2004 meeting, the Council considered a request from the American Dental Education Association (ADEA) on restructuring the ADA *Principles of Ethics and Code of Professional Conduct* to address key issues on social justice, the good society and the moral obligations of health care professionals to provide care to the underserved. As background, ADEA provided the Council with written remarks conveyed by Dr. Frank Catalanotto at the President-elect's Address to the 2004 ADEA House of Delegates, which were helpful in the Council's deliberations.

The Council examined the ADA *Principles of Ethics and Code of Professional Conduct* to determine its relevant sections. This included:

> SECTION 4 — Principle: Justice ("fairness"). The dentist has a duty to treat people fairly. This principle expresses the concept that professionals have a duty to be fair in their dealings with patients, colleagues and society. Under this principle, the dentist's primary obligations include dealing with people justly and delivering dental care without prejudice. In its broadest sense, this principle expresses the concept that the dental profession should actively seek allies throughout society on specific activities that will help improve access to care for all.

The Council recognizes that charitable dental programs, such as Give Kids A Smile, serve to advance this ethical principle in a broad community context. Further, the community-based learning experiences that many dental students fulfill help them envision the part they can play. The profession's efforts in advocacy also serve to further advance this principle.

The Council believes that dentists elevate the esteem of the profession by using their skills, knowledge and experience to improve the dental health of the public, therefore fulfilling the ethical obligation of community service expressed in Section 3A of the ADA *Principles of Ethics and Code of Professional Conduct:*

> 3.A. Community Service. Since dentists have an obligation to use their skills, knowledge and experience for the improvement of the dental health of the public and are encouraged to be leaders in their community, dentists in such service shall conduct themselves in such a manner as to maintain or elevate the esteem of the profession.

Moreover, the *Preamble* to the ADA *Principles of Ethics and Code of Professional Conduct* provides that the qualities of compassion, kindness, integrity, fairness and charity complement the ethical practice of dentistry and help to define the true professional.

With the foregoing provisions in mind, the Council felt the existing framework of the ADA *Principles of Ethics and Code of Professional Conduct* adequately addresses access and advised ADEA of this determination. The Council understands that there are major problems regarding access, but believes the ethical cornerstone already in place can support more comprehensive efforts to build upon it.

The Council is willing to assist other councils, task forces and groups that are seeking solutions to the problems of access. To this end, the Council will be participating in a workshop on access to care in August 2005. Other participating organizations include the American Dental Education Association, the American College of Dentists, the American Society of Dental Ethics and the National Institute of Dental and Craniofacial Research.

Commercialism in Dentistry: The Council will be representing the ADA in a joint collaboration with the American College of Dentists on an ethics summit in 2006. The purpose of the summit will be to explore commercialism in dentistry. Proposed themes include: defining commercialism, determining acceptable features, if any, identifying the underlying ethical properties that may make some commercial practices distasteful, exploring its consequences for the long term integrity of the profession and making recommendations for dentistry. Some commentators have questioned whether the ADA *Principles of Ethics and Code of Professional Conduct* is current on this subject. Therefore, the Council believes it will be helpful to explore commercialism in this venue.

Other Issues: The Council is considering a subcommittee recommendation on a statement about the ethical ramifications regarding gifts given to dentists by patients, industry and other colleagues. The overriding ethical consideration is whether the gifts are intended to lead to a benefit for patients.

The Council met with Dr. Michael Glick, editor of *The Journal of the American Dental Association* (*JADA*), and Ms. Laura Kosden, *JADA's* publisher, to share its views on industry funded research and conflict of interest disclosures. Under Section 5.C of the ADA *Principles of Ethics and Code of Professional Conduct*, dentists have an obligation to disclose to readers and program participants any monetary or other special interests they may have with a company whose products are promoted or endorsed. The Council greatly appreciated hearing about the procedures which *JADA* has in place to address conflicts of interest.

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 ADA *Bylaws*. Since its last report, the Council rendered a decision that is reported below.

Appeal of Dr. [ ] [*](Appellant) appealed to the Council from a penalty of expulsion imposed by his constituent society (Respondent). Respondent admitted accepting and performing professional responsibilities which he had reason to know he was not competent to perform. Appellant also admitted neglecting a patient who was under and in need of urgent care. Respondent issued formal charges specifying that Appellant violated Paragraph A-1, Section 50, Chapter I of Respondent's bylaws and Chapter XII, Section 20A of the *ADA Principles of Ethics and Code of Professional Conduct*. Paragraph A-1 states in relevant part:

> …Notwithstanding any other provisions of the Bylaws or Code of Ethics, any member found guilty of, or disciplined for, professional misconduct by the [state dental board] shall have the case directly referred to the Council on Ethics of the Society… The only matter to be considered is the penalty to be imposed for having been found guilty of, or disciplined for, professional misconduct by the [state dental board]…

A hearing was held at which the Appellant had an opportunity to present testimony and examine the evidence against him. Appellant did not appear at the hearing in person or through legal counsel, nor did he submit a written statement in his defense. Based on the record before it, Respondent concluded that the conduct constituted serious breaches of ethical and professional duties. The penalty of membership expulsion was imposed upon Appellant. Appellant brought this appeal to the Council pursuant to the ADA *Bylaws*. Both Appellant and Respondent filed written briefs. Both parties appeared at the hearing via telephone conference call through their legal counsel.

Chapter XII, Section 20A of the ADA *Bylaws* states in relevant part:

> A member may be disciplined for (1) having been found guilty of a felony, (2) having been found guilty of violating the dental practice act of a state or other jurisdiction of the United States, (3) having been discharged or dismissed from practicing dentistry with one of the federal dental services under dishonorable circumstances, or (4) violating the *Bylaws*, the *Principles of Ethics and Code of Professional Conduct*, or the bylaws or code of ethics of the constituent or component society of which the accused is a member.

The record and arguments of the parties raised two issues which the Council considered in turn.

[*] The names of the parties have been purposefully omitted

1. *Relief from the Entry of the Decision and Disciplinary Penalty*. Respondent's written decision provides that the penalty imposed in this case is based on the underlying state dental board disciplinary order and the fact that Appellant did not appear or offer any mitigation or explanation for Respondent's Council to consider. Expulsion, as defined in the ADA *Bylaws*, is an absolute discipline. It is the most severe penalty that can be imposed against a member and, according to Respondent, the effect is permanent.

Appellant did not dispute that Respondent properly served upon him the hearing notice, as required under the ADA *Bylaws* and the Respondent's bylaws. Rather, by way of an affidavit, Appellant submits additional evidence to explain and mitigate his non-appearance at the hearing.

The Council believed that ethics committees have broad discretion on the issuance of disciplinary decisions, akin to a court of law. It is within their sound discretion to determine whether relief should be granted from a decision due to mistakes, inadvertence, excusable neglect, newly discovered evidence, fraud and other reasons.

Appellant offered assertions to explain his non-appearance at the initial hearing. If Appellant can validate his assertions, Respondent should allow him the opportunity to plead for leniency in the imposition of the disciplinary penalty.

For these reasons, the Council remanded the case back to Respondent for further proceedings consistent with its opinion.

2. *Reasonableness of Disciplinary Penalty.* In light of the ruling on the issue as to the nonappearance, the Council determined it would be premature to consider arguments regarding the reasonableness of the penalty and expressed no opinion on them.

Council Activities

Ethics Component of the SUCCESS Program: The year 2005 marks the eleventh year the Council has offered an ethics seminar as a part of the SUCCESS program. This half-day seminar entitled "An Ethical Perspective to Starting Your Dental Practice" is designed to acquaint junior and senior dental students with the ethical aspects of starting a dental practice. A practicing dentist presents ethical dilemmas faced by new practitioners through lecture and case study. Students are given the opportunity to apply the ADA *Principles of Ethics and Code of Professional Conduct* to current ethical issues. Fourteen seminars were presented at the following schools: Meharry Medical College School of Dentistry, Southern Illinois University School of Dental Medicine, University of Florida College of Dentistry, University of Alabama at Birmingham School of Dentistry, University of Tennessee College of Dentistry, University of Missouri-Kansas City School of Dentistry, University of Mississippi School of Dentistry, University of Washington Health Sciences School of Dentistry, University of Texas Health Science Center at Houston Dental Branch, University of North Carolina at Chapel Hill School of Dentistry, Medical

University of South Carolina College of Dental Medicine, University of California, San Francisco School of Dentistry, University of Michigan School of Dentistry and the Indiana University School of Dentistry. The dental student attendees rated the overall program on average of 4.4, on a 1.0 to 5.0 scale of excellence (5.0 being the highest). The seminar presented at Southern Illinois University School of Dental Medicine combined the practice management and ethics components into one program. Through the ethics component of SUCCESS, approximately 1,400 copies of the ADA *Principles of Ethics and Code of Professional Conduct* were distributed to dental students and faculty this year.

Due to the efforts of the Council on Dental Practice (CDP), corporate sponsorship was obtained to fund expenses for seven out of 14 seminars. The Council gratefully acknowledges CDP's assistance.

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 workshops, articles or other scholarly activities. For 2004, the Council selected the Michigan Dental Association (MDA) as the winning entry for an ethics series published in the MDA Journal.

Ethical Moment Feature in *JADA*: The Council continued its contributions to *The Journal of the American Dental Association* (*JADA*) feature titled, "Ethical Moment," which debuted in May 2004. This feature provides practical answers to everyday dental practice dilemmas based on the ADA *Principles of Ethics and Code of Professional Conduct*. Between November 2004 and June 2005, the following subjects were addressed: financial incentives to staff, obligations to patients when a former employee sets up practice close to the owner's practice, extreme makeovers, helping impaired colleagues and criticism of another dentist's work. The Council welcomes questions from members. Send suggestions to ethics@ada.org.

Meetings: The Council on Ethics, Bylaws and Judicial Affairs met on October 29-30, 2004, and March 31-April 1, 2005, at the ADA's Headquarters Building in Chicago. Dr. Frank C. Grammer, Twelfth District trustee, served as the Board of Trustees' liaison. Mr. Chris Salierno from the American Student Dental Association attended the Council's March-April 2005 meeting as a guest.

Chair and Vice Chair: The Council forwarded the name of Dr. James W. Antoon to the Board of Trustees for approval as the Council's chair for next year. Dr. Rickland G. Asai was elected as vice chair for the next year.

Personnel: The Council welcomed five new members: Dr. Richard C. Black, Dr. Nicholas A. Fontana, Dr. James F. Smith, Dr. W. Scott Waugh and Dr. Carol M. Wolff. The 2005 annual session will mark the completion of the terms of services for four Council members: Dr. Kenneth D. Jones, Jr., chair, Dr. Ralph H. Epstein, Dr. John J. Graeber, and Dr. Stephen S. Morgan. 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.

Summary of Resolutions

21. Resolved, that American Dental Association policy is that any published lists of "best dentists" should incorporate a full disclosure of the selection criteria, including, but not limited to, any direct or indirect financial arrangements.

Council on Government Affairs

Powley, W. Brian, Arizona, 2005, chair
Pope, Theodore R., Ohio, 2005, vice chair
Alfano, Martin A., Pennsylvania, 2005
Bertoch, Daniel A., Florida, 2008
Dow, Jeffrey D., Maine, 2008
Gamble, Howard R., Alabama, 2008
Gelfand, Gerald, California, 2007
Johnson, Curtis Ray, South Dakota, 2005
Kinzel, Timothy R., Wisconsin, 2008
Kneller, Timothy D., *ex officio**
Long, S. Jerry, Texas, 2007
Oyster, Gary D., North Carolina, 2007
Raiber, Robert B., New York, 2007
Rich, William K., Kentucky, 2006
Riva, Richard D., New Jersey, 2006
Roberts, Gary L., Louisiana, 2006
Robinson, Robert W., II, Alaska, 2006
Suchy, Keith W., Illinois, 2008
Vigna, Edward, Nebraska, 2006, *ex officio*[+]
Spangler, Thomas J., director

Meetings: The Council met February 4-6, 2005, in Washington, DC. The Council's second and third meetings are scheduled for May 19-21, 2005, and September 9-11, 2005.

The Strategic Plan of the American Dental Association: *Goal I. Advocacy* of the Association's Strategic Plan is the goal that is met through the legislative and regulatory activities addressed by the Council on Government Affairs (CGA). The Council sees its role as forwarding the ADA's legislative and regulatory policies and priorites; acting as an early warning system for issues and initiatives that will affect the profession, patients and the delivery of oral health care; supporting the principles and core values of the profession; and making recommendations that will help guide the changes that will be made by and to the profession.

Federal Emerging Issues and Trends: Budget shortfalls are demanding action at both the state and federal levels, and are one of the greatest influences on the work of the Council. For example, the federal budgetary shortfall is putting a squeeze on dental programs that rely on federal dollars and is driving changes in Medicaid in a manner that will make it very difficult to simply maintain the status quo. As these programs are cut, and it becomes increasingly difficult to provide access under the current dental delivery system, policy makers may next turn their attention to finding a more cost-effective means of delivering care. At the present time, there is no federal legislation that would change the nature of the dental team concept; however, organizations that may influence policy makers at the federal and state levels, such as foundations and think tanks, are receptive to funding studies that are outside the mainstream of the present dental delivery system. The Dental Health Aide Therapists (DHATs) in Alaska are one of these experiments. Independent practice initiatives in some states are others. The ADA is working to develop its own set of models so that it can be a leader in these efforts (rather than a mere responder), ready to propose any needed changes that will be consistent with the ADA's long held principles. And the Council is working to help develop strategies to get these to policymakers once the House of Delegates approves.

The ever-growing federal budget deficit continues to overshadow congressional activity regarding all discretionary funding programs, making it difficult for the ADA to garner support for its annual lobbying efforts on behalf of needed increases in funding for dental education, research and training programs. For example, the president's fiscal year 2006 budget proposes elimination of some important oral health programs that help train dentists who work in underserved communities and support a sound oral health infrastructure in the states. The presidential budget also provides for elimination of the Preventive Health and Health Services Block Grants within the Centers for Disease Control and Prevention (CDC). A relatively small, but important, portion of the block grant funds are used to underwrite oral health initiatives, which are crucial to assuring a continued CDC role in helping the states address their oral health needs through public health infrastructure support and community water fluoridation initiatives. The block grants account for 50% of the CDC money that flows back to the states for oral health projects.

* Committee on the New Dentist member without the power to vote.
[+] American Dental Political Action Committee chair without the power to vote.

In February 2005, President Bush released a Medicaid budget plan that proposed over $45 billion in cuts to the program over ten years. The ADA expressed opposition to the Medicaid cuts through letters to and meetings with congressional offices, working with other health provider groups and with the Association's grassroots network.

In April 2005, the House and Senate passed a final budget resolution that includes $10 billion in Medicaid cuts over a period of five years (beginning in 2007). The budget also includes a request to set up a bipartisan Medicaid Reform Commission. The ADA endorsed the Commission proposal. Congressional hearings will be held to address needed reforms to the Medicaid program as a whole, and legislation is expected to be introduced that will include provisions negotiated by the governors with members of Congress. Members of Congress may also attempt to reauthorize the State Children's Health Insurance Program (SCHIP) as part of any Medicaid reform legislation, and some members of Congress and governors have expressed an interest in working to make Medicaid more like SCHIP, eliminating federal mandatory requirements (could affect dental coverage requirements for children). The ADA, in partnership with other health provider organizations and patient advocacy groups, will work to ensure that these cuts do not fundamentally alter the structure of the Medicaid program.

Another proposed reform of an entitlement program—Social Security reform—is a high priority for President Bush but has not yet gained traction in Congress due to the lack of public support for the president's personal accounts program and the Administration's failure to create a sense of urgency for change. There are only a few credible ways to fix the Social Security system now under discussion, including lifting the cap now set at $90,000. The ADA is mindful that lifting the cap would place a disproportionate burden on self-employed dentists, who pay both the employer and employee share of the FICA tax. At the present time, the Democrats are simply rejecting all proposals to reform the system and there appears to be little chance for movement this year.

Even the military is being affected by budget deficits, and there are efforts underway—in a desire to save money—to convert full time military billets to contractual arrangements for dentists and other health care providers. Efforts are again underway to reorganize the National Institute of Health, and consolidate Institutes for greater efficiency, and to save money. The Council will keep working to make sure that the ADA speaks for the values of the profession on Capitol Hill and with state dental societies at state legislatures. Policy recommendations and activities will continue to focus on supporting the legislative and regulatory policy goals of the profession, while at the same time, helping guide the ADA as it maneuvers through the changes that are an essential part of the process.

Emerging Issues and Trends in the States:

Access Issues—Medicaid and SCHIP. An overview of the year 2004 reveals that the lifeline for dental access for the underserved is growing and shrinking at the same time—Medicaid needs have increased, but state budgets are still in the red. Most state fiscal officers continue to await any revenue boost as a product of increased consumer spending to mitigate the holes in state spending plans. Medicaid expenditures are soon expected to cost states more money than they spend on primary and secondary education. Increased expenditures coupled with lackluster revenue sets the stage for reductions. Several states have introduced legislative measures in 2005 to improve upon the delivery of dental care for the underserved by trying to restore adult dental services, increase services to adults, or fees to dentists.

Dental Hygiene. The American Dental Hygienists Association (ADHA) took a step in 2004 to redefine the dental workforce in a way that differs significantly from the way it looks today, adopting a policy supporting the creation of an "advanced dental hygiene practitioner" (ADHP). Although no bills have yet been introduced in the states to create this new type of dental hygiene position, there are a number of pending bills in 2005 supported by organized dental hygiene that would pave the way for later ADHP legislation by advocating changes now that would provide for a greater degree of self-regulation and independent practice for existing categories of dental hygienists. One of the ways for increased self-regulation by organized hygiene is the creation of a separate dental hygiene board. Other proposed changes would allow hygienists to practice without dental supervision in institutional settings, allow hygiene practice under prescriptions from a physician, expand hygiene duties in institutions, and, in a few states, permit hygienists to bill Medicaid and receive reimbursement for their services.

Dental Licensure. New York remains the only state that has eliminated the clinical exam as a requirement for initial dental licensure, effective in 2007. Completion of a post-graduate residence of at least one-year's duration takes the place of the exam. The option of passing a clinical exam or completing a residency exists in Minnesota and is proposed in bills pending this year in the states of California and Washington. Dental societies in Connecticut and Ohio have also endorsed this option and legislation may soon be introduced in those states. Colorado, Georgia, and Nebraska modified their licensure laws to attract more faculty to teach in their dental schools.

Taxation of Cosmetic Procedures. As states continue to look for new sources of revenue it was inevitable that sooner or later at least some of them would take a look at taxing cosmetic procedures, given their increasing popularity. Last year, New Jersey imposed a cosmetic health care procedures tax of 6% that included cosmetic dental procedures. Washington state legislators, looking at the projected $25 million a year that New Jersey is expected to generate from its tax, introduced their own legislation in 2005 to tax cosmetic medical procedures (which includes cosmetic dentistry) at 6.5%. Funds collected from the tax would be earmarked for children's

health care services. The New Jersey Dental Association succeeded in getting a bill introduced this year that would strike cosmetic dentistry from the tax and substitute tattooing procedures in its place.

Anesthesia/Enteral Sedation. Several states changed or are in the process of changing their dental anesthesia regulations either through the regulatory process or through legislation. More states are requiring dentists to obtain permits before they can administer conscious sedation and to have sufficient training before administering conscious sedation to pediatric patients. Concern over the appropriate dosage of oral pharmacological agents seems to be a precipitating factor.

Response to Assignments from the 2004 House of Delegates: Following are responses to some of the resolutions assigned to the Council. The remaining resolutions will be addressed in the Council's supplemental report to the House of Delegates.

Deployed Dentists and Mandatory Continuing Education Requirements. Resolution 3H-2004 (*Trans.*2004:314) states that it is the Association's position that military deployment offers a learning experience that provides opportunities to treat complex cases, sometimes under difficult circumstances, and that constituent dental societies be urged to support state legislation or state board regulations that would allow deployed military dentists who are serving on active duty to have their continuing education requirements waived. The Department of State Government Affairs has notified constituents of this resolution and offered to provide assistance in implementation, but has not had any requests.

The Alaska Native Oral Health Access Task Force – Strategies to Assure Access to Quality Health Care for Native Alaskans. Resolution 24H-2004 (*Trans.*2004:291) established the following strategies to help ensure access to quality oral health care services for Alaska Natives:

1. The ADA encourages the establishment of a work group that includes tribal leaders and the Alaska Dental Society (ADS) to facilitate improved access to oral health care for the Alaskan village populations.

The ADA president sent a letter to the head of each tribal corporation in Alaska, offering ADA's assistance in placing dentists in villages where they are requested. The ADA, ADS and Alaska Native Tribal Health Consortium have been in frequent communication since the inception of Operation Backlog, the effort by the ADA and ADS to bring dentists to Alaska.

2. The ADA work with the ADS and tribal leaders to seek federal funding with the goal of placing a dental health aide (i.e., a Primary Dental Health Aide I or II) trained to provide oral health education, preventive services and palliative services (except irreversible procedures, including but not limited to tooth extractions, cavity and stainless steel crown preparation and pulpotomies) in every Alaska Native village that requests an aide.

In virtually every communication to Congress on the matter of providing access to Alaska Natives, the ADA has emphasized that the Association supports the placement of a health aide in every village to provide education and preventive services. Federal funding for those individuals has been broached with key members of Congress but there has been no opportunity to pursue legislation thus far and the budget deficit makes additional funding for this program unlikely, as the Congress seeks to freeze or cut all domestic discretionary programs.

3. The ADA supports the use of Expanded Functions Dental Health Aides I and II where appropriate to improve the efficiency of delivering oral health care services to Alaska Natives within the Community Health Aide Program.

The ADA and ADS are on record as supporting the EFDHA I and II in communications to Capitol Hill and in other advocacy materials on the Alaska access issue.

4. The ADA continues to support current federal policy that facilitates the entry of American Indians/Alaska Natives into the health professions, especially in the field of dentistry.

The ADA has long supported such policy and has made such an effort a key component of its position on how to address the access problems facing the Alaska Natives. Members of the Alaska Native Oral Health Care Access Task Force were instrumental in obtaining written commitments from several dental schools that they would welcome, and facilitate the placement of, AI/AN students.

5. The ADA work to ensure that representatives of the ADS are included in oversight activities concerning the dental health aide program and other programs affecting the delivery of oral health care services to Alaska Natives.

Leadership and staff of the ADA and ADS have worked very closely together on all issues concerning improving access for Alaska Natives. However, the ADA's antipathy to aspects of the DHAT position works against its efforts to be included in the evaluation of the DHA program.

6. The ADA offer, and the ADS be encouraged to offer, to work with the tribal leaders to increase the use of telecommunications to ensure the proper delivery of oral health care in the villages.

The issue of telecommunications has not been specifically addressed at this point in time as the ADA and ADS have focused on other more fundamental concerns.

7. The ADA take actions that help to significantly increase the number of dentists and dental hygienists

available to provide services to Alaska Natives in the rural villages through private contracts and volunteerism and to facilitate the placement of donated dental equipment, including encouraging the ADS to establish a volunteer position to coordinate these activities with the tribes.

The ADA and ADS have worked very diligently at getting Operation Backlog off the ground – an effort that began with the last House of Delegates. At its April meeting, the Board approved funding for a new ADA position: "Manager, American Indian/Alaska Native Dental Placement." The person filling this position will work with the ADS and Alaska tribes to enhance the outreach program to get more dentists to provide oral health care in Native villages. In addition, this person will also develop a business plan for a program to do outreach with tribes in the lower 48.

8. The ADA offer, and the ADS be encouraged to offer, to explore ways of working with the Denali Commission and the tribes to expedite the building of dental clinics in rural Alaska villages.

There has been no opportunity to work with the Denali Commission yet, although as the working relationships mature there may be opportunities in the future, and the ADA staff remains ready to pursue these opportunities.

9. The ADA offer to work with the ADS, Alaska Native Tribal Health Consortium, the Alaska Native Health Board and others to lobby for increased federal funding to help ensure that improvements in community water quality in the rural Alaska villages include fluoridation.

Unfortunately, the Administration in its 2006 budget eliminated all money for water fluoridation. The ADA has been working in a coalition with other dental groups to restore that funding.

10. The ADA work with the ADS and tribes to help reduce the consumption of soft drinks and other cariogenic products.

ADA staff has met with staff of the Alaska congressional delegation to discuss the need for fluoridated water and healthy food choices for Alaska Natives.

11. Consistent with the needs and desires of tribal leaders, the ADA support the increased use and funding of military reservist dentists, including dental specialists, in delivering care to Alaska Natives in remote, rural villages.

The ADA does support such an effort and has contacted the military reservist organizations to determine the availability of such personnel. Details concerning this initiative will be provided in the Council's supplemental report.

12. The ADA through its agencies helps to facilitate the placement of volunteer dentists and dental hygienists in tribal and Indian Health Service facilities nationwide.

As stated earlier, the ADA has established a new position to facilitate the placement of dentists in Alaska and in other parts of the country where needed to provide care to AI/AN people.

13. The ADA is opposed to nondentists making diagnoses, developing treatment plans or performing irreversible procedures.

This is part of the ADA message in all communications concerning the provision of oral health care services to Alaska Natives.

14. The ADA will work to help tribes and tribal leaders understand the dangers and patient health risks of nondentists making diagnoses or performing irreversible dental procedures, including but not limited to tooth extractions, pulpotomies and cavity and stainless steel crown preparation.

The ADA's Board of Trustees in April authorized an additional $50,000 for a public affairs campaign and related activities in connection with Alaska Health Care Issues. This campaign will be designed to tell organized dentistry's story to influence public opinion and decision makers within Alaska. ADA will also be conducting spokesperson training on May 6 in Alaska. This activity will also help the ADS cope with the demands placed on the society to deal with media inquiries and to proactively deliver the dental message – that quality dental care is best delivered by a dental team with a dentist leading that team.

In summary, the ADA has continued full support for the Alaska initiative to provide quality oral health care to Alaska Natives in the rural villages. These efforts in 2005 have to date entailed lobbying Congress (including efforts at the Washington Leadership Conference) to assure that the Indian Health Care Improvement Act when it is reintroduced in the 109th Congress contains language that will preclude nondentists from performing irreversible, surgical dental procedures and testifying before Congressional committees on the ADA position; requesting a determination by the Centers for Medicare and Medicaid Services regarding the legal standing of Dental Health Aide Therapists' services being reimbursed by Medicaid; initiating Operation Backlog to bring dentists to Alaska to address the immediate needs; and instituting an aggressive public affairs program in Alaska to help convey organized dentistry's position to the public and, ultimately, to decision makers in Alaska.

Vision Statement on Access for the Underserved. Resolution 44H-2004 (*Trans.*2004:321) states that the Association continue working with policymakers to establish programs and services that improve access to

oral health care, while maintaining a single standard of oral care; and that the Association urges the nation to join it in: rejecting programs and policies that marginalize oral health; acknowledging that the degree of oral health disparities and the extent and severity of untreated dental disease—especially among underserved children—is unacceptable; and committing, through both advocacy and direct action, to identify and implement commonsense, market-based solutions that capitalize on the inherent strengths of the American dental care system.

The ADA continues to advocate before Congress and the Administration for structural reforms to the dental Medicaid program as part of any comprehensive reform effort. In addition, in an effort to improve relations with The Robert Wood Johnson Foundation (RWJF), encourage collaboration and promote the ADA's extensive efforts to address access to care issues, ADA staff representatives met with RWJF officials at their headquarters in March. The RWJF is currently funding two large initiatives in oral health: a dental pipeline project to recruit more underrepresented minorities into dental school and the State Access for Oral Health Access program grants to six states to develop model access programs.

Federal Legislation Establishing Parameters for Federally Qualified Health Centers. Resolution 55H-2004 (*Trans.*2004:325) states that Federally Qualified Health Centers (FQHCs) be required to issue an annual report that is made available upon request that details the funds they receive and includes a census detailing the types of patients and the number and types of dental procedures provided at their clinics during the previous year, and that the current policy be actively pursued by ADA legislative staff. FQHCs are currently required to submit utilization data annually to the Bureau of Primary Health Care, Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS), which is tabulated by HRSA into a national report. The report may be found at http://bphc.hrsa.gov/uds/data.htm. It provides a variety of demographic, clinical and funding data on the health centers that receive federal funding (called section 330 funding). For example, there are about 1,400 dentists in all federally funded health centers; over 70% of the patients are at 200% of poverty or below, with almost 40% with no coverage, about 35% with Medicaid coverage, and almost 15% with private insurance. The amounts of funding from federal grants and other sources are listed, as are the breakdowns (in dollars and percentages) of the sources of revenue. At the present time, the types of dental procedures are reported only by general category (preventive, restorative, emergency and rehabilitative), however HRSA staff has indicated there is a request for more detailed information regarding the dental services delivered for future reports.

Implementation of Internet-Based, Grassroots, Rapid Contact System for Federal Legislators. Resolution 56H-2004 (*Trans.*2004:326) states that the Board of Trustees explore and implement an electronic grassroots contact system after determining the issues related to deploying such a tool, with a report to the 2005 House of Delegates and to be implemented no later than the 2005 House of Delegates. The network has been established and successfully used on several occasions, and at an annual fee of $4,000 (with a one-time set-up fee of $1,500), well under the budgeted amount. The ADA's new grassroots email system is working well. Four messages have been sent to the grassroots members thus far:

- March 23: Message introducing the new system sent to list of 2,150 grassroots members—1,242 recipients opened the message; three recipients chose to unsubscribe.
- April 27: Update on Medicaid issue sent to 2,150 members—1,073 opened the message.
- May 5: Targeted Action alert sent on Incentive Special Pay/Additional Special Pay for military dentists—385 messages sent; 227 opened the message.
- May 12: Targeted Action alert on the inequity in the rank structure between the dental corps chiefs in the military sent to 254 members.

This effort will be evaluated going forward to determine the program's effectiveness and ease of use.

Exemption from Unemployment Insurance Liability for Active Duty Dentists. Resolution 61H-2004 (*Trans.* 2004:321) states that constituent societies be urged to review their states' unemployment insurance statutes so that dentists who are called to active military duty and close their dental offices are not impacted adversely by the law upon returning to their active practices. The Department of State Government Affairs has notified constituents of this resolution and has offered to provide assistance in implementation, but has not had any requests.

Support for Adult Medicaid Dental Services. Resolution 62H-2004 (*Trans.*2004:327) states that the ADA adopt policy supporting the inclusion of adult dental services in the federal Medicaid program, and take every opportunity to educate policy makers that, consistent with ADA's position on health system reform (*Trans.*1993:664; *Trans*.1994:656) oral health is an integral part of overall health. Also, adult coverage under Medicaid should not be left to the discretion of individual states but rather, should be provided consistent with all other basic health care services.

The ADA has stressed this policy in its statements, testimony and lobbying. In addition, the ADA has endorsed a legislative proposal titled "The Special Care Dentistry Act" that will be introduced in 2005. Among its provisions, the legislation would make comprehensive dental benefits a required federal dental benefit for the aged, blind and disabled (currently only required for children). The bill also outlines additional services that must be required as part of a comprehensive dental benefit (restoration or replacement of teeth, periodontal treatment, adult fluoride application, in-patient and out-patient dental surgical evaluation and examination services,

denture/partial dentures, per patient house calls and nursing facility visits). Also, the ADA advocated for removal of proposed Medicaid cuts in the congressional budget resolutions, arguing that such cuts would lead to states making additional cuts to adult Medicaid oral health programs. Unfortunately, with the congressional budget calling for $10 billion in Medicaid cuts over five years, programmatic expansions are highly unlikely for the foreseeable future and state societies will have to increase their lobbying efforts just to keep the dental programs they have now.

Faculty Recruitment Incentives. Resolution 65H-2004 (*Trans.*2004:319) states that the ADA work with the American Dental Education Association (ADEA) and the National Health Service Corps (NHSC) Loan Repayment Program to encourage legislation/funding to provide student loan deductions or waivers for full-time faculty as an incentive to encourage young health professionals to enter and remain in academic teaching programs.

Legislation was introduced in July 2004 titled S. 2740 the "Dental Health Provider Shortage Act," to address how to improve and expand access to dental services in rural locations. The legislation included a specific provision to provide loan repayment for dental faculty of dental educational programs. This bill did not pass, and the ADA is working with ADEA and the rest of the dental community to address opportunities for reintroduction in 2005.

Continuation of the Alaska Native Oral Health Care Access Task Force. Resolution 66H-2004 (*Trans.* 2004:328) states that an Alaska Native Oral Health Care Access Task Force, constituted by the President, be funded for one more year. The task force has continued and serves as a resource for ADA and Alaska Dental Society leadership and staff.

Diagnosis or Performance of Irreversible Dental Procedures by Nondentists. Resolution 67H-2004 (*Trans.*2004:328) states that the ADA by all appropriate federal legislative and judicial means resist any effort compromising the quality of dental health care services by allowing any nondentist to diagnose or perform irreversible dental procedures except as otherwise authorized by state law with reference to physicians. The Board of Trustees has directed staff to undertake all appropriate preliminary activities in the legal and legislative arenas to position the ADA to carry out Resolution 67H-2004. More specifically, the ADA has taken the opportunity to state its opposition to nondentists performing irreversible procedures in testimony before Congress, in lobbying efforts concerning reintroduction of the Indian Health Care Improvement Act, during the ADA's lobbying efforts at the Washington Leadership Conference, and in letters to key federal regulators, including the Secretary of HHS and the Administrator of the Centers for Medicare and Medicaid Services.

Medicaid "Super Waivers" and State Plan Modifications. Resolution 75H-2004 (*Trans.*2004:328) states that appropriate agencies of the ADA develop draft parameters governing the allowable scope of state plan amendments and/or waivers under the federal Medicaid program for approval by the Board of Trustees prior to lobbying Congress and the federal agencies.

The ADA is developing a state waiver tracking database to identify how state Medicaid reform waiver proposals will affect dental benefits and delivery of services. As information is analyzed, the ADA will work with the state dental associations to identify and address concerns with regard to the waiver proposals. The ADA is also working on its own and through coalitions and partnerships with other dental and health provider organizations to advocate before Congress on Medicaid reform and budgetary programs. A Bipartisan Commission on Medicaid Reform, endorsed by the ADA, is being established and will permit provider insight into reform efforts. The ADA is seeking a formal avenue for input into the Commission. The ADA has also met with representatives of the National Governors Association on these issues.

Responsibility for the Oral Health of Patients. Resolution 98H-2004 (*Trans.*2004:334) states that a dentist must have the primary responsibility for the oral health care of each patient, regardless of the provision of some preventive or education services by nondentists. Consistent with the delivery of quality oral health care services to the American public, the ADA has steadfastly maintained that dentists, and dental teams led by dentists, must continue to have the primary responsibility of delivering oral health care services. This basic tenant forms the foundation for the ADA's advocacy efforts regarding access for underserved populations and other related matters.

Acknowledgments: The Council on Government Affairs announces the addition of five new members: Dr. Daniel Bertoch, Florida; Dr. Jeffery Dow, Maine; Dr. Howard Gamble, Alabama; Dr. Timothy Kinzel, Wisconsin; and Dr. Keith Suchy, Illinois. The 2005 annual session will mark the completion of the terms of service of four Council members: Dr. W. Brian Powley, Dr. Theodore Pope, Dr. Martin Alfano, and Dr. Curtis Johnson. The Council expresses its appreciation to these members for their dedication to the profession and their efforts to address the many legislative and regulatory issues that come before the Council on behalf of the dental profession.

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

Notes

Division of Science

Council on Scientific Affairs

ADA Foundation

ADA Foundation Research Institute

ADA Foundation Paffenbarger Research Center at the National Institute of Standards and Technology

Notes

Council on Scientific Affairs

Zero, Domenick T., Indiana, 2005, chair
Ismail, Amid I., Michigan, 2006, vice chair
Achterberg, Robert J., Washington, 2008
Bakdash, Bashar, Minnesota, 2006
Clark, Glenn T., California, 2008
Dederich, Douglas N., Louisiana, 2006
De Paola, Louis G., Maryland, 2005
Gorlin, Robert J., Minnesota, 2006
Gotcher, Jack E., Jr., Tennessee, 2007
Gray, Brian J., District of Columbia, 2008
Hilton, Thomas J., Oregon, 2005
Mackert, J. Rodway, Georgia, 2006
McGuire, Michael K., Texas, 2007
Murrah, Valerie A., North Carolina, 2007
Sarrett, David C., Virginia, 2005
Shanker, Shiva V., Ohio, *ex officio**
Socher, Jeffrey C., Illinois, 2008
Stanford, Clark M., Iowa, 2007
Todd, Kathleen, senior director, administration, and assistant to the associate executive director, Division of Science

The Strategic Plan of the American Dental Association: The Council on Scientific Affairs pursues the goals and objectives established in the *ADA Strategic Plan: 2002-2005* through the following core activities: evaluating and disseminating scientific information of clinical relevance; serving as the lead agency for ADA evidence-based dentistry activities; developing the annual ADA Research Agenda; conducting the ADA Seal of Acceptance Program for consumer products; evaluating professional dental products and publishing the results; developing standards and guidelines for dental products; and collaborating in scientific studies with the Paffenbarger Research Center, the ADA Foundation's Research Institute and other scientific bodies.

The Council supports the Association's Information goal by, among other things: substantially increasing the quality and amount of information on scientific matters of interest to practicing dentists through ADA.org; assisting with the development of "Practical Science" articles for *JADA*; sponsoring continuing education programs on emerging scientific issues at the 2004 and 2005 Scientific Sessions; taking the lead in communicating to the profession on evidence-based dentistry; and revamping the way the Council evaluates and disseminates information on professional dental products to deliver information that is more responsive to what members want, when and how they want it.

The Council supports the Association's Member and Support Services goal by helping to enhance its "synergistic relationships with associated organizations." Representatives of major governmental and non-governmental research organizations periodically attend Council meetings to discuss issues of mutual interest. The Council through its Research Subcommittee has provided input on the research direction of the National Institute of Dental and Craniofacial Research (NIDCR) and the Centers for Disease Control and Prevention (CDC) consistent with the ADA Research Agenda. The Council is pursuing collaborations with other organizations to find evidence-based answers to members' priority questions about clinical care. The Council collaborated with the Food and Drug Administration (FDA) and other internal and external agencies to update the profession's guide to patient selection for radiographic examination.

The Council continues to set ambitious targets for its activities that fulfill the ADA Strategic Plan and to measure its success in achieving them. In 2004, the Council met or exceeded more than three quarters of its targets.

Response to Assignments from the 2004 House of Delegates: In 2005, the Council addressed the following assignments from the 2004 House of Delegates:

Fluoride Varnish. Resolution 37H-2004 (*Trans.*2004:311) established ADA policy on the safety and efficacy of fluoride varnishes when used appropriately and encouraged the FDA to consider approving professionally applied fluoride varnish for reducing dental caries, based on the substantial amount of available data supporting the safety and effectiveness of this indication. The associate executive director, Science, communicated this position to the FDA by letter dated April 14, 2005.

Dental Sealants. Resolutions 38-2004, 38B-2004, and 38BS-1-2004 (*Trans.*2004:312) address the safety and efficacy of dental sealants in preventing pit and fissure caries and the supporting evidence for using sealants to arrest or manage early carious lesions. The 2004 House of Delegates referred these resolutions to the appropriate agencies for further study. Resolution 38-2004 was

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

developed by the Council on Access, Prevention and Interprofessional Relations and the Council on Scientific Affairs in response to an earlier House assignment (Resolution 85H-2003, *Trans.*2003:389).

To fulfill the further study requested by the 2004 House, the Council on Scientific Affairs will use data from an evidence-based review currently being conducted by the CDC Division of Oral Health on the effectiveness of sealants in managing or arresting caries in permanent teeth, supplementing the data as needed with other relevant research findings. A related activity is the CDC Expert Panel on School-Based Sealant Delivery Programs, which includes an appointed representative from the ADA and a staff representative from the ADA Division of Science. This panel is also waiting for the results of the evidence-based review (which are due late summer or fall) to develop its recommendations.

Standardization of Implant Attachment Mechanisms. Resolution 53B-2004 (*Trans.*2004:312) directs that "appropriate agencies of the American Dental Association work through national and international standards bodies to promote the standardization of the attachment mechanism of dental implant abutment and fixation screws." The resolution was assigned to the Department of Standards Administration. At the Department's request, the Council proposed a new work item to develop a standard for implant screw heads and driver geometry to the ADA Standards Committee on Dental Products.

Scientific Information and Research

"Practical Science" Articles in *JADA*: In 2005, the Council continued its formal collaboration with *JADA* on the "Practical Science" feature series. The goal of the "Practical Science" series is to spotlight scientific knowledge about the issues and challenges facing today's practicing dentists and to assist in bridging the gap between dental research and patient care.

Between October 2004 and April 2005, the following articles appeared as "Practical Science" features:

- *Medications' Impact on Oral Health*
- *State of the Art and Science of Endodontics*
- *Occupation-related Allergies in Dentistry*

Another "Practical Science" article, entitled "Application of Oral Implants to the General Dental Practice," has been accepted for publication in mid-2005. Additional reports have been submitted to *JADA.*

To increase the number of "Practical Science" submissions while maintaining the feature's high standard, the Council formed a subcommittee of CSA members and staff of *JADA* and the Division of Science to serve as a "Practical Science" editorial board. In addition, newly drafted *Practical Science Author Guidelines* should improve the readability and scientific content of the articles. These author guidelines recommend that "Practical Science" contributors prepare concise articles (eight pages maximum) that provide critical reviews of the literature and offer practical recommendations to clinicians.

The Council encourages suggestions from ADA members for future "Practical Science" topics. Send suggestions to the Council at science@ada.org or call the Council office at 1-800-621-8099, ext. 2527.

Evidence-Based Dentistry: As coordinating agency for the ADA Advisory Committee on Evidence-Based Dentistry (EBD), the Council played a central role in organizing the August 2004 ADA Symposium on Evidence-Based Dentistry, the Association's major EBD initiative last year. The August 2004 EBD symposium brought together representatives from 37 associations, specialty groups, research organizations, government, third-party payers and the dental products industry to:

- communicate the ADA definition of evidence-based dentistry;
- help determine the role of the ADA in the evidence-based review process;
- identify roles to be pursued by participating agencies and/or associations; and
- identify the most important clinical questions for systematic review of the best available evidence (obtained from a survey of ADA members and the Council on Scientific Affairs).

The results of the symposium will be discussed in a report to the 2005 House on evidence-based dentistry. The Council is following up on the symposium by contacting the participants about possible areas of scientific collaboration.

The Council's representatives to the ADA Advisory Committee on Evidence-Based Dentistry (EBD) presented the Advisory Committee in February with a strategic plan that proposed the following goals for ADA EBD activities:

- Represent the profession's perspective on evidence-based dentistry in a unified, clear and timely manner to promote the oral health of the public through patient care and public policy.
- Be the source of critically appraised information on all levels of scientific evidence for practicing dentists and the public.
- Develop and implement an educational program on evidence-based dentistry that targets the dental health care team, dental educators, dental students, policymakers and the public.

The Advisory Committee approved the plan and forwarded it for review to the Board of Trustees and other ADA agencies represented on the Committee. The Council at its April 2005 meeting agreed on several immediate actions the Council will take in support of the EBD strategic plan. The Council will prepare and publish summaries on at least five oral health-related systematic reviews in the coming year as follows:

- periodontal disease as a risk factor for adverse pregnancy outcomes;
- combinations of topical fluoride (toothpastes, mouthrinses, gels, varnishes) versus single topical fluoride for preventing dental caries;
- pit and fissure sealants for preventing dental decay;
- interventions for replacing missing teeth: different times for loading dental implants; and
- systemic anti-infective periodontal therapy

The Council will host an expert panel later this year to develop guidance for the profession from published systematic reviews on the use of topical fluoride, thus carrying out another goal of the ADA's EBD activities: to be the source of critically appraised information on EBD to the profession.

Finally, the Council recommended to the ADA's representative to the Agency for Healthcare Research and Quality (AHRQ) that the Association submit a topic involving the dental treatment of pregnant women to AHRQ for systematic review consideration. Each year, AHRQ supports approximately nine evidence reports in collaboration with partners such as professional associations, health plans and others. The Council is seeking a national medical organization to partner with the ADA in this request.

National Library of Medicine Grant Proposal: One recommendation from the August 2004 ADA Symposium on Evidence-Based Dentistry was for the Association to develop a Web site for EBD that would include: 1) a registry of clinical questions of interest; 2) a registry of systematic reviews that are planned, in progress and completed; and 3) a database of published systematic reviews.

To facilitate the development of the Web site on EBD, the ADA submitted, through the ADA Foundation, a translational informatics grant application to the National Library of Medicine (NLM) in February 2005. The proposed project includes: 1) resources and information to help dental health care workers make evidence-based treatment decisions; 2) educational tools and resources on EBD for dental students and continuing education of dental health care workers; and 3) evidence-based information for patients on dental treatment options. If awarded, funds from the grant will be available in November 2005 for a three-year period. The Council will proceed to develop online resources on EBD even in the absence of grant funding, to the extent of its budget resources.

Information Technology: Through Resolution B-115-2004 (*Trans.*2004:272), the Board of Trustees directed ADA agencies to include in their annual reports, summaries of programs, projects or policies dealing with the impact of information technology on the profession or the practice of dentistry.

Recognizing the slow but steady increase in the use of the Internet by ADA members, the Council has increased the quality and quantity of scientific resources available to members at ADA.org. Recent additions include:

- *Chronic Fatigue Syndrome.* In 2004, the ADA received a request from the Chronic Fatigue Syndrome Advisory Committee (CFSAC) that the Association provide resources to dental professionals regarding the management of patients with chronic fatigue syndrome (CFS). To address this request, the Council posted information on CFS, including symptoms, oral manifestations, side effects caused by commonly prescribed medications and links to Web sites with further information.
- *Best Management Practices for Amalgam Waste.* The Council promoted the Association's best management practices (BMPs) for amalgam waste by posting the following information online: a practical guide to integrating BMPs into clinical practice; two *JADA* reports on amalgam separators; and an ADA instructional video for training dental office staff on managing amalgam waste.
- *Safety Alerts.* The Food and Drug Administration's MedWatch program regularly advises health care professionals and consumers on important new safety information for FDA-cleared drugs and devices. To highlight safety alerts of direct importance to dentistry, the Council established a "Safety Alerts" page at ADA.org. As of spring 2005, the Council has informed the membership of the following safety alerts: faulty electric toothbrush heads, bisphosphonate use associated with osteonecrosis of the jaw and manufacturer recalls of oral swab sticks and defibrillator adaptor cords.

Information is being prepared for posting on treatment of pregnant patients, considerations for pregnant dental health care workers and occupational risks in dentistry. The Council continues to monitor the scientific literature on emerging issues, such as the Asian outbreak of avian influenza, and updates its informational resources for members as appropriate.

The Council increasingly uses electronic communications in its business. Council meeting materials are now distributed on compact disc rather than on paper. The Council encourages companies to submit their products to the Seal of Acceptance program electronically. The Council makes extensive use of e-mail and electronic ballots between meetings to communicate and conduct routine business. A special e-mail box has been created for the dentists who have volunteered to serve as clinical evaluators for the Council's new professional product evaluation program. Similarly, the Council's primary vehicle for communicating with the dental industry is an e-mail memorandum, the *CSA Communique*, which is also now accessible at ADA.org.

Dental Radiographic Examinations: In January 2005, the ADA, in conjunction with the FDA, published a report entitled "The Selection of Patients for Dental Radiographic Examinations." Developed as an update of the FDA's 1987 guidelines, the new radiographic guidelines serve as a resource to assist practitioner judgment on how to best use diagnostic imaging for each patient. The guidelines are posted on both the ADA and

FDA Web sites. The Council on Scientific Affairs teamed with the Councils on Dental Benefit Programs and Dental Practice to develop these new radiographic guidelines with the FDA. The guidelines reflect the following updates:

- an additional clinical category entitled "Other Circumstances," which describes the use of radiographs in assessing patients for implants, monitoring enamel remineralization, and evaluating restorative and endodontic needs and other pathology;
- specific monitoring of edentulous patients;
- expanded use of panoramic examination, recognizing the improvements in panoramic technology over the last 15 years;
- clarification that "bitewings" refers to either horizontal or vertical bitewings (or both); and
- an updated bibliography that serves as a valuable reference for practitioners.

In light of this publication, as well as revised guidelines from the National Council on Radiation Protection on reducing radiation exposure and recent CDC recommendations for infection control practices during dental radiography, the Council developed and approved a new report titled, "Dental radiographs: update and recommendations." The report has been submitted to *JADA* as an update of the 2001 CSA report on this topic.

Research of Importance to the Practicing Dentist: The Council on Scientific Affairs is charged by the ADA *Bylaws* with developing an annual Research Agenda to identify emergent issues and areas of research that require response from the research community. During development of this year's Research Agenda, the Council incorporated input from other ADA agencies and the key clinical questions that were identified at the August 2004 EBD symposium for priority systematic review. They are:

- Are sealants effective for managing or arresting carious lesions in permanent teeth?
- At what frequency is dental prophylaxis effective in preventing periodontitis in individuals with and without known risk factors?
- Does correcting malocclusion in children and adults reduce the risk of periodontal disease?
- What is the effectiveness of non-surgical treatments of incipient caries (i.e., sealants and fluorides)?
- Should impacted third molars be extracted in adults over the age of 25?
- What are the clinical, biological, psychosocial and economic outcomes of treating a pulpally involved (periodontally sound) single tooth through: endodontic care, extraction and implant placement, fixed partial denture, or extraction without implant placement?
- What is the optimal frequency for periodontal recall based on a patient's risk profile?

The Board of Trustees approved the revised Research Agenda at its December 2004 meeting (*Trans.*2004:268), and the agenda was disseminated to dental schools, specialty organizations and others with shared interests in oral health research. The 2005 Research Agenda is also available at ADA.org.

In the course of developing the 2005 Research Agenda, the Council took a hard look at the historical impact of the ADA Research Agenda on oral health research. At its November 2004 meeting, the Council heard from a panel of individuals representing industry, academia and government on today's research realities and the ADA's role in promoting dental research. Based on that discussion, the Council agreed that the primary roles of the ADA are: 1) to act as an advocate for practicing dentists to funding agencies and the research community, and to promote clinically relevant research activities; 2) to advocate for systematic reviews of key clinical issues; and 3) to identify emerging concepts and technologies that are likely to influence the clinical practice of dentistry.

To help the ADA fulfill these roles, the Council has undertaken to:

1. leverage existing strategic partnerships between the ADA Washington Office and other organizations, including the American Association for Dental Research and the American Dental Education Association, to influence federal funding of dental research.
2. collaborate with these groups on an annual basis to identify one or two primary topics that will be the research emphasis for the upcoming year and beyond.
3. recruit ADA member involvement in determining research needs of the dental practitioner and "grass roots" advocacy on behalf of these dental research themes.
4. identify and prioritize key clinical issues requiring systematic reviews through a periodic evidence-based dentistry symposium, a periodic survey to practitioners or a registry posted on the Internet, and ascertain those areas requiring more research so as to be able to conduct valid evidence-based reviews.
5. explore opportunities to participate in dental practice-based research networks to enable the ADA to represent the needs of its members, as reflected in the Research Agenda.
6. promote the Research Agenda to industry through the Dental Trade Alliance and other industry communities in order to influence research on topics of mutual interest.

Other Council activities are designed to promote interest in dental research as a career. The Council represented the Association at the 41st annual Dental Students' Conference on Research held on the campuses of the National Institutes of Health (Bethesda, Maryland) and Paffenbarger Research Center (Gaithersburg, Maryland) from April 9-12, 2005. The Conference is sponsored by the Association through the ADA Foundation, with the support of Pfizer Consumer Health Care. Fifty students representing dental schools in the United States and Canada attended the 2005 conference, which featured presentations on oral health research and

career opportunities in not-for-profits, government and industry. Student attendees shared their own dental research experiences through poster presentations.

The Council also provides scientific support to the ADA Foundation as a special awards sponsor of the Intel International Science and Engineering Fair (ISEF). Held each May, the Intel ISEF is the world's largest pre-college celebration of science, involving more than 1,200 high school students from 40 countries. Council members Dr. Bashar Bakdash, University of Minnesota, and Dr. Valerie Murrah, University of North Carolina at Chapel Hill, will serve as volunteer judges at this year's fair.

Council Reports and Statements: In 2004-2005, the Council developed new reports to the profession on the following topics: recent advances in new periodontal therapeutics, radiographic practices, and mouthguards for the prevention of sports-related dental injuries. Upon completion, these reports will be submitted to *JADA* for publication consideration.

Product Evaluations and Evaluation Criteria

ADA Seal of Acceptance Program: The Council is pursuing an action plan to revitalize the ADA Seal of Acceptance for over-the-counter (OTC) products. The ADA Seal is widely recognized by consumers and dentists as a symbol of safety and effectiveness. The Council is building on that recognition to bring more products, especially new and innovative ones, into the program.

One way the Council has done this is by removing an administrative inconvenience that may discourage companies from participating in the OTC Seal Program. Under a Council-approved proposal that was subsequently approved by the Board of Trustees, Seal participants will now be able to distribute their Accepted OTC products with the ADA Seal on the packaging under limited circumstances outside the United States. This change recognizes the growing reality of international markets and the inconvenience companies may face when required to remove the ADA Seal from United States packaging if they need to ship Accepted products in the packaging outside the United States. Timing for implementation of this program enhancement depends on a number of preliminary steps, including registration of the ADA Seal service mark in selected markets and execution of licensing agreements between the ADA and companies that wish to use the ADA Seal abroad.

To further enhance the OTC Seal Program, staff of the Division of Science is working with the Division of Communications to prepare consumer-friendly reports that explain what it takes to gain the ADA Seal of Acceptance and why consumers should look for the Seal when selecting dental products. Consumers who visit ADA.org for oral hygiene information will be connected to these reports by a simple link. Dentists and their staff are some of the best sales people for the ADA Seal to their patients. These reports will give them the information they need to be even more effective. When asked what is the most important thing the ADA could do to attract them to the Seal Program, the number one industry suggestion is that the ADA should promote the Seal to consumers.

Last year, the Council recommended, and the Board approved, elimination of routine advertising review for Accepted products. This step was taken to enable the Council to focus on its core competency of evaluating products for safety and effectiveness. This program change was implemented on January 1, 2005. The effect of this and other program enhancements should begin to appear by the end of 2005.

In 2004, the Seal Program received a total of 160 new product submissions, and the Council subsequently Accepted 58 professional and 52 over-the-counter products. As of April 2005, approximately 283 companies participated in the Seal Program, and 1,002 products carried the ADA Seal. Of these, 408 (41%) are over-the-counter products and 594 (59%) are professional products. The number of over-the-counter products in the Seal Program is down from 444 last year.

Phase-Out of Professional Seal Program. The 2004 House of Delegates approved phase-out of the professional component of the Seal Program to make way for a new professional product evaluation program and newsletter (Resolution 10H-2004). The Council implemented this resolution by providing notice to all participants in the Seal Program that the Council would no longer accept new submissions of professional products after December 31, 2004, or resubmissions after July 1, 2006. All license agreements for use of the ADA Seal on professional products will expire no later than December 31, 2007.

New Professional Product Evaluation Program. The Council is preparing to launch the new professional product evaluation program in July 2006. The Council polled ADA members to find out what type of dental product information they want, and the members spoke loud and clear. The centerpiece of the program will be a newsletter, the "Professional Product Report" that will be provided as a member benefit, initially four times a year. Each issue will provide objective and informative laboratory tests and input from clinicians on products in three categories, as well as timely updates on new technologies. The Council's goal is to assist practitioners in making informed decisions about product purchases. As a preface to the mid-2006 launch of the newsletter, the Council will provide a preview of what is to come by tipping sample product evaluations into three issues of the *ADA News*, beginning with intraoral cameras in the August 22, 2005, issue and diamond points and endodontic posts in subsequent issues.

A key component of the new program—and one that distinguishes it from the Seal for professional products—is the clinical component. Initially, the Council will request input from member dentists-clinicians about their experiences with dental products. Ultimately, the Council would like to initiate practice-based research, perhaps by means of a member practice-based research network. Member dentists who are interested in becoming part of

this exciting ADA activity should contact pprclinical@ada.org or call 1-800-621-8099, ext. 2522 for more information.

Standards Activities: The Council, as part of its *Bylaws* responsibilities, coordinates the development of national and international standards programs 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. The ADA SCDP currently has over 85 projects registered with the American National Standards Institute (ANSI). In 2004, ANSI approved new standards for visible light curing units and orthodontic brackets and tubes as American National Standards. In addition, the Council cooperated with ADA SCDP to update standards on non-sterile latex gloves and the biological evaluation of dental materials. The Council is following SCDP's technical report procedures to prepare a report to the profession on dental lasers and has recommended that a new working group be formed to study whitening products. Currently, some 27 ANSI/ADA specifications have been recognized by the Food and Drug Administration for use in its premarket evaluation of dental products.

ISO/TC106. Through the Council, the Association sponsors U.S. participation in ISO/TC106, Dentistry, as Secretariat of the U.S. Technical Advisory Groups (US TAGs). At the present time the Association holds the Secretariats for two of the seven Secretariats in ISO/TC106: Subcommittee 2, Prosthodontics, and Subcommittee 8, Implants.

The importance of ISO standards development continues to increase on a global basis and is having an impact in the United States as well. In particular, standardization of oral hygiene products is proceeding at a rapid pace and will soon have a noticeable effect on the U.S. marketplace. As of December 2004, 23 ISO standards have been adopted as ADA standards, and additional ISO standards are under consideration.

In 2004, the Council was one of several participants in several strategic-planning sessions designed to measure the effectiveness of the ADA's standards development program for dental products and to consider the perspectives of various other stakeholders. Other participants included staff of the Division of Science, Paffenbarger Research Center and the Departments of Information Technology and Standards Administration, the ADA Office of Strategic Planning and Consulting and the ADA SCDP. The Council also used this opportunity to assess the role of standards in light of the phase-out of the professional-product component of the Seal Program and launch of the new professional product newsletter.

Outside Standards Committees: Other organizations develop standards that can affect the dental profession in areas like indoor air quality and laser safety.

Association participation in standards activities is essential to ensuring that the practice of dentistry is properly represented in any standards or guidelines developed by outside organizations. In 2004, the Council nominated ADA representatives to attend meetings of the following outside standards organizations: American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE); American Society of Testing and Materials; Association for the Advancement of Medical Instrumentation; National Fire Protection Association; and Laser Institute of America. Council suggestions were included in the 2005 edition of the ASHRAE Applications Handbook and in the revision of ANSI Z136.3-1996, American National Standard for Safe Use of Lasers in Health Care Facilities, which was published in 2004.

Guideline Development: Where standards have not been established, the Council develops guidelines for the evaluation of professional and over-the-counter dental products. Although CSA is in the process of phasing out the Seal Program for professional products, new and revised guidelines will remain important for the continued evaluation of consumer products and as a source of test methods that will be used to investigate the safety and efficacy of professional products for the new product evaluation newsletter.

As of May 2005, the Council has completed or is developing guidelines in over 50 product areas.

During the last year, the Council revised or completed guidelines for products for bottled water with fluoride, endosseous implants, orthodontic bracket attachment materials, and tissue engineering products. Guidelines under development or revision include salivary-diagnostic products, fluoride dentifrices, lasers, and manual and powered toothbrushes.

Meetings: The Council on Scientific Affairs met in the ADA Headquarters Building on November 15-17, 2004, and April 4-6, 2005. Dr. Michael E. Biermann, Eleventh District trustee, served as the Board of Trustees' liaison. The Council's remaining meeting will be held on July 20-22.

Personnel: Dr. Domenick Zero served as Council chair for the 2004-2005 term, with Dr. Amid Ismail serving as vice chair. In fall 2004, the Council welcomed four new members: Dr. Robert J. Achterberg, Dr. Glenn T. Clark, Dr. Brian J. Gray, and Dr. Jeffrey C. Socher. The Council recognizes the following members whose terms end this year for their service to the Council, the ADA and the dental profession: Dr. Domenick T. Zero (chair), Dr. Louis G. De Paola, Dr. Thomas J. Hilton, Dr. David C. Sarrett and Dr. Shiva V. Shanker (*ex officio*).

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

ADA Foundation

The Mission of the ADA Foundation: The ADA Foundation (ADAF) is a State of Illinois chartered 501 (c)(3) organization. The mission of the ADAF is to enhance health by securing contributions and providing grants for sustainable programs in dental research, education, access to care and assistance for dentists and their families in need. The Foundation, as an entity separate from the American Dental Association, has developed its own strategic plan and is not specifically referenced in the ADA 2002-2005 Strategic Plan. 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."

Overview: The ADA Foundation has positioned itself as dentistry's premier philanthropic and charitable organization through relevant dental research, high quality education programs, competitive scholarships, innovative recognition awards, access to care projects and charitable assistance grants/loans for dentists and their families in need. The following are several accomplishments to highlight during this reporting period.

National Campaign for Dental Education. Planning for the National Campaign for Dental Education (NCDE) is well underway. The ADA Foundation created a Task Force of 44 individuals – dental educators, deans, practicing dentists, industry representatives, and leaders in organized dentistry, among others – to develop and design the NCDE. The Task Force is being chaired by former ADA President, Dr. D. Gregory Chadwick.

Working side-by-side with its partner organizations (dental schools, specialty organizations and other dental education stakeholders), the ADA Foundation will publicly launch this collaborative initiative in the fall of 2007. This synergistic approach is the most effective strategy to build the campaign, increase awareness, and enhance long-term fundraising capacity.

The National Campaign goal is to raise an estimated $500 million among the partner organizations to address core issues facing the future of dental education. This amount may change based on the number of partner organizations electing to participate. Of this goal, the ADA Foundation will implement a $100 million campaign that will primarily be aimed at supporting innovative approaches to dental education.

The NCDE will serve as a primary resource in dental education philanthropy. The campaign will not be a fundraising entity itself, but rather a support tool to help raise awareness of need. The national campaign will create greater visibility for the fundraising campaigns of its partners who are raising funds for dental education. The campaign will assist its partners who wish to collaborate on specific solicitations and donations will be made to partners rather than to the National Campaign.

The Task Force is diligently working in 2005 to design this unique initiative. In December 2005, the Task Force

will submit a comprehensive National Campaign implementation plan to the ADA Foundation Board of Directors for consideration. Upon its approval, the ADAF Board will begin implementation the National Campaign in early 2006.

By engaging concerned parties and promoting a culture of philanthropy within dentistry, the National Campaign through its many partners can help secure the future for dental education and, as a result, enhance the oral health of this nation.

Aetna Contribution. The Foundation received a $4,524,073 contribution from Aetna, as a result of Aetna's 2004 settlement agreement with the ADA. Of this amount, the ADAF Board earmarked the first $1 million to support the National Campaign for Dental Education. In March 2005, it was determined that of the remaining balance, $2,650,000 would be earmarked for innovation as part of the Foundation's $100 million fundraising campaign. The Board set aside $150,000 of this amount for immediate use via a Request for Proposal designed to identify and stimulate dental education innovation. The remaining $874,073 was placed in a Foundation account to be used for campaign related expenses of the National Campaign and/or the ADA Foundation campaign.

Extended Military Assignment Loan Program. In response to House Resolution 57H-2004 (*Trans.*2004: 291), the ADA Foundation has been engaged in a needs assessment to determine the actual extent of the difficulties experienced by dentists activated for military duty and required to be away from their practices for more than three months. A report addressing this issue will be considered by the Foundation's Board of Directors during its August 10, 2005, meeting.

Unsolicited Grants Program. During its August 2004 meeting, the ADA Foundation Board of Directors discontinued its unsolicited Grants program. As a result, the Foundation will no longer accept unsolicited grant requests for research, education or access to care projects. However, the Foundation is accepting grant requests through the Harris Fund for Children's Dental Health Grants Program, its scholarships and Charitable Assistance Programs, including relief and disaster assistance.

Effective in 2005, the Foundation initiated an annual Request for Proposal (RFP) program focused on dental education, dental research and access to care. Given the Foundation's current activities in the area of dental education, the first RFP, titled *Enhancing the Dental School Faculty Workforce*, was designed to stimulate the development of innovative methods to recruit and retain new dental faculty members. The RFP was distributed in January 2005 with recipients to be named in August 2005.

Tsunami Assistance and Disaster Response Campaigns. In response to the incomprehensible devastation from the tsunami that struck all the way from Somalia to Indonesia, the ADA Foundation established two funds to provide assistance to those nations afflicted by the disaster. To immediately assist the millions of survivors thought to be homeless, or without food or shelter, the Tsunami Assistance Fund was established. The ADA and the Foundation each donated $50,000 to be used as a challenge-matching fund, giving ADA member dentists, team members and others the opportunity to increase the impact of their donations. The outpouring support for the tsunami victims by the dental community allowed the Foundation to direct a $299,477 check to the American Red Cross International Relief Fund.

The ADA and ADAF will coordinate long-term dental outreach and rebuilding efforts with the FDI World Dental Federation and national dental organizations of the countries affected by the disaster. Contributions to the ADAF Disaster Response Fund will be used to work with the affected countries, relief organizations, affected national dental organizations and others to fund the rebuilding and repair of dental clinics, dental hospitals and schools.

Development Activities: The ADA Foundation conducts an annual giving campaign in support of its research, education, access to care and charitable assistance programs. During 2004, past donors to the ADA Foundation were solicited through several combined appeals. This included direct mail and person-to-person solicitations directed to individuals, companies, dental organizations and foundations. A total of $1,518,289 was raised during the year.

In response to the 2004 hurricane season which left many dental offices in shambles and dentists in need of assistance, the Foundation organized a Hurricane Assistance Campaign. The funds raised were used to provide grants for immediate short-term needs, such as food, clothing and shelter. The generous response to the campaign allowed the Foundation to award $20,000 in grants.

ADAF Grant Program: During the reporting period, the Foundation received 366 grant requests seeking more than $3.4 million in financial support. In total, the Foundation awarded 61 grants totaling $515,598 during 2004. In addition, the Foundation provided support for many ongoing activities. In 2004, the Foundation provided funding totaling $542,059 for dental research, $200,000 for education programs, $287,205 for access/preventive dentistry programs and $220,158 in charitable assistance. In total, the ADA Foundation disbursed $1,249,422 in grants in 2004.

Research Grants: The ADA Foundation funds science-based research in areas identified in the ADA's Research Agenda as important to practicing dentists and the patients they serve and which may expedite the transfer of technology from theory to clinical care. During 2004, the following list of dental research grants were disbursed.

- Study titled: Periodontal Bone Tissue Engineering, $67,520

- Study titled: Characterization of Healthy, Carious and Remineralized Dentin and Enamel with FTIR Microspectroscopy, $67,725
- Health Screening Program Database development, $60,000

In addition, the ADAF provided financial support in 2004 for the research awards and fellowships listed below.

American Association for Dental Research (AADR). The Foundation provides support for two fellowship positions. The Foundation provides each fellow with $3,250 to cover a stipend, supplies and travel funds so that the recipient may present research results at the annual AADR meeting. Funding for these fellowships was made possible by the ADA Foundation through a $6,500 contribution from Sunstar America, Inc.

Young Investigator Award. As a requirement of the Specialized Materials Science Research Grant from the National Institute of Dental and Craniofacial Research, the ADAF Paffenbarger Research Center (PRC) annually appoints two young investigators to the industrial scholars program. The $25,319 award was made possible by a contribution from the Colgate-Palmolive Company.

Research Training Fellowship. The Research Training Fellowship program is conducted at the ADAF Paffenbarger Research Center. The program includes a full-time fellow working in conjunction with the PRC's scientific research staff. This annual program is made possible by a $35,000 contribution from the Great-West Life and Annuity Insurance Company.

Dental Student Research Conference. Managed by the ADA Council on Scientific Affairs, the conference introduces pre-doctoral dental students to a wide range of educational opportunities available to those preparing for careers in dental research. In 2004, the conference was held at the Paffenbarger Research Center on the campus of the National Institute of Standards and Technology, Gaithersburg, MD. This annual conference is made possible by a contribution from Pfizer Consumer Healthcare, Pfizer Inc. and participating dental schools from the United States and Canada.

ADA Foundation Health Screening Program. The information gathered by the Foundation's Health Screening Program (HSP) has created the largest national database on the health of dental professionals. During the Orlando meeting, 912 U.S. dentists and 112 international dentists took all, or part of, the screenings offered. Additionally, 270 hygienists and assistants participated in the program. The HSP is generously underwritten by business and corporate contributions.

Gold Medal Award. The Gold Medal Award for Excellence in Dental Research was established to honor individuals who through basic or clinical research contribute to the advancement of the profession of dentistry or to major improvement in the oral health of the community. The award is presented every three years, with Dr. Robert J. Genco the 2003 recipient. This program is made possible by 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 acknowledges outstanding accomplishment in clinical investigation that has significantly contributed to the prevention of oral diseases. Dr. Deborah Greenspan, of the University of California – San Francisco, School of Dentistry, received the $5,000 award in 2004. This program is made possible by Pfizer Consumer Healthcare, Pfizer Inc.

Dental Education Grants: The ADA Foundation promotes and broadens access to excellence in dental education by supporting lifelong learning. The Foundation also offers scholarships for students in dentistry, dental hygiene, dental assisting and dental laboratory technology. In addition, the Foundation provides several awards to support numerous educational activities, which help to increase public and professional awareness of dentistry's contribution in improving health. The following is a list of dental education grants distributed in 2004.

- ADA Council on Scientific Affairs Symposium titled: *The Interrelationship Between Oral and Systemic Health*, $3,400
- American Dental Education Center for Educational Policy and Research, Washington, DC, $10,000
- Dr. Samuel Harris National Museum of Dentistry, Washington, DC, $10,000
- Special Care in Dentistry, Chicago
- Tourette Syndrome Association, Bayside, NY, $5,000
- United Way of Central West Virginia, Charleston, WV, $5,000
- University of California, San Diego, $5,000

Scholarships. A total of $155,000 was distributed for 25 dental student scholarships, 25 dental student minority scholarships, 15 dental hygiene scholarships, 10 dental assisting scholarships and 5 dental laboratory scholarships. These annual scholarships are made possible through contributions from the Harry J. Bosworth Company, the Gillette Company, the Colgate-Palmolive Company, the Procter & Gamble Company, Oral-B Laboratories, Sunstar America, Inc, Handler Manufacturing Company, and the Foundation's JCNDE Student Benefit Fund account.

Access To Care Grants: The ADA Foundation supports funding for national and regional dental access to care programs that make dental care available to the underserved. In addition, the Foundation supports several access to care awards. The following is a list of access to care grants and awards disbursed in 2004

- Abused Adult Resource Center, Bismarck, ND, $8,400

- Alliance of the American Dental Association, Chicago, $27,000
- Beaverton Rotary Foundation, Inc., Beaverton, OR. $5,000
- Clatsop Community Action, Astoria, OR, $500
- Illinois Foundation of Dentistry for the Handicapped, Northbrook, IL, $15,205
- Lifespan of Greater Rochester, Rochester, NY, $5,000
- Sacramento District Dental Foundation, Sacramento, CA, $15,000

Samuel D. Harris Fund for Children's Dental Health Grants Program. In 2004, $186,123 in grants were awarded as part of the Harris Fund grants program to support 43 dental health care and education organizations. The grants were made possible by the Colgate-Palmolive Company, the S.D.S. Kerr Corporation and the Foundation's Samuel D. Harris Fund for Children's Dental Health.

- Academy of Health Careers, Citrus County Schools, Inverness, FL
- Alaska Health Fair, Inc, Anchorage, AK
- Ashtabula County Health Department, Jefferson, OH
- Care for the Homeless, New York
- Children's Dental Services, Minneapolis
- Children's Healthcare of Atlanta, Atlanta
- Collier Health Services, Immokalee, FL
- Columbia University, New York
- Conway Interfaith Clinic, Conway, AR
- Cook Children's Medical Center, Fort Worth, TX
- Doddridge County Parent/Educator Resource Center, West Union, WV
- Dorchester House Multi-Service Center, Dorchester, MA
- East Central District Health Department, Columbus, NE
- Family HealthCare Network, Visalia, CA
- Florida Keys Area Health Education Center, Marathon, FL
- Galesburg Museums, Inc., Galesburg, IL
- Goshen Medical Center, Inc., Faison, NC
- Greater Springfield Dental Foundation, Springfield, MO
- Kids in Need of Dentistry, Denver
- Kno Ho Co Ashland Head Start, Glenmount, OH
- La Clinica de Familia, Inc., Las Cruces, NM
- Lawrence County Family Center, New Castle, PA
- LMAS District Health Department, Newberry, MI
- Mid Columbia Children's Council, Inc., Hood River, OR
- Northland Pines School District, Eagle River, WI
- Oklahoma City Area Inter-Tribal Health Board, Oklahoma City
- Pulaski County Council for Children & Youth Services, Little Rock, AR
- Rural Communities Resource Center, Yuma, CO
- Santa Fe Community College Dental Program, Santa Fe, NM
- Seven Valleys Health Coalition, Cortland, NY
- Spokane Regional Health District, Spokane, WA
- Stone Soup Fresno, Fresno, CA
- Taylor School District, Taylor, MI
- The Family Service Center of South Carolina, Columbia, SC
- The Learning Center for Families, St. George, UT
- Tufts University School of Dental Medicine, Waltham, MA
- United Way of Ponca City, Ponca City, OK
- University of Kentucky Research Foundation, Lexington, KY
- Venice Family Clinic, Venice, CA
- Vernon J. Harris East End Community Health Center, Richmond, VA
- Washington Hancock Community Agency, Milbridge, ME
- Wellstar Foundation, Inc., Marietta, GA
- Winnebago County Dental Society, Loves Park, IL

Access to Oral Health Care for Older Adults Grants Program. The ADA Foundation has established a fund dedicated to the provision of dental care for semi-dependent older adults who live at home and face barriers in accessing oral health care. In 2005, $225,000 in grants were awarded as part of the grants program to support six dental health care and education organizations. The grants were made possible by a contribution from GlaxoSmithKline Consumer Healthcare LP.

- American Red Cross, Church Falls, VA
- Medical College of Georgia, School of Dentistry, Augusta, GA
- National Foundation of Dentistry for the Handicapped, Denver
- New York State Dental Foundation, Albany, NY
- Ohio Dental Association, Columbus, OH
- Spokane Regional Health District, Spokane, WA

Community Preventive Dentistry Award. The Community Preventive Dentistry Award program 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 in 2004 of $2,500 were given to the John C. Lincoln Children's Dental Clinic, Phoenix, Arizona. Also, three meritorious award winners were acknowledged: Share A Smile, Provo, Utah; Seal Dane County, Madison, Wisconsin; and the Champaign County Child Dental Access Program, Urbana, Illinois. Each meritorious winner receives $500. This annual program is made possible by a contribution from Johnson & Johnson Oral Health Products.

Geriatric Oral Health Care Award. The Geriatric Oral Health Care Award recognizes individuals and organizations that have improved the oral health care of older Americans through innovative community health care delivery projects. During 2004, the ADA Council on Access, Prevention and Interprofessional Relations identified the Community Outreach Program, Madison,

Wisconsin, as the $2,500 award recipient. Also presented was one meritorious award winner: Friends of Calvert County Seniors Low Income Dental Program, Prince Frederick, Maryland. This annual program is made possible by a contribution from Pfizer Consumer Healthcare, Pfizer Inc.

E. Bud Tarrson Access to Oral Health Award. The Tarrson Award recognizes the exemplary service of an individual who brings access to care to the grassroots level. Individuals who have received the ADA Council on Access, Prevention and Interprofessional Relations' Access Recognition Award are automatically qualified to be a possible award recipient. In 2004, Dr. Brent Holman of Fargo, North Dakota was named the recipient of the E. Bud Tarrson Award. Dr. Holman donated his $2,500 award to the Red River Valley Dental Access Project.

Charitable Assistance Programs: Through its Charitable Assistance Programs, the ADA Foundation provides a safety net for dentists and their families who are in need. The following is a list of charitable assistance grants/loans disbursed in 2004.

Relief Grants. The ADA Foundation, in partnership with constituent dental society relief funds, provides financial assistance in the form of grants to dentists and their dependents who are in financial need due to injury, advanced age or a medically related condition. Grant monies are used for daily living expenses. During the reporting period, 43 grants awarded by the Foundation and matched by state relief funds totaled $355,866.

Chemical Dependency Treatment Loans. Upon reviewing the comments and recommendations of the ADAF Task Force Committee on Charitable Assistance Programs, the ADA Foundation Board of Directors discontinued the Chemical Dependency Loan Program. Subsequently, the Board directed that $9,725 be provided in support of the ADA Well-Being Institute's activities during the 2005 Annual Session.

Educational Retraining Loans. Dentists who require retraining due to medical disabilities may apply for educational retraining loans. The ADA Foundation provides loans up to $10,000 for fees associated with tuition, books, and other school expenses. Loan monies are paid directly to the educational institution. These loans are interest-free for two years. One educational retraining loan was awarded in 2004.

Emergency Grants to Individuals. The ADA Foundation provides grants of up to $2,500 to dentists who are victims of disasters to assist with their immediate needs, e.g., food, clothing and shelter. Grants totaling $22,500 were given in 2004.

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 Foundation federal assistance program for the year ending December 31, 2004. 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 2004 meeting. No audit findings were disclosed in the report.

Federal and Corporate Sponsored Funding: The Foundation annually receives awards from federal and corporate sponsors to carry out research, educational and other supporting projects. For the year ending December 31, 2004, $3,545,209 was expended for sponsored purposes. The major areas of expense were federal government funded research totaling $1,649,808 and corporate and donor sponsored programs amounting to $1,897,401.

Meetings: The ADA Foundation Board of Directors met in the ADA Headquarters Building in Chicago, on March 3, 2004, and August 11, 2004.

Personnel: The conclusion of the 2005 ADA Annual Session brings to an end the tenure of Dr. Zack D. Studstill, a valued ADA trustee and member of the Foundation's Board of Directors. The Foundation wishes to express its gratitude and appreciation to Dr. Studstill for his leadership and contributions to the success of the Foundation. In addition, the following individuals were appointed to the ADAF Board of Directors: Dr. Robert C. Henderson and Dr. Michael L. Perich serving as public members, and Dr. Kathryn A. Kell, serving as an ADA trustee representative. Each of these individuals received a four-year term. In addition, Dr. Larry J. Ferguson received a two-year appointment to the Foundation Board, serving concomitantly with his two remaining years as a member of the ADAF Charitable Assistance Program Committee.

In anticipation of its expanded duties and the activities of the National Campaign for Dental Education, Ms. Lisa F. Barron joined the staff of the ADA Foundation in the position of Director of Programs.

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

ADA Foundation Research Institute

Siew, Chakwan, director, Research Institute

The Research Institute (RI) is a resource and information center that is supported by the ADA Foundation (ADAF) and housed in the Division of Science laboratories at ADA Headquarters in Chicago. Scientists from the ADAF Research Institute conduct basic and practice-based research to address emerging and long-term professional issues, as identified by the Council on Scientific Affairs and the ADA Research Agenda.

The Research Institute collaborates with scientists at the ADAF Paffenbarger Research Center (PRC), hosts research externs nominated by the American Student Dental Association, and pursues research studies with visiting scientists and representatives from universities and extramural research organizations. Research Institute scientists also evaluate research proposals submitted to ADAF in response to requests for proposals and serve as scientific liaisons to ADAF-funded research projects, including the Health Screening Program, which is held each year in conjunction with the ADA annual session.

The Strategic Plan of the American Dental Association: The ADA Foundation's Research Institute supports the goals and objectives of the *ADA Strategic Plan: 2002-2005* through practical scientific research on issues that impact the oral health of the public, the occupational health of the dental team and everyday clinical practice.

The following primary programs of the Research Institute directly address the "Information" and "Practice Support" goals of the ADA Strategic Plan:

- monitoring the occupational health of the dental profession through the ADAF Health Screening Program;
- evaluating the safety and effectiveness of dental therapeutics and materials;
- analyzing environmental issues with regard to dental office wastewater and dental unit waterlines; and
- responding to public oral health issues (e.g., oral-systemic health interactions)

The Research Institute also strives to promote its scientific findings to the research community at large. At the March 2005 International Association of Dental Research meeting in Baltimore, Research Institute staff presented seven abstracts of their recent research investigations to meeting attendees.

Abstracts and publications, based on current or past RI activities, are available from the Research Institute upon request. Direct all inquiries about RI activities to science@ada.org or call 1-800-621-8099, extension 2767.

ADAF Health Screening Program: Now in its 42nd year, the Health Screening Program (HSP) is one of the premier activities of the ADA. Held each year in conjunction with the annual session, the HSP is a unique screening program that collects many years of sequential data on the health of the dental profession. Since 1964, the program has gathered data for accurate monitoring of trends by dentists, researchers, public health officials and others to make the clinical setting safer for dental health care workers and their patients.

Results of the 2004 Health Screening Program. Of the 8,435 dentists registered for the 2004 annual session in Orlando, Florida, 12.1% (912 U.S. dentists and 112 international dentists) participated in the 2004 Health Screening Program. Additionally, 270 hygienists and assistants took part, boosting total participation to 1,294. Overall, the 2004 HSP attracted the third largest percentage of dentists registered for annual session in the past ten years.

The following basic screenings were offered to dentists in 2004 (tests followed by an asterisk were also offered to dental auxiliaries): HIV screening*; blood pressure and weight*; hemoglobin A1c; clinical chemistry with differential cholesterol; C-reactive protein; electrocardiogram*; head and neck screening (also including oral cancer screening); hepatitis B virus (HBV) serum markers*; hepatitis C virus (HCV) antibodies*; latex hypersensitivity*; *Legionella pneumophila* antibodies*; periodontal screening and recording (PSR); carpal tunnel syndrome (CTS) evaluation*; urinary mercury screening; and mental health screening*. The 2004 Health Screening Program also offered the following elective evaluations to dentists and dental auxiliaries at a nominal charge: N-telopeptide (osteoporosis); thyroid stimulating hormone (TSH); prostate specific antigen (PSA); and the vertical auto profile (VAP) cholesterol test.

Data from the 2004 HSP provided further evidence that dentists have a high compliance rate with current recommendations for hepatitis B virus (HBV) immunization. About 91% of the participating dentists reported that they have been vaccinated. In addition, only 7.8% of dentists demonstrated serum markers indicative of past or current infection with hepatitis B virus, the lowest level of HBV infection since this screening has been offered. Between 1994 and 2003, levels of HBV infection among HSP-tested dentists had remained relatively stable, ranging from 8.5% to 10.5%, yet down significantly from nearly 15% in 1982, the first year a vaccine for HBV became available.

Currently, dentists with past or present hepatitis B infection are generally older and were likely exposed to HBV before the vaccine became available in 1982. A gradual decline in the prevalence of HBV infection had been anticipated as older dentists retired. However, the

significant decline in HBV infection among HSP dentists in 2004 may signal the beginning of a more rapid decline in HBV infection, even among active dentists.

Antibody seroprevalence of hepatitis C virus (HCV) among dentists tested at the 2004 HSP was 0.44%, which is essentially unchanged from previous years and below the 1.8% seroprevalence in the general population. This HSP data demonstrates the effectiveness of standard precautions in helping to prevent HCV transmission from becoming an occupational hazard in dentistry. In the absence of an HCV vaccine, the data can be viewed as anecdotal evidence that standard precautions are effective in preventing occupational exposures to bloodborne pathogens.

Testing was also conducted at the 2004 HSP to determine if dentists are occupationally exposed to *Legionella pneumophila* by breathing aerosols or mists generated by water sources in the dental offices, such as high-speed handpieces. Dentists tested at the 2004 HSP for *Legionella* antibodies showed a seroprevalence of 7.4%, which is similar to the seroprevalence found in a control group of nondentists (tested concurrently) and to the 8.6% seroprevalence reported in 2003. Based on this preliminary HSP data, there is insufficient evidence that dentists are at occupational risk to *Legionella* transmission.

Dentists tested at the 2004 HSP had a mean urinary mercury level of 4.1 µg/L, which is just below the average urinary-mercury level for HSP-tested dentists measured between 1995 and 2004 (4.2 micrograms Hg/L urine). The 2004 urinary-mercury level also does not differ significantly from the level in the general, non-occupational population (4.0 micrograms Hg/L urine). Factors likely contributing to the consistent mean levels of urinary mercury in recent years include: the shift in emphasis towards disease management and prevention; the availability of new and improved dental restorative materials and technology; the increased use of cavity varnishes, sealants and resin composites; the increased use of pre-capsulated amalgam; and a greater awareness of mercury hygiene.

HIV Screening. Since 1987, the HSP has tested almost 21,000 serum samples for antibodies to the human immunodeficiency virus (HIV), and only one possible dentist occupational exposure (in 1988) has been found. At the 2004 HSP, none of the dentist serum samples tested positive for HIV-1 or 2.

Given these findings, the scientific value of continued HIV testing at the HSP is minimal, and there is no compelling reason to assume the present trend will change. Furthermore, there have been no significant changes in infection control practices that increase the risk of HIV infection among dentists. Accordingly, the ADA Foundation, at its spring 2005 Board meeting, suspended further HIV antibody screening until such time as facts or circumstances warrant a resumption of the testing.

Other Blood Tests. The average cholesterol levels for dentists participating in the 2004 HSP indicate a decreased risk for cardiovascular disease. Dentists' cholesterol/high-density lipoprotein (HDL) ratio averaged 3.8, placing them in a somewhat lower risk category relative to the general population. Total cholesterol, HDL and low-density lipoprotein (LDL) levels averaged 201, 57 and 118 mg/dL, respectively.

As a new test offering, the 2004 Health Screening Program offered the glycosylated hemoglobin (glycohemoglobin) test**,** which measures average blood glucose levels over the preceding 90 days. The glycohemoglobin test is used as a better, long-term indicator for evaluating a patient's glucose level and their potential for Type 2 (adult onset) diabetes mellitus. Overall, the average glycohemoglobin level for HSP-tested dentists was 5.7%, which is the high-normal range. Levels at 6.0% and above are predictive for Type 2 diabetes.

In the testing for prostate specific antigen (PSA), 2.3% of the participating dentists showed elevated PSA levels. Based on 2004 HSP data, the average PSA level for dentists was 1.3 ng/mL. Levels of 4.0 ng/mL and greater are indicative of potential prostate cancer and require additional medical evaluation.

Mental Health Screening. Since 2003, the Council on Scientific Affairs and Council on Dental Practice have worked collaboratively on an interagency mental health screening project. At the 2004 HSP, 700 participants completed part or all of the mental health screening form, which employs the same screening tools as those used in a nationwide program by Screening for Mental Health, Inc. for National Depression Screening Day.

Preliminary data from the 2004 mental health screening indicate 13.7% of this self-selected sample report having been treated for depression. Nearly half the respondents reported feeling low in energy and experiencing sleep difficulty, and on the anxiety disorder scale, about one-quarter of the respondents reported sleep problems. Another 15 to 18% of respondents reported experiencing the hallmark symptoms of depression: hopelessness about the future, loss of interest in things, and feelings of worthlessness. It should be emphasized that these data are preliminary and a full analysis will be needed to reach reliable conclusions.

In the 2004 mental health screening, slightly more than 2% of respondents reported some thoughts of suicide in the two weeks before the annual session. However, this response rate is well below the 9% level reported, in response to the same question, in a nondentist population tested on the 2003 National Depression Screening Day.

Regarding symptoms of bipolar illness, about 6% of respondents indicated that their symptoms were troubling enough to have caused: a moderate or serious problem with work; arguments or fights; or family, legal or financial troubles. In the general public, bipolar illness affects approximately 1.2% of the adult population.

In addition, greater than 12% of the respondents answered "yes" to one or more of the questions focusing on alcoholism, a slightly higher rate than that found in the general population. Finally, in the screening for generalized anxiety disorder, 15% of respondents reported that their symptoms are either affecting their daily life or

causing much distress. In a given year, about 13.3% of the general population is diagnosed with generalized anxiety disorder.

Caution is needed when evaluating the 2004 mental health screening results, since four hurricanes hit Orlando and the Florida area in the six weeks preceding the 2004 Health Screening Program. Historically, attendees from the host and neighboring states comprise the largest block of HSP participants. Given the location and frequency of the hurricanes, it is reasonable that the mental health of HSP participants may have been affected by these stressful events.

Plans for the 2005 Health Screening Program. The 2005 HSP will offer the same screenings, with the exception of HIV, to dentists and dental auxiliary staff. The goal for 2005 is to register 2,000 participants, or 15% of all dentists registered for the annual session. Various steps will be taken to increase awareness of the HSP among attendees. For example, in 2005, free influenza vaccinations will be offered at the HSP for the first time, and a blood drive will also be hosted.

HSP Data Bank. Substantial progress has been made in organizing historical HSP data for online access, which will facilitate future research by allowing more investigators to utilize the largest national database on the health of dental professionals. The project will be completed in early 2006.

Oral Manifestations of Systemic Disease: The Research Institute continues to pursue its scientific research on oral-systemic health interactions. A primary example of RI research in this field is its search for evidence that suggests an oral microorganism might exacerbate blood coagulation disorders, which in turn can progress to cardiovascular disease.

In one preliminary study, RI scientists incubated human umbilical endothelial cells or human monocytes with *Porphyromonas gingivalis* (*P. gingivalis*) to examine if this infection induces the expression of tissue factor proteins and initiates coagulation in endothelial cells and monocytes. Based on the results gathered to date, the RI found that *P. gingivalis* can activate tissue factor expression and induce procoagulant activity in endothelial cells and monocytes, which could potentially lead to cardiovascular disease.

To explore this potential interrelationship further, the Research Institute developed a grant proposal to evaluate the cellular and molecular mechanisms by which *P. gingivalis* induces regulation of tissue factor and procoagulation activity in human endothelial cells. The Research Institute submitted this grant proposal to the National Institute of Dental and Craniofacial Research in March 2005.

Curing Lights: The Research Institute continues its ongoing scientific evaluation of dental curing lights. In a clinical situation, intensity output from a curing light is dependent on both the condition of the light (e.g., bulb, filters, light guide and line voltage) and the distance the light is held from the composite-resin surface.

In this RI investigation, scientists estimated the reduction in intensity of one tungsten halogen and one light-emitting diode (LED) using a range of neutral density filters. Staff also determined the depth of cure (DOC) of a composite resin at reduced intensity levels to estimate the correlation between intensity and DOC. The results of this RI study verify a logarithmic correlation between DOC and curing-light intensity. As an example, a low intensity of less than 10 mW/cm^2 produced significant depth of cure, depending on the curing light and the type and shade of composite.

Also, the RI evaluated the reduction in both curing-light intensity and depth of cure with increased distance between optic tip and composite surface. While DOC usually diminishes with decreasing intensity, the rate of decline is light-dependent, being linear for some and exponential for others. For all lights tested in this study, the depth of cure was above the manufacturer-recommended incremental thickness of 2 mm, even at a distance of 10 mm. Though it may be possible to achieve significant cures with certain LEDs at increased distances between optic tip and composite, the RI suggests it may still be prudent to stay within the incremental thickness recommended by the manufacturer, as distance is only one factor influencing intensity.

Quantification and Removal of Ultrafine Particulate Aerosols During Simulated Dental Procedures: In this study, the Research Institute quantified the amount of ultrafine particulate aerosols (<0.1 μm) that are generated during simulated clinical procedures and evaluated the particulate removal efficiencies of three commercial air purifiers. The purpose of this study was to characterize the types of ultrafine particulate aerosols that would get into the air from basic dental procedures and—potentially—pose a health hazard to practicing dentists.

In this RI simulation, particulate aerosols were generated while finishing a microfilled composite using a high-speed handpiece with carbide bur (for composite polishing). The procedures were performed for five minutes with and without high volume evacuation (HVE) and water spray, with ultrafine particulate aerosols monitored using a real-time particle counter.

The investigation determined that the amounts of ultrafine particulate aerosols generated were significantly reduced by the use of HVE and water-spray procedures ($p<0.05$, paired t-test). Furthermore, the particulate removal efficiencies for the three air purifiers evaluated were greater than 99%. This study lends further support to the efficacy of high volume evacuation in reducing aerosols and larger particulates generated during dental procedures.

Emerging Issues and Trends: On an annual basis, the Research Institute reevaluates its goals and objectives to ensure that they closely align with emerging and high-priority research areas identified by the ADA Council on Scientific Affairs and the Association's Research Agenda. Emerging trends in dentistry include novel approaches of

risk assessment, disease management and prevention, rapid chairside diagnostics (e.g., salivary diagnostic technology), chemotherapeutics and early intervention. In the near future, the Research Institute anticipates that the issue of allergy to materials used in dentistry will become increasingly prominent.

To address these and other issues, the RI will continue its efforts to identify antigens commonly encountered in dental practice. Also high on the Research Institute's priority list is the continued evaluation of emerging scientific studies related to dental infection control, oral and systemic diseases, the safety of dental materials and equipment, and waste management issues.

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

ADA Foundation Paffenbarger Research Center at the National Institute of Standards and Technology

Eichmiller, Frederick C., managing director
Carey, Clifton M., 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, Jerold L., chief research scientist, dental cariology
Schumacher, Gary E., associate director, 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 Foundation (ADAF) and a department of the Division of Science. The PRC receives funding through the ADA's annual grant to the Foundation, from National Institutes of Health grants, from industrial contracts and grants, and from service contracts and in-kind contributions from NIST. The PRC also has access to royalties paid to the Foundation from the sale of products based on patents emanating from research at the PRC. Eighteen 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. Projects address the practice needs of members, the ADA Research Agenda and respond to critical issues identified by the Council on Scientific Affairs. PRC scientists published or had accepted 43 peer-reviewed papers, one United States patent, and presented at 14 dental continuing education programs. 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 and on the ADAF Web page.

The Strategic Plan of the American Dental Association: The ADA Foundation, as an entity separate from the ADA, is not specifically referenced in the 2002-2005 Strategic Plan. However, the Foundation supports the objectives put forth in the ADA *Constitution* and the Future of Dentistry Report by advancing the oral health of the public through basic and applied research and the development of improved dental materials and treatment technologies. Several examples of how the PRC directly addresses objectives within the Strategic Plan are:

- Education—by providing quality continuing education programs for constituent organizations; topics included dental materials and amalgam waste management.
- Professionalism—by communicating PRC accomplishments directly to the profession through programs, presentations, and the public media. Included were press releases on new discoveries, presentations to state dental associations and local societies, booths at national dental meetings, and publication of a compact disc highlighting PRC accomplishments.
- Public Presence—by responding to critical issues through the Division of Science and the Council on Scientific Affairs, through direct participation in national and international standards organizations, and the promotion of ADA benefits to members and the public through media, tours and presentations. This included providing testimony at hearings related to dental amalgam, hosting the ADAF Board meeting and the Dental Students' Conference on Research.
- Data and Information—by researching issues that have direct impact on practice and public health, and the publication and dissemination of these research results. Studies included the collaborative evaluation of dental aerosols, light curing instruments, and dental burs.

Activities

Clinical Research: The third phase of the Aerosol and Particle Project was completed in collaboration with researchers from the ADA Division of Science. Two clinical studies involving human subjects were completed: salivary calcium and phosphate concentrations after chewing an experimental chewing gum and salivary fluoride concentration after rinsing with a two-part fluoride rinse. A third clinical study of the remineralization of tooth structures is in the planning stages. An NIDCR-funded project on fracture analysis of restorative materials continued into its third year of funding.

Dental Chemistry: PRC-developed calcium phosphate bone cements are currently being used for maxillofacial repairs, and laboratory and animal studies are being

conducted to broaden the applications to dental uses, such as implant grouting, periodontal repairs, endodontic procedures and ridge augmentation. A five-year extension of the NIDCR grant that partially supports these studies has been awarded. A new project to develop methods for producing nano-sized bioactive materials resulted in a new patent application and an NIDCR grant application. A reflective infrared mapping project continued the study of cell culture substrates, tissue scaffolds, polymer coatings and mineralized tissues. Collaborative projects included development of calcium and phosphate releasing whisker reinforced dental materials and improved fluoride releasing devices.

Polymer Chemistry: Clinical evaluation of an experimental calcium phosphate pulp-capping composite was nearly completed with very favorable results. An NIDCR grant to fund these projects was renewed for an additional five-year period. A new postdoctoral position was established to develop cell culture testing capabilities for evaluation of new materials and several studies were completed. The ADAF funded a new project to develop calcium phosphate cements tailored for regenerating periodontal bone support. Pilot studies were initiated to develop remineralizing composites based upon newly discovered nano fillers.

Dental Cariology: Two NIDCR-funded projects resulted in the development of new types of fluoride rinses, dentifrices, and gels that produce an enhanced anticaries effect and the development of a chewing gum that releases higher concentrations of anticaries calcium and phosphate ions. A new NIDCR grant application to study the mechanism of oral fluoride retention was submitted. A development grant from the ADA Foundation resulted in a patent application for a procedure to enhance the anticaries effect of current commercial fluoride rinses and dentifrices. A NIDCR-funded project on the development of amorphous calcium phosphate-containing materials showed exceptional progress this year resulting in several preventive and restorative products based upon patents obtained as a result of these studies.

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

Notes

ADA Business Enterprises, Inc.

Notes

ADA Business Enterprises, Inc.

For-Profit Subsidiary Annual Report and Financial Affairs

Hunt, Donald S., chair (outside director)
Chaput, Ronald, vice chair (at-large member dentist)
Bramson, James B., secretary (ADA executive director)
Zimmermann, William T., chief executive officer
Feldman, Roddy, treasurer (ADA trustee)
Barrett, Lee (outside director)
Brandjord, Robert M., (ADA president-elect)
Haught, Richard (ADA president)
Kittredge, Roger R. (outside director)
McDermott, Bernard (ADA trustee)
McFadden, Judith (at-large member dentist)
Williams, Edward J. (outside director)

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 the *ADA Member Advantage Program* for 2004 and early 2005.

ADA Member Advantage Program: ADABEI's endorsed programs are branded "ADA Member Advantage." The mission of the program is to enhance member value by providing a broad range of products and services from "best in class" providers, and grow revenue to support the ADA's non-dues revenue stream. The supporting strategy to accomplish this is to:

- increase brand recognition of *ADA Member Advantage*;
- refine and enhance product offerings; and
- increase the number of members using one or more product.

Financials: *ADA Member Advantage Program* royalties are shared by ADA and ADABEI based on agreements between these companies and the providers, which were restructured during 2003 to direct a higher proportion to the ADA.

The total program generated $5,775,839 of revenue in 2004, representing strong growth of 12.2% over the 2003 level of $5,149,774, due to increased utilization of products and services by members. The ADA received approximately 55% of this revenue stream, with the remainder directed to ADABEI. The first quarter of 2005 shows total program revenue of $1,397,184, approximately 8.8% ahead of planned revenue for the period.

For 2004, ADABEI reported net income of $147,926 compared to a net after tax loss of ($14,710) in 2003. The increase between years is partly due to the transfer of the publishing unit to the ADA in mid 2003, a year when publishing experienced a net loss in the first six months. The elimination of the publishing loss was partly offset by the decrease in ADABEI's share of program royalties, mentioned above. As in previous years, a $60,000 contribution was made to the ADA Foundation.

Highlights: For ADABEI, 2004 was a significant year in the areas of marketing, product offerings and state dental society endorsements.

- Increased marketing efforts in 2004 included implementing four new direct mail packages, enhancing the ADA Member Advantage toll free number with speech recognition, and redesigning the ADA Member Advantage Web site.
- Two new products were added to the program – Appointment Confirmations with Tel-A-Patient and a Business Credit Card with Citibank. One provider, for Fee Recovery, was replaced when contract re-negotiation ended. After completing an RFP, AllianceOne was selected to offer Fee Recovery, and their program offers better member pricing.
- Five provider contracts were renewed in 2004, including Health Savings Accounts with MSAver, Patient Financing with CareCredit, Postage Meters with Pitney Bowes, Payroll with SurePayroll and Student Loan Consolidations with CFS.
- Increased relationships with the state dental societies as 90 additional product endorsements were added in 2004. At the close of 2004, ADABEI partnered with 44 dental societies with a total of 269 individual product endorsements, a 45% growth over 2003.

Members are able to find out about the *ADA Member Advantage* program through integrated marketing and communications plans. ADABEI's efforts include direct mail, advertising, editorials, the Internet and tradeshows. Members are 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. With five products launched in the first four months of 2005, the *ADA Member Advantage* program currently includes 20 product lines. The newest products include – Auto Financing, Patient Record Keeping, Real Estate Assistance, and

Student Loan Originations. The program groups products into two broad categories for marketing – For Your Practice & For Your Life.

Practice products include:

- Appointment Confirmations – offered by Tel-A-Patient. Members can confirm appointments and recall patients more efficiently than and just as personally as office staff.
- Business Credit Card – offered by Citibank. Allows dentists to more effectively manage their business expenses while earning travel points that tie in to the existing consumer cards' rewards program.
- Credit Card Processing – offered by Paymentech. Members can take advantage of excellent rates. Paymentech will perform a free competitive analysis on the member's current provider to determine if Paymentech can reduce their costs.
- Electronic Transactions – offered by WebMD. ADABEI continues to enjoy a strong relationship delivering electronic transactions to the dental community. Offices can verify plan benefits before treatment is rendered as well as submit claims.
- Fee Recovery / Collections – offered by AllianceOne. Practices can collect outstanding balances for a low fee of 27% of first collections, with no upfront or start up fees. Letter series and legal services are also available.
- Message On-Hold – offered by Tel-A-Patient. Turns on-hold time into a powerful practice building tool, with professionally produced recordings and ADA reviewed scripts.
- Patient Charts – offered by The Dental Record. Improve office productivity plus the clinical, legal, financial and administrative areas of patient record keeping with the most complete dental record keeping system available.
- Patient Financing – offered by Care Credit. Members might reduce their receivables and increase their treatment acceptance by offering their patients various payment plans, including no interest options. ADA members currently save $200 on their Enrollment Fees.
- Payroll – offered by SurePayroll. ADA members can now utilize an online payroll service and enjoy free set-up, free processing for the first 30 days, and Free W-2s for the first year.
- Postage Meters – offered by Pitney Bowes. ADA members can eliminate trips to the post office with a postage meter and scale. New customers will receive a special offer of up to $50 in postage.
- Practice Financing – offered by Matsco. Members receive a complete line of financing for dental professionals, ranging from practice acquisition, start-up, to practice expansion, working capital and business consolidation loans.

Products for members' individual needs include:

- Auto Financing – offered by CitiFinancial Online. This product was launched in April 2005. Members and their families will receive the highest priority processing status with competitive rates for auto loans up to $60,000.
- Credit Card – offered by Citibank. Two cards are available. The first is a no annual fee travel rewards card that allows members to earn points towards free merchandise or travel. The second card offers a low variable interest rate.
- Health Savings Accounts - offered by MSAver. These products continue to grow in popularity. They can help members save on health insurance costs, while providing tax savings. Available for members and their staff.
- Hotel Discounts – offered by Starwood. Members receive special discounts at over 250 selected Starwood Hotels and Resorts. Additionally in 2004, all members were enrolled in Starwood's SPG (Starwood Preferred Guest) Program at the Preferred Plus Level, in which members earn points and receive special perks at all Starwood properties.
- Line of Credit – offered by Citibank. Members can obtain an unsecured line of credit with check writing capabilities, and a competitive rate of prime plus 3.9%.
- Mortgage & Home Equity Loans – offered by CitiMortgage. Members will enjoy preferred member discounts on mortgages waived lending fees that on average will save members $900.
- Real Estate Assistance – offered by CitiMortgage. Members are assigned a real estate consultant at no cost to guide them through the entire buying and selling process. And if members buy or sell their home through the program, they can receive up to $3,000 cash back in most states.
- Student Loan Originations – offered by The Student Loan Corporation, a subsidiary of Citibank. This product was also added in April 2005. ADA members, their families and staff are eligible for exclusive lending benefits. Special loans for Dental Students as well as loans for the children of dentists (K-12, College and Graduate levels).
- Student Loan Consolidation – offered by Collegiate Funding Service. Members can reduce their monthly student debt payments with consolidation to a single bill and a reduction in the fixed rate by an additional 1.25% is available for ADA members.

State Endorsements: Originally the ADABEI program required states to endorse every available product and in 2002, 13 states endorsed the full product line. In 2003, ADABEI unbundled the program and allowed state societies to select individual products to endorse. This approach began with WebMD and met with great success. Thirty states endorsed at least one product by the end of 2003. ADABEI continued this approach in 2004, reaching out to additional states and seeking additional collaboration from the states that had endorsed just one product. From those efforts, ADABEI saw a 45% increase in the number of individual product endorsements in 2004 (from 186 to 269). ADABEI also

added many states that had not previously endorsed any product and moved many products from single product endorsement to multiple product endorsers. After the first five months in 2005, 46 state societies endorse one or more product; 28 of those states endorse more than one product, averaging ten endorsements a piece; only five state societies do not participate in the program. This strategy will continue through 2005, with efforts to enhance the relationships with the state societies with a robust communication plan that allows for increased feedback and that demonstrates ADABEI's value through products with greater member benefits, turnkey marketing and enhanced measurements.

Focus: The Company's focus for 2005 is as follows:

1. Add new customers and retain existing customers.
2. Manage the existing product lines to maximize member benefits and revenues.
3. Evaluate and launch new products, as appropriate.
4. Grow brand awareness of *ADA Member Advantage.*
5. Gain an increased number of State Dental Society endorsements.

CEO Transition: The Chief Executive Officer of ADABEI, James H. Sweeney, retired effective August 1, 2004, and has continued as CEO in a part-time interim-temporary position. It was announced that William T. Zimmermann, the CFO of the ADA, will become the ADABEI Chief Executive Officer effective June 30, 2005. The transition of responsibilities is currently in process. The Board of Directors wants to again express its sincere gratitude to Mr. Sweeney for his years of service to ADABEI and the ADA.

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

Notes

Resolutions

Notes

2004 Resolutions Referred to 2005 House of Delegates

Eighth Trustee District

Creation of Vice-Speaker Position

The following resolution was submitted by the Eighth Trustee District and transmitted on September 21, 2004, by Mr. Robert Rechner, executive director, Illinois State Dental Society.

Background: The ADA in its many years of service to member dentists has been fortunate to avoid a situation in which the Speaker of the House of Delegates was unable to perform his or her duties at the annual session. It would seem naive to assume that this will always be the case. Presently the ADA President is named by the *Bylaws* as the designated replacement for an "absent" Speaker of the House. Certainly the ADA President is expected to be in attendance at all sessions of the House of Delegates and should be well versed in parliamentary procedure. However, during the ADA annual session, the demands on both the President and Speaker, whether the House is in session or not, would seem to be so unique, varied and numerous as to preclude the President from simultaneously performing both roles to the standards and expectations the ADA has become accustomed**.** Indeed, the individual serving as Speaker of the House must perform the specific duties decisively, satisfactorily and with the utmost efficiency.

There is a clear necessity for careful preparation involving significant study, forethought and deliberation well before the time the annual session is to take place. Critical duties and responsibilities of the ADA Speaker of the House are demanding and include, but are not limited to serving as consultant to the Committee on Credentials, Rules and Order, member of the Resolutions Committee, appointing any necessary Special Committees, various obligations to the Standing Committee on Constitution and Bylaws, and being readily available for questions, general guidance, rule interpretation, and parliamentary opinion during Reference Committee hearings and district caucuses. Continuing to perpetuate a potential circumstance in which the ADA President could suddenly and unexpectedly be harnessed with the vast obligations and accountability of the Speaker would seem shortsighted and ill advised.

39-2004. Resolved, that the *Constitution*, Article V. OFFICERS, Section 20. APPOINTIVE OFFICER be amended by substitution of the following new section in place of the existing section:

> *Section 20.* APPOINTIVE OFFICERS: The appointive officers of this Association shall be an Executive Director and a Vice-Speaker of the House of Delegates. The Executive Director shall be appointed by the Board of Trustees as provided in Chapter IX of the *Bylaws*. The Vice-Speaker of the House of Delegates shall be appointed by the Board of Trustees as provided in Chapter V of the *Bylaws*.

Resolved, that the *Bylaws* be amended in Chapter V, Section 110, subsection A, in the first sentence of the second paragraph by substituting the word "Vice-Speaker" for the word "President", so that the new section with then read:

> CHAPTER V. HOUSE OF DELEGATES.
> *Section 110*. OFFICERS:
>
> A. SPEAKER AND SECRETARY. The officers of the House shall be the Speaker of the House of Delegates and the Secretary of the House of Delegates. The Executive Director of this Association shall serve as Secretary of the House of Delegates.
>
> In the absence of the Speaker the office shall be filled by the ~~President~~ Vice-Speaker. In the absence of the Secretary of the House of Delegates the Speaker shall appoint a Secretary of the House of Delegates *pro tem*.

and be it further
Resolved, that the *Bylaws* be amended in Chapter V, Section 110 by the addition of a new subsection B, and the existing subsection B be re-lettered as subsection C, the new subsection B to read as follows:

> CHAPTER V. HOUSE OF DELEGATES.
> *Section 110*. OFFICERS:
>
> B. VICE-SPEAKER
>
> a. APPOINTMENT. A Vice-Speaker of the House of Delegates shall be appointed annually. In making the appointment, the Speaker of the House shall select a nominee from the current year's list of delegates and alternates. The Speaker's nominee shall be affirmed by a majority vote of the Board of Trustees at a regular meeting prior to the annual session.
>
> b. QUALIFICATIONS. In making this appointment, the Speaker of the House and the Board of Trustees shall give due consideration to the candidates' parliamentary procedure background.
>
> c. DUTIES. In the event the Speaker cannot perform the functions of the office, the Vice-Speaker of the House shall assume the office and duties of the Speaker, during the current annual session only, with all rights and privileges of the

Speaker. The Vice-Speaker shall perform these duties until the return of the Speaker or until the close of the current annual session. Should the Vice-Speaker assume the duties of the Speaker, the Vice-Speaker shall relinquish all duties as an ADA delegate or alternate delegate while serving as the Speaker.

and be it further
Resolved, that the *Bylaws*, Chapter V, Section 110, subsection B, subsection "a" be amended by addition of the phrase "nominate a delegate or alternate delegate for Vice-Speaker of the House" so that the amended subsection "a" will then read:

CHAPTER V. HOUSE OF DELEGATES.
Section 110. OFFICERS:

B. DUTIES
a. SPEAKER. The Speaker shall preside at all meetings of the House of Delegates and, in accordance with Chapter V, Section 140Bb, determine the order of business for all meetings subject to the approval of the House of Delegates, nominate a delegate or alternate delegate for Vice-Speaker of the House , appoint tellers to assist in determining the result of any action taken by vote and perform such other duties as custom and parliamentary procedure require. The decision of the Speaker shall be final unless an appeal from such decision shall be made by a member of the House, in which case final decision shall be by majority vote. In addition, following adjournment of the Standing Committee on Constitution and Bylaws, the Speaker and the chair of the Council on Ethics, Bylaws and Judicial Affairs shall be responsible for reviewing and either approving or redrafting any new resolutions or changes to resolutions that propose amendments to the *Constitution and Bylaws*, in accordance with Chapter V, Section Ab.

and be it further
Resolved, that the *Bylaws*, Chapter VII. Board of Trustees, Section 110. DUTIES, be amended by the addition of a new subpart "R" as follows, and to re-letter existing subparts "R" and "S" as "S" and "T":

Section 110. DUTIES: It shall be the duty of the Board of Trustees:

R. To affirm the nomination of the Speaker of the House for Vice-Speaker.

and be it further
Resolved, that implementation of the above *Constitution and Bylaws* amendments shall take effect with the close of the 2005 House of Delegates.

ADA Audit

Notes

ADA Finances: A Joint Letter from the Treasurer and the Executive Director

Introduction

We are pleased to present this report to the membership summarizing the American Dental Association's financial position as of December 31, 2004. This report highlights the significant financial events that occurred during the year, provides an overview of the consolidated audit, analyzes the ADA's investment accounts including several special accounts set up to manage ongoing activities, discusses subsidiary operations, and concludes with a reconciliation of the reported operating results to the 2004 budget approved by the House of Delegates.

The ADA again produced very strong financial performance in 2004. Consolidated net assets increased $16.4 million to $128.6 million. Consolidated total revenues remained virtually unchanged at $116.5 million. The 2004 operating surplus of the ADA itself was $3.8 million. The transfer of this surplus to reserves coupled with robust investment returns brought year-end 2004 reserves up to 48.2% of budgeted 2005 operating expenses.

A consolidated audited financial report is prepared for the Association inclusive of its subsidiary operations. In addition, separate audits were conducted for each of these consolidated subsidiaries. The accounting firm of Grant Thornton conducted each annual audit and in all cases expressed an unqualified opinion on the 2004 financial statements. Those audit reports follow this introductory letter.

ADA and Subsidiary Operations

The comments that follow relate to the audit reports of the ADA 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.

In addition to the basic consolidated statements of financial position, activities, and cash flows, the 2004 audit report includes supplementary "consolidating" statements for the ADA and all of its subsidiary organizations. 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 the ADA and its subsidiaries are eliminated in consolidation to remove double counting.

Consolidated numbers are comprised of the following:

- American Dental Association
  - Operating Division
    - Operating Account
    - Capital Improvement Account
    - Renovation Program
  - Reserve Division
    - Capital Formation Account
    - Investment Account
- American Dental Political Action Committee
- American Dental Real Estate Corporation
- ADA Foundation
- ADA Business Enterprises, Inc.

Consolidated Association Statement of Financial Position: The Association's equity position on a consolidated basis increased $16.4 million in 2004.

Consolidated, December 31:	**2004**	**2003**
Total Assets	$162,197,558	147,587,881
Total Liabilities	(33,644,296)	(35,410,098)
Total Net Assets	$128,553,262	112,177,783

The net increase of $14.6 million in total assets is primarily attributable to a $12.2 million increase in marketable securities, as well as a net $3.5 million increase in property and equipment due to headquarters building renovation expenditures. The increase in marketable securities is attributable to very strong investment performance, the transfer of the ADA's 2003 operating surplus of $3.4 million to reserves, and the $4.5 million Aetna settlement payment received by the Foundation. It should be noted that the net Citibank signing bonus of $4.2 million was transferred to reserves in April 2003.

Liabilities decreased primarily due to a $1.4 million reduction in deferred revenue, mainly from dues. Dues received in advance of the membership year are deferred. The timing of those receipts slowed at the end of 2004 when compared to the end of 2003.

Consolidated Association Revenues and Expenses:

Consolidated:	**2004**	**2003**
Total Revenues	$116,491,264	116,783,443
Total Expenses	(99,477,710)	(96,429,298)
Income Tax (Expense) Benefit	(1,337,442)	78,567
Net Income	15,676,112	20,432,712
Decrease in Minimum Pension Liability	699,367	3,099,054
Increase in Net Assets	$16,375,479	23,531,766

Total revenues decreased approximately $292,000 in 2004. Investment income was $3.1 million lower in 2004. Investment returns in 2004 represented above average performance, but 2003 was an extraordinary year. Publication and product sales declined by $1.4 million due to the surge of HIPAA and CDT product sales in 2003 that did not take place to the same degree in 2004. Royalties showed a decrease of $2.8 million due to the Citibank signing bonus of $4.5 million in 2003; absent that one-time event, royalties would have increased $1.7 million. Partly offsetting these decreases is the Aetna settlement of $4.5 million reflected in other income in 2004, as well as an increase in testing and accreditation revenues.

Expenses increased $3 million with staff compensation, taxes and benefits accounting for $2.5 million of that total increase. Salaries rose due to merit increases, as well as a significantly lower number of unfilled staff positions during the year. Group medical insurance and payroll taxes also increased.

The ADA recorded a minimum pension liability of $7.3 million at the end of 2002. The impact of the unprecedented depressed investment markets of the previous three years upon the pension plan's assets triggered the recording of this liability as required by generally accepted accounting principles. This liability is strictly an accounting calculation which has no funding requirement, and thus no effect upon the ADA's cash and reserve assets. The Minimum Pension Liability was reduced $3.1 million in 2003 and approximately $700,000 in 2004 as a direct result of the investment returns achieved by the pension plan during those years.

Reserve Investments: The reserve investment accounts of the ADA are segregated into two categories: Capital Formation, which holds long-term investments that are not easily liquidated, such as the Washington Office Building and ADABEI; and the Reserve Investment Account, which is primarily comprised of investments in mutual funds.

A recap of year-end balances for the five-year period ended December 31, 2004, follows. These balances represent the total net assets in each account. The Reserve Investment Account holds marketable securities that could be readily liquidated to satisfy future contingencies of the Association. The Capital Formation account balances are illiquid.

Recap of Year-End Balances
Reserve Investment Accounts

Year Ended	**Operating Division**	**Reserve Division**	**Total Marketable Securities**	**Capital Formation**	**Total Reserve Accounts**
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
2002	*	16,042,160	16,042,160	17,146,755	33,188,915
2003	*	34,931,542	34,931,542	13,299,532	48,231,074
2004	*	43,994,473	43,994,473	13,280,807	57,275,280

*Operating and Reserve Divisions were combined in 2002.

Capital Improvement Account: Continuing work on the Capital Improvement Program during 2004 resulted in remodeling and asbestos abatement improvements to the Headquarters Building for tenant space and certain common areas totaling $1,046,372. 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.

Through December 31, 2004, improvements with the following costs, net of depreciation, have been completed:

Asbestos Abatement	$5,776,991
Remodeling	15,882,591
Total Expenditures	21,659,582
Less Accumulated Depreciation	10,722,981
Net Expenditures	$10,936,601

Unspent monies collected for this activity are maintained in a separate short-term investment account to generate interest earnings. At December 31, 2004, the Capital Improvement investment account had a balance of $2,996,048. Since these monies will be utilized to convert certain space currently used by ADA into tenant space at the end of the ADA renovation program, and to abate and renovate the building lobby after all other building renovation work is completed, the Capital Improvement Account must retain monies at least through 2006.

ADA Renovation Program: The 2000 House of Delegates approved a plan for renovation and asbestos abatement of ADA occupied space in the Headquarters Building. To help fund this initiative, a six-year $30 dues assessment for ADA members was enacted, effective from 2001 to 2006. Additionally, $2.5 million and $1.5 million were transferred from the Capital Improvement Account and the Building Fund, respectively.

Also $1.0 million of budgeted funds are being transferred annually to the Renovation Program from the Operating Account beginning in 2004 when the Building Fund was eliminated.

Through December 31, 2004, improvements with the following costs, net of depreciation, have been completed:

Asbestos Abatement	$2,404,309
Remodeling	17,866,823
Total Expenditures	20,271,132
Less Accumulated Depreciation	2,594,716
Net Expenditures	$17,676,416

Unspent monies collected for this activity are maintained in a separate short-term investment account to generate interest earnings. At December 31, 2004, the Renovation Program Account held $1,968,247 in short-term investment funds.

Subsidiary Operations: In 2004 ADA Business Enterprises, Inc. (ADABEI), realized net income of $147,926 compared to a net loss of ($14,710) in 2003. This improvement primarily resulted from the 2003 transfer of the publishing operation from ADABEI to ADA as of July 1, a year when that unit exhibited a net loss of ($202,317) for the first six months. This was partly offset by a decrease in ADABEI's share of ADA Member Advantage royalties that was implemented during 2003 but in effect for all of 2004.

Another significant benefit realized from the ADABEI restructuring was the utilization of the formerly unusable net operating loss tax carryforwards of ADREC. Tax savings of approximately $220,000 and $650,000 were realized in 2004 and 2003 to offset Unrelated Business Income Taxes on the advertising revenue of ADA Publishing. No net operating loss carryforwards remain at December 31, 2004.

American Dental Real Estate Corporation (ADREC) experienced losses of ($166,651) and ($211,627) in 2004 and 2003, respectively. These deficits should be considered in light of the fact that the Association occupies its Washington premises rent-free. After including the imputed value of rent of approximately $350,000 in 2004 and $295,000 in 2003 for the ADA occupied space, ADREC would have produced net income of approximately $185,000 in 2004 and $85,000 in 2003.

In 2004, the American Dental Association Foundation (ADAF) generated net income of $5,765,598 compared to $1,860,721 in 2003. This change between years primarily reflects the receipt of the $4.5 million payment from Aetna in settlement of a class action lawsuit in 2004.

The American Dental Political Action Committee (ADPAC), realized a net loss of ($296,059) in 2004 versus net income of $402,232 in 2003, primarily due to an increased level of spending in an election year.

ADA General Fund Operating Account

The 2004 budget projected a net deficit of ($445,980) while actual results yielded a net surplus of $3,783,824. This represents a favorable variance of approximately $4.2 million to budget.

The surplus transfer was determined by adjusting net income reported on the audited financial statements to a budgetary basis. These adjustments represent specific items that are treated differently by prescribed

accounting rules than by the ADA's budget funding guidelines as shown below:

Net income per 2004 financial statements	$3,766,241	
Additions to net income:		
Transfer of Building and Technology Funds	1,658,200	(1)
Net capital expenditures	48,959	(2)
Deductions from net income:		
Renovation Program funding	(1,000,000)	(3)
Pension adjustment to restate expense per accounting rules to contribution amount	(689,576)	(4)
Net Surplus	$3,783,824	

Notes:

(1) The Building and Technology Funds were dissolved and their December 31, 2003 balances transferred to the operating account, but this is not considered revenue in the audited financial statements.

(2) Capital spending is not considered an expense in the audited financial statements while depreciation is a recognized expense but does not require cash spending. Since the budget reflects capital spending greater or less than depreciation, this amount adjusts for the net impact of depreciation in excess of the capital spending level.

(3) The transfer of monies to the Renovation Program are not expenses in the audited financial statements.

(4) 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 adjustment amount is meant to restate financial statement net income to reflect the higher contribution.

Actual Results Versus Budget: The 2004 operating surplus of $3,783,824 was $4,229,804 better than the budgeted deficit.

Revenue	**2004 Actual**	**2004 Budget**	**Variance Favorable (Unfavorable)**
Membership	$47,721,745	47,573,570	148,175
All Other Revenue	46,477,556	43,673,650	2,803,906
Total Revenue	94,199,301	91,247,220	2,952,081
Expense	89,132,226	90,322,100	1,189,874
Net Operating Results Before Taxes	5,067,075	925,120	4,141,955
Income Tax Expense	(1,300,834)	(1,090,000)	(210,834)
Net Operating Results After Taxes	3,766,241	(164,880)	3,931,121
Cash Items			
Capital Expenditures	(2,977,733)	(2,539,000)	(438,733)
Depreciation (add back)	3,026,692	2,499,900	526,792
Net Capital Expenditures	48,959	(39,100)	88,059
Transfer of Building and Technology Funds	1,658,200	758,000	900,200
Renovation Program Funding	(1,000,000)	(1,000,000)	—
Pension Adjustment to restate expense per accounting rules to contribution amount	(689,576)	—	(689,576)
Net ADA Operations	$3,783,824	(445,980)	4,229,804

The following key items contributed to the higher than budgeted net operating results:

	Variance Favorable (Unfavorable)	
Salable Materials, net	$1,450,241	(1)
Division of IT and Standards, net	1,006,476	(1)
Excess Building and Technology Funds	900,200	
Division of Conference Services, net	587,488	(1)
Division of Education, net	574,851	(1)
Member Advantage Royalties less payments to states	456,935	
Division of Communications, net	443,727	(1)
ADA Foundation Grant	416,513	
Travel	(170,742)	(2)
Capital Expenditures in excess of budget	(438,733)	
Publishing Division, net	(523,225)	(1)
Compensation, Taxes, and Benefits	(809,694)	(2)
All Other Variances, net	335,767	
Total Improvements in net operating results	$4,229,804	

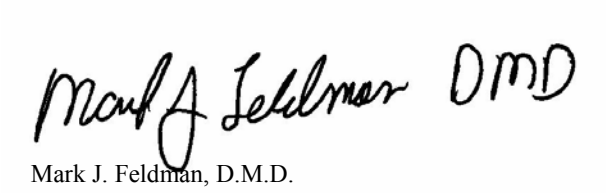
(1) These amounts are net of compensation and travel variances listed separately.
(2) Net of budgeted savings.

Conclusion

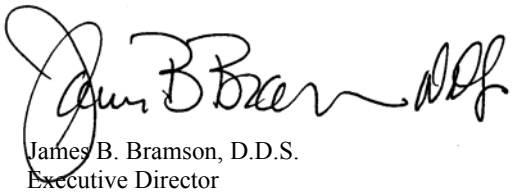
The American Dental Association had another very successful year in 2004. The ADA generated a sizable operating surplus, achieved strong investment returns, continued to strengthen its reserve position, continued to be on schedule and on budget with the headquarters renovation, and added a number of new and innovative programs and services to better address the needs of the profession, members, and public. And all of this was achieved without a dues increase.

2004 was a year which graphically illustrated successful execution of the ADA's long-term financial strategy of dues stabilization. The strengthening of reserves with a $3.8 million surplus and strong investment performance allowed for the funding of the budgeted $1.1 million deficit for 2005 from reserves with no dues increase for the second consecutive year. The Association is well positioned to develop a 2006 budget which is consistent with the dues stabilization strategy.

The ADA's finances will be discussed at the Reference Committee on the Budget, Business and Administrative Matters scheduled for the annual meeting in Philadelphia. 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

Report of Independent Certified Public Accountants

The Board of Trustees
American Dental Association

We have audited the accompanying consolidated statements of financial position of American Dental Association and subsidiaries as of December 31, 2004 and 2003, and the related consolidated statements of activities and cash flows for the years then ended. These financial statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America as established by the Auditing Standards Board of the American Institute of Certified Public Accountants. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of American Dental Association and subsidiaries as of December 31, 2004 and 2003, and the consolidated results of their operations and their consolidated cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole of the American Dental Association and subsidiaries. The consolidating information included in Schedules 1 through 3 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the 2004 consolidated financial statements taken as a whole.

GRANT THORNTON LLP

Chicago, Illinois
February 18, 2005

American Dental Association and Subsidiaries

Consolidated Statements of Financial Position

December 31, 2004 and 2003

	2004	2003
ASSETS		
Cash and cash equivalents	$ 5,262,828	7,845,560
Receivables, net of allowance of $258,000 in 2004 and $241,036 in 2003 (Note 2)	5,159,358	4,769,461
Deferred taxes (Note 6)	83,287	278,017
Income tax refund receivable	--	18,884
Inventories, net of reserves of $352,917 in 2004 and $236,769 in 2003	1,981,215	1,765,396
Marketable securities, at market (Note 3)	87,872,483	75,664,623
Property and equipment, net (Note 4)	51,333,392	47,824,001
Funds held for deferred compensation (Note 5)	4,845,762	4,491,108
Prepaid pension (Note 7)	2,952,631	2,166,573
Prepaid expenses and other assets (Note 7)	2,706,602	2,764,258
TOTAL ASSETS	$ 162,197,558	147,587,881
LIABILITIES AND NET ASSETS		
Liabilities:		
Accounts payable and other accrued liabilities	$ 16,631,036	16,748,236
Income taxes payable	174,791	34,833
Deferred revenues	8,516,139	9,959,986
Liability for deferred compensation (Note 5)	4,845,762	4,491,108
Minimum pension liability	3,476,568	4,175,935
TOTAL LIABILITIES	33,644,296	35,410,098
Net assets (Note 8):		
Unrestricted	115,399,353	100,146,755
Temporarily restricted	10,819,700	9,742,279
Permanently restricted	2,334,209	2,288,749
TOTAL NET ASSETS	128,553,262	112,177,783
TOTAL LIABILITIES AND NET ASSETS	$ 162,197,558	147,587,881

See accompanying notes to consolidated financial statements.

American Dental Association and Subsidiaries

Consolidated Statements of Activities

Years Ended December 31, 2004 and 2003

	2004	2003
REVENUES		
Membership dues	$ 51,009,805	50,895,913
Advertising	7,456,065	7,261,278
Rental income	4,033,171	3,671,676
Publication and product sales	8,835,647	10,281,172
Testing and accreditation fees	8,142,786	7,100,504
Meeting and seminar income	9,851,756	9,582,771
Grants, contributions and sponsorships (including temporarily restricted contributions of $2,275,842 in 2004 and $2,196,457 in 2003 and permanently restricted contributions of $45,460 in 2004 and $91,293 in 2003)	5,658,574	5,068,705
Royalties (Note 9)	7,959,716	10,802,896
Investment income (including temporarily restricted income of $898,377 in 2004 and $1,278,747 in 2003)	7,405,182	10,526,817
Other income (including temporarily restricted income of $1,002,379 in 2004 and $5,038 in 2003) (Note 10)	6,138,562	1,591,711
TOTAL REVENUES	116,491,264	116,783,443
EXPENSES		
Staff compensation, taxes and benefits (Note 7)	46,465,656	43,926,146
Printing, publication and marketing	15,172,167	14,620,255
Meeting expenses	2,759,140	3,953,062
Travel expenses	5,460,774	5,285,019
Professional services	9,532,451	9,801,435
Office expenses	5,027,119	4,903,635
Facility and utility expenses	3,964,444	3,919,942
Grants and awards	2,129,074	1,634,643
Royalty expenses (Note 9)	728,437	924,374
Depreciation and amortization	6,208,312	5,600,028
Bank and credit card fees	476,827	547,277
Other expenses	1,553,309	1,313,482
TOTAL EXPENSES	99,477,710	96,429,298
Net income before income tax	17,013,554	20,354,145
Income tax (expense) benefit (Note 6)	(1,337,442)	78,567
Net income	15,676,112	20,432,712
Decrease in minimum pension liability (Note 7)	699,367	3,099,054
Increase in net assets	16,375,479	23,531,766
Net assets at beginning of year	112,177,783	88,646,017
Net assets at end of year	$ 128,553,262	112,177,783

See accompanying notes to consolidated financial statements.

American Dental Association and Subsidiaries

Consolidated Statements of Cash Flows

Years Ended December 31, 2004 and 2003

	2004	2003
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase in net assets	$ 16,375,479	23,531,766
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	6,208,312	5,600,028
Decrease in minimum pension liability	(699,367)	(3,099,054)
Deferred income tax expense (benefit)	194,730	(152,928)
Unrealized appreciation in market value of marketable securities	(2,669,256)	(8,762,722)
Net realized gain on sale of marketable securities	(3,463,495)	(285,839)
Gain on sale of property and equipment	(4,650)	(6,250)
Provision for uncollectible loans receivable	7,000	14,201
Contributions received for long-term purposes	(45,460)	(91,293)
Changes in assets and liabilities:		
Receivables, net	(396,668)	338,550
Income tax refund receivable	18,884	97,300
Inventories, net	(215,819)	(124,950)
Prepaid pension	(786,058)	(481,063)
Prepaid expenses and other assets	57,656	(272,025)
Accounts payable and accrued liabilities	(117,200)	227,408
Income taxes payable	139,958	26,583
Deferred revenues	(1,443,847)	(612,376)
Net cash provided by operating activities	13,160,199	15,947,336
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of marketable securities	(64,310,184)	(60,434,592)
Sale and maturity of marketable securities	58,235,075	52,265,606
Loan disbursements	(10,000)	(10,000)
Loan repayments	9,771	2,508
Acquisitions of property and equipment	(9,718,813)	(10,011,290)
Proceeds from sale of property and equipment	5,760	6,250
Net cash used by investing activities	(15,788,391)	(18,181,518)
CASH FLOWS FROM FINANCING ACTIVITIES		
Contributions received for long-term purposes	45,460	91,293
Net decrease in cash and cash equivalents	(2,582,732)	(2,142,889)
Cash and cash equivalents at beginning of year	7,845,560	9,988,449
Cash and cash equivalents at end of year	$ 5,262,828	7,845,560
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid during the year for income taxes	$ 1,046,000	60,450

See accompanying notes to consolidated financial statements.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 2004 and 2003

1. Significant Accounting Policies

Basis of Presentation: The American Dental Association (Association) is organized as an association of members of the dental profession, residing primarily in the United States of America and is designed, as its corporate purpose states, "to encourage the improvement of the health of the public and to promote the art and science of dentistry".

The accompanying consolidated financial statements include the accounts of the Operating and Reserve Divisions of the Association, the American Dental Political Action Committee (ADPAC), the American Dental Association Foundation (ADAF), the Association's wholly-owned not-for-profit real estate corporation, American Dental Real Estate Corporation (ADREC) and the Association's wholly-owned for-profit subsidiary, ADA Business Enterprises, Inc. (ADABEI).

ADPAC promotes the Association's political and legislative agenda.

ADAF was organized to operate exclusively for charitable, scientific and educational purposes.

ADREC was organized for the exclusive purpose of holding title to the Washington, DC Office building, collecting rental income thereon, and remitting the net income to the Association. ADREC intends to hold the property for continued use.

ADABEI manages the for-profit activities organized by the Association. The business and financial services division of ADABEI primarily offers a range of financial services to Association members in conjunction with Citibank USA, a Citigroup affiliate, and various other financial service providers under the title of ADA Member Advantage. The publishing division of ADABEI performed certain publishing functions for the publications of the Association, including *JADA* and *ADA News*. Effective July 1, 2003 the publishing division of ADABEI transferred to the Association.

All significant intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates: In preparing financial statements in conformity with accounting principles generally accepted in the United States of America, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents: Cash equivalents at December 31, 2004 and 2003 consist primarily of interest bearing deposits under overnight repurchase agreements. The Association, ADPAC, ADAF, ADREC and ADABEI each maintain their cash balances in financial institutions which at times may exceed federally insured limits. The Association, ADPAC, ADAF, ADREC and ADABEI have not experienced any losses in such accounts and believe they are not exposed to any significant credit risk on cash.

Receivables: The allowance for doubtful receivables is determined after considering a number of factors, including the length of time receivables are past due, the Association's previous loss history, the customer's current ability to pay its obligations and the condition of the general economy as a whole. Uncollectible accounts are written off, and payments subsequently received on such receivables are credited to the allowance for doubtful receivables.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 2004 and 2003 (continued)

Marketable Securities: Investments in marketable securities are carried at fair value based on quoted market prices. Realized and unrealized investment gains and losses are included within investment income in the accompanying consolidated financial statements. Net realized capital gains or losses on sales are calculated based on the first-in, first-out cost of securities sold.

Marketable securities held in the Operating Division are available for current use while marketable securities held in the Reserve Division are not intended for current use. Reserve Division assets may be used for operations upon approval of the Board of Trustees, with subsequent reporting to the Association's House of Delegates. Investment expenses of $120,073 and $117,729 in 2004 and 2003, respectively, are included in professional services in the accompanying consolidated financial statements.

Inventories: Inventories, consisting principally of salable educational materials and supplies, are carried at the lower of cost or market (net realizable value). Cost is primarily determined using the first-in, first-out method.

Property and Equipment: Property and equipment are stated at cost, less accumulated depreciation and amortization. Depreciation is computed on the straight-line method once assets are put into service over the estimated useful lives of the assets, which are as follows:

Buildings	30-55 years
Building improvements	7-20 years
Furniture, equipment and libraries	3-20 years

Tenant leasehold improvements are amortized over the shorter of their estimated useful lives or the remaining term of the lease.

Deferred Compensation: Investments held for deferred compensation are carried at market value and are not available for current use.

Revenue and Expense Recognition: Membership dues and assessments are recognized as income during the membership year, which ends on December 31. Amounts received in advance are deferred to the subsequent year. Unearned membership dues and assessments, which have been included in deferred revenues in the accompanying consolidated financial statements, amounted to approximately $6,109,000 and $7,554,000 at December 31, 2004 and 2003, respectively.

Periodical subscriptions are recognized as revenue over the terms of the subscriptions. Subscriptions paid in advance are recorded as deferred revenue. Advertising revenue and direct publication costs are recognized in the period the related publication is issued.

Rental income from the Association's Headquarters Building and Washington, DC Office Building is recorded as revenue when earned.

Testing fees are recognized as income when the related examinations are administered.

Contributions, which are defined as non-reciprocal transfers, are recognized as revenues in the period pledged or received and classified according to the existence or absence of donor-imposed restrictions. When a donor restriction has been satisfied by incurring expenses consistent with the designated purpose, temporarily restricted net assets are reclassified to unrestricted net assets for reporting of related expenses.

Corporate grants that do not constitute contributions are recognized as income when costs of the related programs or projects are incurred. Corporate grants received but not yet expended are reported as deferred revenues. Grants to other organizations are recorded as expense when authorized by the Board of Trustees.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 2004 and 2003 (continued)

Pension Costs: Pension costs are determined under the projected unit credit cost method. This method determines the present value of benefits accrued to date under the provisions of the pension plan and ignores any further benefit accruals.

Income Taxes: Deferred taxes are established for temporary differences between the financial reporting basis and the tax basis of assets and liabilities. Deferred taxes are based upon enacted tax rates, which would apply during the period in which taxes become payable or recoverable, and the adjustment of cumulative deferred taxes for any changes in the tax rate.

Net Assets: Net assets subject to donor-imposed stipulations are classified as temporarily or permanently restricted net assets while net assets not subject to such restrictions are classified as unrestricted net assets. If a restriction is fulfilled in the same time period in which the contribution is received, the Association reports the support as unrestricted.

Reclassifications: Certain 2003 amounts have been reclassified to conform to the 2004 presentation.

2. Receivables

Receivables at December 31, 2004 and 2003 consist of the following:

	2004	2003
Trade receivables	$ 2,989,961	2,778,456
Royalties receivable	1,611,901	1,547,950
Grants and contracts receivable	660,176	363,977
Loans receivable	116,161	115,932
Interest and dividends receivable	1,313	73,988
Other	37,846	130,194
Total	5,417,358	5,010,497
Less allowance for doubtful receivables	(258,000)	(241,036)
Net accounts receivable	$ 5,159,358	4,769,461

Changes in the Association's allowance for doubtful receivables for the years ended December 31, 2004 and 2003 are as follows:

	2004	2003
Beginning balance	$ 241,036	310,183
Provision for uncollectible accounts	31,340	101,340
Accounts written-off	(16,678)	(178,793)
Recoveries	2,302	8,306
Ending balance	$ 258,000	241,036

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 2004 and 2003 (continued)

3. Marketable Securities

Marketable securities at December 31, 2004 and 2003 consisted of the following:

	2004		2003	
	Cost	Market	Cost	Market
Money market funds	$ 24,004,481	24,234,170	23,553,222	23,834,002
Certificates of deposit	--	--	363,076	369,911
Bonds and bond funds	11,104,815	11,100,097	6,785,837	6,978,311
Equities and equity funds	41,485,580	52,538,216	34,947,410	43,054,488
U.S. Government obligations	--	--	1,406,698	1,427,911
	$ 76,594,876	87,872,483	67,056,243	75,664,623

The fair value of marketable securities held in the Reserve Division amounted to $49,811,898 and $40,238,065 at December 31, 2004 and 2003, respectively.

Investment income for the years ended December 31, 2004 and 2003 consisted of the following:

	2004	2003
Interest and dividends	$ 1,272,135	1,478,256
Net realized and unrealized appreciation in market value of marketable securities	6,133,047	9,048,561
	$ 7,405,182	10,526,817

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 2004 and 2003 (continued)

4. Property and equipment

Property and equipment at December 31, 2004 and 2003 consisted of the following:

	2004			2003		
	Chicago, IL	Washington, DC	Total	Chicago, IL	Washington, DC	Total
Land	$ 712,113	3,030,000	3,742,113	712,113	3,030,000	3,742,113
Building	12,381,169	9,602,195	21,983,364	12,381,169	9,602,195	21,983,364
Building improvements	50,581,269	725,704	51,306,973	45,534,191	685,047	46,219,238
Furniture and equipment	28,198,817	1,755,803	29,954,620	24,377,100	1,755,803	26,132,903
Film and book libraries	348,435	--	348,435	295,803	--	295,803
Tenant leasehold improvements	733,132	1,101,514	1,834,646	326,440	885,196	1,211,636
	92,954,935	16,215,216	109,170,151	83,626,816	15,958,241	99,585,057
Less accumulated depreciation and amortization	50,522,653	7,314,106	57,836,759	45,097,578	6,663,478	51,761,056
	$42,432,282	8,901,110	51,333,392	38,529,238	9,294,763	47,824,001

Building improvements at December 31, 2004 and 2003, include the following costs related to renovation and asbestos abatement for the Association's Headquarters building within the Capital Improvement and ADA Renovation Programs:

	2004		2003	
	Capital Improvement Program	ADA Renovation Program	Capital Improvement Program	ADA Renovation Program
Asbestos abatement	$ 5,776,991	2,404,309	5,303,258	1,344,978
Remodeling	15,882,591	17,866,823	15,309,953	13,531,700
	21,659,582	20,271,132	20,613,211	14,876,678
Less accumulated depreciation	10,722,981	2,594,716	9,597,084	1,272,323
	$10,936,601	17,676,416	11,016,127	13,604,355

The Capital Improvement Program encompasses remodeling and asbestos abatement activities primarily on tenant space funded by a four-year $55 dues increase for Association members, effective from 1993 to 1996, relating to this endeavor. The Capital Improvement Account within the Operating Division was established to classify revenues, expenses, assets and liabilities restricted to this activity.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 2004 and 2003 (continued)

The ADA Renovation Program, approved by the 2000 House of Delegates, extends the remodeling activities to 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 transferred from the Capital Improvement Account in 2000 with another $1.5 million transferred from the Building Fund in 2001. Also, $1.0 million of the annual budgeted provision from the Operating Account to the Building Fund was redirected to the Renovation project beginning in 2002. On January 1, 2004 the Building Fund was eliminated and monies were transferred to the ADA's operating account. $1.0 million was directed from the operating account to the renovation project in 2004. 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.

The Association leases portions of both the Headquarters Building and the Washington, DC Office Building to unrelated parties under operating leases with varying terms. These amounts may be adjusted upon renewal of the leases. Minimum future rentals to be earned from leases currently in effect as of December 31, 2004 are:

2005	$ 3,908,784
2006	3,733,353
2007	3,385,970
2008	3,068,161
2009	2,832,147
Thereafter	9,068,592
	$ 25,997,007

Building expenses include the cost of facilities occupied by the Association, as well as those costs related to other tenants.

5. Deferred Compensation

Pursuant to agreements between the Association and certain officers and employees of the Association and its affiliates, portions of their compensation have been retained by the Association and invested as directed by those participants. The assets are owned by the Association until distributed to the participants after termination of employment or services.

6. Income Taxes

The Association, ADAF and ADREC have received favorable determination letters from the Internal Revenue Service stating that they are exempt from taxation on income related to their exempt purposes under Section 501(a) of the Internal Revenue Code as organizations described in sections 501(c)(6), 501(c)(3) and 501(c)(2), respectively. As exempt organizations, the Association, ADAF and ADREC are subject to federal and state income taxes on income determined to be unrelated business taxable income. ADPAC is exempt from federal income taxes under section 527 of the Internal Revenue Code, except on net investment income. The income of the Association's for-profit subsidiary, ADABEI, determined separately, is also subject to federal and state income taxes.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 2004 and 2003 (continued)

The Association files consolidated income tax returns with ADREC. ADABEI, ADPAC and ADAF file their own tax returns.

Income tax expense (benefit) for the years ended December 31, 2004 and 2003 is as follows:

	2004	2003
Current:		
Federal	$ 928,521	64,513
State	214,191	9,848
Current income tax expense	1,142,712	74,361
Deferred:		
Federal	158,341	(123,857)
State	36,389	(29,071)
Deferred income tax expense (benefit)	194,730	(152,928)
Income tax expense (benefit)	$ 1,337,442	(78,567)

Income tax expense differs from the amount computed by applying the statutory federal income tax rate of 34% to income before income tax expense primarily because a significant portion of consolidated income is exempt from income tax.

Deferred taxes receivable at December 31, 2004 and 2003 consisted of:

	2004	2003
Deferred tax assets resulting from:		
Net operating loss carryforward	$ --	221,940
Excess of the tax basis over book basis of postretirement health benefits	95,529	71,868
	95,529	293,808
Deferred tax liability resulting from:		
Excess of book basis over tax basis of furniture and equipment	(12,242)	(15,791)
Deferred tax assets, net	$ 83,287	278,017

ADREC's non-exempt operating results are included in the income tax returns of the Association. Any federal or state income taxes owned on ADREC's unrelated business activities in 2004 and 2003 are included in the joint return with the Association. Under the terms of a formal intercompany tax sharing agreement, the Association is allowed to utilize the net operating loss derived from ADREC's operations without payment of the tax benefit to ADREC. For the years ended December 31, 2004 and 2003, the Association utilized $572,791 and $1,683,218 of the net operating loss, respectively. No net operating loss carryforwards remain at December 31, 2004.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 2004 and 2003 (continued)

7. Employee Benefit Plans

Defined Benefit Plan and Supplemental Plan: The Association sponsors a noncontributory defined benefit pension plan, which covers substantially all employees of the Association, its subsidiaries and affiliates meeting certain eligibility requirements. Generally, the Association's funding policy is to contribute annually to the pension plan such amounts that may be deducted for Federal income tax purposes. Retirement benefit payments are based on years of credited service, average compensation during the five years of employment that produce the highest average, and the average Social Security limit at employment termination date.

At December 31, 2004 and 2003 the accumulated benefit obligation exceeds the fair value of plan assets, requiring the recognition of a minimum pension liability. This liability adjustment affects net assets but is not reflected in net income and does not impact pension funding. The decrease in the minimum pension liability was $699,367 and $3,099,054 at December 31, 2004 and 2003, respectively.

Pursuant to agreements between the Association and a certain prior employee, the Association also maintains a frozen unfunded supplemental retirement income plan funded through Association general assets. Investments designated for the supplemental plan of $606,703 and $672,276 at December 31, 2004 and 2003, respectively, are carried at fair value and included in prepaid expenses and other assets.

The Internal Revenue Service has informed the Employees' Retirement Trust administration that the plan is qualified under provisions of the Code and, therefore, the related trust is exempt from federal income taxes. The Employees' Supplemental Trust is a non-qualified plan and as such is not exempt from federal income taxes.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 2004 and 2003 (continued)

The following table sets forth the plans' funded status and amounts recognized in the Association's consolidated financial statements:

	2004			
	Employees' Retirement Trust	Employees' Supplemental Trust	Total	2003 Total
Projected benefit obligation at December 31	$ 64,734,877	928,868	65,663,745	57,444,079
Plan assets at fair value	54,031,752	--	54,031,752	46,169,657
Funded status	$ (10,703,125)	(928,868)	(11,631,933)	(11,274,422)
Accumulated benefit obligation	$ 53,626,821	928,868	54,555,689	48,179,019
Prepaid pension (accrued pension liability)	$ 3,462,408	(509,777)	2,952,631	2,166,573
Minimum pension liability	$ (3,476,568)	--	(3,476,568)	(4,175,935)
Benefit cost	$ 4,038,232	68,506	4,106,738	4,673,665
Employer contribution	$ 4,800,000	92,796	4,892,796	5,154,728
Benefits paid	$ 2,302,460	92,796	2,395,256	2,249,232
Weighted average assumptions as of December 31:				
Discount rate	6.75%	6.75%	6.75%	7.00%
Expected return on plan assets	8.00%	8.00%	8.00%	8.00%
Rate of compensation increase	4.50%	4.50%	4.50%	4.50%

The discount rate is determined each year as of the measurement date, based on a review of interest rates associated with long-term high quality corporate bonds. The discount rate determined on each measurement date is used to calculate the benefit obligation as of that date, and is also used to calculate the net periodic benefit cost for the upcoming plan year.

The pension fund's expected return on assets assumption is derived from a review of actual historical returns achieved by the pension trust and anticipated future long-term performance of individual asset classes with consideration given to the appropriate investment strategy. While the method gives appropriate consideration to recent trust performance and historical returns, the assumption represents a long-term prospective return. The expected return on plan assets determined on each measurement dates is used to calculate the net periodic benefit cost for the upcoming plan year.

The actual allocations for the pension assets as of December 31, 2004 and 2003, and target allocations by asset category, are as follows:

Asset Category	2004	2003	Target Allocation
Fixed income	28%	27%	30%
Equity			
Small cap	14%	14%	14%
Large cap value	22%	22%	21%
Large cap growth	20%	21%	21%
International	16%	16%	14%
	100%	100%	100%

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 2004 and 2003 (continued)

Pension assets are allocated with a goal to achieve diversification between and within various asset classes. The target asset allocations are expected to earn an average annual rate of return of approximately 8% measured over a planning horizon of 20 years with a reasonable and acceptable level of risk. Actual allocation percentages will vary from target allocation percentages based upon short term fluctuations in cash flows and benefit payments.

Domestic equity includes securities of domestic companies listed on the US exchanges or traded OTC, diversified across industry and individual holdings. International equity includes securities primarily of companies located outside the US diversified across countries and industries. Fixed income refers to a diversified portfolio of marketable debt instruments with an average quality rating of at least AA or equivalent.

Required pension contributions under Employee Retirement Income Security Act (ERISA) regulations will be approximately $4,500,000 in 2005.

The table below reflects the total pension benefits expected to be paid in each of the next five years and in the aggregate for the five years thereafter.

2005	$ 1,451,103
2006	$ 1,690,808
2007	$ 2,207,461
2008	$ 2,697,508
2009	$ 2,915,553
2010-2014	$ 22,151,620

401(k) Plan: The Association has a savings and retirement plan for all eligible employees. The Association matches 50% of contributed amounts up to a maximum of $500 per participant each year. The Association's contributions under this plan were $185,557 in 2004 and $183,070 in 2003.

The Internal Revenue Service has informed the Savings Plan administrator that the plan is qualified under provisions of the Code and, therefore, the related trust is exempt from federal income taxes.

Executive Parity Plan: The Association has established the Executive Parity Plan which compensates executives of the Association and its subsidiaries who suffered restrictions in their pension benefits beginning in 1994 as a result of the Omnibus Budget Reconciliation Act. This is a deferred compensation arrangement which allows the Compensation Committee of the Board of Trustees to set aside, on an annual basis, a specified cash amount for those individuals who suffered a benefit loss during the year, to be paid upon vesting. Awards totaling $353,850 and $338,068 (reflected in accrued liabilities) at December 31, 2004 and 2003, respectively, were granted, after payments totaling $484,436 in 2004 and $559,898 in 2003 were made to participants.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 2004 and 2003 (continued)

Postretirement Health Plan: The Association sponsors a contributory defined benefit postretirement health plan, which covers substantially all employees of the Association, its subsidiaries and affiliates. The plan provides both medical and dental benefits.

The following table sets forth the plan's funded status:

	2004	2003
Benefit obligation at December 31	$ (9,060,949)	(7,512,064)
Plan assets at fair value	--	--
Funded status	$ (9,060,949)	(7,512,064)
Accrued postretirement benefit cost	$ (5,858,889)	(5,025,120)
Benefit cost	$ 1,128,758	982,657
Employer contribution	$ 294,989	282,108
Plan participant contributions	--	--
Benefits paid	$ 294,989	282,108
Weighted average assumptions used to determine obligations at December 31:		
Discount rate	6.75%	7.00%
Weighted average assumptions used to determine net periodic benefit cost for the years ended December 31:		
Discount rate	7.00%	7.50%
Health care cost trend rate	6.00%	6.00%
Assumed health care cost trend rates at December 31:		
Health care cost trend rate assumed next year	15.00%	6.00%
Ultimate trend rate	6.00%	6.00%
Year that trend reached ultimate rate	2007	2004

The Association expects to contribute approximately $300,000 to the postretirement health plan in 2005.

The table below reflects the postretirement health payments expected in each of the next five years and in the aggregate for the five years thereafter:

2005	$ 358,924
2006	$ 320,292
2007	$ 339,765
2008	$ 371,415
2009	$ 393,726
2010-2014	$ 2,570,044

Notes to Consolidated Financial Statements, December 31, 2004 and 2003 (continued)

8. Net Assets

The following activity impacted unrestricted, temporarily restricted and permanently restricted net assets during 2004 and 2003:

	2004				2003			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Revenues	$112,269,206	4,176,598	45,460	116,491,264	113,265,663	3,480,242	91,293	116,837,198
Net assets released from restrictions	3,099,177	(3,099,177)	--	--	2,041,983	(2,041,983)	--	--
Total revenues	115,368,383	1,077,421	45,460	116,491,264	115,307,646	1,438,259	91,293	116,837,198
Expenses, including income taxes	100,815,152	--	--	100,815,152	96,404,486	--	--	96,404,486
Net income	14,553,231	1,077,421	45,460	15,676,112	18,903,160	1,438,259	91,293	20,432,712
Decrease in minimum pension liability	699,367	--	--	699,367	3,099,054	--	--	3,099,054
Increase in net assets	15,252,598	1,077,421	45,460	16,375,479	22,002,214	1,438,259	91,293	23,531,766
Net assets at beginning of year	100,146,755	9,742,279	2,288,749	112,177,783	78,144,541	8,304,020	2,197,456	88,646,017
Net assets at end of year	$115,399,353	10,819,700	2,334,209	128,553,262	100,146,755	9,742,279	2,288,749	112,177,783

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 2004 and 2003 (continued)

8. Net Assets (continued)

Temporarily restricted net assets at December 31, 2004 and 2003 were available for the following purposes:

	2004	2003
Trusts and endowments	$ 2,179,763	1,914,722
Extramural programs	328,211	429,351
Research	84,497	102,423
Awards	251,818	235,998
Education	976,185	176,144
Access	590,154	316,274
Political and legislative	1,092,939	1,388,998
Relief program	5,316,133	5,178,369
	$ 10,819,700	9,742,279

Temporarily restricted trusts and endowments include funds restricted by donors for periodontal research, public education in dental health and memorial commemoration.

Temporarily restricted net assets were released from donor restrictions during 2004 and 2003 by incurring expenses satisfying the restricted purposes as follows:

	2004	2003
Trusts and endowments	$ 5,505	7,421
Extramural programs	228,209	216,887
Research	111,015	183,109
Awards	17,101	86,261
Education	547,887	165,371
Access	223,842	27,647
Political and legislative	1,608,775	892,858
Relief program	356,843	462,429
	$ 3,099,177	2,041,983

Permanently restricted net assets at December 31, 2004 and 2003 totaled $2,334,209 and $2,288,749, respectively. Earnings on these net assets are restricted by donors for children's oral health and education in dental entrepreneurship and leadership.

9. Royalties

Effective, April 1, 2003, the Association and ADABEI renewed agreements with Citibank to continue the credit card business under the ADA Member Advantage Program. In connection with this renewal, the Association received an upfront payment of $4.5 million from Citibank for use of the ADA name and logos. Distributions of $387,916 from these funds were made to endorsing state dental societies in 2003.

10. Other Income

In settlement of a class action lawsuit between the Association and Aetna, Inc. as well as Aetna's subsidiaries (collectively Aetna), the United States District Court for the Southern District of Florida approved an agreement in 2004 that included a payment of approximately $4.5 million by Aetna to the Foundation. This payment, included in other income, consists of a direct payment of $1 million to the Foundation, plus approximately $3.5 million representing class members' donations of their shares of the settlement fund to the Foundation. The agreement also mandates that Aetna undertake various business changes related to dental insurance claims processing.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 2004 and 2003 (continued)

11. Expenses by Functional Classification

The following table summarizes the costs of providing various programs and activities on a functional basis:

	2004	2003
Administration and Policy	$ 9,235,094	8,833,092
Legal Affairs	2,045,556	2,260,525
Government Affairs	3,377,804	3,358,490
Communications	3,332,363	3,156,532
Membership and Dental Society Services	4,362,531	4,050,219
Conference and Meeting Services	7,336,179	7,928,064
Finance and Operations	3,282,826	3,267,624
Headquarters Building	3,975,873	3,845,020
Salable Materials	4,407,758	4,375,045
Central Administration	17,226,788	15,160,247
Information Technology and Standards	5,207,230	4,647,980
Dental Practice	3,658,947	3,461,759
Health Policy Resources Center	1,998,597	1,662,806
Education	8,095,892	7,756,948
Science	2,952,908	3,017,753
ADA Publishing	7,439,477	3,971,643
Grant from ADA to ADAF	2,497,237	2,345,560
Carryforwards Expended	--	239,066
	90,433,060	83,338,373
Capital Improvement Account	1,125,898	1,173,743
ADA Renovation Program	1,337,500	1,007,818
Eliminations of intercompany activity -		
Grant from ADA to ADAF	(2,497,237)	(2,345,560)
Headquarters building management office rent expense	(31,392)	(31,392)
	90,367,829	83,142,982
ADPAC	1,608,775	892,858
ADREC	1,303,554	1,313,235
ADAF	6,374,074	5,873,627
ADABEI	2,320,988	7,033,451
Eliminations of intercompany activity -		
Legal expenses	(44,672)	(54,563)
ADABEI rental charges	(67,280)	(164,073)
Accounting fees charged to ADAF	(27,000)	(27,000)
Printing expenses	(189,148)	(265,979)
Advertising and promotion	(15,000)	--
Meeting expenses	(17,970)	--
Donation from ADABEI to ADAF	(60,000)	(60,000)
Other contributions from ADA to ADAF	--	(75,014)
Overhead recovery and ADABEI publishing division royalty	(738,998)	(878,793)
ADABEI publishing division contract fee	--	(380,000)
	$ 100,815,152	96,350,731

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 2004 and 2003 (continued)

12. Commitments and Contingencies

The Association is involved in various asserted and unasserted claims incidental to the normal conduct of its business. In the opinion of management and the Association's legal counsel, the ultimate disposition of these matters will not have a material adverse effect on the consolidated results of operations or financial position of the Association.

American Dental Association and Subsidiaries
CONSOLIDATING STATEMENT OF FINANCIAL POSITION
December 31, 2004

	General Fund												
	Operating Division				Reserve Division								
	Operating Account	Capital Improvement Account	ADA Renovation Program	Total	Capital Formation Account	Investment Account	Total General Fund	ADPAC	ADREC	ADAF	ADABEI	Eliminations	Total
ASSETS													
Cash and cash equivalents	$ 2,200,629	-	-	2,200,629	-	-	2,200,629	1,095,337	397,049	687,403	882,410	-	5,262,828
Receivables, net	3,885,329	-	-	3,885,329	-	-	3,885,329	-	2,195	735,956	535,878	-	5,159,358
Due from (to) affiliates	(186,824)	(52,288)	475,386	236,274	-	587,235	823,509	-	(49,099)	(789,886)	15,476	-	-
Deferred taxes	57,588	-	-	57,588	-	-	57,588	-	-	-	25,699		83,287
Inventories, net	1,981,215	-	-	1,981,215	-	-	1,981,215	-	-	-	-	-	1,981,215
Marketable securities, at market	9,278,204	2,996,048	1,968,247	14,242,499	-	49,811,898	64,054,397	-	-	21,118,406	2,699,680	-	87,872,483
Investment in subsidiaries	-	-	-	-	10,250,807	-	10,250,807	-	-	-	-	(10,250,807)	-
Property and equipment, net	13,615,742	10,936,601	17,676,416	42,228,759	3,030,000	-	45,258,759	-	5,871,110	150,771	52,752	-	51,333,392
Funds held for deferred compensation	4,845,762	-	-	4,845,762	-	-	4,845,762	-	-	-	-	-	4,845,762
Prepaid pension	2,952,631	-	-	2,952,631	-	-	2,952,631	-	-	-	-	-	2,952,631
Prepaid expenses and other assets	2,601,172	-	-	2,601,172	-	-	2,601,172	-	84,022	21,408	-	-	2,706,602
Total Assets	$ 41,231,448	13,880,361	20,120,049	75,231,858	13,280,807	50,399,133	138,911,798	1,095,337	6,305,277	21,924,058	4,211,895	(10,250,807)	162,197,558
LIABILITIES AND NET ASSETS													
Liabilities:													
Accounts payable and accrued liabilities	$ 7,917,066	43,226	1,645,448	9,605,740	-	6,404,660	16,010,400	-	129,207	397,467	93,962	-	16,631,036
Income taxes payable	129,197	-	-	129,197	-	-	129,197	2,398	-	-	43,196	-	174,791
Deferred revenues	8,035,671	-	366,931	8,402,602	-	-	8,402,602	-	-	113,537	-	-	8,516,139
Liability for deferred compensation	4,845,762	-	-	4,845,762	-	-	4,845,762	-	-	-	-	-	4,845,762
Minimum pension liability	3,476,568	-	-	3,476,568	-	-	3,476,568	-	-	-	-	-	3,476,568
Total Liabilities	24,404,264	43,226	2,012,379	26,459,869	-	6,404,660	32,864,529	2,398	129,207	511,004	137,158	-	33,644,296
Net assets:													
Common stock	-	-	-	-	-	-	-	-	100	-	100,100	(100,200)	-
Additional paid-in capital	-	-	-	-	-	-	-	-	14,234,005	-	500,000	(14,734,005)	-
Unrestricted	16,827,184	13,837,135	18,107,670	48,771,989	13,280,807	43,994,473	106,047,269	-	(8,058,035)	9,352,084	3,474,637	4,583,398	115,399,353
Temporarily restricted	-	-	-	-	-	-	-	1,092,939	-	9,726,761	-		10,819,700
Permanently restricted	-	-	-	-	-	-	-	-	-	2,334,209	-		2,334,209
Total Net Assets	16,827,184	13,837,135	18,107,670	48,771,989	13,280,807	43,994,473	106,047,269	1,092,939	6,176,070	21,413,054	4,074,737	(10,250,807)	128,553,262
Total Liabilities and Net Assets	$ 41,231,448	13,880,361	20,120,049	75,231,858	13,280,807	50,399,133	138,911,798	1,095,337	6,305,277	21,924,058	4,211,895	(10,250,807)	162,197,558

American Dental Association and Subsidiaries
CONSOLIDATING STATEMENT OF ACTIVITIES
Year ended December 31, 2004

	General Fund												
	Operating Division				Reserve Division								
	Operating Account	Capital Improvement Account	ADA Renovation Program	Total	Capital Formation Account	Investment Account	Total General Fund	ADPAC	ADREC	ADAF	ADABEI	Eliminations	Total
REVENUES													
Membership dues	$ 47,721,745	-	3,288,060	51,009,805	-	-	51,009,805	-	-	-	-	-	51,009,805
Advertising	7,642,732	-	-	7,642,732	-	-	7,642,732	-	-	-	-	(186,667)	7,456,065
Rental income	2,997,672	-	-	2,997,672	-	-	2,997,672	-	1,134,169	-	-	(98,670)	4,033,171
Publication and product sales	8,729,671	-	-	8,729,671	-	-	8,729,671	-	-	108,457	-	(2,481)	8,835,647
Testing and accreditation fees	8,142,786	-	-	8,142,786	-	-	8,142,786	-	-	-	-	-	8,142,786
Meeting and seminar income	9,825,526	-	-	9,825,526	-	-	9,825,526	-	-	44,200	-	(17,970)	9,851,756
Grants, contributions and sponsorships	1,578,376	-	-	1,578,376	-	-	1,578,376	1,306,070	-	5,346,365	-	(2,572,237)	5,658,574
Royalties	4,893,578	-	-	4,893,578	-	-	4,893,578	-	-	661,671	2,404,467	-	7,959,716
Investment income (loss)	279,345	64,988	41,833	386,166	(18,725)	5,527,573	5,895,014	6,646	-	1,450,350	34,447	18,725	7,405,182
Other income	2,387,870	-	-	2,387,870	1	-	2,387,871	-	2,734	4,528,629	30,000	(810,672)	6,138,562
Total Revenues	**94,199,301**	**64,988**	**3,329,893**	**97,594,182**	**(18,724)**	**5,527,573**	**103,103,031**	**1,312,716**	**1,136,903**	**12,139,672**	**2,468,914**	**(3,669,972)**	**116,491,264**
EXPENSES													
Staff compensation, taxes and benefits	41,904,467	-	-	41,904,467	-	-	41,904,467	-	28,440	3,640,919	915,041	(23,211)	46,465,656
Printing, publication and marketing	14,311,904	-	-	14,311,904	-	-	14,311,904	178,898	-	101,970	801,513	(222,118)	15,172,167
Meeting expenses	2,609,860	-	-	2,609,860	-	-	2,609,860	78,650	-	67,832	2,798	-	2,759,140
Travel expenses	5,171,621	-	-	5,171,621	-	-	5,171,621	-	-	204,474	84,679	-	5,460,774
Professional services	8,426,618	-	15,107	8,441,725	-	-	8,441,725	121,099	51,007	828,804	161,488	(71,672)	9,532,451
Office expenses	4,710,092	-	-	4,710,092	-	-	4,710,092	25,000	6,623	246,138	39,266	-	5,027,119
Facility and utlity expenses	3,441,465	-	-	3,441,465	-	-	3,441,465	-	552,018	-	69,633	(98,672)	3,964,444
Grants and awards	287,935	-	-	287,935	-	-	287,935	1,195,362	-	645,777	60,000	(60,000)	2,129,074
Grant to ADA Foundation	2,497,237	-	-	2,497,237	-	-	2,497,237	-	-	-		(2,497,237)	-
Royalty expenses	728,437	-	-	728,437	-	-	728,437	-	-	-		-	728,437
Depreciation and amortization	3,026,692	1,125,898	1,322,393	5,474,983	-	-	5,474,983	-	650,628	70,451	12,250	-	6,208,312
Bank and credit card fees	472,387	-	-	472,387	-	-	472,387	173	1,968	2,199	100	-	476,827
Other expenses	1,543,511	-	-	1,543,511	-	-	1,543,511	7,229	12,870	565,510	139,976	(715,787)	1,553,309
Total Expenses	**89,132,226**	**1,125,898**	**1,337,500**	**91,595,624**	**-**	**-**	**91,595,624**	**1,606,411**	**1,303,554**	**6,374,074**	**2,286,744**	**(3,688,697)**	**99,477,710**
Net income (loss) before income tax	5,067,075	(1,060,910)	1,992,393	5,998,558	(18,724)	5,527,573	11,507,407	(293,695)	(166,651)	5,765,598	182,170	18,725	17,013,554
Income tax expense	(1,300,834)	-	-	(1,300,834)	-	-	(1,300,834)	(2,364)	-	-	(34,244)	-	(1,337,442)
Net income (loss)	**3,766,241**	**(1,060,910)**	**1,992,393**	**4,697,724**	**(18,724)**	**5,527,573**	**10,206,573**	**(296,059)**	**(166,651)**	**5,765,598**	**147,926**	**18,725**	**15,676,112**
Decrease in minimum pension liability	699,367	-	-	699,367	-	-	699,367		-	-	-	-	699,367
Increase (decrease) in net assets	**4,465,608**	**(1,060,910)**	**1,992,393**	**5,397,091**	**(18,724)**	**5,527,573**	**10,905,940**	**(296,059)**	**(166,651)**	**5,765,598**	**147,926**	**18,725**	**16,375,479**
Net assets at beginning of year	16,896,933	14,898,045	15,115,277	46,910,255	13,299,532	34,931,542	95,141,329	1,388,998	(7,891,384)	15,647,456	3,326,711	4,564,673	112,177,783
Equity transfers	(4,535,357)	-	1,000,000	(3,535,357)	(1)	3,535,358	-	-	-	-	-	-	-
Net assets at end of year	**$ 16,827,184**	**13,837,135**	**18,107,670**	**48,771,989**	**13,280,807**	**43,994,473**	**106,047,269**	**1,092,939**	**(8,058,035)**	**21,413,054**	**3,474,637**	**4,583,398**	**128,553,262**

American Dental Association and Subsidiaries
CONSOLIDATING STATEMENT OF CASH FLOWS
Year ended December 31, 2004

	General Fund												
	Operating Division				Reserve Division								
	Operating Account	Capital Improvement Account	ADA Renovation Program	Total	Capital Formation Account	Investment Account	Total General Fund	ADPAC	ADREC	ADAF	ADABEI	Eliminations	Total
Cash flows from operating activities:													
Increase (decrease) in net assets	$ 4,465,608	(1,060,910)	1,992,393	5,397,091	(18,724)	5,527,573	10,905,940	(296,059)	(166,651)	5,765,598	147,926	18,725	16,375,479
Adjustments to reconcile increase (decrease) in net assets to net cash provided (used) by operating activities:													
Depreciation and amortization	3,026,692	1,125,898	1,322,393	5,474,983	-	-	5,474,983	-	650,628	70,451	12,250	-	6,208,312
Additional minimum pension liability	(699,367)	-	-	(699,367)	-	-	(699,367)	-	-	-	-	-	(699,367)
Deferred income tax expense (benefit)	201,637	-	-	201,637	-	-	201,637	-	-	-	(6,907)	-	194,730
Unrealized (appreciation) depreciation in market value of marketable securities	44,788	466	3,222	48,476	-	(3,719,039)	(3,670,563)	-	-	1,001,307	-	-	(2,669,256)
(Gain) loss on sale of marketable securities	(58,379)	(9,164)	(5,908)	(73,451)	-	(1,302,170)	(1,375,621)	-	-	(2,087,874)	-	-	(3,463,495)
Equity in earnings of subsidiaries	-	-	-	-	18,725	-	18,725	-	-	-	-	(18,725)	-
(Gain) loss on sale of property and equipment	(5,460)	-	-	(5,460)	-	-	(5,460)	-	-	810	-	-	(4,650)
Provision for uncollectible loans receivable	-	-	-	-	-	-	-	-	-	7,000	-	-	7,000
Contributions received for long-term purposes	-	-	-	-	-	-	-	-	-	(45,460)	-	-	(45,460)
Changes in assets and liabilities:													
Receivables, net	(151,741)	-	-	(151,741)	-	-	(151,741)	-	4,679	(253,590)	3,984	-	(396,668)
Income tax refund receivable	-	-	-	-	-	-	-	-	-	-	18,884	-	18,884
Inventories, net	(215,819)	-	-	(215,819)	-	-	(215,819)	-	-	-	-	-	(215,819)
Prepaid pension	(786,058)	-	-	(786,058)	-	-	(786,058)	-	-	-	-	-	(786,058)
Prepaid expenses and other assets	87,379	-	-	87,379	-	-	87,379	-	(27,207)	(2,516)	-	-	57,656
Due from/to affiliated organizations	(528,797)	11,165	97,435	(420,197)	-	(192,280)	(612,477)	-	24,212	348,146	240,119	-	-
Accounts payable and accrued liabilities	(1,874,765)	43,226	1,102,103	(729,436)	-	703,182	(26,254)	-	13,146	(29,969)	(74,123)	-	(117,200)
Income taxes payable	129,197	-	-	129,197	-	-	129,197	(3,574)	-	-	14,335	-	139,958
Deferred revenues	(1,445,315)	-	(91,804)	(1,537,119)	-	-	(1,537,119)	-	-	93,272	-	-	(1,443,847)
Net cash provided (used) by operating activities	**2,189,600**	**110,681**	**4,419,834**	**6,720,115**	**1**	**1,017,266**	**7,737,382**	**(299,633)**	**498,807**	**4,867,175**	**356,468**	**-**	**13,160,199**
Cash flows from investing activities:													
Purchase of marketable securities	(17,254,292)	(56,291)	(4,350,220)	(21,660,803)	-	(5,096,129)	(26,756,932)	-	-	(37,525,167)	(28,085)	-	(64,310,184)
Sale and maturity of marketable securities	19,588,610	991,982	4,324,840	24,905,432	-	543,505	25,448,937	-	-	32,784,138	2,000	-	58,235,075
Loan disbursements	-	-	-	-	-	-	-	-	-	(10,000)	-	-	(10,000)
Loan repayments	-	-	-	-	-	-	-	-	-	9,771	-	-	9,771
Acquisitions of property and equipment	(2,977,733)	(1,046,372)	(5,394,454)	(9,418,559)	-	-	(9,418,559)	-	(256,975)	(43,279)	-	-	(9,718,813)
Proceeds from sale of property and equipment	5,460	-	-	5,460	-	-	5,460	-	-	300	-	-	5,760
Net cash used by investing activities	**(637,955)**	**(110,681)**	**(5,419,834)**	**(6,168,470)**	**-**	**(4,552,624)**	**(10,721,094)**	**-**	**(256,975)**	**(4,784,237)**	**(26,085)**	**-**	**(15,788,391)**
Cash flows from financing activities:													
Contributions received for long-term purposes	-	-	-	-	-	-	-	-	-	45,460	-	-	45,460
Net cash provided by financing activities	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**45,460**	**-**	**-**	**45,460**
Net increase (decrease) in cash and cash equivalents	1,551,645	-	(1,000,000)	551,645	1	(3,535,358)	(2,983,712)	(299,633)	241,832	128,398	330,383	-	(2,582,732)
Cash and equivalents at beginning of year	5,184,341	-	-	5,184,341	-	-	5,184,341	1,394,970	155,217	559,005	552,027	-	7,845,560
Equity transfers	(4,535,357)	-	1,000,000	(3,535,357)	(1)	3,535,358	-	-	-	-	-	-	-
Cash and cash equivalents at end of year	**$ 2,200,629**	**-**	**-**	**2,200,629**	**-**	**-**	**2,200,629**	**1,095,337**	**397,049**	**687,403**	**882,410**	**-**	**5,262,828**

Schedule 3

Report of Independent Certified Public Accountants

The Board of Directors
American Dental Association Foundation

We have audited the accompanying statements of financial position of the American Dental Association Foundation as of December 31, 2004 and 2003, and the related statements of activities and cash flows for the years then ended. These financial statements are the responsibility of the American Dental Association Foundation's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America as established by the Auditing Standards Board of the American Institute of Certified Public Accountants and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the American Dental Association Foundation's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and the significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the American Dental Association Foundation as of December 31, 2004 and 2003, and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

In accordance with *Government Auditing Standards*, we have also issued our report dated February 18, 2005 on our consideration of American Dental Association Foundation's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audits.

Our audits were conducted for the purpose of forming an opinion on the basic financial statements taken as a whole. The accompanying detailed statement of activities for the year ended December 31, 2004 is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and, in our opinion, is fairly stated, in all material respects, in relation to the basic financial statements taken as a whole.

GRANT THORNTON LLP

Chicago, Illinois
February 18, 2005

American Dental Association Foundation

Statements of Financial Position

December 31, 2004 and 2003

	2004	2003
ASSETS		
Cash	$ 687,403	559,005
Receivables	662,795	409,205
Loans receivable, net (Note 3)	73,161	79,932
Marketable securities, at market (Note 2)	21,118,406	15,290,810
Furniture and equipment, net (Note 4)	150,771	179,053
Prepaid expenses	21,408	18,892
TOTAL ASSETS	$ 22,713,944	16,536,897
LIABILITIES AND NET ASSETS		
Liabilities:		
Accounts payable and accrued liabilities	$ 287,243	167,755
Due to constituent societies	110,224	259,681
Due to the American Dental Association (Note 11)	789,886	441,740
Deferred revenues	113,537	20,265
TOTAL LIABILITIES	1,300,890	889,441
Net assets:		
Unrestricted	9,352,084	5,005,426
Temporarily restricted (Note 7)	9,726,761	8,353,281
Permanently restricted (Note 7)	2,334,209	2,288,749
TOTAL NET ASSETS	21,413,054	15,647,456
TOTAL LIABILITIES AND NET ASSETS	$ 22,713,944	16,536,897

See accompanying notes to financial statements.

American Dental Association Foundation

Detailed Statement of Activities

Years Ended December 31, 2004 and 2003

	2004				2003			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
REVENUE								
Government contracts and grants	$ 1,655,510	--	--	1,655,510	1,428,212	--	--	1,428,212
Royalties	661,671	--	--	661,671	478,424	--	--	478,424
Other grants and contributions	327,736	820,422	45,460	1,193,618	55,632	916,890	91,293	1,063,815
American Dental Association grant (Note 11)	2,347,887	149,350	--	2,497,237	2,345,560	--	--	2,345,560
Investment income	558,619	891,731	--	1,450,350	1,068,033	1,263,224	--	2,331,257
Publication and product sales	108,457	--	--	108,457	45,255	--	--	45,255
Meeting and seminar income	44,200	--	--	44,200	19,200	--	--	19,200
Other income (Note 9)	3,526,250	1,002,379	--	4,528,629	17,587	5,038	--	22,625
Net assets released from restrictions (Note 8)	1,490,402	(1,490,402)	--	--	1,149,125	(1,149,125)	--	--
TOTAL REVENUE	10,720,732	1,373,480	45,460	12,139,672	6,607,028	1,036,027	91,293	7,734,348
EXPENSES (Note 9)								
Staff compensation, taxes and benefits (Note 11)	3,640,919	--	--	3,640,919	3,501,610	--	--	3,501,610
Printing, publication and marketing	101,970	--	--	101,970	194,349	--	--	194,349
Meeting expenses	67,832	--	--	67,832	68,774	--	--	68,774
Travel expenses	204,474	--	--	204,474	123,807	--	--	123,807
Professional services	828,804	--	--	828,804	467,052	--	--	467,052
Laboratory and office expenses	246,138	--	--	246,138	280,617	--	--	280,617
Grants and awards	645,777	--	--	645,777	684,265	--	--	684,265
Depreciation	70,451	--	--	70,451	82,458	--	--	82,458
Other expenses, including indirect costs (Note 11)	567,709	--	--	567,709	470,695	--	--	470,695
TOTAL EXPENSES	6,374,074	--	--	6,374,074	5,873,627	--	--	5,873,627
Increase in net assets	4,346,658	1,373,480	45,460	5,765,598	733,401	1,036,027	91,293	1,860,721
Net assets at beginning of year	5,005,426	8,353,281	2,288,749	15,647,456	4,272,025	7,317,254	2,197,456	13,786,735
Net assets at end of year	$ 9,352,084	9,726,761	2,334,209	21,413,054	5,005,426	8,353,281	2,288,749	15,647,456

See accompanying notes to financial statements.

American Dental Association Foundation

Statements of Cash Flows

Years Ended December 31, 2004 and 2003

	2004	2003
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase in net assets	$ 5,765,598	1,860,721
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Provision for uncollectible loans receivable	7,000	14,201
Depreciation	70,451	82,458
Net unrealized depreciation (appreciation) in market value of marketable securities	1,001,307	(2,005,629)
Net realized (gain) loss on sale of marketable securities	(2,087,874)	34,418
Loss on sale of property and equipment	810	--
Contributions received for long-term purposes	(45,460)	(91,293)
Changes in assets and liabilities:		
Receivables	(253,590)	179,428
Prepaid expenses	(2,516)	5,884
Accounts payable and accrued liabilities	119,488	36,542
Due to constituent societies	(149,457)	(78,219)
Due to the American Dental Association	348,146	198,411
Deferred revenues	93,272	20,000
Net cash provided by operating activities	4,867,175	256,922
CASH FLOWS FROM INVESTING ACTIVITIES		
Loan disbursements	(10,000)	(10,000)
Loan repayments	9,771	2,508
Purchase of marketable securities	(37,525,167)	(18,767,463)
Sale and maturity of marketable securities	32,784,138	18,816,698
Acquisition of furniture and equipment	(43,279)	--
Proceeds from sale of property and equipment	300	--
Net cash (used) provided by investing activities	(4,784,237)	41,743
CASH PROVIDED BY FINANCING ACTIVITIES		
Contributions received for long-term purposes	45,460	91,293
Net increase in cash	128,398	389,958
Cash at beginning of year	559,005	169,047
Cash at end of year	$ 687,403	559,005

See accompanying notes to financial statements.

American Dental Association Foundation

Notes to Financial Statements, December 31, 2004 and 2003

1. Significant Accounting Policies

Basis of Presentation: The American Dental Association Foundation (Foundation), an affiliated foundation of the American Dental Association (Association), was organized to operate exclusively for charitable, scientific and educational purposes.

The Foundation is an Illinois not-for-profit corporation.

Use of Estimates: In preparing financial statements in conformity with accounting principles generally accepted in the United States of America, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Cash: The Foundation maintains its cash balance in financial institutions which at times may exceed federally insured limits. The Foundation has not experienced any losses in such accounts and believes it is not exposed to any significant credit risk on cash.

Receivables: Receivables primarily consist of amounts due under federal government sponsored grants and contracts and accrued interest and dividends receivable. These amounts are estimated to be fully collectible and, accordingly, no allowance for uncollectible amounts has been recorded.

Loans receivable: The allowance for uncollectible loans receivable is determined after considering a number of factors, including the length of time loans receivable are past due, the Foundation's previous loss history, the borrower's current ability to pay its obligation and the condition of the general economy as a whole. Uncollectible loans are written off, and payments subsequently received on such receivables are credited to the allowance for uncollectible loans.

Marketable Securities: Investments in marketable securities are carried at fair value. The fair value of investments in marketable securities is based on quoted market prices. Net realized capital gains or losses on sales are calculated based on the first-in, first-out (FIFO) cost of securities sold.

Furniture and Equipment: Furniture and equipment are stated at cost less accumulated depreciation. Depreciation is computed on the straight-line method over the estimated useful lives of the assets, which is five to ten years.

Revenue Recognition: Contributions, which are defined as nonreciprocal transfers, are recognized as revenues in the period pledged or received and classified according to the existence or absence of donor-imposed restrictions. When a donor restriction has been satisfied by incurring expenses consistent with the designated purpose, temporarily restricted net assets are reclassified to unrestricted net assets for reporting of related expenses.

Corporate grants that do not constitute contributions are recognized as income when costs of the related programs or projects are incurred. Corporate grants received but not yet expended are reported as deferred revenues.

Contributed Facilities: The Foundation occupies, without charge, certain premises located in government-owned research facilities. No amounts have been reflected in the financial statements for their use as no objective basis is available to measure the value of such facilities.

Net Assets: Net assets subject to donor-imposed stipulations are classified as temporarily or permanently restricted net assets while net assets not subject to such restrictions are classified as unrestricted net assets.

American Dental Association Foundation

Notes to Financial Statements, December 31, 2004 and 2003 (continued)

2. Marketable Securities

Marketable securities at December 31, 2004 and 2003 consisted of the following:

	2004		2003	
	Cost	Market	Cost	Market
Equities and equity funds	$ 11,252,464	11,957,467	9,011,045	10,523,129
Bonds and bond funds	4,378,559	4,367,303	1,669,513	1,824,465
US government obligations	--	--	1,406,698	1,427,911
Money market funds	4,793,636	4,793,636	1,158,470	1,158,470
Certificates of deposit	--	--	350,000	356,835
	$ 20,424,659	21,118,406	13,595,726	15,290,810

3. Loans receivable

Loans receivable consist of loans to disaster victims, loans to assist in the treatment of chemically dependent dentists and loans for educational retraining, which are non-interest bearing until maturity. After maturing, annual interest rates are 1% over the prime rate.

Loans receivable at December 31, 2004 and 2003 consisted of the following:

	2004	2003
Disaster loans	$ 77,000	77,000
Chemical dependency loans	33,161	38,932
Educational retraining loans	6,000	--
	116,161	115,932
Less allowance for uncollectible loans	43,000	36,000
	$ 73,161	79,932

The repayment status of loans receivable at December 31, 2004 and 2003 was as follows:

	2004	2003
Loans in repayment	$ 23,161	19,432
Loans maturing in the future		
2004	--	9,500
2005	77,000	77,000
2006	16,000	10,000
	$ 116,161	115,932

American Dental Association Foundation

Notes to Financial Statements, December 31, 2004 and 2003 (continued)

Changes in the allowance for uncollectible loans were as follows:

	2004	2003
Beginning balance	$ 36,000	41,000
Provision for uncollectible loans	7,000	14,201
Loans written off	--	(19,201)
Ending balance	$ 43,000	36,000

4. Furniture and Equipment

Furniture and equipment at December 31, 2004 and 2003 consisted of the following:

	2004	2003
Furniture and equipment	$ 1,564,422	1,524,922
Less accumulated depreciation	1,413,651	1,345,869
	$ 150,771	179,053

5. Relief Program Contributions and Grants

The rules of the Relief Program provide that refunds of contributions may be made to constituent societies if those societies have been established as charitable organizations having purposes consistent with those of the Relief Program, and have been accorded tax-exempt status under the Internal Revenue Code. Prior to payment of any refund, constituent society relief funds are also required to submit annual financial statements. Refunds in the amount of $49,387 and $80,486 at December 31, 2004 and 2003 (from prior years' Relief Program contributions), are payable to societies whose relief funds have not yet qualified for payment under the rules of the Relief Program. As of December 31, 2004 and 2003, $60,837 and $179,195 are reflected as due to constituent societies for the twelve-month campaign that ended December 31, 2004 and eighteen-month campaign that ended December 31, 2003.

Grants to relief recipients are recorded when the grant is paid. Conditional commitments for future grant payments previously authorized are not recorded as grant expense, and amounted to $62,884 and $42,467 at December 31, 2004 and 2003, respectively. The Relief Program retains the right to discontinue future payments to grant recipients at any time. Grants paid are usually shared equally by the Relief Program and the recipient's constituent society.

6. Income Taxes

The Foundation has received a favorable determination letter from the Internal Revenue Service stating that it is exempt from taxation on income related to its exempt purpose under Section 501(a) of the Internal Revenue Code as an organization described in Section 501(c)(3). There was no significant unrelated business income in 2004 or 2003 and therefore a provision for income taxes was not required.

American Dental Association Foundation

Notes to Financial Statements, December 31, 2004 and 2003 (continued)

7. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets at December 31, 2004 and 2003 were available for the following purposes:

	2004	2003
Trusts and endowments	$ 2,179,763	1,914,722
Extramural programs	328,211	429,351
Research	84,497	102,423
Awards	251,818	235,998
Education	976,185	176,144
Access	590,154	316,274
Relief program	5,316,133	5,178,369
	$ 9,726,761	8,353,281

Temporarily restricted trusts and endowments include funds restricted by donors for periodontal research, public education in dental health and memorial commemoration.

Permanently restricted net assets at December 31, 2004 and 2003 totaled $2,334,209 and $2,288,749, respectively. Earnings on these net assets are restricted by donors for children's oral health and education in dental entrepreneurship and leadership.

8. Net Assets Released from Donor Restrictions

Net assets were released from donor restrictions during 2004 and 2003 by incurring expenses satisfying the restricted purposes as follows:

	2004	2003
Trusts and endowments	$ 5,505	7,421
Extramural programs	228,209	216,887
Research	111,015	183,109
Awards	17,101	86,261
Education	547,887	165,371
Access	223,842	27,647
Relief program	356,843	462,429
	$ 1,490,402	1,149,125

9. Other Income

In settlement of a class action lawsuit between the Association and Aetna, Inc., as well as Aetna's subsidiaries (collectively Aetna), the United States District Court for the Southern District of Florida approved an agreement in 2004 that included a payment of approximately $4.5 million by Aetna to the Foundation. This payment, included in other income, consists of a direct payment of $1 million to the Foundation, plus approximately $3.5 million representing class members' donations of their shares of the settlement fund to the Foundation. The agreement also mandates that Aetna undertake various business changes related to dental insurance claims processing.

American Dental Association Foundation

Notes to Financial Statements, December 31, 2004 and 2003 (continued)

10. Expenses by Functional Classification

The following table summarizes the costs of providing various programs or activities on a functional basis for the years ended December 31, 2004 and 2003:

	2004	2003
Association sponsored research	$ 1,669,770	1,701,373
Federal government sponsored research	1,647,808	1,428,212
Corporate and donor sponsored programs relating to research, education, access and awards	1,897,401	1,367,086
Relief grants	166,516	186,115
Fundraising	337,380	407,704
Administrative and general	655,199	783,137
	$ 6,374,074	5,873,627

11. Transactions With Related Parties

The Foundation receives an annual grant from the Association for sponsorship of the Foundation's research activities and the development of a national campaign to support dental education. The grant amounted to $2,497,237 and $2,345,560 in 2004 and 2003, respectively. The Foundation receives financial and administrative services from the Association as may be required. In 2004 and 2003, the Foundation paid $411,750 and $343,047, respectively, for such services.

The Association sponsors a noncontributory defined benefit pension plan and a savings and retirement plan which cover substantially all employees of the Association, its subsidiaries and affiliates meeting certain eligibility requirements. Pension expense charges are allocated to the Foundation in connection with its employees' participation in the Association's retirement plans. These expenses amounted to $320,746 and $414,838 for 2004 and 2003, respectively. Information is not sufficient to permit the Foundation to determine its share, if any, of unfunded, vested benefits.

Additionally, the Association sponsors a contributory defined benefit postretirement health plan, which covers substantially all employees of the Association, its subsidiaries and affiliates. The Foundation expensed postretirement benefit charges of $92,863 and $84,428 for 2004 and 2003, respectively, associated with participating Foundation employees.

Pursuant to agreements between the Association and certain officers and employees of the Association and its affiliates, portions of their compensation have been retained by the Association and invested as directed by those participants. The assets are owned by the Association until distributed to the participants after termination of employment or services.

Periodically, expenses of one organization may be paid by an affiliated organization and subsequently reimbursed.

The Foundation received donations of $60,000 from ADA Business Enterprises, Inc. (a wholly-owned subsidiary of the Association) in both 2004 and 2003. The Foundation received donations of $0 and $75,014 from the Association in 2004 and 2003, respectively.

American Dental Association Foundation

Detailed Statement of Activities

Year Ended December 31, 2004

	ADA Sponsored	Federal Government Sponsored	Corporate and Donor Sponsored	Relief Program	Eliminations	Total
REVENUE						
Government contracts and grants	$ --	1,655,510	--	--	--	1,655,510
Royalties	--	--	661,671	--	--	661,671
Other grants and contributions	--	--	1,147,334	46,284	--	1,193,618
American Dental Association grant	2,347,887	--	149,350	--	--	2,497,237
Investment income	--	--	1,004,406	445,944	--	1,450,350
Publication and product sales	--	--	108,457	--	--	108,457
Meeting and seminar income	--	--	44,200	--	--	44,200
Other income	125,002	--	4,526,248	2,379	(125,000)	4,528,629
TOTAL REVENUE	2,472,889	1,655,510	7,641,666	494,607	(125,000)	12,139,672
EXPENSES						
Staff compensation, taxes and benefits	2,117,435	1,111,711	319,404	92,369	--	3,640,919
Printing, publication and marketing	7,309	4,099	52,947	37,615	--	101,970
Meeting expenses	18,836	620	48,102	274	--	67,832
Travel expenses	54,298	19,307	124,605	6,264	--	204,474
Professional services	180,621	58,405	666,017	48,761	(125,000)	828,804
Laboratory and office expenses	51,629	39,754	150,418	4,337	--	246,138
Grants and awards	--	--	479,261	166,516	--	645,777
Depreciation	12,844	11,044	46,186	377	--	70,451
Other expenses, including indirect costs	25,527	413,912	127,940	330	--	567,709
TOTAL EXPENSES	2,468,499	1,658,852	2,014,880	356,843	(125,000)	6,374,074
Increase (decrease) in net assets	4,390	(3,342)	5,626,786	137,764	--	5,765,598
Net assets at beginning of year	72,221	23,406	10,373,460	5,178,369	--	15,647,456
Net assets at end of year	$ 76,611	20,064	16,000,246	5,316,133	--	21,413,054

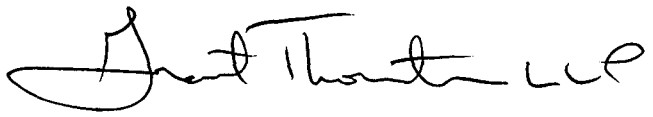
Report of Independent Certified Public Accountants

The Board of Directors and Stockholder
American Dental Real Estate Corporation

We have audited the accompanying balance sheets of American Dental Real Estate Corporation (ADREC) (a wholly-owned subsidiary of American Dental Association) as of December 31, 2004 and 2003 and the related statements of revenues, expenses and accumulated deficit, and cash flows for the years then ended. These financial statements are the responsibility of ADREC's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America as established by the Auditing Standards Board of the American Institute of Certified Public Accountants. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of American Dental Real Estate Corporation as of December 31, 2004 and 2003 and the results of its operations and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.



GRANT THORNTON LLP

Chicago, Illinois
February 18, 2005

American Dental Real Estate Corporation

(A wholly-owned subsidiary of American Dental Association)

Balance Sheets

December 31, 2004 and 2003

	2004	2003
ASSETS		
Cash and cash equivalents	$ 397,049	155,217
Receivables	2,195	6,874
Prepaid expenses and other assets	84,022	56,815
Building, equipment and tenant leasehold improvements, net (Note 2)	5,871,110	6,264,763
TOTAL ASSETS	$ 6,354,376	6,483,669
LIABILITIES AND STOCKHOLDER'S EQUITY		
Liabilities:		
Accounts payable and accrued liabilities	$ 129,207	116,061
Due to American Dental Association	49,099	24,887
TOTAL LIABILITIES	178,306	140,948
Stockholder's equity:		
Common stock, $1 par value; authorized 1,000 shares; issued and outstanding 100 shares	100	100
Additional paid-in capital	14,234,005	14,234,005
Accumulated deficit	(8,058,035)	(7,891,384)
TOTAL STOCKHOLDER'S EQUITY	6,176,070	6,342,721
TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY	$ 6,354,376	6,483,669

See accompanying notes to financial statements.

American Dental Real Estate Corporation

(A wholly-owned subsidiary of American Dental Association)

Statements of Revenues, Expenses and Accumulated Deficit

Years Ended December 31, 2004 and 2003

	2004	2003
REVENUES		
Rental income	$ 1,134,169	1,093,754
Other income	2,734	7,854
TOTAL REVENUES	1,136,903	1,101,608
EXPENSES		
Staff compensation, taxes and benefits	28,440	26,499
Facility costs, including utilities	552,018	501,827
Professional services	51,007	44,995
Office expenses	6,623	4,995
Depreciation and amortization	650,628	707,087
Bank and credit card fees	1,968	4,372
Bad debt expense	--	1,897
Other expenses	12,870	21,563
TOTAL EXPENSES	1,303,554	1,313,235
Excess of expenses over revenues	(166,651)	(211,627)
Accumulated deficit at beginning of year	(7,891,384)	(7,679,757)
Accumulated deficit at end of year	$ (8,058,035)	(7,891,384)

See accompanying notes to financial statements.

American Dental Real Estate Corporation

(A wholly-owned subsidiary of American Dental Association)

Statements of Cash Flows

Years Ended December 31, 2004 and 2003

	2004	2003
CASH FLOWS FROM OPERATING ACTIVITIES:		
Excess of expenses over revenues	$ (166,651)	(211,627)
Adjustments to reconcile excess of expenses over revenues to net cash provided by operating activities:		
Depreciation and amortization	650,628	707,087
Changes in assets and liabilities:		
Receivables	4,679	4,601
Prepaid expenses and other assets	(27,207)	16,616
Due to American Dental Association	24,212	(137,174)
Accounts payable and accrued liabilities	13,146	(43,627)
Net cash provided by operating activities	498,807	335,876
NET CASH USED BY INVESTING ACTIVITIES:		
Acquisition of building, equipment and tenant leasehold improvements	(256,975)	(269,499)
NET CASH USED BY FINANCING ACTIVITIES:		
Payment of liquidating dividend	--	(435,700)
Net increase (decrease) in cash and cash equivalents	241,832	(369,323)
Cash and cash equivalents at beginning of year	155,217	524,540
Cash and cash equivalents at end of year	$ 397,049	155,217

See accompanying notes to financial statements.

American Dental Real Estate Corporation

(A wholly-owned subsidiary of American Dental Association)

Notes to Financial Statements, December 31, 2004 and 2003

1. Significant Accounting Policies

Basis of Presentation: American Dental Real Estate Corporation (ADREC), a wholly-owned subsidiary of the American Dental Association (Association), was organized as a not-for-profit corporation for the exclusive purpose of holding title to the Washington, DC Office building, collecting rental income thereon, and remitting the net income to the Association. ADREC intends to hold the property for continued use.

Use of Estimates: In preparing financial statements in conformity with accounting principles generally accepted in the United States of America, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents: Cash equivalents at December 31, 2004 and 2003 consist of interest bearing deposits under overnight repurchase agreements which are carried at their fair value. ADREC maintains its cash balances in financial institutions which at times may exceed federally insured limits. ADREC has not experienced any losses in such accounts and believes it is not exposed to any significant credit risk on cash and cash equivalents.

Building, Equipment and Tenant Leasehold Improvements: Building, equipment and tenant leasehold improvements are carried at cost, net of accumulated depreciation and amortization. Depreciation is computed on the straight-line method over the estimated useful lives of the assets, which are 30 years for the building and building improvements, and seven years for equipment. Tenant leasehold improvements are amortized over the shorter of their estimated useful lives or the remaining term of the lease.

Revenue Recognition: Building rental income is recorded as revenue when earned.

Reclassifications: Certain 2003 amounts have been reclassified to conform to the 2004 presentation.

2. Building, Equipment, and Tenant Leasehold Improvements

Building, equipment and tenant leasehold improvements at December 31, 2004 and 2003 consisted of the following:

	2004	2003
Building	$ 9,602,195	9,602,195
Building improvements	725,704	685,047
Building equipment	1,755,803	1,755,803
Tenant leasehold improvements	1,101,514	885,196
	13,185,216	12,928,241
Less accumulated depreciation and amortization	7,314,106	6,663,478
	$ 5,871,110	6,264,763

ADREC leases portions of the building to unrelated parties under operating leases with varying terms. Minimum future rentals to be earned from non-cancelable leases currently in effect are $1,162,961 in 2005, $987,521 in 2006, $710,658 in 2007, $384,689 in 2008, $238,757 in 2009 and $54,643 thereafter. These amounts may change upon renewal of the leases.

American Dental Real Estate Corporation

(A wholly-owned subsidiary of American Dental Association)

Notes to Financial Statements, December 31, 2004 and 2003 (continued)

3. Income Taxes

ADREC has received a favorable determination letter from the Internal Revenue Service stating that it is exempt from taxation on income related to its exempt purpose under Section 501(a) of the Internal Revenue Code as an organization described in Section 501(c)(2).

ADREC's non-exempt operating results are included in the income tax returns of the Association. Any federal or state income taxes owed on ADREC's unrelated business activities in 2004 and 2003 are included in the joint return with the Association. Under the terms of an intercompany tax sharing agreement, the Association is allowed to utilize the net operating loss derived from ADREC's operations without payment of the tax benefit to ADREC. For the years ended December 31, 2004 and 2003, the Association utilized $572,791 and $1,683,218, of the ADREC net operating loss, respectively. No net operating loss carryforwards remain at December 31, 2004.

4. Additional Paid-In-Capital

ADREC paid a liquidating dividend to the Association of $435,700 during 2003, representing a return of capital.

5. Transactions With Related Parties

The Association occupies approximately 17% of space in the building owned by ADREC. The building owned by ADREC is situated on land owned by the Association. A nominal rental is exchanged in connection with these arrangements.

Periodically, expenses of one organization may be paid by an affiliated organization and subsequently reimbursed.

Report of Independent Certified Public Accountants

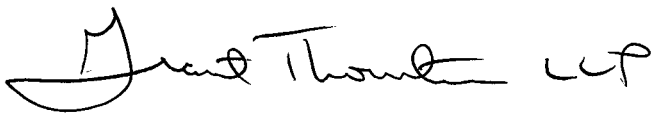
The Board of Directors and Stockholder
ADA Business Enterprises, Inc.

We have audited the accompanying balance sheets of ADA Business Enterprises, Inc. (ADABEI) (a wholly-owned subsidiary of American Dental Association) as of December 31, 2004 and 2003, and the related statements of operations and retained earnings, and cash flows for the years then ended. These financial statements are the responsibility of ADABEI's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America as established by the Auditing Standards Board of the American Institute of Certified Public Accountants. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of ADA Business Enterprises, Inc. as of December 31, 2004 and 2003, and the results of its operations and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the basic financial statements taken as a whole of ADA Business Enterprises, Inc. as of and for the years ended December 31, 2004 and 2003. The divisional statement of continuing operations is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.



GRANT THORNTON LLP

Chicago, Illinois
February 18, 2005

ADA Business Enterprises, Inc.

(A wholly-owned subsidiary of American Dental Association)

Balance Sheets

December 31, 2004 and 2003

	2004	2003
ASSETS		
Cash and cash equivalents	$ 882,410	552,027
Receivables	535,878	539,862
Due from the American Dental Association (Note 7)	15,476	255,595
Income tax refund receivable	--	18,884
Deferred taxes (Note 5)	25,699	18,792
Marketable securities, at market (Note 2)	2,699,680	2,673,595
Furniture and equipment, net (Note 3)	52,752	65,002
TOTAL ASSETS	$ 4,211,895	4,123,757
LIABILITIES AND STOCKHOLDER'S EQUITY		
Liabilities:		
Accounts payable and accrued liabilities	$ 93,962	168,085
Income taxes payable	43,196	28,861
TOTAL LIABILITIES	137,158	196,946
Stockholder's Equity:		
Common stock, $1 par value;		
Authorized 101,000 shares; issued and outstanding 100,100 shares	100,100	100,100
Additional paid-in capital	500,000	500,000
Retained earnings	3,474,637	3,326,711
TOTAL STOCKHOLDER'S EQUITY	4,074,737	3,926,811
TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY	$ 4,211,895	4,123,757

See accompanying notes to financial statements.

ADA Business Enterprises, Inc.

(A wholly-owned subsidiary of American Dental Association)

Statements of Operations and Retained Earnings

Years Ended December 31, 2004 and 2003

	2004	2003
REVENUES		
Royalties and service fees	$ 2,404,467	2,812,933
Investment income	34,447	43,798
Other income	30,000	60,000
TOTAL REVENUES	2,468,914	2,916,731
EXPENSES		
Staff compensation, taxes and benefits	915,041	1,038,833
Printing and marketing expenses	801,513	871,580
Royalty expenses	--	111,102
Professional services	161,488	178,873
Facility and utility costs	69,633	70,229
Office expense	39,266	38,635
Donation to the American Dental Association Foundation	60,000	60,000
Meeting expenses	2,798	3,145
Travel expenses	84,679	87,923
Depreciation	12,250	12,250
Other expenses, including allocated general and administrative expenses	140,076	162,192
TOTAL EXPENSES	2,286,744	2,634,762
Net income from continuing operations before income tax expense	182,170	281,969
Income tax expense (Note 5)	(34,244)	(94,362)
Income from continuing operations	147,926	187,607
Discontinued operations (Note 4)		
Loss from operations of publishing division transferred to American Dental Association (less applicable income taxes of $46,223)	--	(202,317)
Net income (loss)	147,926	(14,710)
Retained earnings at beginning of year	3,326,711	6,526,607
Dividends declared (Note 6)	--	(3,185,186)
Retained earnings at end of year	$ 3,474,637	3,326,711

See accompanying notes to financial statements.

ADA Business Enterprises, Inc.

(A wholly-owned subsidiary of American Dental Association)

Statements of Cash Flows

Years Ended December 31, 2004 and 2003

	2004	2003
CASH FLOWS FROM OPERATING ACTIVITIES		
Net income (loss)	$ 147,926	(14,710)
Adjustments to reconcile net income (loss) to net cash provided by operating activities:		
Depreciation	12,250	37,988
Deferred income tax (benefit) expense	(6,907)	106,297
Changes in assets and liabilities:		
Receivables	3,984	700,487
Income tax refund receivable	18,884	97,300
Inventory	--	9,670
Other assets	--	(111,316)
Accounts payable and accrued liabilities	(74,123)	175,208
Income taxes payable	14,335	28,861
Due from the American Dental Association	240,119	(713,310)
Deferred revenues	--	12,300
Net cash provided by operating activities	356,468	328,775
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of marketable securities	(28,085)	(37,633)
Sale of marketable securities	2,000	3,102,000
Net cash (used) provided by investing activities	(26,085)	3,064,367
CASH USED BY FINANCING ACTIVITIES		
Payment of dividends	--	(3,100,000)
Net increase in cash and cash equivalents	330,383	293,142
Cash and cash equivalents at beginning of year	552,027	258,885
Cash and cash equivalents at end of year	$ 882,410	552,027
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid during the year for income taxes	$ 76,000	60,450
SUPPLEMENTAL DISCLOSURE OF NON CASH ACTIVITIES		
Net publishing division assets transferred to ADA	$ --	85,186

See accompanying notes to financial statements.

ADA Business Enterprises, Inc.

(A wholly-owned subsidiary of American Dental Association)

Notes to Financial Statements, December 31, 2004 and 2003

1. Significant Accounting Policies

Basis of Presentation: ADA Business Enterprises, Inc. (ADABEI), a wholly-owned subsidiary of the American Dental Association (Association), manages the for-profit activities organized by the Association.

Prior to July 1, 2003, ADABEI's activities were organized in three divisions, which were the CEO office, publishing, and business and financial services. The CEO office reflects the costs of Board and executive oversight and various expenses not allocated to the operating divisions. The publishing division performed certain publishing functions for the publications of the Association, including *JADA* and *ADA News*. The business and financial services division offers a range of financial services to Association members in conjunction with Citibank USA, a Citigroup affiliate, and various other financial service providers under the title of ADA Member Advantage.

Effective July 1, 2003 the publishing division was transferred to the Association.

Use of Estimates: In preparing financial statements in conformity with accounting principles generally accepted in the United States of America, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents: Cash equivalents at December 31, 2004 and 2003 consist of interest bearing deposits under overnight repurchase agreements, which are carried at their fair value. ADABEI maintains its cash balances in financial institutions which at times may exceed federally insured limits. ADABEI has not experienced any losses in such accounts and believes it is not exposed to any significant credit risk on cash and cash equivalents.

Marketable Securities: Marketable securities are carried at fair value. The fair values of the marketable securities are based on quoted market prices.

Furniture and Equipment: Furniture and equipment are stated at cost less accumulated depreciation. Depreciation is computed on the straight-line method over five to ten years, the estimated useful lives of the assets.

Revenue and Expense Recognition: Royalties and service fees are recognized when earned pursuant to agreements with financial service providers. Royalty expenses are recognized when conditions for their accrual under the agreements with participating state societies or their subsidiaries are satisfied.

Royalty Expenses: Royalty expenses represent service fees or royalties to certain state dental societies or their related financial service subsidiaries pursuant to agreements with ADABEI to endorse ADA Member Advantage products. Based on a restructuring of these agreements the responsibility for paying these costs transferred from ADABEI to the Association during 2003.

Income Taxes: Deferred taxes are established for temporary differences between the financial reporting basis and the tax basis of assets and liabilities, based upon enacted tax rates which would apply during the period in which taxes become payable or recoverable, and the adjustment of cumulative deferred taxes for any changes in the tax rate.

Reclassifications: Certain 2003 amounts have been reclassified to conform to the 2004 presentation.

ADA Business Enterprises, Inc.

(A wholly-owned subsidiary of American Dental Association)

Notes to Financial Statements, December 31, 2004 and 2003 (continued)

2. Marketable Securities

Marketable securities at December 31, 2004 and 2003 consisted of the following:

	2004		2003	
	Cost	Market	Cost	Market
Money market funds	$ 2,699,680	2,699,680	2,673,595	2,673,595

3. Furniture and Equipment

Furniture and equipment at December 31, 2004 and 2003 consisted of the following:

	2004	2003
Furniture and equipment	$ 135,759	135,759
Less accumulated depreciation	83,007	70,757
	$ 52,752	65,002

4. Discontinued Operations

Effective July 1, 2003 the publishing division was transferred to the Association. Accordingly results of this operation were reclassified as discontinued operations with regard to ADABEI for 2003.

Summarized financial information for publishing operations is set forth below:

	2003
Revenue	$ 4,102,010
Expense	4,258,104
Net loss	(156,094)
Income tax expense	(46,223)
Net loss	$ (202,317)

There was no gain or loss recognized on the transfer of the publishing division.

ADA Business Enterprises, Inc.

(A wholly-owned subsidiary of American Dental Association)

Notes to Financial Statements, December 31, 2004 and 2003 (continued)

5. Income Taxes

Income tax expense for the years ended December 31, 2004 and 2003, was as follows:

	2004	2003
Current:		
Federal	$ 30,563	58,541
State	10,588	9,848
Current income tax expense	41,151	68,389
Deferred:		
Federal	(5,687)	59,434
State	(1,220)	12,762
Deferred income tax (benefit) expense	(6,907)	72,196
Total income tax expense	34,244	140,585
Income tax expense applicable to discontinued operations	--	46,223
Income tax expense applicable to continuing operations	$ 34,244	94,362

Income tax expense differs from the amount computed by applying the statutory federal income tax rate of 34% to income before income tax expense for the years ended December 31, 2004 and 2003, as follows:

	2004	2003
Statutory federal income tax	$ 61,938	42,798
State income taxes	8,777	6,065
Write off deferred tax balance related to publishing division	--	109,303
Other, net	(36,471)	(17,581)
Income tax expense	$ 34,244	140,585

Net deferred taxes receivable at December 31, 2004 and 2003 consisted of:

	2004	2003
Deferred tax assets resulting from excess of tax basis over book basis of post-retirement health benefits	$ 37,941	34,583
Deferred tax liability resulting from excess of book basis over tax basis of furniture and equipment	(12,242)	(15,791)
Deferred tax assets, net	$ 25,699	18,792

ADA Business Enterprises, Inc.

(A wholly-owned subsidiary of American Dental Association)

Notes to Financial Statements, December 31, 2004 and 2003 (continued)

6. Dividends

During 2003, ADABEI declared dividends to the Association of $3,185,186. The 2003 dividends represented $85,186 of publishing net assets transferred to the Association on July 1, 2003 as well as $3,100,000 in cash. The 2003 cash dividend was transferred to the Association's reserve investment account.

7. Transactions With Related Parties

The Association provides ADABEI with administrative services as may be required. The allocated cost of such services amounted to $134,362 and $335,030 during the years ended December 31, 2004 and 2003, respectively.

The Association sponsors a noncontributory defined benefit pension plan and a savings and retirement plan, which cover substantially all employees of the Association, its subsidiaries, and affiliates meeting certain eligibility requirements. In addition to the allocated expenses described above are pension expense charges associated with ADABEI employees who are participants in the Association's retirement plans, amounting to $131,626 and $331,815 in 2004 and 2003, respectively. Information is not sufficient to permit ADABEI to determine its share, if any, of unfunded vested benefits.

Additionally, the Association sponsors a contributory defined postretirement health plan, which covers substantially all employees of the Association, its subsidiaries and affiliates. ADABEI expensed postretirement benefit charges of $8,131 and $59,264 for the years ended December 31, 2004 and 2003, respectively, associated with participating employees.

The Association also leases office space and equipment to ADABEI. Rent expense under these leases amounted to $67,278 and $164,071 during 2004 and 2003, respectively. The publishing division office space lease of $14,670 a month was terminated effective June 30, 2003 due to the division's transfer to the Association. The financial services division office space lease of $4,444 a month expires September 30, 2006. Minimum future rentals to be paid on the financial services division office lease are $53,328 in 2005 and $39,996 in 2006. The publishing division equipment lease of $1,250 a month was terminated effective June 30, 2003 due to the division's transfer to the Association.

During both 2004 and 2003, ADABEI authorized payment of charitable contributions of $60,000 to the American Dental Association Foundation, a not-for-profit affiliate.

Periodically, expenses of one organization may be paid by an affiliated organization and subsequently reimbursed.

ADABEI and the Association operated under a publishing agreement dated January 1, 1990 that was initiated with a predecessor corporation of ADABEI's publishing division. Such agreement was terminated effective June 30, 2003 when the publishing division was transferred to the Association. Under the terms of the agreement, the publishing division performed all publishing and distribution functions related to the Association's two major publications. In connection with the agreement, the Association assigned all relevant production and advertising contracts, together with all non-member subscriptions and the revenue from single copy sales, to ADABEI. Under the terms of the agreement, the Association paid publishing fees in the amount of $380,000 during the year ended December 31, 2003.

ADA Business Enterprises, Inc.

(A wholly-owned subsidiary of American Dental Association)

Divisional Statement of Operations

Year Ended December 31, 2004

	CEO Office	Business & Financial Services	Total
REVENUES			
Royalties and service fees	$ --	2,404,467	2,404,467
Investment income	34,447	--	34,447
Other income	30,000	--	30,000
TOTAL REVENUES	64,447	2,404,467	2,468,914
EXPENSES			
Staff compensation, taxes and benefits	339,021	576,020	915,041
Printing, publication and marketing expenses	102,774	698,739	801,513
Professional services	99,100	62,388	161,488
Facility and utility costs	--	69,633	69,633
Office expense	5,703	33,563	39,266
Donation to the American Dental Association Foundation	60,000	--	60,000
Meeting expenses	518	2,280	2,798
Travel expenses	51,743	32,936	84,679
Depreciation	--	12,250	12,250
Other expenses, including allocated general and administrative expenses	38,926	101,150	140,076
TOTAL EXPENSES	697,785	1,588,959	2,286,744
Net income (loss) before income taxes	(633,338)	815,508	182,170
Income tax (expense) benefit	120,384	(154,628)	(34,244)
Net income (loss)	$ (512,954)	660,880	147,926

American Dental Association

Supplemental Financial Information for the Year Ended December 31, 2004

(Unaudited)

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
REVENUES		
Membership Dues	$ 47,721,745	47,573,570
Advertising	7,642,732	8,314,950
Rental Income	2,997,672	2,826,800
Publication and Product Sales	8,729,671	8,359,200
Testing and Accreditation Fees	8,142,786	7,460,950
Meetings and Seminar Income	9,825,526	8,934,750
Grants, Contributions and Sponsorships	1,578,376	1,569,350
Royalties	4,893,578	3,257,000
Investment Income	279,345	515,000
Other Income	2,387,870	2,435,650
TOTAL REVENUES	94,199,301	91,247,220
EXPENSES (Note A)		
Staff Compensation	41,904,467	41,784,350
Printing, Publication and Marketing	14,311,904	14,811,950
Meeting Expenses	2,609,860	2,317,210
Travel Expenses	5,171,621	5,000,880
Professional Services	8,426,618	10,007,600
Office Expenses	4,710,092	5,135,110
Facility and Utility Expenses	3,441,465	3,237,350
Grants and Awards	287,935	245,500
Grant to ADA Foundation	2,497,237	2,913,750
Endorsement Costs	728,437	440,000
Depreciation and Amortization	3,026,692	2,499,900
Bank & Credit Card Fees	472,387	527,650
Other Expenses	1,543,511	1,400,850
TOTAL EXPENSES	89,132,226	90,322,100
NET REVENUE/(EXPENSE) BEFORE INCOME TAXES	5,067,075	925,120
Income Tax Expense	(1,300,834)	(1,090,000)
NET REVENUE/(EXPENSE) AFTER INCOME TAXES	3,766,241	(164,880)
CASH FLOW ITEMS		
Capital Expenditures	(2,977,733)	(2,539,000)
Depreciation	3,026,692	2,499,900
Net capital expenditures	48,959	(39,100)
Transfer of Building & Technology Funds	1,658,200	758,000
Renovation Program Funding	(1,000,000)	(1,000,000)
Pension adjustment	(689,576)	
NET SURPLUS (DEFICIT)	$ 3,783,824	(445,980)

Notes:

(A) The contingency fund is included by natural accounts based on the activities approved by the Board.

Divisional Summary Worksheets

Division of Administrative Services

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
REVENUES		
Meetings and Seminar Income	$ -	24,000
Grants, Contributions and Sponsorships	30,000	30,000
TOTAL REVENUES	30,000	54,000
EXPENSES		
Staff Compensation	3,125,906	3,096,850
Printing, Publication and Marketing	2,556,232	2,788,100
Meeting Expenses	106,159	119,200
Travel Expenses	1,236,679	1,149,200
Professional Services	1,169,753	1,229,350
Office Expenses	545,932	555,150
Grants and Awards	5,564	10,000
Bank & Credit Card Fees	122	400
Other Expenses	488,737	428,000
TOTAL EXPENSES	9,235,084	9,376,250
NET REVENUE/(EXPENSE)	$ (9,205,084)	(9,322,250)

Division of Legal Affairs

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
REVENUES		
Publication and Product Sales	$ 594	1,300
Other Income	44,922	54,350
TOTAL REVENUES	45,516	55,650
EXPENSES		
Staff Compensation	1,472,310	1,437,800
Printing, Publication and Marketing	5,839	9,000
Meeting Expenses	1,092	2,400
Travel Expenses	54,600	98,600
Professional Services	470,958	557,800
Office Expenses	40,649	51,500
Facility and Utility Expenses	108	-
TOTAL EXPENSES	2,045,556	2,157,100
NET REVENUE/(EXPENSE)	$ (2,000,040)	(2,101,450)

Division of Government Affairs

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
REVENUES		
Meeting and Seminar Income	$ 16,642	16,250
TOTAL REVENUES	16,642	16,250
EXPENSES		
Staff Compensation	2,093,256	2,122,400
Printing, Publication and Marketing	28,709	35,100
Meeting Expenses	108,638	124,350
Travel Expenses	662,641	630,050
Professional Services	204,013	187,600
Office Expenses	241,220	249,400
Facility and Utility Expenses	7,200	7,200
Grants and Awards	27,100	77,500
Depreciation and Amortization	8	-
Bank & Credit Card Fees	106	150
Other Expenses	4,913	-
TOTAL EXPENSES	3,377,804	3,433,750
NET REVENUE/(EXPENSE)	$ (3,361,162)	(3,417,500)

Division of Communications

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
REVENUES		
Meeting and Seminar Income	$ 3,600	13,000
Grants, Contributions and Sponsorships	75,000	-
TOTAL REVENUES	78,600	13,000
EXPENSES		
Staff Compensation	1,794,702	1,748,500
Printing, Publication and Marketing	992,727	1,400,000
Meeting Expenses	83,731	6,100
Travel Expenses	144,038	130,150
Professional Services	216,596	241,950
Office Expenses	100,175	123,700
Facility and Utility Expenses	268	-
Other Expenses	126	-
TOTAL EXPENSES	3,332,363	3,650,400
NET REVENUE/(EXPENSE)	$ (3,253,763)	(3,637,400)

Division of Membership and Dental Society Services

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
REVENUES		
Advertising	$ 78,500	40,000
Meeting and Seminar Income	122,193	120,100
Grants, Contributions and Sponsorships	323,500	302,200
TOTAL REVENUES	524,193	462,300
EXPENSES		
Staff Compensation	2,832,561	2,809,450
Printing, Publication and Marketing	455,127	498,950
Meeting Expenses	114,147	121,560
Travel Expenses	397,553	465,340
Professional Services	336,189	383,000
Office Expenses	221,469	275,050
Facility and Utility Expenses	821	800
Bank & Credit Card Fees	2,291	-
Other Expenses	2,373	-
TOTAL EXPENSES	4,362,531	4,554,150
NET REVENUE/(EXPENSE)	$ (3,838,338)	(4,091,850)

Division of Conference and Meeting Services

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
REVENUES		
Advertising	$ 226,440	470,750
Rental Income	166,390	75,000
Meeting and Seminar Income	8,851,131	7,901,400
Grants, Contributions and Sponsorships	714,500	843,900
Royalties	143,537	110,000
Other Income	197,682	118,050
TOTAL REVENUES	10,299,680	9,519,100
EXPENSES		
Staff Compensation	1,360,169	1,464,050
Printing, Publication and Marketing	1,274,180	1,459,150
Meeting Expenses	2,044,351	1,713,950
Travel Expenses	417,616	492,500
Professional Services	1,333,248	1,417,800
Office Expenses	753,436	667,300
Facility and Utility Expenses	5,769	23,000
Bank & Credit Card Fees	139,762	82,300
Other Expenses	7,646	1,800
TOTAL EXPENSES	7,336,177	7,321,850
NET REVENUE/(EXPENSE)	$ 2,963,503	2,197,250

Headquarters Building

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
REVENUES		
Rental Income	$ 2,831,282	2,751,800
Other Income	14,817	12,000
TOTAL REVENUES	2,846,099	2,763,800
EXPENSES		
Staff Compensation	248,103	260,950
Printing, Publication and Marketing	38,426	27,100
Professional Services	136,913	88,100
Office Expenses	69,636	50,700
Facility and Utility Expenses	3,400,163	3,190,350
Other Expenses	82,632	66,600
TOTAL EXPENSES	3,975,873	3,683,800
NET REVENUE/(EXPENSE)	$ (1,129,774)	(920,000)

Division of Finance and Operations

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
REVENUES		
Publication and Product Sales	$ 40,966	70,000
Royalties	445,462	330,000
Investment Income	279,345	515,000
Other Income	741,217	871,400
TOTAL REVENUES	1,506,990	1,786,400
EXPENSES		
Staff Compensation	2,698,530	2,945,150
Printing, Publication and Marketing	30,253	12,650
Meeting Expenses	1,961	4,400
Travel Expenses	56,975	73,200
Professional Services	265,040	247,000
Office Expenses	74,053	110,500
Facility and Utility Expenses	129	-
Bank & Credit Card Fees	824	400
Other Expenses	155,065	146,100
TOTAL EXPENSES	3,282,830	3,539,400
NET REVENUE/(EXPENSE)	$ (1,775,840)	(1,753,000)

Salable Materials

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
REVENUES		
Publication and Product Sales	$ 7,521,952	7,151,400
Royalties	824,169	103,000
TOTAL REVENUES	8,346,121	7,254,400
EXPENSES		
Staff Compensation	657,191	507,100
Printing, Publication and Marketing	2,922,185	2,938,150
Meeting Expenses	46,719	116,900
Travel Expenses	27,937	37,000
Professional Services	463,824	860,000
Office Expenses	55,508	33,400
Facility and Utility Expenses	296	-
Bank & Credit Card Fees	119,726	132,700
Other Expenses	114,372	-
TOTAL EXPENSES	4,407,758	4,625,250
NET REVENUE/(EXPENSE)	$ 3,938,363	2,629,150

Central Administration (Without Contingency Fund)

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
REVENUES		
Membership Dues	$47,721,745	47,573,570
Royalties	3,371,372	2,626,000
Other Income	810,893	761,250
TOTAL REVENUES	51,904,010	50,960,820
EXPENSES		
Staff Compensation	10,773,238	9,806,300
Travel Expenses	-	(450,000)
Professional Services	38,212	20,000
Office Expenses	4,254	44,400
Facility and Utility Expenses	9,131	6,000
Grants and Awards	142,000	67,000
Grant to the ADA Foundation	2,497,237	2,913,750
Endorsement Costs	728,437	440,000
Depreciation and Amortization	3,026,684	2,499,900
Bank & Credit Card Fees	116,548	129,500
Other Expenses	422,975	520,850
TOTAL EXPENSES	17,758,716	15,997,300
Income Taxes Expenses	1,300,834	1,090,000
NET REVENUE/(EXPENSE)	$32,844,460	33,873,120

Contingency Fund

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
EXPENSES		
Printing, Publication and Marketing	$ 109,307	102,800
Meeting Expenses	1,294	3,300
Travel Expenses	101,598	175,340
Professional Services	204,988	308,800
Office Expenses	24,629	14,760
Grants and Awards	25,000	25,000
Other Expenses	197,658	197,650
TOTAL EXPENSES	664,474	827,650
NET REVENUE/(EXPENSE)	$ (664,474)	(827,650)

Note: The contingency fund budget is assigned to line items as individual activities are approved by the Board of Trustees

Division of Information Technology

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
REVENUES		
Publications and Product Sales	$ 11,265	7,500
Royalties	110	600
Other Income	32,657	58,200
TOTAL REVENUES	44,032	66,300
EXPENSES		
Staff Compensation	3,312,088	3,271,550
Printing, Publication and Marketing	5,539	5,850
Meeting Expenses	6,585	11,600
Travel Expenses	137,035	153,100
Professional Expenses	399,230	1,263,800
Office Expenses	1,346,574	1,505,600
Bank & Credit Card Fees	178	-
TOTAL EXPENSES	5,207,229	6,211,500
NET REVENUE/(EXPENSE)	$ (5,163,197)	(6,145,200)

Division of Dental Practice

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
REVENUES		
Publication and Product Sales	$ 3,870	9,100
Meeting and Seminar Income	699,360	727,900
Grants, Contributions and Sponsorships	415,376	393,250
Other Income	10,952	8,700
TOTAL REVENUES	1,129,558	1,138,950
EXPENSES		
Staff Compensation	2,308,971	2,352,800
Printing, Publication and Marketing	114,742	123,050
Meeting Expenses	29,292	45,100
Travel Expenses	563,535	624,300
Professional Services	499,019	475,300
Office Expenses	117,258	149,800
Facility and Utility Expenses	963	1,300
Bank & Credit Card Fees	1,510	300
Other Expenses	23,667	16,850
TOTAL EXPENSES	3,658,957	3,788,800
NET REVENUE/(EXPENSE)	$ (2,529,399)	(2,649,850)

Health Policy Resources Center

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
REVENUES		
Publication and Product Sales	$ 296,731	323,300
TOTAL REVENUES	296,731	323,300
EXPENSES		
Staff Compensation	1,158,234	1,262,050
Printing, Publication and Marketing	41,076	31,200
Meeting Expenses	3,252	2,000
Travel Expenses	38,303	45,300
Professional Services	536,512	547,500
Office Expenses	216,198	178,700
Facility and Utility Expenses	96	-
Bank & Credit Card Fees	4,681	2,900
Other Expenses	245	-
TOTAL EXPENSES	1,998,597	2,069,650
NET REVENUE/(EXPENSE)	$(1,701,866)	(1,746,350)

Division of Education

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
REVENUES		
Testing and Accreditation Fees	$ 8,142,786	7,460,950
Meeting and Seminar Income	132,600	132,100
Other Income	95,726	82,000
TOTAL REVENUES	8,371,112	7,675,050
EXPENSES		
Staff Compensation	3,743,713	3,795,450
Printing, Publication and Marketing	541,690	417,400
Meeting Expenses	19,299	19,300
Travel Expenses	1,167,918	1,149,800
Professional Services	1,983,127	1,832,650
Office Expenses	483,060	565,100
Facility and Utility Expenses	2,211	2,800
Grants and Awards	80,731	60,000
Bank & Credit Card Fees	73,249	165,800
Other Expenses	894	-
TOTAL EXPENSES	8,095,892	8,008,300
NET REVENUE/(EXPENSE)	$ 275,220	(333,250)

Division of Science

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
REVENUES		
Grants, Contributions and Sponsorships	$ 20,000	-
Other Income	432,189	465,000
TOTAL REVENUES	452,189	465,000
EXPENSES		
Staff Compensation	2,447,818	2,923,200
Printing, Publication and Marketing	35,032	3,600
Meeting Expenses	28,869	11,800
Travel Expenses	155,146	202,350
Professional Services	52,498	177,300
Office Expenses	224,768	333,300
Grants and Awards	6,000	6,000
Bank & Credit Card Fees	1,125	-
Other Expenses	1,652	-
TOTAL EXPENSES	2,952,908	3,657,550
NET REVENUE/(EXPENSE)	$(2,500,719)	(3,192,550)

Division of ADA Publishing

NATURAL ACCOUNTS	2004 ACTUAL	2004 BUDGET
REVENUES		
Advertising	$ 7,337,792	7,804,200
Publication and Product Sales	854,293	796,600
Royalties	108,928	87,400
Other Income	6,815	4,700
TOTAL REVENUES	8,307,828	8,692,900
EXPENSES		
Staff Compensation	1,877,677	1,980,750
Printing, Publication and Marketing	5,160,840	4,959,850
Meeting Expenses	14,471	15,250
Travel Expenses	10,047	24,650
Professional Services	116,498	169,650
Office Expenses	191,273	226,750
Facility and Utility Expenses	14,310	5,900
Grants and Awards	1,540	-
Bank & Credit Card Fees	12,265	13,200
Other Expenses	40,556	23,000
TOTAL EXPENSES	7,439,477	7,419,000
NET REVENUE/(EXPENSE)	$ 868,351	1,273,900

2004 Contingency Fund

Board-Approved Allocations Compared with Actual

	Actual Expenses Net	Board Approved Allocations
Administration and Policy		
Macro Panel Feb Board Retreat	$ 5,847	6,600
Council & Commission Chairs Meeting	3,096	3,500
UOP School Naming	50,000	50,000
Task Force on Work Force Model	6,298	21,600
Access to Care Workgroup	0	10,700
Event Cancellation Insurance for Annual Session	197,658	197,650
Legal Affairs		
Matching Funds to CDA	110,000	110,000
Government Affairs		
Alaska Taskforce Additional Funding	28,500	28,500
Conference and Meeting Services		
Additional Marketing Monies for 2005 Annual Session	25,000	25,000
Dental Practice		
Oral Health Care Series Development	4,602	12,400
Education		
Credentialing-Non Specialty	30,528	46,000
Study of the ADA Relationship with Commission on Dental Accreditation	19,036	19,350
National Fund for Dental Education	19,500	19,500
National Clinical Exam	6,089	10,000
Science		
Amalgam Waste Programs	140,621	245,000
Publishing		
JADA Editor Search	17,698	21,850
Total Expense Allocation for 2004 Contingency Fund	$ 664,473	827,650

Notes

Appendix

Notes

Index of Resolutions

2004 Resolutions