2007

2007 Annual Reports and Resolutions

American Dental Association

American Dental Association
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148th Annual Session

San Francisco, California

September 28 – October 2, 2007

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Special Note
Copies of *2007 Annual Reports and Resolutions* have been mailed to delegates and alternate delegates. Please bring your copy to the meetings of the House of Delegates. Electronic copies of council and commission reports are available online at www.ada.org/goto/hod.

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Reports of Councils and Commissions

Notes

Council on Access, Prevention and Interprofessional Relations

Filanova, Vincent, New York, 2007, chair
Robinson, Lindsey A., California, 2009, vice chair
Antonelli, Morris, Maryland, 2008
Bordenave-Bishop, Susan, Illinois, 2008
Boseman, J. Jerald, Utah, 2009
Briskie, Daniel M., Michigan, 2009
Crabtree, Mark A., Virginia, 2010
Flaherty, Kevin T., Wisconsin, 2007, American Medical Association
Holm, Steven J., Indiana, 2008
Howard, Lisa P., Maine, 2007
Lingle, Scott D., Minnesota, 2009
Low, Samuel B., Florida, 2008
McCaslin, Alston Jones, VI, Georgia, 2008
Miller, Rodney E., Sr., U.S. Virgin Islands, 2007, American Hospital Association
Oneacre, Lee P., Texas, 2010
Siegel, Philip T., Pennsylvania, 2007
Smith, Jon Christopher, West Virginia, *ex officio*[*]
Stanislav, Leon E., Tennessee, 2010
Stasch, Jeffrey J., Kansas, 2010
Windell, Henry C., Oregon, 2007
Lampiris, Lewis N., director
Mangan, Lynne M., manager
McGinley, Jane S., manager
Muraoka, Sharon G., manager
Podschun, Gary D., manager
Stoufflet, Nicole M., manager

The Strategic Plan of the American Dental Association: The Council's programs and activities support objectives in each of the five goals of the *ADA Strategic Plan: 2007-2010*. At its September 2006 meeting, the Council's strategic discussions focused on positioning CAPIR as an advocacy leader in the access to care arena and identifying methods for positioning the ADA as a leader in the prevention and control of oral cancer. Council initiatives tied to these new strategic goals include partnering with multiple stakeholders to plan for an American Indian/Alaska Native Oral Health Summit, to expand the scope of the Give Kids a Smile program, to develop programs to address the oral health care needs of the elderly through the development of an elder care focus area and the roll out of the OralLongevity™ project, and to build relationships with the American Academy of Pediatrics, Sesame Workshop and American Association of Public Health Dentistry.

Access, Community Outreach and Capacity Development

Focus: Access to oral health care is a vital issue for dentistry from the clinical, community and regulatory perspectives. The Council directs nongovernmental advocacy activities, assists with policy development for the ADA and is the touch point for numerous interagency access to care initiatives.

Emerging Access to Care Trends—Community Oral Health Infrastructure and Capacity: The Council continues to field an increased number of e-mails and calls from members and advocates on building/maintaining community partnerships, elder oral health care including programs targeting residents of long term care facilities, providing oral

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

health care services for populations with special health care needs, building community oral health infrastructure and capacity including but not limited to the dental safety net, mobile programs and school based/linked programs. The recent death of a young boy in Maryland this year from a brain infection that may have resulted from severe and untreated dental disease publicly highlighted oral health disparities culminating in the Council's request for a 2008 Access to Dental Care Summit as noted below. The Council is playing an increasing role in providing input and collaborating with agencies to address access to dental care.

2007 Access Grant Program. Through the generosity of the ADA Foundation, the Council helped develop the first Request for Proposals for an access to oral health care grant program. The Council requested that the Request for Proposals provide funding in two areas: State Capacity Building and Oral Health Planning Grants, and Community Water Fluoridation Infrastructure. The Council congratulates the funded programs described in the Annual Report of the ADA Foundation (see page 145).

Emerging Access to Care Trends—American Indian/Alaska Native Populations Through Volunteerism, the Dental Placement Program: The dental placement program is an effort of the ADA to: 1) address the oral health disparities experienced by American Indian/Alaska Native people (AI/AN), 2) improve access to dental services of AI/AN communities, and 3) create meaningful volunteer service opportunities for member dentists. The ADA's volunteer program is one strategy in a multi-faceted approach to improve access to oral health care for AI/AN populations. Resolution 38H-2006 (*Trans.*2006:335) provides for the development and implementation of an ADA-coordinated program of volunteer dentists and dental students to serve in rural or frontier areas of the U.S. to provide oral health care to American Indian/Alaska Native people. In response to this resolution, collaborative agreements were executed between the ADA and nine Indian Health Service/tribal clinics in Minnesota, North Dakota and South Dakota. Recruitment announcements and informational articles were published in *ADA News*, the Executive Director's Update (EDU) and the electronic Community Brief. "Member highlights" will continue to be published as volunteers complete their assignments. The Council will work with ADA Publishing to also cover volunteer recruitment efforts during ADA annual session and standard information on how to volunteer. Volunteers were placed in each of these areas and one returned for a second assignment in Minnesota.

Emerging Access to Care Trends—Elders and Populations with Special Health Care Needs:

Elder Care. The Council coordinates the three-year OralLongevity™ grant project, a joint initiative between the ADA, ADA Foundation and GlaxoSmithKline Consumer Healthcare to increase awareness about elders' oral health. OralLongevity™ will be launched in the fall of 2007 with a Special Supplement of *The Journal of the American Dental Association*, followed by several annual session activities. These include distribution of an educational brochure and DVD at a special OralLongevity™ exhibit in the World Marketplace Exhibition, a continuing education track focused on healthy aging and a national media campaign. ADA.org content focused on OralLongevity™ will be launched in 2007 as well. These activities fulfill many of the public and professional education recommendations from Resolution 5H-2006 (*Trans.*2006:317).

National Foundation of Dentistry for the Handicapped (NFDH). Liaison with the ADA's charitable affiliate, NFDH, helped publicize the Donated Dental Services (DDS) programs in 36 states and a national program that includes any state without a designated DDS program. During 2005-06, 12,307 dentists and 3,374 dental laboratories donated $14.4 million of care to 5,829 disabled, elderly and medically compromised individuals through NFDH's DDS programs. There are about 14,109 individuals on waiting lists in both state DDS programs and the national program.

Emerging Trends—Collaborative Efforts to Improve Access and Community Health:

Oral Health Literacy. The National Oral Health Literacy Advisory Committee, an ad hoc committee to the Council, was appointed by the ADA President and includes 12 representatives from the fields of dentistry, academia and research, industry and professional medical associations. The Committee also includes a CAPIR liaison and a Council on Communications liaison.

The Committee had its first meeting April 11-12, 2007, at ADA Headquarters. Committee members discussed their vision of the committee [in light of Resolution 17H-2006 (*Trans.*2006:317) and *ADA Strategic Plan: 2007-2010*],

identified possible challenges and barriers to the ADA's efforts to improve oral health literacy, developed strategic focus areas to address these obstacles and created a set of strategic goals to guide the Committee's future work. Nine strategic focus areas were identified. These include making oral health literacy a priority for partners, the insufficient evidence base supporting effective health literacy interventions, the broad and complex scope of oral health literacy, the limited recognition of the importance of oral health literacy by the dental team, identification of responsible parties for taking action, identifying sustainable funding streams to support programs and interventions, limited public demand for good oral health, the likelihood of more problems emerging while solutions are being sought and the absence of oral health literacy research instruments.

The Committee recommended that oral health literacy questions be included in the periodic ADA "Survey of Current Issues in Dentistry" which is also scheduled to be administered this year. The Committee selected Dr. Lawrence H. Meskin (Colorado) as its Chair.

American Indian/Alaska Native (AI/AN) Oral Health Access Summit. In order to engage stakeholders to address the oral health needs of American Indian/Alaska Natives, the Council proposed the AI/AN Oral Health Access Summit for 2007. Summit planners include representatives from dental education (i.e., American Dental Education Association), the Indian Health Service, national AI/AN organizations (e.g., National Congress of American Indians, Cherokee Nation, Navajo Nation), national and regional Tribal health boards, local Tribal clinics, Society of American Indian Dentists and the Health Resources and Services Administration.

The planning committee identified 12 stakeholder groups and articulated the following focus question for the event: "What are we going to do, both individually and collectively, to create access to dental treatment and prevention strategies that address the oral health of American Indian and Alaskan Native people?"

Give Kids A Smile National Expansion. The Council in collaboration with the ADA Foundation, continues to move ahead with plans for expanding Give Kids A Smile (GKAS) to "More Than Just A Day." In December 2006, the ADA Board of Trustees approved a proposal to expand the annual GKAS event to year-round activities which included the establishment of a GKAS National Advisory Board. This Advisory Board is unique in that it is made up of a diverse group of people, including a non-dentist as Chair. In August 2006, a GKAS Fund was officially established in the ADA Foundation. CareCredit, the founding donor of the GKAS Fund, presented a $100,000 check to the GKAS National Advisory Board in January 2007 during the Board's first meeting. Also, as part of the expansion, three committees have been formed: Best Practices, Program Expansion and Fundraising. The Dental Trade Alliance has agreed to co-sponsor a GKAS "Promising Practices" Symposium for the next three years. The first Symposium is scheduled for August 27, 2007, at ADA Headquarters, followed by publication of the Symposium proceedings at the ADA annual session in San Francisco. The GKAS National Advisory Board held its first strategic planning meeting on March 28, 2007.

Access to Dental Care Summit. This year the Council focused on its role as a convener, leader and ADA voice of community health. The Council envisions an Access to Dental Care Summit that would include all agencies within the ADA that work on access, along with broad outside stakeholders to:

- Consolidate information on current internal and external access activities
- Develop a coordinated strategy for addressing access to oral health care challenges
- Establish metrics for activities related to the defined strategies

Further information on the proposed Summit will be provided in a supplemental report to the 2007 House of Delegates.

Family Violence Awareness. Increasing awareness within dentistry about recognition and appropriate reporting of suspected family violence continues as an 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. At the March 2007 conference, several presentations and posters specific to dental professionals were heard by the 1,000 attendees from a variety of professional disciplines.

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 policymakers and opinion leaders. The Council devotes time and resources to public recognition of member and stakeholder efforts to deliver oral health care to vulnerable populations by sponsoring four award programs. Recipients of the Access Recognition Award, Community Dentistry Award, Geriatric Oral Health Care Award and Council's Choice Award were featured in the October 2, 18, 19, November 6 and June 6, 2006, and March 5, 2007, issues of the *ADA News.*

Preventive Health and Fluoridation 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 health education, oral cancer prevention, tobacco use prevention and cessation, dental sealants, early childhood caries, sports dentistry and nutrition.

Emerging Trends—Community Water Fluoridation: The number of requests from members, constituent and component societies, and state and local governments for fluoridation technical assistance by phone, e-mail and fax continues to rise. Increasingly, some fluoridation programs are stopped when aging equipment requires replacement and communities faced with shrinking budgets choose not to expend the funds to purchase new equipment. Some opposed to fluoridation have developed a world-wide network that is active in efforts to defeat fluoridation initiatives and discontinue fluoridation in communities with long histories of successful fluoridation programs. It appears that water plant personnel have become a new focus for some opposed to fluoridation. From a massive effort in Tennessee to scattered reports across the United States, water plant personnel are being encouraged to stop fluoridating their systems. The Council continues to work closely with constituent societies, public health departments and the Centers for Disease Control and Prevention Division of Oral Health to ensure that water plant personnel have accurate information on fluoridation. Lastly, a number of publications in the popular media and from scientific sources have had a dramatic effect on fluoridation efforts and will continue to do so into the future.

Federal Fluoride Report. In the past year, the Council, with assistance from its National Fluoridation Advisory Committee, took the lead in reviewing the National Academies' 500-page report, "Fluoride in Drinking Water: A Scientific Review of EPA's Standards." At the request of the Environmental Protection Agency (EPA), this report was developed to advise the EPA on the adequacy of its standards for natural occurring fluoride in drinking water to protect children and others from adverse effects. Additionally, the authors identified data gaps and made recommendations for future research relevant to setting the standards for fluoride. The EPA is currently reviewing the report. While it appears that the EPA may not act on the report prior to 2008, the Council has drafted preliminary comments on the report's recommendations for use by ADA staff who may have the opportunity to discuss the report with the EPA as the EPA completes its review.

Interim Guidance on Fluoride Intake for Infants and Young Children. On November 9, 2006, the ADA issued "Interim Guidance on Fluoride Intake for Infants and Young Children." This followed a number of interagency ADA meetings and two conference calls with state dental societies. When the interim guidance was posted on ADA.org, ADA alerted members about its release via an E-gram. In collaboration with the Division of Communications, an FAQ and talking points were also added to ADA.org.

On November 1, 2006, the ADA convened a meeting of stakeholders and fluoridation experts to discuss an evidence-based review of fluoride intake for children 0-2 years of age. The systematic review on this topic is targeted for completion by the end of 2007. An expert panel will be convened in 2008 to develop evidence-based clinical recommendations.

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. In 2006, the NFAC held four additional conference calls and one additional meeting on November 17 in order to complete its review of the National Academies' report and discuss the issues surrounding fluoride intake for infants and young children. The 2006 annual NFAC meeting was held on July 27. The following members are serving one-year terms on the NFAC: Dr. Lisa Howard, ME, (CAPIR member); Ms. Diane Brunson, CO; Dr. Robert Crawford, Jr., FL; Dr. Jayanth Kumar, NY; Dr. Ernest Newbrun, CA; Dr. Howard Pollick, CA; and Mr. Thomas Reeves, GA.

Emerging Trends—Partnerships to Promote Children's Oral Health through Health Education and Health Promotion: The ADA has been invited to serve on the Oral Health Advisory Board for the Sesame Workshop Education Outreach Initiative. Dr. Lindsey Robinson, Council vice chair, represents the ADA and dentistry on the Board. This comprehensive public health/health education initiative serves as an exceptional opportunity to use the powerful Sesame Street brand to increase oral health awareness for children and their parents and caregivers.

Emerging Trends—Tobacco/Oral Cancer: According to the American Cancer Society's *Cancer Facts & Figures 2007*, the number of cancer cases and deaths for most major cancers, including breast, prostate and colorectal cancers, will decline in the coming year. And while lung cancer remains the top cancer killer among both men and women, incidence and death rates among women have flattened in recent years, and have declined for men. Yet African-Americans are still much more likely than any other group to develop cancer and die from it. The issue of "harm reduction" strategies for tobacco users and as a public health measure has polarized members of the health community. The ADA agrees with the U.S. Surgeon General who concluded that smokeless tobacco is not a safe alternative to smoking tobacco as these products can lead to cancer and non-cancerous conditions as well as nicotine addiction.

The ADA as a Leader in Oral Cancer Prevention. In an ongoing effort to ensure that the ADA is positioned as a leader in oral cancer prevention, CAPIR has completed an environmental scan of ADA internal activities and an external environmental scan of oral cancer and tobacco programs and resources. The results of the internal scan revealed that the ADA has and continues to undertake a number of activities related to the prevention of oral cancer in numerous ADA divisions and departments. To better coordinate these activities and maximize resources, CAPIR has identified a clear need to established a cross divisional/interagency workgroup to review internal and external activities and develop an action plan for the Association.

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. In January 2007, the ADA joined numerous health organizations in a letter of support for federal legislation that would provide the Federal Drug Administration the authority to regulate the manufacture, distribution, and sale of tobacco products. An update of the tobacco content pages on ADA.org was completed in December 2006.

Oral Cancer Prevention Grant. In August 2002, the ADA was awarded a five-year, $1.2 million grant from the National Cancer Institute based on the proposal, "Behavior Modification, Dentists and Oral Cancer Control." Prior to the end of the grant in July 2007, the five-hour continuing education course regarding the early detection of oral cancer and tobacco use cessation developed as part of the grant had been presented in 64 locations across the United States. Publication and dissemination of grant outcomes are in process.

Sports Dentistry/Mouthguards. The Council joined with the Council on Scientific Affairs to publish "Using mouthguards to reduce the incidence and severity of sports-related oral injuries" in the December issue of *The Journal of the American Dental Association*. This ADA report noted that safety is essential to maintaining oral health and a properly fitted mouthguard can minimize the risks of sustaining oral injuries during participation in sports.

Interprofessional Relations

Focus: Interprofessional Relations activities fulfill the Council's mission by maintaining and fostering 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—Fostering Partnerships with Professional Associations to Promote Children's Oral Health:

American Academy of Pediatrics (AAP). The AAP has received a multi-year Maternal and Child Health Bureau grant award, "Partnership to Reduce Oral Health Disparities in Early Childhood (PROHD)." Dr. Lindsey Robinson, CAPIR vice chair, serves as the ADA's representative to the PROHD Advisory Committee. Externally and in response to the AAP identification of oral health as a strategic priority for 2006-07, the ADA took the initiative to invite AAP leadership to meet with ADA leadership. On March 5, 2007, leaders held a cordial and fruitful meeting resulting in more than 24 potential areas for further collaboration.

American Academy of Pediatric Dentistry (AAPD). In cooperation with the AAPD Foundation and the Dental Trade Alliance Foundation the ADA, through the Council, helped raise awareness among general dentists on the importance of a dental home for young children. An 8½ inch by-11 inch, two-sided flyer, "The Dental Home: It's Never Too Early to Start," was sent to every general practice ADA member dentist during National Children's Dental Health Month. The informative brochure described the dental home; offered dentists ideas on how they could make a difference for the health and well being of parents and children in their practice; and highlighted key messages for parents. This venture was a direct result of collaborative efforts begun with the ADA's first-ever Collaborative Strategies Conference held in April 2006 and represents a cooperative effort between the ADA and two other dental organizations.

Emerging Trends—Interprofessional Relations:

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. 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.

Dr. Vincent Filanova, Council chair, was the Official Observer to the Annual Meeting of the American Hospital Association (AHA). The theme of the AHA meeting was "Building Better Lives and Healthier Communities."

American Medical Association (AMA). Dr. David A. Whiston (Virginia) was the Official Observer to the 2006 Annual and Interim Meetings of the AMA. The AMA House of Delegates discussed a variety of issues including Medicare payment rates, pay-for-performance, universal health care, medical liability reform, hospital standards, physician shortage concerns and health information technology. Additionally, scope of practice issues continue to be raised in several resolutions at the AMA House of Delegates. Generally these resolutions target groups such as optometrists, podiatrists and nurse anesthetists, among others, being viewed by the AMA House as practicing medicine outside their scope of authority. Although there were no specific references to dentistry in these resolutions, it is expected that dentists may come under scrutiny and it will be important to track this issue closely. The ADA continues to track past sensitive issues, e.g., oral and maxillofacial surgeons vs. plastic surgeons. The issue of sugar sweetened soft drinks was raised in a resolution proposing a tax to raise money to pay for anti-obesity efforts. Although a similar measure had failed by a margin of two votes at the previous AMA meeting, the margin of defeat was considerable at this year's meeting. Testimony at the Reference Committee by the ADA again called attention to the primary oral health effects of the excessive ingestion of sugar sweetened soft drinks and the general premise of oral-systemic health links. AMA delegates voted to strengthen mercury pollution policy due to the global public health threat assigned to environmental mercury. Due to the combined efforts of ADA scientists and the Council on Scientific Affairs, dentistry was not included in the discussion regarding mercury pollution at this session.

The Joint Commission. The Joint Commission on Accreditation of Healthcare Organizations shortened its name to The Joint Commission. The Joint Commission refreshed its brand identity (name and logo) in support of its continuing efforts to improve the value of accreditation and its utility as a mechanism for improving the quality and safety of patient care. Additionally, the new identity is reflected in a redesigned Web site at www.jointcommission.org; redesigned Gold Seal of Approval™ with the new logo and a new tagline: Helping health care organizations help patients.

The ADA continued participation on the Joint Commission Public Policy Roundtable regarding the Hospital of the Future. This Roundtable and additional related discussions will eventually lead to a public policy white paper based on the 2007 symposium's proceedings and the recommendations of the expert Roundtable. Dr. Ronald L. Tankersley, trustee, Sixteenth District, serves on this Roundtable and is sincerely thanked for his contributions. The ADA served as a supporting organization for the Joint Commission public policy symposium, "The Hospital of the Future: Strategies for Driving Organizational Transformation," on April 26-27, 2007.

Dr. David Whiston continues to serve as the ADA Commissioner on the Joint Commission Board of Commissioners. Additionally, this year he was selected Vice Chair to the Joint Commission Executive Committee.

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). The following Council activities are pertinent to this issue.

Wrong Site Surgery Summit. The Joint Commission hosted a special one-day Summit on Wrong Site Surgery on February 23, 2007, a reprise of the original 2003 Summit on this subject that led to the creation of the Joint Commission's Universal Protocol for the Prevention of Wrong Site, Wrong Procedure, Wrong Person Surgery™. The ADA co-convened the Summit along with the American Medical Association, American Hospital Association, American College of Physicians, American College of Surgeons, American Academy of Orthopaedic Surgeons, Association of Operating Room Nurses and Partnership for Patient Safety. Approximately 50 representatives of professional societies, associations and special interest groups were in attendance. Despite the subsequent implementation of the Universal Protocol and its endorsement by leading surgical and nursing associations and other health care leadership organizations, wrong site surgery persists as a significant problem. This follow-up Summit reviewed experience to date with the Universal Protocol, examined some of the barriers to achieving consistent compliance with the performance expectations and explored potential strategies for eliminating wrong site surgery.

Patient Involvement. The Joint Commission extended a requirement that all accredited organizations define and communicate the means for patients and their families to report concerns about safety, as part of their National Patient Safety Goals. New language in one of two Requirements under the existing medication reconciliation Goal stipulates that a complete list of current medications be provided to the patients on discharge from care. The purpose of these Goals and associated Requirements is to promote specific improvements in patient safety. For more information on the National Patient Safety Goals, including a Frequently Asked Questions section and other resources, visit www.jointcommission.org.

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. Evolving research indicates that there may be a relationship between chronic oral inflammation in the form of periodontitis and diseases such as heart disease, stroke and diabetes, as well as possibly contributing to problems such as low birth-weight.

Oral Health Care Series. The *Oral Health Care Series* provides information on oral health for patients with complex medical conditions. Through its Oral Health Care Series Workgroup, the Council is continuing to update and develop new monographs. The volume *Women's Oral Health Issues* was completed and is available currently on ADA.org. Women have special oral health needs and considerations, and hormonal fluctuations have a surprisingly strong influence on the oral cavity. Puberty, menses, pregnancy, menopause and the use of contraceptive medications all influence women's oral health and the way a dentist should approach treatment. Documents regarding cancer therapy, HIV/AIDS and renal disease are in various stages of production and scheduled for publication in 2007. Additional topics are in development this year.

Response to Assignments from the 2006 House of Delegates:

Strategies to Address Oral Health Issues of Vulnerable Elders: Resolution 5H-2006 (*Trans.*2006:317) adopted 29 recommendations from the 2004-06 Task Force on Elder Care in the areas of public education, professional education, advocacy, research, dental benefits and workforce needs related to addressing oral health issues of vulnerable elders. At the direction of the 2006 House, the Board of Trustees will present a report to the 2007 House of Delegates on this issue. For additional information on the Council's response to Resolution 5H-2006, see the section of this report titled Emerging Access to Care Trends—Elders and Populations with Special Health Care Needs (page 10).

Definition of Oral Health Literacy: Resolution 13H-2006 (*Trans.*2006:315) amended the definition of Oral Health Literacy (*Trans.*2005:322) to read as follows:

> **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.

Limited Oral Health Literacy Skills and Understanding in Adults: Resolution 14H-2006 (*Trans.*2006:317) recognizes "that limited oral health literacy is a potential barrier to effective prevention, diagnosis and treatment of oral disease." The resolution requests the Council and other appropriate ADA agencies work "to increase awareness that many adults have limited oral health literacy skills and difficulty understanding oral health information and available services." The Council's National Oral Health Literacy Advisory Committee (NOHLAC) is addressing such in its planning activities.

Advocacy Strategy for Oral Health Education for Grades K-12 Students: Resolution 16H-2006 (*Trans.*2006:315) requests the development and implementation of an advocacy strategy to increase the number of school districts requiring oral health education for K-12 students and that this position be communicated to the proper external educational organizations and institutes. The Council, in consultation with other ADA agencies and advice from the NOHLAC, will develop and implement a strategy to advocate for increasing the number of school districts requiring oral health education. This will also be addressed in the action plan recommended by the NOHLAC.

Oral Health Literacy Ad Hoc Advisory Committee: In response to Resolution 17H-2006 (*Trans.*2006:317) which requested the ADA President to appoint a three-year oral health literacy ad hoc advisory committee to assist the Council in developing policy recommendations, targeted educational strategies and other health promotion programs to address oral health literacy issues, see the section of the report titled Emerging Trends—Collaborative Efforts to Improve Access and Community Health (page 10).

Funding to Support a Comprehensive Oral Health Literacy Awareness and Education Strategy: Resolution 18H-2006 (*Trans.*2006:315) requests the Council to develop a funding proposal and seek external funding to support the design and execution of a comprehensive oral health literacy awareness and education strategy targeting the entire dental team. The Council, through the NOHLAC, is in the preliminary stages of developing the comprehensive plan. The Committee has developed strategic goals on which to focus, and will be preparing an action plan during its next meeting in autumn 2007. Part of the plan will be identifying potential sources of financial support. The Council also plans to engage interested parties, including philanthropy and government agencies, in the refinement of the action plan. These communities of interest may also serve as potential sponsors of future oral health literacy activities.

Guidelines for Oral Health Literacy Educational Products: Resolution 23H-2006 (*Trans.*2006:315) encourages the development of undergraduate, graduate and continuing education programs to train dentists and allied dental team members to effectively communicate with patients with limited literacy skills. The Council, in consultation with the Department of Public Information and Education and with advice from the NOHLAC, will be developing guidelines for the development and review of oral health educational materials for the public. This will also be addressed in the action plan developed by the NOHLAC.

Travel Expenses for Volunteers in Tribal Areas: For response to Resolution 38H-2006 (*Trans.*2006:335), see the section of this report titled Emerging Access to Care Trends—American Indian/Alaska Native Populations Through Volunteerism, the Dental Placement Program (page 10).

Incentives for Dental School Graduates to Work in Tribal Areas: Resolution 39H-2006 (*Trans.*2006:337) will be reported on by the Council on Government Affairs, which has principal responsibility for this activity. The Council continues to work to support the efforts of the Council on Government Affairs.

Determining the Feasibility of Oral Health Demonstration Projects in Tribal Areas: Resolution 40H-2006 (*Trans.*2006:335) advocates investigation of the feasibility of a demonstration project in remote American Indian/Alaska Native areas to investigate the effects of preventive oral health interventions. The Council continues to work cooperatively with Indian Health Service personnel and ADA agencies to explore the feasibility of oral health demonstration projects in tribal areas. This will be a primary issue to be discussed at the American Indian/Alaska Native Oral Health Access Summit proposed for the third quarter of 2007.

Medically Necessary Care Consensus Statement: Resolution 60H-2006 (*Trans.*2006:323) proposes the ADA develop a consensus statement in order to support existing ADA policy and validate the need for medical insurance coverage for medically necessary services associated with dental treatment. The Council will be discussing this resolution at its September 2007 meeting after consulting with the Council on Dental Benefit Programs and the Council on Government Affairs. Following this discussion, the Council, in consultation with other ADA agencies, will work with appropriate national medical associations and other organizations of interest, to attempt to develop this consensus statement which will include, but not be limited to, care for young children with extensive dental pathology and patients with disabilities.

Meetings: The Council met in the ADA Headquarters Building on September 15-16, 2006, and March 23-24, 2007. The Council is scheduled to meet again September 7-8, 2007. Dr. Ronald L. Tankersley, trustee, Sixteenth District, serves as the Board of Trustees' liaison to the Council.

Personnel: The close of the 2007 annual session brings to an end the terms of four valued members of the Council: Dr. Vincent Filanova, Dr. Lisa P. Howard, Dr. Philip T. Siegel and Dr. Henry C. Windell. These members have given unselfishly of their time and energy on behalf of the profession. The Council acknowledges their efforts with great appreciation.

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

Council on ADA Sessions

McDougall, Kenneth, North Dakota, 2007, chair
Berlanga, Pamela S., Texas, *ex officio*
Brucia, Jeffrey J., California, *ex officio*
Carstensen, Stephen W., Washington, 2010, *ad interim*
Dubin, Gary K., Connecticut, 2010
Dunn, Mary Beth, New York 2010
Feldman, James K., Washington, D.C., 2009
Frey, John T., Michigan, 2008
Jordan, John R., Jr., Florida, 2007
Leighty, Chad R., Indiana, 2007
Lyman, Risé L., Texas 2010
Medovic, Michael D., West Virginia, 2009
Mohme, Edward H., Georgia, 2008
Shinbori, Dennis D., California, 2008
Skinner, Robert L., Arkansas, 2009
Smith, Philip E., South Carolina, 2008
Twesme, A. Ted, Nevada, 2008
Weber, **Charles R.,** Pennsylvania, 2007
Williams, John R., Illinois, 2009
Zuknick, Stephen J., Florida, *ex officio*[*]
Donovan, James P., director

The Strategic Plan of the American Dental Association: The Council on ADA Sessions has updated their Vision and Mission Statements to provide better direction and focus for the Council.

Vision Statement

The Council on ADA Sessions holds the primary responsibility to create and continuously improve every aspect of the ADA Annual Session, to attain and maintain the stature of being the premier meeting in the worldwide dental community.

Mission Statement

The Council on ADA Sessions (CAS) is the Association agency that serves ADA members and the worldwide dental community by providing valuable professional, educational and social experiences, ultimately to benefit the patients they serve. The CAS provides recommendations to the ADA's policymaking bodies on ADA annual session programs and related activities. It oversees the development of programs and supports related efforts in the areas of community building, member recruitment and retention, continuing education, exhibits, logistics and local arrangements. The CAS is also charged with maintaining the annual session as a revenue source for the ADA in a manner consistent with the strategic plan of the organization.

The Council continues to identify action plans to connect with and support various goals and objectives of the ADA Strategic Plan. It has established criteria for measuring success and has evaluated the effectiveness of its activities using those criteria. The Council on ADA Sessions has reviewed and identified primary and secondary goals and objectives of the *ADA Strategic Plan: 2007-2010*. As a result of this review, the Council has also revised their "Guiding Principals, Values and Beliefs" statement as follows:

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

The Council on ADA Sessions believes that:

1. Attending the annual session provides a unique and rewarding experience that will increase the Association's value to the profession.
2. Member involvement in ADA activities through service on this Council and/or the volunteer corps for the annual session will promote a positive view of the value of ADA membership. This will aid in improving market share through sharing between member and nonmember dentists.
3. Keeping the ADA annual session as the premier dental meeting sets the culture in the entire membership that lifelong learning and a continuous advancement of knowledge is a critical value.
4. The annual session provides the best opportunity for the dental profession to keep abreast of the latest advances in the science and practice of dentistry, the materials and equipment available, and the value of professional collaboration.
5. The annual session helps every member dentist by maximizing non-dues revenue in an appropriate manner.
6. Survey results and data mined from our work will assist ADA policymakers as they seek to maintain excellence in and improve all operations of the Association.
7. The Council strives to provide "Wow Customer Service" to all annual session attendees.

147th Annual Session, Las Vegas, Nevada, October 16 - October 19, 2006

The ADA's 147th Annual Session and Technical Exhibition was held at the Mandalay Bay Convention Center from October 16-19, 2006, under the direction of the Council on ADA Sessions. Total registration for the meeting was 40,223 total attendees. Twelve thousand three hundred and eighty-one (12,381) dentists came to the meeting, more than any other convention in the last ten years with the exception of San Francisco. Seventy-seven percent of the attendees pre-registered online and 16% registered by mail or fax. Only 8-10% of the attendees registered onsite.

In an effort to attract non-members to the annual session, the one-time reduced registration fee was continued for non-member attendees who did not take advantage of this offer in 2005. This reduced registration fee was $75 (regularly $750). As a result, more than 1,200 non-members attended the annual session. A work group made up of the ADA's Membership Council staff and the Council on ADA Sessions staff worked to implement several unique membership recruitment and retention programs including follow up with these non-members after the annual session.

The Las Vegas meeting drew 6,646 "first timers" to the annual session, compared to 5,500 that attended the 2005 Annual Session. The First-Time Attendee Orientation Center was continued to provide concierge style service to non-members and first-time attendees at the meeting.

The Nevada dental societies were excited to host the annual session and more than 500 volunteers from the Committee on Local Arrangements assisted the Council on ADA Sessions in providing "'WOW Customer Service" to attendees and exhibitors.

Continuing Education: The scientific program offered a curriculum of more than 300 courses and workshops. Both fee and no-fee courses were held at the Mandalay Bay Convention Center. There was something for everyone—dentists, hygienists, dental assistants, staff members and guests.

Featured speakers included: Thomas Abrahamsen, James Bahcall, Lois J. Banta, Irwin M. Becker, Paul C. Belvedere, Scott Benjamin, Jen Blake, Lee A. Brady, L. Stephen Buchanan, Timothy J. Caruso, Gordon J. Christensen, Bruce D. Christopher, Sebastian G. Ciancio, Donald Coluzzi, Louis E. Costa, Harold L. Crossley, William M. Dorfman, James R. Dunn, Robert R. Edwab, Lawrence Emmott, Allan Farman, Paul H. Feuerstein, John C. Flucke, Cynthia Fong, Michael Glick, Henry A. Gremillion, Mel Hawkins, Randy Huffines, Martin Jablow, Karl R. Koerner, Vincent G. Kokich, Rise Lyman, James Mah, Daniel Meyer, Linda C. Niessen, Kary Odiatu, Uche Odiatu, Gregory L. Psaltis, Steve Ratcliff, Clifford J. Ruddle, Jon B. Suzuki, Michael G. Unthank, John D. West, Joel M. White and many more.

Continuing Education (CE) Credit for these courses was recorded at special CE verification pavilions during the convention. CE credit can still be obtained for attended courses online at any time for up to six months post-session. Recordings of courses in CD and MP3 format are also available.

Satellite Symposia. A new program offered in 2006, the Satellite Symposia offered manufacturers the opportunity to present their own research and techniques in sponsored sessions held on Wednesday, October 15. These symposia were held "off agenda" or one day prior to the annual session. In addition, there were the following programs offered:

- Special Conferences on Aging, Women's Issues, Technology, Prevention and Team Building, and a two day Aesthetics Forum.
- General Interest Programs on Dental Education, Veterinary Dentistry, Dentistry and Marriage, Handling Difficult People, Family Violence, Charity Care and Strategies for Success
- Marketplace Theaters in the exhibit hall, showcasing a variety of one-hour topics for CE credit.

ADA/DENTSPLY Student Clinician Program: The student program, which celebrated its 47th anniversary at the 2006 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 Wednesday, October 18, and were later open for general attendance on Wednesday afternoon at The Mandalay Bay Convention Center. On Thursday morning, October 19, the winning students presented their clinics.

Winning students in Category I, Clinical Application and Technique, were: First place, Amira Baker, Howard University College of Dentistry; Second place, James W. Thomas, Nova Southeastern University, College of Dental Medicine; Third place, Neepa Patel, University of Missouri, Kansas City School of Dentistry.

Winning students in Category II, Basic Science and Research, were: First place, Lindsay A. Pfeffer, University of Pennsylvania School of Dentistry; Second place, Michael S. Stosich, Temple University School of Dentistry; Third place, Winna E. Goldman, Tufts University School of Dental Medicine.

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; Dr. Linda C. Niessen, Dallas, TX; 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, D.C.; Dr. Jon B. Suzuki, Pittsburgh, PA; Dr. Angella Tomlinson, Tampa, FL; Dr. Thomas Van Dyke, West Roxbury, MA; Dr. Rekha C. Gehani, Jackson Heights, NY; Dr. Sharon M. Gordon, Washington, D.C.; Dr. Joseph V. Levy, Burlingame, CA; Dr. Ronald I. Maitland, Amherst, NY; Dr. Joel M. Pascuzzi, Summit, NJ; and Dr. Joel M. White, San Francisco, CA.

Exhibition: The ADA Marketplace featured 1,831 booths from more than 700 companies during a three-day exhibition period. For the third, and final year, the exhibits were arranged into 4 categories instead of the customary random layout: Over-the-Counter and Pharmaceuticals, Dental Services, Materials/Infection Control and Instruments/Equipment. This layout was developed in an effort to make it easier for members to do comparison-shopping for a special piece of equipment or product. Due to negative feedback from the exhibitors, the categories are being phased out after the 2006 meeting.

Also featured in the exhibition hall:

- The ADA Member Services Pavilion continues to provide attendees the opportunity to learn first-hand about ADA products and services. ADA staff received intensive cross-training in an effort to provide better customer service to our members visiting the Pavilion.
- Three Marketplace Theatres brought continuing education directly to the exhibit floor. Tomorrow's Dental Office Today, or TDOT, which was launched in 2004, made its final appearance at a dental meeting. Programming in the Marketplace theatres supported this initiative.
- The New Product Showcase was given a fresh look and gave attendees the opportunity to preview new products being introduced on the exhibit floor.
- The free (fourth annual) commemorative lapel pin and a tote bag sponsored by Oral-B Laboratories were distributed at stations located strategically around the exhibit halls.
- The third annual Super Sunday Sweepstakes—the most visible traffic building program, encouraged attendees to visit five participating exhibitors in order to enter the drawing for a daily trip for two to the 2007 annual session to San Francisco. The grand prize was a 42" flat screen monitor. This program is funded by corporate sponsorship.

Special Social and Entertainment Events: Socializing and networking added to the excitement of this year's annual session:

ADA General Sessions featuring the Johnson & Johnson Distinguished Speaker Series. Attendees at the annual session had a rare opportunity to hear some of the most influential personalities of our times. This year's Distinguished Speakers were entrepreneur Sir Richard Branson and former Nightline anchor Ted Koppel. Each of the two General Sessions featured a Las Vegas style production with a Beatles look-alike band "The Dentals" and a world of magic featuring Rick Thomas.

Evening Entertainment. Because of the wide array of evening entertainment and dinner options, the Council did not host any evening events. Rather, every effort was made to inform attendees of when and how to get tickets to all the top Las Vegas shows.

ADA Presidential Gala. The Presidential Gala honored ADA President Dr. and Mrs. Robert M. Brandjord. In addition to the dinner for 970 attendees, the event provided a "Blast from the Past—the most glamorous era of Vegas entertainment" as well as dance music.

ADA/AADA/FDHE Brunch and Fashion Show. The annual AADA brunch was held at the stunning Liberace Villa, featuring an elaborate brunch and a private tour of the residence. Proceeds subsidized the AADA's Foundation for Dental Health Education, which provides grants for community-based dental health education programs.

Related Events. Meetings and social events were sponsored by 37 dental school alumni, three dental fraternities, four military organizations and 44 academies, specialty and allied organizations. At least two ADA Councils also sponsored reunions.

Hospitality Lounges and Cocktail Parties. Special lounges and cocktail parties were hosted for clinicians, exhibitors, international dentists, retired members and students.

ADA House of Delegates: ADA's supreme legislative body met on Monday, October 16, Thursday, October 19, and Friday, October 20. The Reference Committees convened on Tuesday, October 17, at the Mandalay Bay North Convention Center. Members had a chance to see how ADA policies and programs are all determined and participate in the democratic process.

Housing, Registration and Transportation: ADA selected eight hotels as official meeting hotels. Shuttle bus transportation and tram service were provided from the hotels to the convention center.

Additional Services: The annual session offered additional services:

- ADAF Health Screening
- Internet Café and Wi-Fi Lounge sponsored by Colgate
- ADA Book Store —for the Association's latest products and publications
- Publicity for upcoming regional and national meetings
- ADA Pavilion to promote ADA benefits and services
- Four special issues of *ADA News* highlighting each day's events

Registration and housing for the 2007 annual session in San Francisco was made available in Las Vegas and over 1,000 people pre-registered. Dr. Jeff Brucia along with members of the 2007 Committee on Local Arrangements was also on-hand to answer questions and promote the meeting in San Francisco.

148th Annual Session, San Francisco, CA, September 27–September 30, 2007 ADA07SanFrancisco

The 148th Annual Session will take place at the Moscone Convention Center in San Francisco. The schedule of events will be:

Scientific Sessions:	September 27 – 30 (Thursday - Sunday)
Technical Exhibition:	September 27 – 29 (Thursday - Saturday)
House of Delegates:	September 28 – October 2 (Friday, Monday, Tuesday)

The beautiful Moscone Convention Center will set the stage for what promises to be an exciting meeting. The three building Moscone Complex will house the entire scientific program, workshops and Marketplace Exhibition under one roof including the House of Delegates.

ADA World Marketplace Exhibition: The exhibition name has been changed to reflect the expanded marketing efforts to attract international attendees and manufacturers. Maximum capacity of the exhibit hall is just over 1,800 booths. A complete sell out of the exhibition hall is projected. The exhibition has a new schedule, opening on the first day of the meeting and running Thursday, Friday and Saturday.

General Sessions and Distinguished Speaker Series: Two General Sessions and keynote addresses (ADA Distinguished Speaker Series) are scheduled for Friday, September 28 and Saturday, September 29. The General Sessions are designed to update attendees on key ADA activities, increase members' sense of the dental community, and to help facilitate spending time socially with colleagues, staff and family. Included in the sessions will be the Distinguished Speaker Series which is again sponsored by Johnson & Johnson. The series features ABC News correspondent Barbara Walters and 7-time winner of the Tour de France, Lance Armstrong.

A very special evening event has been scheduled featuring Billy Crystal. Tickets are available in four categories with prices ranging from $75 up to $150 premium seating. Complete annual session information including continuing education, registration and housing, and entertainment is available online at http://www.ada.org.

Scientific Program: The 2007 scientific program the Scientific Sessions will be held from Thursday through Sunday, with pre-sessions and the Satellite Symposia being held on Wednesday, September 26.

The 2007 continuing education line-up offers the top speakers from around the globe and features a wide range of course topics selected to meet the lifelong learning needs of dentists and their professional staff. New for 2007 are three educational formats developed in response to annual session survey data:

- *Education in the Round*—An interactive, multi-media learning experience that augments the need for hands-on workshops. This new format delivers 14 courses in a high-tech, demonstrative setting.
- *The Refinement Series*—A collection of eight advanced level courses covering six different dental topics. Offered in lecture and workshop formats.
- *Educational Tracks*—Seven different educational tracks which organize created to make it easier for attendees to identify courses of interest and plan their meeting schedule.

Once again in 2007, 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 have been put on hold pending review and improvement by the Council.

ADA/DENTSPLY Student Clinician Program: 2007 marks the 48th year of the program. The program format has been revamped to better mirror medical research presentations, in the format of the American Association of Dental Research. This year in San Francisco, the students will make their presentations to the public on Saturday, September 29 from 1:00 p.m. to 3:00 p.m.

Meetings: The Council met at the San Francisco Marriott, February 15-18, 2007, and at the ADA Headquarters Building, May 17-19, 2007.

Personnel: Dr. Kenneth McDougall has served as Council chair for the 2006-2007 term, with Dr. Chad R. Leighty serving as 2007 program director.

Acknowledgments: The Council wishes to express its appreciation to Dr. Jeff J. Brucia, general chair of the 2007 Committee on Local Arrangements, for his assistance in the planning and production of the 2007 meeting, and for his many useful contributions to all of the Council's deliberations during his tenure. The Council also wishes to thank those who capably assisted the Committee's activities related to the 2007 annual session, most importantly the 2007 Committee on Local Arrangements for their valuable assistance in the production of the annual session and they were: Dr. Dennis D. Shinbori, general co-chair; Dr. Harvey J. Barish and Dr. Stafford J. Duhn, program co-chairs; Dr. Dudley Cheu and Dr. Nader A. Nadershahi, registration co-chairs; Dr. Nava Fathi and Dr. Michael Fox, hospitality co-chairs. The Council also expresses its sincere appreciation to the entire California Dental Association for their support of this year's ADA annual session. Without the assistance and cooperation of these individuals and organizations, the 2007 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 2007 annual session, they are: Dr. Kenneth McDougall, Dr. John R. Jordan, Jr., Dr. Chad R. Leighty and Dr. Charles R. Weber. The Council also would like to recognize the contributions made by Dr. Charles L. Smith, Board of Trustees Liaison, Dr. Stephen J. Zuknick, Committee on the New Dentist Liaison and Mr. Bradley Harrelson, ASDA Liaison, who served on the Council on ADA Sessions during 2007. 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

Cram, Sally J., District of Columbia, 2007, chair
Herwig, Larry D., Texas, 2008, vice chair
Austin, David N., Louisiana, 2009
Barnes, Bradley W., Illinois 2007
Bell, Alonzo M., Virginia, 2008
Carroll, Peter J., Pennsylvania, 2008
Dodell, David S., Arizona, 2008
Ellison, Naomi L., California, 2008
Engel, Dennis W., Wisconsin, 2007
Green, Edward J., Georgia, 2010
Icyda, Teri-Ross, Florida, 2008
Knight, Judson M., Kentucky, 2009
Maddox, Brandon R., Illinois, *ex officio*[*]
Nielson, David L., Alaska, 2010
Perrino, Thomas J., Ohio, 2010
Reardon, Gayle T., South Dakota, 2010
Smail, Douglas B., New York, 2007
Tandy Bruce, Connecticut, 2009
Williams, Leslee, director
Hall, Lydia, manager

The Strategic Plan of the American Dental Association: Goal I. Advocacy of the Association's Strategic Plan is addressed in part through the strategic communications activities of the Council on Communications. The Council is the primary ADA agency dedicated to identifying, recommending and maintaining external communications strategies that have implications for the Association's public image. In accordance with the ADA *Bylaws*, the Council advises the Association on external image and brand implications of Association programs, identifies and maintains an external strategic communications plan for the Association and serves as a communications resource to other Association agencies.

Give Kids A Smile (GKAS) and National Children's Dental Health Month (NCDHM): The Council agreed that one of the most significant ADA issues in which the Council should be involved is Access to Care. Keeping in mind the role that access plays in the public's perception of the ADA, the Council chose to continue involvement in GKAS and NCDHM through 2007. A Council representative is appointed to the GKAS Board and a work group was appointed for NCDHM.

Media Monitoring Team: The Council appointed a media monitoring team to keep the Council apprised of trends in media coverage on key issues such as access to care, dental restoratives and water fluoridation. In addition, this team will also serve as an environmental scanner for the Association's Strategic Planning Committee to provide an external perspective on key oral health issues which may impact the image of the profession and the Association.

Podcasting: In collaboration with the Council on Membership, the Council determined that the ADA should use popular technology, such as podcasts, to reach dental students and new dentists in order to establish the Association as a professional resource. The Council proposed topics for the podcasts, and in April 2007, ten new podcasts will be launched every three weeks through the end of the year. The topics span continuing education, healthcare trends, technology, management skills, money management and team development.

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

Response to Assignments from the 2006 House of Delegates: The following are the responses to the resolutions assigned to the Council. Some of the resolutions will be addressed further in the Council's supplemental report to the House of Delegates.

Limited Oral Health Literacy Skills and Understanding in Adults. Resolution 14H-2006 (*Trans.*2006:317) states that the ADA recognizes that limited oral health literacy is a potential barrier to effective prevention, diagnosis and treatment of oral disease. The ADA directed the Council on Access, Prevention and Interprofessional Relations (CAPIR) and other appropriate ADA agencies to work with constituent and component societies, other dental and non-dental organizations, the health care community and governmental agencies to increase awareness that many adults have limited oral health literacy skills and difficulty understanding oral health information and available services.

The Council served as a consulting body to CAPIR and selected Dr. Teri-Ross Icyda to serve as a liaison to CAPIR's newly-created National Oral Health Literacy Advisory Committee, which was created to develop a comprehensive plan to address Oral Health Literacy. Dr. Icyda participated in the committee's first meeting in April to begin framing the committee's work and will continue to participate as an official liaison between the Council and the committee.

Amendment of ADA Bylaws Regarding Duties of the Council on Communications. Resolution 26H-2006 (*Trans*. 2006:309) states that Chapter X, COUNCILS, Section 120, DUTIES, Subsection C. COUNCIL ON COMMUNICATIONS, of the ADA *Bylaws* be amended by deleting subsections a through g in their entirety and substituting in their place the following new subsections:

a. To identify, recommend, and maintain an external strategic communications plan for the Association to facilitate other work throughout and on behalf of the Association.
b. To advise the Association on the external image and brand implications of Association plans, programs, services and activities.
c. To provide counsel to the Association on the priority and allocation of externally focused communication resources, to advise on their implications, and to identify the areas where the greatest strategic communications impact can be achieved.
d. To identify, recommend, articulate and maintain strategies for significant external communications campaigns across the Association.
e. To serve as a strategic communications resource to other Association agencies on communications to the profession.
f. To create, implement, monitor and update an ongoing communication support strategy for the constituent and component dental societies.

To help discharge its *Bylaws* duties, the Chair appointed a work group to develop a Strategic Communications Plan for the ADA designed to support the ADA Strategic Plan by focusing on the need to coordinate communications to external audiences on key oral health issues in order to present a consistent message to the public. The plan will also be designed to encourage other ADA agencies to factor in the decision-making process the impact their proposed positions might have on the image of the profession and the Association.

Establishment of Formal Liaison Relationships with ADA Agencies. Resolution 27H-2006 (*Trans.*2006:309) states that the Council on Access, Prevention and Interprofessional Relations (CAPIR), the Council on Scientific Affairs (CSA), Council on Government Affairs (CGA) and the Council on Dental Practice (CDP) invite, and that the American Dental Political Action Committee (ADPAC) be urged to invite, the Council to establish a formal liaison relationship through the 2008 House of Delegates, in order for those agencies to pilot the enhanced exchange of information on the external image and brand implications of their decisions.

The Council approved members to serve as liaisons and alternate liaisons to CAPIR, CSA, CGA and CDP. In addition, the Council approved members to serve as a liaison and alternate liaison to ADPAC if invited to attend its meeting. The liaison to CAPIR, CSA, CGA and CDP attended the host council's meeting and identified issues that may impact the ADA's image and/or have external communications implications. For example, access to care was discussed in both the CAPIR and CGA meetings. CAPIR proposed a summit on access to care and CGA expressed interest in jointly sponsoring the summit with CAPIR. The Council on Communications believes such a summit has external communications implications that have the potential to affect the image of the ADA, and has offered CAPIR and CGA the Council's resources in developing external communications strategy for the summit.

Development of Success Measures for Council on Communications. Resolution 29H-2006 (*Trans*.2006:309) states that the Council develop success measures in 2007 for its new role and responsibilities, and that the Council, in 2008, conduct a critical evaluation of its new role, including whether the current 17 member, geographic based Council structure is essential to its new role and, with input from other councils and the Board of Trustees on the success of the new role, provide a report and recommendations to the 2008 House of Delegates.

The Chair appointed a team to create metrics for the Council's new strategic role and responsibilities within the ADA. In addition, the Chair appointed a separate team to develop metrics to measure the effectiveness of the council liaison program (Resolution 27H-2006).

Pursuant to the House directive, the Council will evaluate the effectiveness of the liaison program in order to provide a report to the 2008 House of Delegates.

Integrated Public Affairs Plan. Resolution 41H-2006 (*Trans.*2006:305) states that the ADA initiate a nationally coordinated, state targeted integrated public affairs plan, to partner the ADA with selected state dental societies that are at the greatest risk of having significant advocacy issues such as environmental initiatives, scope of practice concerns, the freedom to choose safe and effective restorative materials, community water fluoridation, and access to care, with the purpose of developing and implementing targeted public affairs strategies in cooperation with the state dental societies in order to position the ADA and the state dental society as the source of the best solutions to providing the best possible oral health care to the greatest possible number of the affected states' residents. In addition, the resolution states that the Board will develop appropriate success measures for the program and provide the House with an analysis and report each year on whether the program is meeting its intent and the success measures, with recommended changes or discontinuation of the program.

At a strategic level, Council members have kept abreast of developments in the state-based Public Affairs Plan in order to advise the ADA's leadership of developments pertaining to key oral health issues and their potential impact on the Association's image.

Awards: The Council selected the winners of the 2006 Golden Apple Awards for excellence in Dental Health Promotion. The Ohio Dental Association won the constituent category for "Smiles for Seniors," and the Louisville Dental Society won the component category for "Smile Kentucky." Nominations for the 2007 awards will be considered at the Council's June meeting.

Meetings: The Council met January 19-20, 2007, and will meet June 22-23, 2007, at the ADA Headquarters in Chicago.

Personnel: The Council expresses appreciation to retiring members Dr. Bradley W. Barnes, Dr. Sally J. Cram, Dr. Dennis W. Engel and Dr. Douglas B. Smail. The Council is grateful to Dr. Cram for her thoughtful leadership as chair as the Council redefines its role within the ADA. The Council thanks Dr. Murray D. Sykes, Fourth District Trustee, for his commitment, support and valuable input as the Board of Trustees' liaison to the Council.

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

Commission on Dental Accreditation

Cole, James R., II, New Mexico, 2007, chair, American Association of Dental Examiners
Hutter, Jeffrey W., Massachusetts, 2008, vice chair, American Association of Endodontists
Adair, Steven M., Georgia, 2007, American Academy of Pediatric Dentistry
Barrette, Bruce J., Wisconsin, 2009, American Association of Dental Examiners
Boyle, Ann M., Illinois, 2007, American Dental Education Association
Crow, Heidi C., New York, 2009, American Association of Hospital Dentists and American Dental Education Association
Dolan, Teresa A., Florida, 2008, American Association of Public Health Dentistry
Edgar, Bryan, Washington, 2010, American Association of Dental Examiners
Feldman, Cecile A., New Jersey, 2008, American Dental Education Association
Fong, Jennifer, California, 2007, American Dental Education Association and American Student Dental Association
Gann, Gary, Florida, 2009, National Association of Dental Laboratories
Gillespie, M. Joan, Virginia, 2007, American Dental Association
Iacono, Vincent J., New York, 2010, American Academy of Periodontology
Koelbl, James J., West Virginia, 2009, American Dental Education Association
Louis, Patrick J., Alabama, 2009, American Association of Oral and Maxillofacial Surgeons
McKay, Kay J., Arizona, 2007, Public Member
McPherron, Sharon, Missouri, 2008, Public Member
Nissen, Larry W., Florida, 2009, American Dental Association
Potter, Brad J., Colorado, 2007, American Academy of Oral and Maxillofacial Radiology
Reed, Michael J., Missouri, 2010, American Dental Education Association
Richter, Mary K., Illinois, 2010, Public Member
Roberts, Matthew B., Texas, 2008, American Dental Association
Smith, Richard D., West Virginia, 2008, American Association of Dental Examiners
Sullivan, Diana Macalus, Minnesota, 2008, American Dental Assistants Association
Tarver, E. Les, Louisiana, 2010, American Dental Association
Thomalla, Kenneth, Illinois, 2010, Public Member
Vaden, James L., Tennessee, 2007, American Association of Orthodontists
Woody, Ronald D., Texas, 2009, American College of Prosthodontists
Wright, John M., Texas, 2010, American Academy of Oral and Maxillofacial Pathology
Zinser, Nancy C., Florida, 2007, American Dental Hygienists' Association
Preble, David M., director
Monehen, Rosemary, lead manager
Horan, Catherine A., 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 mega issue discussions in July 2006 and January 2007; the topics were "What Role Do the Accreditation Standards Play in Curriculum Change?" and "Allied Dental Workforce Models," respectively. 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 2006 through January 2007 are summarized in Table 1. At the July 2006 and January 2007 meetings, a total of 532 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, one dental (DDS/DMD) program, ten dental hygiene programs, one dental assisting program, ten advanced specialty programs and three postdoctoral general dentistry programs held the accreditation status of "Initial Accreditation." As indicated in Table 2, the total number of educational programs accredited is 1,350. This represents an increase of three programs from the previous reporting period. Of the 1,350 accredited programs, 37 (2.7%) hold the status of "Initial Accreditation." One thousand two hundred and forty-six (1,246) programs (92.3%) are in compliance with all requirements and have been awarded "Approval *without* Reporting Requirements." During this reporting period, 67 programs (5.0%) were found to have deficiencies or areas of noncompliance and hold the status of "Approval *with* Reporting Requirements." Each of the 67 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, one program had its accreditation withdrawn. The Commission *Rules* stipulate that when the Commission takes action 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, programs may also discontinue accreditation at any time during the process upon written notification by the sponsoring institution. During this time period 12 programs voluntarily discontinued their participation in the Commission's accreditation program.

Table 1. Accreditation Actions: Two Meetings – July 2006 and January 2007

	Dental	Specialty	Advanced General Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Initial Accreditation	1	10	3	1	9	0	24
Approval without reporting requirements	15	124	74	55	73	2	343
Approval with reporting requirements	5	20	17	50	50	1	143
Accreditation Denied	0	0	0	0	0	0	0
Discontinued Programs	0	5	6	1	0	0	12
Intent to Withdraw	1	2	3	1	2	0	9
Accreditation Withdrawn	0	0	0	1	0	0	1
Decision Appealed	0	0	0	0	0	0	0
Number of Accreditation Actions	22	162	103	108	134	3	532

Table 2. Number of Accredited Programs – January 2007

	Dental	Specialty	Advanced General Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Initial Accreditation	2	15	5	3	12	0	37
Approval without reporting requirements	53	413	265	241	255	19	1,246
Approval with reporting requirements	1	9	7	27	22	1	67
Number of Accredited Programs	56	437	277	271	289	20	1,350

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:

- Activities of the Commission on Dental Accreditation of Canada (CDAC) and Mexican National Council on Dental Education (MNCDE).
- Reauthorization of the Higher Education Act of 1965 and United States Department of Education (USDE) negotiated rulemaking.
- Activities of the Secretary of Education's Commission on the Future of Higher Education.
- Trends in the National Advisory Committee on Institutional Quality and Integrity (NACIQI) evaluation of accreditors for USDE recognition.

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

Validity and Reliability Studies: Such studies are conducted periodically in accord with good accreditation practice and requirements of the USDE. 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. During the past year, the Commission reviewed progress on the validity and reliability studies of accreditation standards for education programs in dental assisting, dental hygiene, dental laboratory technology, dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics.

The Commission approved the circulation of proposed revised standards for education programs in dental assisting, dental hygiene, dental laboratory technology, dental public health education, oral and maxillofacial radiology and new standards for clinical fellowship training programs in craniofacial and special care orthodontics to the communities of interest for comment. The Commission also held or will hold open hearings on the proposed revised standards at the March 2007 ADEA annual session, the May 2007 American Association of Orthodontists' annual session, the June 2007 ADEA Allied Program Director's conference, the June 2007 American Dental Hygienists' Association annual session and the October 2007 ADA/American Dental Assistants Association annual session.

Accreditation Standards: The Commission adopted revised Accreditation Standards for the following:

a. Dental Education Programs with an implementation date of January 25, 2007.
b. Advanced Education Programs in General Dentistry and General Practice Residency with an implementation date of January 1, 2008.
c. Revised examples of evidence to support Standard 1 – Institutional Effectiveness for inclusion in the accreditation standards for all programs with an implementation date of July 28, 2006.
d. Revised intent statement to support Standard 5 – Advanced Education Students for inclusion in the accreditation standards for all advanced specialty education programs with an implementation date of July 28, 2006.
e. Revised intent statement to support Standard 4 – Education Support Services for inclusion in the accreditation standards for advanced education general dentistry and general practice residency programs with an implementation date of July 28, 2006.
f. Accreditation Standards for Two-Year Certificate Programs for International Graduates with an implementation date of July 28, 2006.
g. Accreditation Standards for Advanced General Dentistry Education Programs in Oral Medicine with an implementation date of January 1, 2007.
h. Accreditation Standards for Advanced General Dentistry Education Programs in Dental Anesthesiology with an implementation date of January 25, 2007.
i. Revised Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery (residency) with an implementation date of July 1, 2007.
j. Revised Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery with an implementation date of July 1, 2007.

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 policies on *Complaints Directed at CODA-Accredited Educational Programs, Complaints, Procedure for Disclosure Notice of Adverse Actions, Function and Procedures of the Appeal Board, Notice of Decision to Let Accreditation Lapse, Policy Statement on Accreditation Consideration and Policy Statement on Consultant Training.*

New and Revised Policy:

Revised Review Committee Structures and Policies. At the January 2006 meeting, the Commission approved revisions to the structure of review committees and policy for appointment of review committee members. In addition, the chair appointed an ad hoc committee to make recommendations to the Commission at its next meeting regarding the training of review committee members. The Commission further directed that outcome measures be developed and implemented for monitoring the impact of changes to the structure and function of review committees and that the outcomes be reviewed at the January 2010 Commission meeting.

At the July 28, 2006, Commission meeting, the Oral and Maxillofacial Surgery Review Committee (OMS RC) expressed concerns that the new review committee structure might leave a review committee with too few discipline-specific experts to maintain the quality of educational program reviews. The AAOMS-appointed Commissioner, Dr. Patrick Louis, urged the Commission to establish a mechanism to appoint additional members as a committee's workload increases, rather than wait for the outcomes study of the revised structure in 2010. CODA concurred with the OMS RC's recommendation and directed the establishment of a mechanism to determine the need for appointing additional review committee members as committee workloads increase, to be presented at the January 2007 Commission meeting. An Ad Hoc Addition Process Committee was appointed following the July 2006 Commission meeting.

The Ad Hoc Committee met twice before the January 2007 CODA meeting, engaged in lengthy and lively discussion, and made recommendations to the Commission. The Commission took action, at the January 25, 2007, meeting, by directing the standing Review Committees to request one additional discipline-specific expert and one non-expert, in order to maintain the balance prescribed in the Commission's policy on the restructuring of the review committees, if they believe there is a need for additional members. The Commission determined that requests could be made beginning July 2007.

Operational Effectiveness Assessment Plan. The Commission adopted an updated Operational Effectiveness Assessment Plan.

Accreditation of U.S.-Based Two-Year Certificate Programs for Graduates of International Dental Schools: During this reporting period, the Commission approved Accreditation Standards for Two-Year Certificate Programs for International Graduates. CODA and the Commission on Dental Accreditation of Canada (CDAC) approved the extension of the reciprocal agreement between CODA and CDAC to include CODA's Two-Year Certificate Programs for International Graduates and the CDAC's Qualifying Programs, effective March 1, 2007.

Commission on Dental Accreditation of Canada: Representatives of CDAC attended the July 2006 meeting, but were unable to attend the January 2007 meeting. A reciprocal agreement exists between CODA and CDAC due to the comparability of the accreditation standards and the accreditation process. Each year, staff from CODA and CDAC participate in cross-agency site visits to support this reciprocal arrangement.

Mexican National Council on Dental Education (MNCDE): Representatives of the MNCDE attended the July 2006 meeting and the January 2007 meeting. 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.

Responses to Assignments from 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 to Resolution 41H-2004, an ad hoc committee was appointed to continue the dialogue regarding international consultation and evaluation activities. The Ad Hoc Committee developed a business plan which demonstrated the potential level of ADA/CODA activity for fee-based consultation and evaluation services. The Ad Hoc Committee recommended that the Commission report to the 2005 House of Delegates noting that fee-based consultation to international dental schools is likely to be successful only if offered in conjunction with accreditation services. The Committee further recommended that the Commission proceed with the development of a program and process for accreditation of international dental schools.

House of Delegates Resolution 39H-2005 (*Trans.*2005:298) resolved that the ADA and its Board of Trustees support the Commission on Dental Accreditation's initiative to offer consultation and accreditation services to international dental schools and that a Joint ADA/CODA Advisory Committee be established to provide guidance to the Commission in the selection, development and implementation of an international program of consultation and accreditation for dental education. In accord with Resolution 39H-2005, the Joint ADA/CODA Advisory Committee on International Accreditation was formed with Dr. Donald Cadle, Jr., Dr. Steven Bruce and Dr. Roger Simonian representing the ADA and Dr. James R. Cole, II and Dr. Cecile A. Feldman representing CODA.

The Commission on Dental Accreditation also directed the following:

1. That the Joint ADA/CODA Advisory Committee report to the Commission through the Review Committee on Predoctoral Dental Education and to the ADA through the Board of Trustees.
2. That the international programs seeking accreditation by the Commission meet the same Accreditation Standards for Dental Education Programs as the U.S.-based dental education programs.
3. That the accreditation services follow the same process and procedures as U.S.-based programs.
4. That any international program first undergo a comprehensive consultation visit to determine its readiness for accreditation.
5. That additional predoctoral consultants be appointed and additional site visitor evaluation training for all predoctoral consultants be provided.
6. That the state boards of dentistry and the state legislatures be kept apprised, through periodic communication, of the Commission's international accreditation plans and progress.
7. That it is important for all to be mindful of the Commission's reciprocity agreement with the Commission on Dental Accreditation of Canada (CDAC) and keep the CDAC informed of the activities and involved as appropriate.

The Committee determined that each program requesting services will need to complete a preliminary survey and meet broad criteria. The Committee will then use the survey and the criteria in determining program eligibility for a Preliminary Accreditation Consultation Visit (PACV). Programs that are successful in the PACV Process and wish to seek CODA accreditation will then follow the standard accreditation application process.

At the July 2006 meeting, the Commission adopted CODA International Policies and Procedures and the PACV Timeline. The Commission also supported the recommendation of the Joint Advisory Committee on International Accreditation that it prepare to receive requests for fee-based consultation and accreditation services beginning January 2007.

The Commission's International Consultation Documents, including the PACV Survey, were developed and provided to the 12 programs that expressed a continuing interest in CODA's consultation and accreditation services. The Joint Advisory Committee on International Accreditation is prepared to receive requests. The 12 programs are located in the following countries: Australia, Columbia, India, Korea, Mexico, Peru, Saudi Arabia, South Africa, Sweden and Turkey.

Meetings: The Commission conducted meetings on July 28, 2006, and January 25, 2007, at ADA Headquarters. The Commission's discipline-specific review committees met prior to these meetings. Approximately 10% of the review committees conducted business via teleconferencing. Reports, meeting minutes and the Commission's communications to the communities of interest were disseminated via e-mail and online at ADA.org. The increased use of electronic communications has allowed the Commission to expedite business and decrease mailing and copying costs.

Board of Trustees' liaisons Dr. Frank C. Grammer, trustee, Twelfth District, and Dr. Jeanne Strathearn, trustee, First District, attended the July 2006 and January 2007 meetings, respectively. The next meeting of the Commission is July 26, 2007.

Acknowledgments: The Commission acknowledges with appreciation the many significant contributions made by those members who will complete their terms in 2007: Dr. Steven M. Adair, Dr. Ann M. Boyle, Dr. James R. Cole, II, Dr. Jennifer Fong, Dr. M. Joan Gillespie, Dr. Kay J. McKay, Dr. Brad J. Potter, Dr. James L. Vaden and Ms. Nancy C. Zinser.

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

Council on Dental Benefit Programs

Friedel, Alan E., Florida, 2007, chair
Schripsema, Thomas J., New Mexico, 2007, vice chair
Bishop, Deborah S., Alabama, 2008
Boyle, Patricia I., Michigan, 2007
Cooley, Ralph A., Texas, 2009
Faiella, Robert A., Massachusetts, 2008
Hagenbruch, Joseph F., Illinois, 2009
Halbur, Martin J., Iowa, 2010
Hansen, Henrik E., California, 2009
Hight, James R., Jr., Tennessee, 2009
Jaworski, Stephen J., Pennsylvania, 2008
Mooney, John T., Idaho, 2008
Oettmeier, Bert W., Jr., Kansas, 2010
Plage, Robert G., North Carolina, 2010
Rempell, Jeffrey H., New Jersey, 2008
Seiver, Jeffrey, New York, 2010
Simpson, Stephen P., Ohio, 2007
Preble, David M., director
Conway, Thomas E., senior manager
Ellek, Donalda, manager
McHugh, Dennis, manager
Pokorny, Frank, senior manager

The Strategic Plan of the American Dental Association: The Council's activities are consistent with and continue to support the *ADA Strategic Plan: 2007-2010,* particularly with the following Goals: Achieve Effective Advocacy; Build Dynamic Communities; Create and Transfer Knowledge; and Lead in the Advancement of Standards. The Council annually reviews the Strategic Plan to assure that its activities and programs remain effective and relevant.

Emerging Issues: The Council discussed the following emerging issues during the period covered by this report:

- Dental tourism and the potential effects on patients, members and the profession in general.
- Cross-coding; submitting dental treatment against a patient's medical benefits and the possibility of developing resources for use by dental offices.
- Alternative distribution mechanisms for publications such as the *CDT* manual, as members of the profession continue their move to electronic media for exchange and retention of information. This discussion recognized the importance of maintaining the ADA's rights to its intellectual property and to the maintenance of revenue streams.
- Use and potential misuse of evidence-based dentistry (EBD) by third-party payers and mechanisms by which the ADA could accelerate its development of EBD. Examples of the mechanisms discussed include providing correct information, in conjunction with the Division of Science, at the grass roots level to practicing dentists and developing articles to educate dentists about the differences between EBD as defined by the ADA and EBD as defined by third-party payers.
- Pay-for-performance and the ADA's readiness to participate in this issue at such time that dentistry is included in pay-for-performance programs.

Dental Codes Maintenance and Development:

Code on Dental Procedures and Nomenclature. Requests for changes to the *Code* are addressed through the process known as the Code Revision Committee (CRC), and are supported administratively by Council staff. The review and revision cycle, which leads to the version of the *Code* that will be effective on January 1, 2009, is underway. CRC meetings are held at ADA Headquarters and the Committee met in February 2007 and will meet in August 2007 and in February 2008. The final number of additions, revisions and deletions to the *Code* will be known after that meeting.

CDT Manual. The current edition of the manual, titled *CDT-2007/2008*, contains the latest version of the *Code on Dental Procedures and Nomenclature* that is effective January 1, 2007 - December 31, 2008. The *CDT* manual content does not change until the next edition is published in the third quarter of 2008. That edition is tentatively titled "CDT-2009/2010" and will contain the next version of the *Code* that is effective January 1, 2009-December 31, 2010.

CDT Companion. The Council delivered technical content for a new publication to the Department of Salable Materials, and sales began in April 2007. This publication, based on content from the *CDT* manual and from the Council's "Code Workshop," complements information provided in these two sources and serves as an ongoing reference for dentists and their practice staff. The *CDT Companion* conveys information about dental procedure coding to members of the dental community who are not able to attend a session of the Council's "Code Workshop" and is a revenue-generating product.

Code Workshop. Council members continue to deliver this half-day seminar at sessions sponsored by constituent and component dental societies. The current version incorporates information about the current version of the *Code* and includes real world coding scenarios. This material will be revised in 2008 to reflect changes incorporated into the next version of the *Code*.

Dental Claim Form. This ADA salable item was last revised in 2006 to accommodate transmittal of a National Provider Identifier (NPI) for both the billing dentist/dental entity, and the treating dentist. NPI as a unique dentist identifier began on May 23, 2007, and its use on the paper claim form is mandatory where there is applicable state legislation or when required by a participating provider contract.

Dental Content Committee. The ADA's Dental Content Committee (DeCC), housed administratively within the Council, meets annually at the ADA Headquarters Building. It last met on December 8, 2006, and is scheduled to meet again on November 5, 2007. DeCC membership increased with the addition of another payer organization, the National Association of Dental Plans (NADP). To maintain the balance of payer and dentist votes, the ADA increased its voting members to six.

Membership Services. The Council staff field approximately 7,500 telephone and electronic requests for code information on an annual basis. These calls help identify particular problems or common misunderstandings that are addressed in Questions and Answers published in the *CDT* manual and on ADA.org.

Dental Benefit Information Service: The Dental Benefit Information Service (DBIS) within the Council on Dental Benefit Programs was established as the authority and primary resource at the 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.

Electronic Transaction Payment Card Project. The Council recognized that successfully integrating the direct reimbursement concept into the current dental benefits marketplace may require the development of a peripheral product that could provide purchasers with a tool to administer DR more easily and at lower cost. The Council believes a dental benefits transaction card could enable the ADA to transition its marketing focus from promoting a "concept" to promoting a product, while at the same time serve as a potential source of revenue.

The Council commissioned Aspire!One (the name was recently changed to AspireUp) to conduct a preliminary investigation of an electronic transaction card for administration of dollar-based employee benefits. An electronic

payment card is a potential solution for automating payments for dental services from a DR account or other healthcare plans, such as HSA/HRA accounts.

After 22 interviews were conducted by AspireUp, in Stage 1, with ADA stakeholders, TPA/brokers, industry experts in banking and electronic cards and HR benefits managers, it was recommended that a multifunctional health care payment card be researched further as the most flexible product. This card would be similar to a debit card using existing swipe technology. A patient could potentially use the card at a number of healthcare providers (e.g., dentist, physician, pharmacy, vision provider) to pay for the employer-reimbursed portion of the bill or the portion of the bill that is the employee's responsibility. The multifunction card was selected because the functions of the card could be adapted to the needs of individual plan purchasers. Further research is needed to determine if this is a viable product for the ADA. Stage 2 of the research project is designed to conduct a qualitative research analysis and market needs assessment in order to deliver a high-level feasibility assessment and a refined product concept statement.

Stage 1 of the AspireUp project was completed at a cost of $92,000 and the Board of Trustees approved re-allocation of funds within the DR marketing campaign budget to cover expenses for Stage 2 of the project.

DR Research Activity. The ADA hired Forrester Research to conduct market research to determine what employers are looking for in dental benefit plans and how employers make their purchasing decisions. Forrester's overall objective for this engagement is to provide the ADA with insight and recommendations that can be used to better understand how to successfully promote DR. In order to accomplish this, Forrester will conduct in-depth interviews with employers, brokers and state dental society staff at a quoted fee of $79,800, plus reasonable travel expenses. The Council provided Forrester with several hypotheses to help focus the interviews to yield specific information regarding market conditions and barriers to market penetration.

The research is ongoing as of the writing of this report and Forrester will provide project updates, including project status reports as needed. The deliverables will consist of:

- employer, broker and constituent dental society interview guidelines
- conducting employer, broker and constituent dental society interviews
- direct reimbursement product, channel and marketing recommendations
- direct reimbursement recommendations workshop

A supplemental report on these two research projects will be submitted to the 2007 House of Delegates.

National Dental Benefits Conference 2007. The National Dental Benefits Conference 2007 is scheduled for August 24-25, 2007, at ADA Headquarters. The conference features DR and general dental benefit issues. It is expected that approximately 120 people will participate. Attendees typically include benefits brokers, consultants, third-party administrators (TPAs), constituent and component dental society staff and dentists and their staff involved in the promotion of DR and third-party issues.

Direct Reimbursement Campaign—Overview. Highlights of the 2007 advertising campaign include:

- The 2007 DR marketing campaign budget was reduced from $1,930,000 to $850,000.
- Testing of market segments (banks and school districts), lists and formats are being conducted as part of the direct mail campaigns.
- Internal resources will once again be utilized for their cost-effectiveness in the production and mailing of direct mail.
- Print advertising and online advertising have been eliminated from the marketing program due to high costs and poor results.

Direct Reimbursement Campaign—Direct Mail. Innovative ways to market DR are being employed through the testing of new lists, formats and market segments to determine if targeting specific industries (banks and school districts) through customized copy and using new mailing lists will affect the response rate.

Any possible branding changes to the DR logo and/or tagline will be made later in 2007 after the Forrester research has been completed and will be reflected in the fall direct mail campaign if appropriate. Response channels and tracking will continue through business reply cards, the DR Web site, source codes and toll free telephone numbers.

Listed below are statistics reflecting the number of DR plan implementations reported to the Council as of March 26, 2007, for the year 2006.

- 56 new DR plans reported
- 4,371 new covered employees added
- 10,246 total new covered lives added

Promotional Co-op Program. The DR Promotional Co-op program is designed to augment the reach and impact of the ADA's national DR marketing campaign by making additional funds available to each participating constituent dental society for the purpose of promoting DR locally. In 2006, eight state dental societies participated in the program and $35,674 was spent by those dental societies to support local DR promotional efforts. In 2006, each participating dental society could utilize up to $5,000 in co-op funds. ADA leadership recommended, in July 2006, that matching grant and mentoring provisions be incorporated into the promotional co-op program for 2007 and the Council has revised the program accordingly. Past co-op projects have included: customization of national print advertisements; placement of print advertisements in local publications; mailing lists and postage for direct mail promotions; trade show exhibit fees and the purchase of cost-estimation software.

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 as well as brokers that promote and administer DR plans. An article titled "Fee for Service Dentistry – The Florida Way" appeared in the February 26, 2007, issue of the *ADA Community Brief* and focused on the success Florida has had in promoting DR.

The Council is currently revising the *Buyer's Guide to Dental Benefits* to create a new guide titled "Understanding Your Dental Benefits." This publication will include a new informational piece that is intended to help employers know what questions to ask and what features to look for in a quality dental plan. Upon completion, the guide will be available online and in printed format. The draft contains five sections: Things to consider before selecting or changing your dental plan; Dental benefit plan models; Exclusions/limitations and cost containment; Coordination of benefits; Plan analysis service.

Incentives for Companies Providing Goods and Services to the Dental Community. The ADA recognized two exhibitors at the 2006 annual session for offering a direct reimbursement dental program to their employees. The recognition included special exhibit hall signage, special badge ribbons, mention in the official program guide, recognition in "Shuttlevision" programs on busses and hotel in-room messaging. This year the Council is looking to expand the recognition for these exhibitors and an enhanced recognition program will be available for the annual session in San Francisco.

DR Information Repository. The Council maintains a database containing information on all DR plans that have been reported to the ADA. The information in the database is voluntarily supplied by constituent dental societies, brokers and TPAs that sell and administer DR plans. The database includes information such as implementation date, location, industry type and number of participating employees. As of March 26, 2007 the Council was aware of the following DR plans:

Life-to-Date Results (1986-2007)*

- 4,156 total DR plans reported
- 610,284 total estimated employees covered
- 1,430,506 total estimated lives covered

** The ADA started its original promotion of DR in 1986. These numbers include all reported DR plan implementations through March 26, 2007.*

Third-Party Issues. The Council Chair and ADA leadership continue to meet regularly with individual third-party payer or national payer organizations. The Council Chair and senior management met with leadership of the National Association of Dental Plans (NADP) on January 22, 2007. Issues discussed at this meeting included radiograph return policy of NADP member companies, the *ADA News* series on the top ten concerns reported by member dentists, the expanded GKAS program and the Oral Health Literacy program. Dr. Alan Friedel, Council chair, and Dr. John Luther, senior vice president, Practice/Professional Affairs, both spoke at NADP's 2006 annual meeting in September. In addition, NADP will be sponsoring a payer panel at this year's ADA annual session in San Francisco.

The Council Chair, director and senior management met with the leadership of Delta Dental Plans Association (DDPA) on April 19, 2007, and discussed areas of possible collaboration.

Contract Analysis Service: Since its inception in 1987, the Contract Analysis Service has received and analyzed approximately 3,962 dental provider contracts. The Service is operated out of the ADA's Legal Division. In 2006, 150 contracts were analyzed.

To maximize the Service's efficiency, member dentists are encouraged to submit requests through their state or local dental societies, free of charge. Individual members submitting requests directly to the Service must pay $50 for an analysis of a provider contract.

The Service responds frequently to telephone inquiries from members about dental provider contracting issues and offers programs and written information on such matters. The Service also issues the publication, *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.

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 2, 2007.

The Office of Quality Assessment and Improvement also provides consultation on ergonomics to the Council on Dental Practice's Dentist Health and Well Being Program. In this role, the Office developed a tip sheet on hand pain for posting on the ADA's ergonomics section of ADA.org.

The Subcommittee developed an online source of information related to the major structural components of the quality of care, such as infection control, medical emergency procedures, environmental hazards, dental office safety, patient privacy, and compliance with the Americans with Disabilities Act. The Subcommittee has also continued to develop a knowledge base on risk assessment and has continued to monitor the developments in the application of pay for performance programs and value based purchasing.

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, which met via conference call on February 12, 2007, 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 developed information, explaining the difference between parameters, guidelines and standards and explaining their interface with evidence-based studies.

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 continues to contribute substantially to the mission and goals of the EBD project, particularly in advocating the appropriate use of systematic reviews by third-party payers.

Peer Review Structure and Process. The ADA'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. This year, the Subcommittee on Quality Assessment and Improvement provided clarification regarding contemporaneous service on state dental boards and peer review committees. The Council recommends that dentists who serve simultaneously on both the state board and peer review committee recuse themselves from any case on which they have already acted in their other role as either a board member or peer review committee member.

Peer Review and Mediation Workshops. The Council conducted eight peer review/mediation workshops in 2007. The workshops are offered by the ADA 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. The CDBP provided workshops during the year for the following dental societies: Connecticut State Dental Association; Mississippi Dental Association; Nebraska Dental Association; Oklahoma Dental Association; Oregon Dental Association; Virginia Dental Association; Southern Nevada Dental Society; and Wyoming Dental Association.

Response to Assignments from the 2006 House of Delegates:

Funding for the 2007 Direct Reimbursement Marketing Campaign. Resolution 30H-2006 (*Trans.*2006:321), allotted an additional $350,000 to the 2007 national DR marketing campaign for the purposes of marketing research activities and innovative support of constituent dental society DR promotional efforts. The marketing research activities which consist of an electronic transaction payment card study and an extensive market research study to determine what employers are looking for in dental benefit plans are described earlier in this report. The enhanced promotional co-op program, designed to better meet the needs of constituent dental societies in regard to their local promotion of DR, is described earlier on this report.

Dental Benefits for Dental Tourists. Resolution 44H-2006 (*Trans.*2006:323) calls for the appropriate ADA agency to research the issues surrounding the practice of dental tourism and to initiate dialog with representatives of the dental insurance industry to address treatment, payment and claim-related issues related to dental tourism and to report findings to the 2007 House of Delegates. Staff has been working with the Board of Trustees on refining this issue. A description of the Council's action with regard to this resolution will be reported in a supplemental report to the 2007 House of Delegates.

Meetings: The Council met in the ADA Headquarters Building on April 21-23, 2006, November 2-5, 2006, and April 20-22, 2007. The Council is scheduled to meet again on November 9-11, 2007. Dr. William G. Glecos, Third District, served as the Board of Trustees' liaison to the Council.

Chair and Vice Chair: Dr. Stephen Jaworski was nominated as chair of the Council for the 2007-2008 term at the April 2007 meeting. Dr. Jeffrey Rempell was elected vice chair of the Council for the 2007-2008 term at the April 2007 meeting.

Personnel: The close of the 2007 annual session brings to an end the terms of four valued members of the Council: Dr. Alan E. Friedel, Dr. Patricia I. Boyle, Dr. Thomas J. Schripsema and Dr. Stephen P. Simpson. 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.

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

Council on Dental Education and Licensure

Young, Stephen K., Oklahoma, 2008, chair, American Dental Education Association
Maggio, Frank A., Illinois, 2008, vice chair, American Association of Dental Examiners
Dahl, Eva C., Wisconsin, 2007, American Dental Association
First, Louise R., Missouri, 2009, American Dental Association
Gilson, Kate C., Wisconsin, *ex officio*[*]
Haering, Harold J., Florida, 2009, American Association of Dental Examiners
Himmelberger, Linda K., Pennsylvania, 2007, American Dental Association
Hupp, James R., Mississippi, 2010, American Dental Education Association
Kanna, Stanwood H., Hawaii, 2010, American Association of Dental Examiners
Kiesling, Roger L., Montana, 2008, American Dental Association
Lemmo, Ronald, Ohio, 2008, American Dental Association
Lobb, William K., Wisconsin, 2009, American Dental Education Association
Miller, Jade A., Nevada, 2010, American Dental Association
Reinhardt, John W., Nebraska, 2007, American Dental Education Association
Rich, Barbara A., New Jersey, 2010, American Dental Association
Shampaine, Guy, Maryland, 2007, American Association of Dental Examiners
Simon, Denis (Chip) E., Louisiana, 2009, American Dental Association
Hart, Karen M., director
Boehm, Diane M., manager
Borysewicz, Mary, manager
Haglund, Lois J., manager

Meetings: The Council on Dental Education and Licensure (CDEL) met in the ADA Headquarters Building on November 16-17, 2006, and April 26-27, 2007. Dr. Donald I. Cadle, Jr., Seventeenth District, served as the Board of Trustees' liaison to the Council.

The Strategic Plan of the American Dental Association: The Council continued to develop action plans and strategies which complement the new *ADA Strategic Plan: 2007-2010* and are relevant to its mission and duties. The Council discussed how the Plan is changing and had a brainstorming session at its November meeting. In April 2007, the Council conducted a Mega Issue Discussion on proposed allied workforce models.

Collaborating with Councils, Agencies and Associations: Members of the Council served on a number of interagency committees and subcommittees in 2006-07, including the Dental Practice Parameters Committee, the Council on Dental Benefit Program's Subcommittee on Quality Assessment and Improvement, the Advisory Committee on Evidence-Based Dentistry, the Committee on International Programs and Development and the Dental School Programming Advisory Group.

CDEL and the American Dental Education Association (ADEA) co-hosted the American Association of Dental Examiners' (AADE) March 2007 meeting. CDEL and the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) sponsored the Symposium on Integrity and Ethics in Dental Education in June 2007 in collaboration with ADEA and the American College of Dentists. CDEL also responded to a request from the Council on Membership regarding ways the ADA can partner with dental education and research organizations. During the ADA 2006 annual session, CDEL and ADEA co-sponsored a panel presentation workshop for practitioners interested in applying for teaching positions.

Dental Education

Golden Apple Awards: In 2006, there were no faculty nominees for the Council's Golden Apple Award for outstanding mentoring of students and/or junior faculty interested in academic careers. In response, the Council made changes to increase overall promotion and participation. For example, the name of the award category, "Outstanding

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

Mentoring of Dental Students and/or Junior Faculty Interested in Academic Careers" was changed to "Inspiring Careers in Dental Education." The Council will market the Golden Apple Award by collaborating with the American Dental Education Association and the American Student Dental Association. Beginning in 2008, the Council will provide funding for award recipients to attend the ADA annual session.

Matters Relating to Accreditation: A duty of the Council is to act as the agency of the Association in matters related to the accreditation of dental and allied dental education programs. This past year, the Council reviewed the following documents circulated by the Commission on Dental Accreditation: *Accreditation Standards for Advanced Specialty Education Programs in Endodontics, Standard 4-10;Accreditation Standards for Dental Hygiene Education Programs; Accreditation Standards for Advanced Specialty Education Programs in Dental Public Health; Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Radiology; Accreditation Standards for Dental Assisting Education Programs; Accreditation Standards for Dental Laboratory Technology Education Programs* and *Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics.*

The Council supported the proposed draft documents in general, with the exception of the *Accreditation Standards for Dental Hygiene Education Programs.* The Council expressed concern with the term "dental hygiene diagnosis" in the dental hygiene standards. In the Council's opinion, the term diagnosis is inappropriate in Standard 2-17: only a dentist may conduct a diagnosis of the oral cavity. The term "dental hygiene assessment" was suggested as a substitute for "dental hygiene diagnosis," complementing the terminology used throughout the Standards document. Correspondence to this effect was sent to CODA. The Council also communicated with other appropriate ADA agencies to encourage them to forward any comment they may have as well.

Dental Education Curriculum Study: Dr. Stephen K. Young continued to represent the Council on the ADEA's Commission on Change and Innovation (CCI) in Dental Education. The CCI was established in 2005 to engage the full community of stakeholders in exploring systemic changes to the dental school curriculum. The CCI's intent is to redefine core competencies and related foundation knowledge that will lead to a change in competency-based dental education and curriculum, the construction of National Board examinations, the updating of accreditation standards and the reassessing of clinical licensure processes. Other ADA representatives on the CCI include Dr. Joel F. Glover, Fourteenth District Trustee; Dr. James R. Cole, II, Commission on Dental Accreditation; Dr. D. Gregory Chadwick, ADA Foundation; Dr. Ronald L. Winder, Joint Commission on National Dental Examinations; and Dr. Laura M. Neumann, ADA Division of Education.

Training Dentists with a Focus in Community-Based Dentistry: Resolution 48H-2005 (*Trans.*2005:308) directed the appropriate ADA agencies to develop a model for curriculum changes or use existing models to facilitate the development of dentists trained with a focus on community-based dentistry. Further, the resolution directs that the model be field-tested by one or more pilot projects that would deliver not only acute care to patients, but also work to provide public health interventions to maximize prevention of oral disease.

The Council reviewed existing examples of community-based dental education models such as those sponsored by Marquette University, School of Dentistry, and the University of Connecticut, School of Dental Medicine, noting that each one has unique features. The Council also learned about a new "comprehensive community oral health" program under development at two California dental schools. The Council determined that a resource listing of "best practices" for community-based education gleaned from the current dental school models would be helpful to all dental schools. The resource listing of best practices will be available in late 2007.

Guide to Developing an Accredited GPR or AEGD Program: Over the past two years, the Council has collaborated with the Commission on Dental Accreditation (CODA) on the development of a step-by-step guide for starting an accredited general practice residency (GPR) or advanced education in general dentistry (AEGD) program. This activity supports the intent of Resolution 73H-2005 (*Trans.*2005:337) that calls for the ADA to encourage and support the expansion of postgraduate training for dental school graduates. An advisory committee of experts in AEGD/GPR program development and management and CDEL's Committee on Dental Education have provided guidance to ensure that the Guide is comprehensive, practical and user friendly. The Council plans to have the Guide available in late 2007.

Trends in Dental Licensure and Clinical Licensing Examinations

Dental Licensure via PGY-1: In January 2007, New York became the first state to eliminate the clinical licensing examination requirement and mandate completion of a postgraduate residency of at least one year in length (PGY-1) that is accredited by the Commission on Dental Accreditation (CODA). California, Connecticut and Minnesota continue to offer the option of a clinical examination or completion of a PGY-1 to licensure applicants. Washington law permits dentists who complete an accredited PGY-1 residency to practice in designated shortage areas and become licensed without further examination. A pilot program on this provision is being conducted in Washington, with the first class graduating in July 2007. Vermont law now allows the state board to grant licensure by credentials to dentists who have obtained licensure in another state via completion of a CODA-accredited PGY-1 rather than by passing a clinical examination.

The Council is very interested in obtaining information regarding individuals licensed initially by clinical examination versus those licensed by completion of an accredited postgraduate year of study (PGY-1). This year, the executive administrators of the state boards of dentistry where PGY-1 is a licensure pathway were contacted to determine their ability and willingness to collect data on their licensees' pathways to licensure. The state board executive directors in California, Connecticut, Minnesota, New York, Vermont, and Washington indicated that nearly all of the boards do not have the capacity to collect this type of data. The Council concluded that it has exhausted its options for collecting this information.

Licensure by Credentials: Dental boards in 46 states plus the District of Columbia and Puerto Rico grant licensure by credentials to dentists. Only Delaware, Florida, Hawaii, Nevada and the Virgin Islands do not grant licensure by credentials. Hawaii has a community service license law which allows dentists with proper credentials to come to Hawaii to work *only* in federally qualified health centers, native Hawaiian health centers and post-secondary dental training programs.

Volunteer Licensure: A number of states are granting authority to dental boards to license dentists who agree to donate their services to underserved populations. Volunteer licenses are most often granted to retired dentists. Currently 22 states have volunteer licensure laws, and more are expected to enact this type of legislation to assist in access to care issues.

Clinical Licensure Examinations—Uniform Exam with National Acceptance: Progress has been made on the goal to develop a uniform clinical licensure examination that could be accepted by all state boards of dentistry and increase freedom of movement for dentists. Until recently, there were 16 individual clinical examinations: four regional exams and 12 independent state exams. Today, there are five regional testing agencies and four remaining independent agencies (a fifth regional testing agency, the Council of Interstate Testing Agencies [CITA] was established in July 2005). Many formerly independent states have now joined a regional testing agency. Additionally, instead of each testing agency administering its own examination, some testing agencies are administering the same exam, i.e., the American Dental Licensing Examination (ADLEX) developed by the American Board of Dental Examiners (ADEX). As a result, the number of individual clinical examinations has been reduced from 16 to eight. ADEX currently has approximately 28 member state boards. At this time, approximately 40 states will accept results of ADLEX.

Each spring, the Council provides current information to the dental school deans about each state's membership in the clinical testing agencies and contact information for the state boards of dentistry and the clinical testing agencies. The Council also contacts the constituent dental societies, encouraging them to undertake initiatives to implement ADA policies related to licensure and freedom of movement.

Use of Human Subjects: The debate continues over the use of human subjects in clinical examinations. In recent years, testing agencies have reduced the number of patient-based procedures and increased the use of manikin, written or computer-simulated experiences. Based on information in the regional testing agencies candidates' guides, only the restorative and periodontal portions of the examinations are patient-based. The remaining portions of the examinations are written, manikin and/or computer-simulated exercises.

Curriculum Integrated Format: Resolutions 34-2006 and 34S-1-2006 (*Trans.*2006:334) were referred to the Council with a mandate to "develop a definition of curriculum integrated format and the necessary steps from the communities of interest to implement such an evaluation and report to the 2007 House of Delegates."

The North East Regional Board, Inc. (NERB) initially developed the curriculum integrated format (CIF) in response to ADA Resolution 89H-2001 (*Trans.*2001:411), which encouraged the dental testing agencies to collaborate with dental educators to investigate offering clinical licensing examinations to dental students on patients within dental schools, and that these examinations be given early enough in the year to allow those who do not pass the board examination to remediate prior to graduation. The CIF has been a permanent part of the NERB examination process since 2003. The CIF is now a part of the examination developed by the American Board of Dental Examiners and administered since 2005 by NERB and the Central Regional Dental Testing Service (CRDTS). The Council of Interstate Testing Agencies also uses a CIF.

The Council requested input on a definition from the clinical dental testing agencies, the American Association of Dental Examiners, the American Dental Education Association and the American Student Dental Association. Based on the information collected, the Council drafted a definition. The Council recognizes that implementation of the CIF will vary somewhat among testing agencies and plans to monitor the agencies' progress. Accordingly, the Council presents the following proposed CIF definition for consideration. This resolution supports the ADA Strategic Plan Goal: Achieve Effective Advocacy.

1. Resolved, that the American Dental Association adopt the following definition:

Curriculum Integrated Format: An initial clinical licensure process that provides candidates an opportunity to successfully complete an independent "third party" clinical assessment prior to graduation from a dental education program accredited by the ADA Commission on Dental Accreditation.

If such a process includes patient care as part of the assessment, it should be performed by candidates on patients of record, whenever possible, within an appropriately sequenced treatment plan. The competencies assessed by the clinical examining agency should be selected components of current dental education program curricula.

All portions of this assessment are available at multiple times during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake any portions of the assessment which they have not successfully completed.

ADA-Recognized Dental Specialties and ADA-Recognized Specialty Certifying Boards

Annual Activities: In August 2006, the Council hosted its annual meeting with the ADA-recognized dental specialty certifying boards and sponsoring organizations at ADA Headquarters in Chicago. Representatives from all nine specialty boards and organizations attended the meeting. The attendees participated in a mega issue discussion on evidence based dentistry.

As part of its *Bylaws* responsibilities for national dental specialty certifying boards, the Council annually surveys the recognized dental specialty certifying boards. The 2007 *Report of the ADA Recognized Dental Specialty Certifying Boards* is available on ADA.org at www.ada.org/prof/ed/specialties/natcert.asp. The report shows that during this time period, all nine specialty certifying boards certified diplomates and six boards recertified diplomates. The report also reflects changes that some boards made to the eligibility requirements, examination procedures, application and registration procedures, reexamination policies, recertification polices or *Bylaws*.

Anesthesiology

Proposed Guidelines and Policy on Sedation and General Anesthesia: The 2005 ADA House of Delegates adopted Resolution 42H-2005 (*Trans.*2005:333) supporting the CDEL Committee on Anesthesiology's comprehensive review of the ADA's anesthesia guidelines documents and policies. Other dental and medical organizations (American Society of Anesthesiologists, American Academy of Pediatric Dentistry, American Academy of Pediatrics, American Academy of Periodontology, and American Association of Oral and Maxillofacial Surgeons) with policies and guidelines on sedation and anesthesia had recently made significant changes to their documents. The Council believed it was imperative for the ADA documents to be updated to reflect contemporary terminology and to be reorganized by levels of sedation versus routes of administration, making the ADA's documents current and consistent with other leading organizations' policies and guidelines. The documents and policies under review included:

- Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists (Guidelines for Dentists) (*Trans.*2005:334)
- Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry (Guidelines for Teaching) (*Trans.*2005:334)
- ADA Policy Statement: The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry (Policy Statement) (*Trans.*2005:334)
- Dentist's Right to Administer Conscious Sedation, Deep Sedation and General Anesthesia (*Trans.*2000:470)

The Committee began by hosting an Invitational Anesthesia Conference at the ADA Headquarters in May 2006 to gather information from nationally-recognized experts in the science and clinical practice of sedation and general anesthesia in dentistry. The following organizations had representatives at the conference: American Society of Anesthesiologists, American Society of Dentist Anesthesiologists, American Academy of Periodontology, American Association of Oral and Maxillofacial Surgeons, American Dental Society of Anesthesiology, American Academy of Pediatric Dentistry, Academy of General Dentistry (AGD), AADE, American Association of Endodontists, American Association of Hospital Dentists, American College of Prosthodontics, ADEA, Dental Organization for Conscious Sedation and the National Institutes of Health.

Throughout the summer and fall, the Committee developed draft documents, focused on being consistent with other leading organizations and reorganizing the content from a "route of administration" approach to a "level of sedation" approach. In November 2006, CDEL carefully reviewed and forwarded the proposed documents to the Board of Trustees with a request to circulate the documents to the communities of interest for comment. The Board approved the request at its December 2006 meeting.

A call for comments was issued to the communities of interest on December 15, 2006, with a February 23, 2007, deadline date for submission of written comments. The communities of interest included the ADA Councils on Dental Practice, Scientific Affairs, Access Prevention and Interpersonal Relations, Government Affairs, the ADA Committee on the New Dentist, constituent and component dental societies, state boards of dentistry, dental school deans and advanced education program directors, ADA-recognized dental specialty organizations and certifying boards, ADEA, AADE, AGD, American Student Dental Association, American Society of Dentist Anesthesiologists, American Dental Society of Anesthesiology and the American Society of Anesthesiology. A general call for comments appeared in the January 8, 2007, issue of *ADA News* and was posted on ADA.org.

More than 1,400 letters were received by the February 23 deadline: 18 state and national dental–related organizations, one constituent dental society, three state dental boards, one ADA Council, one dental sedation continuing education organization, 313 individual dentists and 33 dental patients. Letters contained both support for and concern about the proposed guidelines. Additionally, a nonprofit organization, Trust for Equal Access Medicine (TEAM) 1500 submitted over 1,000 letters from dentists and dental patients. TEAM 1500 describes itself as "a non-profit coalition of more than 1,500 independent healthcare providers who are dedicated to making quality medical and dental care available to all Americans," advocating against burdensome regulation of healthcare professionals.

Those expressing support for the proposed guidelines noted that they provide appropriate guidance to dental practitioners, educators and regulators for the safe and effective administration of sedation and general anesthesia in the dental office. Many commenters also expressed support for the development of an alternative course to the current Advanced Cardiac Life Support (ACLS) requirement in Section III of the Use Guidelines, Educational Requirements for Moderate Sedation, and Deep Sedation or General Anesthesia that would have a strong focus on sedation emergencies and airway management.

In general, concerns focused on 1) very similar definitions for minimal and moderate sedation; 2) an unclear provision for state dental boards to grandfather those already administering sedation and anesthesia services; 3) the requirement that dentists must remain in the room to monitor sedated patients until they meet the criteria for discharge; and 4) the educational requirement for moderate enteral sedation to be 60 hours of instruction and 10 patient experiences per participant, including experience in establishing intravenous access.

Some who opposed the draft documents, particularly those from TEAM 1500, expressed the belief that dentists would not be able to continue to use sedation in the dental office under the proposed new guidelines. Many of the letters received expressed concern that some of the requirements would result in higher fees overall and reduce access to care for dental phobic patients, who would not seek needed dental treatment without sedation services.

The Committee on Anesthesia met on March 10, 2007, to carefully consider all comments and additional changes to the proposed documents. At its April 2007 meeting, the Council considered the revised documents as proposed by the

Committee. The following is a summary of those deliberations, including rationale for the original proposed changes and those now suggested based on the comments from the communities of interest.

Proposed Revisions to Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists (Guidelines for Dentists): The initial changes to the Guidelines for Dentists focused on:

- A new title for the document—ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists (Use Guidelines)
- The use of the American Society of Anesthesiologists (ASA) definitions, either all or in part, from the ASA document—Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2004—to reflect level of sedation rather than routes of administration;
- Amendments to the "Education Guidelines" and the "Clinical Guidelines" sections to reflect the new definitions (level of sedation versus route of administration)
- A new "Additional Resources" section at the end of the document to provide the reader with additional information.

The Council also recommended that a course be developed with a curriculum specifically designed for dentists, which concentrates on the emergency management situations faced by dentists administering sedation or general anesthesia in the dental office. Council and Committee members believed this course could serve as an alternative to the ACLS training currently recommended in the Guidelines. Current ACLS courses involve interventions concentrating on cardiac arrhythmias, which are not the early presentation of the emergencies most commonly faced by dentists administering sedation. Rather, dentists may experience the eventual result of an unrecognized, untreated or improperly treated emergency. CDEL is working with the ADA Foundation to develop the criteria for a Request for Proposals (RFP) for a project that could be funded via the Foundation's 2008 funding cycle. The project would be for development of an emergency management course focusing on airway management for dentists administering sedation or general anesthesia.

Additional Proposed Revisions Based on Comments from the Communities of Interest. The Council agreed with many commenters who noted that the definitions of minimal and moderate sedation were too similar and made clarifying edits to both definitions. Additionally, the definition of "titration" was moved from under the minimal sedation definition to the moderate sedation definition. A definition of "supplemental dosing" was placed in the minimal sedation definition, which the Council felt more accurately reflects what occurs when dentists administer oral sedative drugs to achieve minimal sedation (Appendix 1, pages 54-56).

The requirement that the dentist remain in the room with a minimally sedated patient until that patient meets the criteria for recovery was carefully reconsidered by the Committee and Council. Those commenting believed that the dentist should be able to leave the patient, for example, to see an emergency patient or check a patient who is seeing the dental hygienist. The Committee and Council agreed, noting that once treatment stops, patients who are minimally sedated meet the criteria for post-sedation care and/or discharge and no longer require monitoring by the dentist. Accordingly, the Council made additional clarifications regarding the monitoring requirements for minimally sedated patients, revising the proposed monitoring requirement to state that "a dentist, or at the dentist's direction, an appropriately trained individual must remain in the operatory during active dental treatment to monitor the patient continuously until the patient meets the criteria for discharge. The appropriately trained individual must be familiar with monitoring techniques and equipment." Provisions in states where dental assistants or hygienists are currently authorized to monitor sedated patients would not be affected by the guidelines.

The proposed monitoring requirements for *moderate* sedation were not changed because the standard of care requires the dentist to monitor the patient until that patient meets the criteria for recovery. To clarify, the Council has proposed additional language that the dentist must not leave the facility until the patient meets the criteria for discharge, and is discharged from the facility.

Commenters also expressed concern that dentists who have been safely practicing sedation and anesthesia under current state rules and regulations would not be able to continue practicing without further education. Although Section IV. Educational Requirements of the current document states that the guidelines should not exclude individuals who would be grandfathered by individual state laws, the Council believed it could further strengthen the intent of this language. The proposed language states, "For all levels of sedation and anesthesia, dentists who are currently

providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document, are not subject to these educational requirements" (Appendix 1, page 59, lines 15-17).

Proposed Revisions to Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry (Guidelines for Teaching): The initial proposed changes to the Guidelines for Teaching focused on:

- A new title for the document—Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (Teaching Guidelines).
- Use of the American Society of Anesthesiologists (ASA) definitions, either all or in part, from the ASA document Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2004. [The ASA uses the terms minimal sedation (anxiolysis) and moderate sedation, where as the ADA 2005 Guidelines use the terms conscious sedation and combination inhalation-enteral conscious sedation (combined conscious sedation)].
- Elimination of educational requirements pertaining to deep sedation and general anesthesia from the Teaching Guidelines because the Committee believed this instruction must take place at the advanced education level in a program with Standards set by the Commission on Dental Accreditation.
- Elimination of Parts I, II and III and reorganization of the educational requirements by level of sedation, whether the dentist is at the predoctoral, advanced education or continuing education level.
- A requirement that education courses for enteral moderate sedation contain 60 hours of didactic training and 10 patient experiences per participant, including experience in establishing intravenous access.
- A new "Additional Resources" section at the end of the document to provide the reader with additional information.

Additional Proposed Revisions Based on Comments from the Communities of Interest. To complement the Use Guidelines, the Council made clarifying edits to the definitions of minimal and moderate sedation, moved the definition of "titration" from the minimal sedation definition and relocated it under moderate sedation definition, and added a definition for "supplemental dosing" under the definition for minimal sedation.

Comments on the Teaching Guidelines also addressed the educational requirements for minimal and moderate sedation courses. Commenters expressed concern that the initially proposed training requirements would be difficult to provide and could be cost prohibitive for both course providers and participants. Limited availability of proper facilities also would limit a dentist's ability to find the training required. As a result, access to care could be affected because dental phobic patients would not be able to readily find a dentist who could provide sedation services.

The Council carefully reconsidered the minimum number of instructional didactic hours and clinical cases that would be required to teach moderate enteral sedation exclusively and proposed a new educational framework separating the didactic instruction from the clinical experiences. In doing so, the Council believes that the moderate enteral sedation training requirements should reflect 24 hours of didactic instruction and the management of at least 10 adult case experiences, which includes at least three live clinical dental experiences managed by participants in groups no larger than five (the remaining cases may include simulations and/or video presentation, but must include one experience in returning (rescuing) a patient from deep to moderate sedation), and a participant/faculty ratio of 5:1. Further, the Council agreed that clinical experience in establishing intravenous access for moderate enteral sedation should not be required.

In summary, the Council made the following changes to the proposed Teaching Guidelines:

- Inhalation Sedation—Course Duration (Appendix 2, page 80, lines 5-6) add language to clarify that the inhalation sedation course most often is completed as part of the predoctoral program, but could also be completed in a postdoctoral continuing education competency course. This clarification addresses concerns that a dentist would need additional training outside dental school education to qualify to administer inhalation sedation.
- Enteral and/or Combination Inhalation-Enteral Minimal Sedation—Course Duration (Appendix 2, page 82, lines 20-21): add a similar statement under the inhalation course duration that indicates the training may be obtained in the predoctoral curriculum or postdoctoral continuing education competency course.
- Moderate Enteral Sedation Course Duration (Appendix 2, page 84, lines 22-38) and Faculty; page 85, lines 27-31):
    - Revise the requirement of 60 hours of instruction, management of 10 patients that includes experience in establishing intravenous access and the participant/faculty ratio of 3:1 to 24 hours of didactic instruction,

management of at least 10 adult case experiences, which includes at least three live clinical dental experiences managed by participants in groups no larger than five (the remaining cases may include simulations and/or video presentation, but must include one experience in returning (rescuing) a patient from deep to moderate sedation), and a participant/faculty ratio of 5:1.

- Eliminate the requirement to receive clinical experience in establishing intravenous access.

Proposed Revisions to the ADA Policy Statement: The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry: The initial proposed changes to the ADA Policy Statement focused on:

- A complementary new title for the document—ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists (Policy Statement).
- Expansion of the "Introduction" section to include information on dentistry's contributions to sedation and anesthesia in dentistry and medicine.
- Revisions to reflect the restructure of the Guidelines documents from route of administration to level of sedation.

Additional Proposed Revisions Based on Comments from the Communities of Interest. In addition to the proposed revisions listed above, the Council suggests new language under the section State Regulation (Appendix 3, page 89, lines 6-10) to address the use of permits and to emphasize that dentists who were providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of the revised documents are not subject to the requirements as outlined in the Policy Statement or Use Guidelines.

Dentist's Right to Administer Conscious Sedation, Deep Sedation and General Anesthesia: The Council considered the 2000 ADA policy, Dentist's Right to Administer Conscious Sedation, Deep Sedation and General Anesthesia, for the purpose of revising this policy to be consistent with the proposed revised documents.

Dentist's Right to Administer Conscious Sedation, Deep Sedation and General Anesthesia (*Trans.*2000:470)

Resolved, that the American Dental Association supports the right of appropriately trained dentists to administer conscious sedation, deep sedation and general anesthesia for the management of dental patients and is committed to ensuring and supporting the safe and effective use of these modalities by dentists.

The same or similar language appears in the Introduction sections of all three ADA anesthesia documents. In accordance with Resolution 15H-1995, which directs that policies be reviewed for currency and usefulness on a periodic basis, the Council believes that duplicate policies are not necessary and recommends that this policy be rescinded. The Council emphasizes that this is to relocate, not eliminate the concepts in the policy.

After thorough review of the Association's anesthesia guidelines documents and policies, the Council presents the following resolutions. These resolutions support the ADA Strategic Plan Goals: Achieve Effective Advocacy, Create and Transfer Knowledge:

2. Resolved, that the Guidelines for the Use of Sedation and General Anesthesia by Dentists (Appendix 1) and Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (Appendix 2) be adopted, and be it further
Resolved, that the previous Guidelines for Dentists (*Trans.*2000:490, 511; 2002: 400; 2003:368; 2005:334) and the previous Guidelines for Teaching (*Trans.*2000:490, 518; 2002:400; 2003:368; 2005:334) be rescinded.

3. Resolved, that the Policy Statement: The Use of Sedation and General Anesthesia by Dentists (Appendix 3) be adopted, and be it further
Resolved, that the previous Policy Statement (*Trans.*1999:326, 935; 2005:334) be rescinded.

4. Resolved, that the policy "Dentists Right to Administer Conscious Sedation, Deep Sedation and General Anesthesia" (*Trans.*2000:470) be rescinded.

Career Recruitment, Resources and Related Activities

New Committee: The Council established the Subcommittee on Career Guidance and Diversity Activities that reports directly to the Council on activities related to its national campaign, "Something to Smile About—Careers in the Dental Profession." Formerly the Council's Ad Hoc Committee on Diversity, the Subcommittee is composed of 11 members from national underrepresented minority organizations and student groups as well as a corporate member. The Committee oversees career guidance activities, maintains and develops career recruitment strategies, specifically diversity-related initiatives and assesses outcomes of its activities.

Career Resources: Dental and allied career resources were exhibited at several national conferences including the 2006 ADA annual session in Las Vegas, the 2007 ADEA annual meeting in New Orleans, the Hispanic Dental Association and the U.S. Hispanic Leadership Institute in Chicago. Promotion of careers in dentistry appeared in the Fall/Winter issue of the American School Counselor Association (ASCA) and the Black Collegian magazines. Sullivan-Schein Dental supported the inclusion of 2,500 dentistry career posters in the Give Kids A Smile kits. Three additional dentistry and two allied career exhibits were developed to meet the needs of dentists and others who participate in career events. Between April 2006 and April 2007, the Council received over 661 requests for career materials from member dentists, dental education programs, constituent/component dental societies, students, public health facilities, career centers, college health advisors, libraries and other professional organizations. Approximately 27,000 career brochures, 112 packets and 15 career exhibits were distributed.

Be a Dentist Web Site: In April a new "Be a Dentist" Web site was launched that contains comprehensive career information tailored for a number of targeted audiences, such as high school and college students, college advisors and parents. The new organization of career information at www.ada.org/goto/careers is more attractive and user friendly to the targeted groups.

Career Mentoring: A key component of the national careers campaign is the mentor coordinators network which links member dentists with students that may be interested in dentistry and job shadowing at a dental office. Students interested may directly access one of the 22 mentor coordinators listed online at www.ada.org/public/careers/beadentist/mentoring.asp.

To stimulate interest in mentoring and increase the skills of mentors, a Mentoring Skills Workshop was offered in 2006 at the ADA annual session and again in 2007 in San Francisco. Participants include the mentor coordinators and member dentists interested in learning about mentoring young students. The session, co-sponsored by the American Dental Education Association, highlights the dentist's unique role as a mentor and offers strategies to effectively coach the millennial generation interested in dentistry as well as students from diverse backgrounds.

Student Ambassador Program: The Student Ambassador Program, piloted at the 2006 ADA annual session, will be held again in San Francisco. In 2006, 49 dental student representatives sponsored by their dental school deans were introduced to successful peer-to-peer predental outreach programs. Many good ideas came out of the brainstorming sessions which students could incorporate into their schools' predental recruitment activities. In follow-up, student ambassadors were sent a packet of resources that included statistics on numbers of minority students applying and enrolling in dental school; a list of Web sites of successful dental school programs; PowerPoint presentations of programs presented with simple steps on how to begin an outreach activity; and information on financial support to help minority students. The 2007 program, planned by the students on the new Subcommittee on Career Guidance and Diversity Activities, will be extended to a full day with presentations to include a variety of successful new model Student Ambassador outreach programs.

Minority Youth Outreach Initiative: As an outgrowth of last year's *Outreach Forum: Increasing Diversity in the Dental Profession*, co-sponsored by the Council and the Division of Membership, the Council is working with several dental societies in tailoring a minority outreach effort similar to the model outreach projects of the Institute for Diversity in Leadership graduates.

New Career Pathways Network: Graduates of the ADA Institute for Diversity in Leadership were invited along with other interested individuals to be part of an active network of dentists with special interests in strategies for "clearing pathways" for a wide range of students interested in careers in the health professions, in particular dentistry. The Network, primarily a communications forum developed in collaboration with Council and Dental Society Services

staff, will support all of the established career recruitment initiatives and strategies and work to mobilize new career programs within dental societies.

Dental Admission Testing Program

Dental Admission Testing Program (DAT) Trends and Activities: The DAT continues to be administered exclusively on computer at Thomson Prometric Testing Centers throughout the United States. Ongoing survey findings indicate that the testing center surroundings have been satisfactory and the computer administration of the examination has performed to expectations.

Currently, DAT score information is provided to examinees and dental schools in various forms. To help reduce printing costs and decrease the turnaround time for score reporting, the ADA's Testing Services Department is transitioning to paperless reporting of DAT scores within the next year. This change will also benefit the dental schools by eliminating documents containing confidential information that can be cumbersome for schools to dispose of.

The number of DAT examinations given increased by an average of 10.8% per year since 2001, as well as an overall increase of 5,919 examinations or an increase of 80.9% from 2001 to 2006. From 2001 to 2006, there have been slight changes in the percentages of males and females participating in the testing program. The percentages of males, relative to females, have shown a relatively consistent pattern of decline in recent years. During the six-year period beginning in 2001, the percentage of males declined from 53% to 51%. Concerning ethnicity for the same period, the total number of examinations administered by ethnicity has been consistent. The percentages of traditionally underrepresented minorities have remained relatively stable across years. The repeat rate was the highest at 32.8% in 2006. Typically, as the number of tests administered increases, the repeat rate also increases. Despite the relatively higher repeat rates beginning in 2003, the percentages of first-time examinees increased. The average percentage increase in the number of first-time examinees over the recent six-year period is 8.8%. The increase in the percentage of examinees, from 2001 to 2006, is 61%.

ADA Continuing Education Recognition Program (CERP)

The ADA CERP assists members and the broad-based dental profession in identifying and participating in quality continuing dental education (CE). The ADA CERP promotes continuous quality improvement of CE and assists dental regulatory agencies in establishing a sound basis for increasing their uniform acceptance of CE credits earned by dentists to meet the CE relicensure requirements currently mandated by 49 licensing jurisdictions. At the time this report was prepared, there were 355 ADA CERP recognized providers. Providers are distributed in the following categories: 20% dental education companies, 19% dental specialty organizations or societies, 19% dental/medical schools, universities, and colleges in the United States and Canada, 11% constituent dental societies, 8% pharmaceutical/dental equipment companies, 4% study clubs, 3% communications/publishing companies, 3% hospitals, 2% component dental societies, 2% federal agencies, 1% insurance companies, and 1% consulting companies.

The Extended Approval Process (EAP): The ADA CERP includes an extended approval process (EAP) through which ADA CERP recognized constituent dental societies and recognized dental specialty organizations can extend approval to their component societies and local affiliates. The state or specialty society submits the application to ADA CERP and, after gaining approval, can extend its ADA CERP recognition to its local groups. Currently, 14 constituent dental societies (Illinois, Indiana, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Nevada, New York, Ohio, Pennsylvania, Tennessee, Virginia and Washington) have been granted the authority to extend their ADA CERP approval to their local societies. The American Academy of Oral and Maxillofacial Pathology, the American Association of Endodontists and the American Association of Orthodontists also use the extended approval process. A total of 121 component dental societies and specialty component organizations have ADA CERP recognition through the EAP. (These are in addition to the 355 providers profiled above.)

Continuing Education Course Listing: ADA CERP-recognized providers are given access to enter and update their provider information and CE course offerings on www.ada.org/prof/ed/ce/cerp/index.asp. They regularly list between 1,000 and 1,500 courses.

Abbreviated Application for Continued ADA CERP Approval: ADA CERP continues to streamline its operations and improve the application process. Beginning in 2007, providers granted a three- or four-year approval period will complete an abbreviated reapplication with 70% fewer questions.

Outcomes Assessment for ADA CERP Process: A survey was initiated to collect feedback from the providers that have recently completed the application process. Results from providers surveyed in the spring 2007 decision cycle indicate that overall respondents found the application instructions clear and complete, the organization of the application appropriate and logical, and the questions clear. Providers surveyed also strongly agreed that the newly offered pre-printed tabs helped to organize and simplify the application process. A large majority of survey respondents indicated that they would be capable of completing and submitting future applications electronically. The ADA CERP Committee will continue to survey applicants during each decision cycle and will monitor results. The Committee also plans to revise the full application and improve instructions regarding documentation to be appended; develop materials and guidelines for new applicants; make available examples of best practices in the areas of needs assessment, evaluation and objectives; and encourage applicants to pay particular attention to the areas most frequently cited in Decision Reports.

Status of Proposed Changes to ADA CERP Recognition Standards: The *ADA CERP Recognition Standards and Procedures (Standards and Procedures)* undergo review on a periodic basis to ensure currency. In addition, changes may be proposed by ADA CERP's communities of interest. In turn, the Council solicits feedback from the communities of interest prior to adopting any proposed changes. During this reporting period, the Council considered the following proposed revisions to the *Standards and Procedures.*

Product Training. CDEL has been monitoring commercialism in continuing dental education and studying what changes might be considered in the *Standards and Procedures.* In 2006, the Council circulated among the communities of interest a proposed revision that would allow for product training as continuing education. Comments received from the dental industry were supportive of the proposed changes, while some commented that CE credit is not necessary for product training. Additionally, university and other providers were not in support of the changes. Specifically, the comments received from the agencies of the American Dental Association, including the Board of Trustees, were opposed to the proposed changes, citing potential challenges in "policing" product training as CE and the difficulty in writing clear policies for its implementation and enforcing such changes. Without consensus for the proposed change, the Council maintained the existing Standard which is designed to separate commercial or promotional content from continuing education activities through several mechanisms. ADA CERP Recognized Providers must ensure that 1) no products or commercial services are marketed or promoted within continuing education activities; 2) balanced views of all therapeutic options are presented; and 3) all commercial relationships that the provider and faculty may have with commercial interests are fully disclosed to participants.

ADA CERP Recognition Standard VII, Instructors. The 2006 ADA House of Delegates referred Resolution 63 (*Trans.*2006:330) to CDEL. The Council and the ADA CERP Committee carefully considered the resolution which called for the addition of Criterion #6 to Standard VII, Instructors, to read, "Providers are to insure that course instructors, if dentists, are members (or eligible for membership) in good standing with no sanctions by the component society, constituent society or the American Dental Association."

The Committee and CDEL agree with the intent of the resolution. ADA CERP must have strong standards related to the qualifications and ethical conduct of continuing education instructors affiliated with ADA CERP-approved providers. However, they believe that that the proposed criterion would be impossible to implement. Member sanctions by component societies, constituent societies and the ADA are confidential and not available to CE providers. Further, the ADA and ADA CERP have no way to monitor non-members with respect to eligibility or sanctions. The Council concluded that it cannot pursue the proposed revision to ADA CERP Recognition Standard VII, Instructors at this time.

Sole Provider Eligibility Requirement. Since 2003, representatives of ADA CERP and AGD Program Approval for Continuing Education (PACE) have been working toward mutual recognition of the two programs to better meet the needs of the profession, providers and the public. Currently, AGD PACE accepts credits from ADA CERP recognized providers for its Fellowship and Mastership programs. However, AGD PACE does not recognize ADA CERP approved providers that earned their CERP approval through the Extended Approval Process. ADA CERP does not

offer a reciprocal relationship to AGD PACE approved providers. AGD PACE allows sole providers (individuals) to apply for approval. ADA CERP approves CE program providers, not individual instructors/presenters.

Representatives of the ADA and AGD agreed in principle to mutual recognition to providers at the national level only and to continue to pursue reconciliation of the differences between the programs at the state level. In the fall of 2006, the ADA CERP Committee and the Council considered this recommendation, but felt strongly that because "ADA CERP does not recognize individual instructors or authors," and approximately 30% of AGD PACE approved providers at the national level are sole providers, mutual recognition even at the national level should not be endorsed.

In December 2006, the ADA Board of Trustees asked the ADA CERP Committee and CDEL to reconsider their positions and on April 15, 2007, the Chair of ADA CERP met with the Board of Trustees to further discuss the issues. The Board was very supportive of the ongoing efforts to achieve mutual recognition, noting that the ADA CERP and AGD PACE standards for recognition are almost identical. Both sets of standards are rigorous, addressing all of the components necessary to deliver quality dental education programs. However, there is one significant difference related to AGD PACE's recognition of sole providers and ADA CERP's exclusion of sole providers via its Eligibility Criteria. The Board suggested that if a sole provider can demonstrate compliance with all the standards, the provider should not be excluded from the ADA CERP review process because s/he is an individual instructor or author. The Board adopted a resolution urging CDEL to pursue mutual recognition between ADA CERP and AGD PACE, and in doing so, consider deleting the statement, "The ADA CERP does not recognize individual instructors or authors" from the Eligibility Criteria of the *ADA CERP Recognition Standards and Procedures.*

At its April 26-27, 2007, meeting, the Council considered the Board's recommendations and directed that the proposed deletion be circulated among the communities of interest for review and comment. The Council will consider the feedback from the communities of interest at its November 2007 meeting.

Composition of the ADA CERP Committee: Resolution 49H-2006 (*Trans.*2006:334) directed CDEL to review Resolution 82H-1996 (*Trans.*1996:706) that established the composition of the ADA CERP Committee. The Resolution also directed that the Council seek input from a focus group of dental meeting planners. In response to Resolution 49H-2006, the Council appointed an ad hoc committee to review the history of the ADA CERP program and conducted a focus group with meeting planners during the February 2007 Chicago Mid-Winter Meeting. The Council chair also charged the ad hoc committee to consider ADEA's request to allow for dentists and non-dentists to serve as the ADEA representative on the ADA CERP Committee.

History of ADA CERP. In 1992, the ADA House of Delegates adopted Resolution 25H-1992 establishing the ADA CERP (*Trans.*1992:613), including an 18-member Steering Committee (Policy Board), which set the standards and policies related to program governance, and an eight member Review Committee, which conducted the provider reviews and managed program operations. In 1995, the House of Delegates adopted Resolution 133H-1995 (*Trans.*1995:646) directing a review of ADA CERP, including the structure and function of its supporting committees. A Special Committee on ADA CERP was assigned this responsibility. The Special Committee's 1996 Report 13, Proposed Organizational Restructure of the ADA CERP Committees, proposed that the Policy Board's responsibilities be transferred to the Council on Dental Education (CDE) and the Review Committee to become a subcommittee of the CDE. The intent was for the Council to be responsible for the appointment of the ADA CERP Committee members, based on nominations made by the representing organizations. The House supported the proposal. The size of the Subcommittee was revised from 8 to 15 members representing the following communities:

1 American Association of Dental Schools
1 American Association of Dental Examiners
4 American Dental Association (general dentists)
8 ADA recognized dental specialty organizations
1 Canadian Dental Association

In 2002, the ADA CERP added a representative from the American Society of Constituent Dental Executives (ASCDE) to the Committee composition as a result of concerns raised by the ASCDE about ADA CERP. To date, both individuals who have served as ASCDE representatives have been non-dentists.

Focus Group Input. The Council reviewed input received from the Conference of Dental Meetings during the February 2007 Chicago Mid-Winter Meeting. In general, the meeting planners in attendance believed that it is

important for a representative from their community to participate in ADA CERP because meeting planners are responsible for ensuring that their organizations and speakers comply with ADA CERP standards.

ADA CERP Committee Input. The ADA CERP Committee did not support the proposal to add a meeting planner to the Committee noting that almost all of the ADA CERP-approved providers and organizations represented on the ADA CERP Committee have meeting planners within their organizational structures. The Council agreed, also noting that dental meeting planners' concerns typically focus on procedural matters, rather than CE content or speaker qualifications, and unlike all other organizations represented on the ADA CERP, the Conference of Dental Meetings is not a formalized organization/agency. The Council also agreed with the Committee to support ADEA's request that it be permitted to nominate a dentist or a non-dentist to serve on the ADA CERP Committee, noting that former and current ASCDE representatives on the ADA CERP Committee are not dentists.

The Council concluded that the current composition of ADA CERP is appropriate and that the House's intentions for the four ADA appointees to be general dentists should be maintained. Further, all dentist representatives serving on the Committee must be ADA members. The Council believed that the ADA CERP Committee should not be expanded to include dental meeting planners at this time, but that the composition of the Committee should be revisited periodically to ensure that it accurately reflects the continuing dental education communities of interest. Accordingly, the CDEL presents the following resolution for consideration. This resolution supports the ADA Strategic Plan Goal: Create and Transfer Knowledge.

5. Resolved, that the ADA policy on the Organizational Restructure of the ADA CERP Committees (*Trans.*1996:705) be amended as follows [deleted language struck through; additions are underscored]:

> **Resolved,** that responsibility for the conduct of the American Dental Association's Continuing Education Recognition Program (ADA CERP) be transferred from the existing ADA CERP Policy Board to the Council on Dental Education, and be it further
> **Resolved,** that a continuing education subcommittee of the Council be created to facilitate the conduct of the ADA CERP by developing expertise and making recommendations regarding continuing education provider recognition for consideration by the Council, and be it further
> **Resolved,** that the continuing education subcommittee shall have the following composition: one representative each representing the ~~dental education community~~ American Dental Education Association, the ~~dental licensure community~~ American Association of Dental Examiners, the parent organizations of the ADA-recognized dental specialties, the ~~dental profession in Canada~~ Canadian Dental Association, the American Society of Constituent Dental Executives and four American Dental Association general dentists, and be it further
> **Resolved,** that all representatives who are dentists be members of the American Dental Association or the Canadian Dental Association. , and be it further
> **Resolved,** that the CERP Standards and Criteria for Recognition and related program documents be revised to reflect this change in program governance.

Response to Assignments from the 2006 House of Delegates

Encouraging the Development of Oral Health Literacy Continuing Education Programs: Resolution 19H-2006 (*Trans.*2006:315) called for CDEL and other appropriate agencies to encourage the development of undergraduate, graduate and continuing education programs to train dentists and allied dental team members to effectively communicate with patients with limited literacy skills. The Council has communicated its interest in collaborating with the Council on Access, Prevention and Interprofessional Relations' (CAPIR) recently appointed National Oral Health Literacy Advisory Committee and looks forward to working with CAPIR and other ADA agencies in encouraging the development of these materials.

Definition for Curriculum Integrated Format: Actions taken by the Council in response to referred Resolutions 34-2006 and 34S-1-2006 (*Trans.*2006:334) are provided in the Trends in Dental Licensure and Clinical Licensing Examinations section of this report under "Curriculum Integrated Format."

Composition of ADA CERP Committee: As requested by Resolution 49H-2006 (*Trans.*2006:334), the Council reviewed the composition of the ADA CERP Committee and concluded that the current composition of ADA CERP is appropriate. Details related to the Council's study are provided in the ADA CERP section of this report.

ADA CERP Recognition Standards and Criteria for Recognition: Resolution 63-2006 (*Trans.*2006:330) was referred to CDEL to consider the intent of the proposed addition to the ADA CERP Standards and report to the 2007 House of Delegates. The ADA CERP Committee and the Council carefully reviewed the proposed revision and concluded that such a revision cannot be pursued at this time. Details related to the Council's deliberations are provided in the ADA Continuing Education Recognition Program (CERP) section of this report.

Online Availability of Licensure by Credentials Information: Resolution 52H-2006 (*Trans.*2006:330) called for the development of an informational section in the members-only section of ADA.org to include the conditions, requirements and associated costs for a dentist to obtain a license by credentials in each state. CDEL and the Department of State Government Affairs have created a comprehensive document that contains the information requested in the resolution. The information will be posted on ADA.org by July 2007.

Personnel: At the 2007 annual session, Dr. Eva C. Dahl, Dr. Linda K. Himmelberger, Dr. John W. Reinhardt, Dr. Guy Shampaine and Dr. Kate C. Gilson complete their terms as Council members. Mr. Jared Lee completes his term as the American Student Dental Association's consultant to the Council. The Council wishes to express deep appreciation to these individuals for exemplary leadership and contributions during their tenure.

Summary of Resolutions

1. Resolved, that the American Dental Association adopt the following definition:

> **Curriculum Integrated Format:** An initial clinical licensure process that provides candidates an opportunity to successfully complete an independent "third party" clinical assessment prior to graduation from a dental education program accredited by the ADA Commission on Dental Accreditation.
>
> If such a process includes patient care as part of the assessment, it should be performed by candidates on patients of record, whenever possible, within an appropriately sequenced treatment plan. The competencies assessed by the clinical examining agency should be selected components of current dental education program curricula.
>
> All portions of this assessment are available at multiple times during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake any portions of the assessment which they have not successfully completed.

2. Resolved, that the Guidelines for the Use of Sedation and General Anesthesia by Dentists (Appendix 1) and Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (Appendix 2) be adopted, and be it further
Resolved, that the previous Guidelines for Dentists (*Trans.*2000:490, 511; 2002: 400; 2003:368; 2005:334) and the previous Guidelines for Teaching (*Trans.*2000:490, 518; 2002:400; 2003:368; 2005:334) be rescinded.

3. Resolved, that the Policy Statement: The Use of Sedation and General Anesthesia by Dentists (Appendix 3) be adopted, and be it further
Resolved, that the previous Policy Statement (*Trans.*1999:326, 935; 2005:334) be rescinded.

4. Resolved, that the policy "Dentists Right to Administer Conscious Sedation, Deep Sedation and General Anesthesia" (*Trans.*2000:470) be rescinded.

5. Resolved, that the ADA policy on the Organizational Restructure of the ADA CERP Committees (*Trans.*1996:705) be amended as follows [deleted language struck through; additions are underscored]:

> **Resolved,** that responsibility for the conduct of the American Dental Association's Continuing Education Recognition Program (ADA CERP) be transferred from the existing ADA CERP Policy Board to the Council on Dental Education, and be it further

Resolved, that a continuing education subcommittee of the Council be created to facilitate the conduct of the ADA CERP by developing expertise and making recommendations regarding continuing education provider recognition for consideration by the Council, and be it further,

Resolved, that the continuing education subcommittee shall have the following composition: one representative each representing the ~~dental education community~~ American Dental Education Association, the ~~dental licensure community~~ American Association of Dental Examiners, the parent organizations of the ADA-recognized dental specialties, the ~~dental profession in Canada~~ Canadian Dental Association, the American Society of Constituent Dental Executives and four American Dental Association general dentists, and be it further

Resolved, that all representatives who are dentists be members of the American Dental Association or the Canadian Dental Association., and be it further

Resolved, that the CERP Standards and Criteria for Recognition and related program documents be revised to reflect this change in program governance.

AMERICAN DENTAL ASSOCIATION

GUIDELINES FOR THE USE OF SEDATION AND GENERAL ANESTHESIA BY DENTISTS

(2000:490, 511; 2002:400; 2003:368; 2005:334)

I. Introduction

The administration of local anesthesia, sedation and general anesthesia is an integral part of dental practice. The American Dental Association is committed to the safe and effective use of these modalities by appropriately educated and trained dentists. The purpose of these guidelines is to assist dentists in the delivery of safe and effective sedation and anesthesia.

Dentists providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document are not subject to *Section III. Educational Requirements.*

II. Definitions

Methods of Anxiety and Pain Control

analgesia - the diminution or elimination of pain.

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

Note: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression, especially in combination with sedative agents.

minimal sedation - a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond *normally* to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.[1]

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.

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[1] Portions excerpted from *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia,* 2004, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

When the intent is minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use.

The use of preoperative sedatives for children (aged 12 and under) except in extraordinary situations must be avoided due to the risk of unobserved respiratory obstruction during transport by untrained individuals.

Children (aged 12 and under) can become moderately sedated despite the intended level of minimal sedation; should this occur, the guidelines for moderate sedation apply.

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.*

Nitrous oxide/oxygen may be used in combination with a single enteral drug in minimal sedation.

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

The following definitions apply to administration of minimal sedation:

maximum recommended dose (MRD) - maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use.

incremental dosing - administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).

supplemental dosing - during minimal sedation, supplemental dosing is a single additional dose of the initial dose of the initial drug that may be necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD.

moderate sedation - a drug-induced depression of consciousness during which patients respond *purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. [2]

[2] Excerpted from *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia,* 2004, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

Note: 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. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to the administration of moderate or greater sedation:

titration-administration of incremental doses of a drug until a desired effect is reached. Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

deep sedation - a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.[2]

general anesthesia - a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.[2]

For all levels of sedation, the practitioner must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.

Routes of Administration

enteral - any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

parenteral - a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].

transdermal - a technique of administration in which the drug is administered by patch or iontophoresis through skin.

transmucosal - a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

inhalation - a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

Terms

qualified dentist - meets the educational requirements for the appropriate level of sedation in accordance with Section III of these *Guidelines*, or a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document.

must/shall - indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

should - indicates the recommended manner to obtain the standard; highly desirable.

may - indicates freedom or liberty to follow a reasonable alternative.

continual - repeated regularly and frequently in a steady succession.

continuous - prolonged without any interruption at any time.

time-oriented anesthesia record - documentation at appropriate time intervals of drugs, doses and physiologic data obtained during patient monitoring.

immediately available – on site in the facility and available for immediate use.

American Society of Anesthesiologists (ASA) Patient Physical Status Classification System[3]

ASA I - A normal healthy patient.

ASA II - A patient with mild systemic disease.

ASA III - A patient with severe systemic disease.

ASA IV - A patient with severe systemic disease that is a constant threat to life.

ASA V - A moribund patient who is not expected to survive without the operation.

ASA VI - A declared brain-dead patient whose organs are being removed for donor purposes.

[3] ASA Physical Status Classification System is reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

E - Emergency operation of any variety (used to modify one of the above classifications, i.e., ASA III-E).

III. Educational Requirements

A. Minimal Sedation

1. To administer minimal sedation the dentist must have successfully completed:

a. training to the level of competency in minimal sedation consistent with that prescribed in the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*, or a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the *ADA Guidelines* at the time training was commenced,

or

b. an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage minimal sedation commensurate with these *Guidelines*;

and

c. a current certification in Basic Life Support for Healthcare Providers.

2. Administration of minimal sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

B. Moderate Sedation

1. To administer moderate sedation, the dentist must have successfully completed:

a. a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced,

or

b. an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage moderate sedation commensurate with these *Guidelines*;

and

c. a current certification in 1) Basic Life Support for Healthcare Providers and 2) Advanced Cardiac Life Support (ACLS) or an appropriate dental sedation/anesthesia emergency management course.

2. Administration of moderate sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

C. Deep Sedation or General Anesthesia

1. To administer deep sedation or general anesthesia, the dentist must have completed:

a. an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage deep sedation or general anesthesia, commensurate with Part IV.C of these *Guidelines*;

and

b. a current certification in 1) Basic Life Support for Healthcare Providers and 2) Advanced Cardiac Life Support (ACLS) or an appropriate dental sedation/anesthesia emergency management course.

2. Administration of deep sedation or general anesthesia by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

For all levels of sedation and anesthesia, dentists who are currently providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document are not subject to these educational requirements.

IV. Clinical Guidelines

A. Minimal sedation

1. Patient Evaluation

Patients considered for minimal sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this may consist of a review of their current medical history and medication use. However, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Preoperative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.

- A focused physical evaluation must be performed as deemed appropriate.
- Preoperative dietary restrictions must be considered based on the sedative technique prescribed.
- Preoperative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

3. Personnel and Equipment Requirements

Personnel:

- At least one additional person trained in Basic Life Support for Healthcare Providers must be present in addition to the dentist.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.

4. Monitoring and Documentation

Monitoring: A dentist or, at the dentist's direction, an appropriately trained individual must remain in the operatory during active dental treatment to monitor the patient continuously until the patient meets the criteria for discharge to the recovery area. The appropriately trained individual must be familiar with monitoring techniques and equipment. Monitoring must include

- Oxygenation:
  - Color of mucosa, skin or blood must be evaluated continually.
  - Oxygen saturation by pulse oximetry may be clinically useful and should be considered.
- Ventilation:
  - The dentist and/or appropriately trained individual must observe chest excursions continually.
  - The dentist and/or appropriately trained individual must verify respirations continually.

- Circulation:
  - Blood pressure and heart rate should be evaluated preoperatively, postoperatively and intraoperatively as necessary (unless the patient is unable to tolerate such monitoring).

  Documentation: An appropriate sedative record must be maintained, including the names of all drugs administered, including local anesthetics, dosages and monitored physiological parameters.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The qualified dentist or appropriately trained clinical staff must monitor the patient during recovery until the patient is ready for discharge by the dentist.
- The qualified dentist must determine and document that the level of consciousness, oxygenation, ventilation and circulation are satisfactory prior to discharge.
- Postoperative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

6. Emergency Management

If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation.

The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of minimal sedation and providing the equipment and protocols for patient rescue.

7. Management of Children

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.*

B. Moderate Sedation

1. Patient Evaluation

Patients considered for moderate sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this should consist of at least a review of their current medical history and medication use. However, patients with significant medical considerations (e.g., ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Preoperative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.
- A focused physical evaluation must be performed as deemed appropriate.
- Preoperative dietary restrictions must be considered based on the sedative technique prescribed.
- Preoperative verbal or written instructions must be given to the patient, parent, escort, guardian or care giver.

3. Personnel and Equipment Requirements

Personnel:

- At least one additional person trained in Basic Life Support for Healthcare Providers must be present in addition to the dentist.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

- Consciousness:
  - Level of consciousness (e.g., responsiveness to verbal command) must be continually assessed.
- Oxygenation:
  - Color of mucosa, skin or blood must be evaluated continually.
  - Oxygen saturation must be evaluated by pulse oximetry continuously.
- Ventilation:
  - The dentist must observe chest excursions continually.
  - The dentist must monitor ventilation. This can be accomplished by auscultation of breath sounds, monitoring end-tidal CO_2 or by verbal communication with the patient.
- Circulation:
  - The dentist must continually evaluate blood pressure and heart rate (unless the patient is unable to tolerate and this is noted in the time-oriented anesthesia record).
  - Continuous ECG monitoring of patients with significant cardiovascular disease should be considered.

Documentation:

- An appropriate time-oriented anesthetic record must be maintained, including the names of all drugs administered, including local anesthetics, dosages and monitored physiological parameters.
- Pulse oximetry, heart rate, respiratory rate and blood pressure must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The qualified dentist or appropriately trained clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The qualified dentist must determine and document that the level of consciousness, oxygenation, ventilation and circulation are satisfactory for discharge.
- Postoperative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

- If a reversal agent is administered before discharge criteria have been met, the patient must be monitored until recovery is assured.

6. Emergency Management

If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation.

The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue.

7. Management of Children

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.*

C. Deep Sedation or General Anesthesia

1. Patient Evaluation

Patients considered for deep sedation or general anesthesia must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this must consist of at least a review of their current medical history and medication use and NPO status. However, patients with significant medical considerations (e.g., ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Preoperative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative or anesthetic agents and informed consent for the proposed sedation/anesthesia must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.
- A focused physical evaluation must be performed as deemed appropriate.
- Preoperative dietary restrictions must be considered based on the sedative/anesthetic technique prescribed.
- Preoperative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

- An intravenous line, which is secured throughout the procedure, must be established except as provided in part IV. C.6. Pediatric and Special Needs Patients.

3. Personnel and Equipment Requirements

Personnel: A minimum of three (3) individuals must be present.

- A dentist qualified in accordance with part III. C. of these *Guidelines* to administer the deep sedation or general anesthesia.
- Two additional individuals who have current certification in Basic Life Support for Healthcare Providers.
- When the same individual administering the deep sedation or general anesthesia is performing the dental procedure, one of the additional appropriately trained team members must be designated for patient monitoring.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.
- Equipment and drugs necessary to provide advanced airway management and advanced cardiac life support must be immediately available.
- If volatile anesthetic agents are utilized, an inspired agent analysis monitor and capnograph should be considered.
- Resuscitation medications and an appropriate defibrillator must be immediately available.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

- Oxygenation:
  - Color of mucosa, skin or blood must be continually evaluated.
  - Oxygenation saturation must be evaluated continuously by pulse oximetry.
- Ventilation:
  - Intubated patient: End-tidal CO_2 must be continuously monitored and evaluated.
  - Non-intubated patient: Breath sounds via auscultation and/or end-tidal CO_2 must be continually monitored and evaluated.
  - Respiration rate must be continually monitored and evaluated.
- Circulation:
  - The dentist must continuously evaluate heart rate and rhythm via ECG throughout the procedure, as well as pulse rate via pulse oximetry.
  - The dentist must continually evaluate blood pressure.
- Temperature:
  - A device capable of measuring body temperature must be readily available during the administration of deep sedation or general anesthesia.
  - The equipment to continuously monitor body temperature should be available and must be performed whenever triggering agents associated with malignant hyperthermia are administered.

<u>Documentation:</u>

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs administered, including local anesthetics, doses and monitored physiological parameters.
- Pulse oximetry and end-tidal CO_2 measurements (if taken), heart rate, respiratory rate and blood pressure must be recorded at appropriate intervals.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The dentist or clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The dentist must determine and document that the level of consciousness, oxygenation, ventilation and circulation are satisfactory for discharge.

- Postoperative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

6. Pediatric and Special Needs Patients

Because many dental patients undergoing deep sedation or general anesthesia are mentally and/or physically challenged, it is not always possible to have a comprehensive physical examination or appropriate laboratory tests prior to administering care. When these situations occur, the dentist responsible for administering the deep sedation or general anesthesia should document the reasons preventing the recommended preoperative management.

In selected circumstances, deep sedation or general anesthesia may be utilized without establishing an indwelling intravenous line. These selected circumstances may include very brief procedures or periods of time, which, for example, may occur in some pediatric patients; or the establishment of intravenous access after deep sedation or general anesthesia has been induced because of poor patient cooperation.

7. Emergency Management

The qualified dentist is responsible for sedative/anesthetic management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of deep sedation or general anesthesia and providing the equipment, drugs and protocols for patient rescue.

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V. Additional Sources of Information

American Academy of Pediatric Dentistry (AAPD). *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update.* Developed through a collaborative effort between the American Academy of Pediatrics and the AAPD. Available at http://www.aapd.org/media/policies.asp.

American Academy of Periodontology (AAP). *Guidelines: In-Office Use of Conscious Sedation in Periodontics.* Available at http://www.perio.org/resources-products/posppr3-1.html.

American Dental Association Council on Scientific Affairs. Acceptance Program Guidelines: *Nitrous Oxide-Oxygen Conscious Sedation Systems, 2000.* Available at http://www.ada.org/prof/resources/positions/standards/denmat.asp#ada.

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Parameters and Pathways: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParPath o1) Anesthesia in Outpatient Facilities.* Contact AAOMS at 1-847-678-6200 or visit http://www.aaoms.org/index.php.

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Office Anesthesia Evaluation Manual 7th Edition.* Contact AAOMS at 1-847-678-6200 or visit http://www.aaoms.org/index.php.

American Society of Anesthesiologist (ASA). *Practice Guidelines for Preoperative Fasting and the Use of Pharmacological Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures.* Available at http://www2.asahq.org/publications/p-178-practice-guidelines-for-preoperative-fasting.aspx.

American Society of Anesthesiologists (ASA). *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists.* Available at http://www.asahq.org/publicationsAndServices/practiceparam.htm#sedation. The ASA has other anesthesia resources that might be of interest to dentists. For more information, go to http://www.asahq.org/publicationsAndServices/sgstoc.htm.

Commission on Dental Accreditation (CODA). *Accreditation Standards* for Predoctoral and Advanced Dental Education Programs. Available at http://www.ada.org/prof/ed/accred/standards/index.asp.

National Institute for Occupational Safety and Health (NIOSH). *Controlling Exposures to Nitrous Oxide During Anesthetic Administration* (NIOSH Alert: 1994 Publication No. 94-100). Available at http://www.cdc.gov/niosh/noxidalr.html.

Dionne, Raymond A.; Yagiela, John A., et al. Balancing efficacy and safety in the use of oral sedation in dental outpatients. JADA 2006;137(4):502-13. ADA members can access this article online at http://jada.ada.org/cgi/content/full/137/4/502.

AMERICAN DENTAL ASSOCIATION

GUIDELINES FOR TEACHING PAIN CONTROL AND SEDATION TO DENTISTS AND DENTAL STUDENTS

(2000:490, 518; 2002:400; 2003:368; 2005:334)

I. Introduction

The administration of local anesthesia, sedation and general anesthesia is an integral part of the practice of dentistry. The American Dental Association is committed to the safe and effective use of these modalities by appropriately educated and trained dentists.

Anxiety and pain control can be defined as the application of various physical, chemical and psychological modalities to the prevention and treatment of preoperative, operative and postoperative patient anxiety and pain to allow dental treatment to occur in a safe and effective manner. It involves all disciplines of dentistry and, as such, is one of the most important aspects of dental education. The intent of these *Guidelines* is to provide direction for the teaching of pain control and sedation to dentists and can be applied at all levels of dental education from predoctoral through continuing education. They are designed to teach initial competency in pain control and minimal and moderate sedation techniques.

These *Guidelines* recognize that many dentists have acquired a high degree of competency in the use of anxiety and pain control techniques through a combination of instruction and experience. It is assumed that this has enabled these teachers and practitioners to meet the educational criteria described in this document.

It is not the intent of the *Guidelines* to fit every program into the same rigid educational mold. This is neither possible nor desirable. There must always be room for innovation and improvement. They do, however, provide a reasonable measure of program acceptability, applicable to all institutions and agencies engaged in predoctoral and continuing education.

The curriculum in anxiety and pain control is a continuum of educational experiences that will extend over several years of the predoctoral program. It should provide the dental student with the knowledge and skills necessary to provide minimal sedation to alleviate anxiety and control pain without inducing detrimental physiological or psychological side effects. Dental schools whose goal is to have predoctoral students achieve competency in techniques such as local anesthesia and nitrous oxide inhalation and minimal sedation must meet all of the goals, prerequisites, didactic content, clinical experiences, faculty and facilities, as described in these *Guidelines.*

Techniques for the control of anxiety and pain in dentistry should include both psychological and pharmacological modalities. Psychological strategies should include simple relaxation techniques for the anxious patient and more comprehensive behavioral techniques to control pain. Pharmacological strategies should include not only local anesthetics but also sedatives, analgesics and other useful agents. Dentists should learn indications and techniques for

administering these drugs enterally, parenterally and by inhalation as supplements to local anesthesia.

The predoctoral curriculum should provide instruction, exposure and/or experience in anxiety and pain control, including minimal and moderate sedation. The predoctoral program must also provide the knowledge and skill to enable students to recognize and manage any emergencies that might arise as a consequence of treatment. Predoctoral dental students must complete a course in Basic Life Support for the Healthcare Provider (BLS). Though BLS courses are available online, any course taken online should be followed up with a hands-on component and be approved by the American Heart Association or the American Red Cross.

Local anesthesia is the foundation of pain control in dentistry. Although the use of local anesthetics in dentistry has a long record of safety, dentists must be aware of the maximum safe dosage limit for each patient, since large doses of local anesthetics may increase the level of central nervous system depression with sedation. The use of minimal and moderate sedation requires an understanding of local anesthesia and the physiologic and pharmacologic implications of the local anesthetic agents when combined with the sedative agents.

The knowledge, skill and clinical experience required for the safe administration of deep sedation and/or general anesthesia are beyond the scope of predoctoral and continuing education programs. Advanced education programs that teach deep sedation and/or general anesthesia to competency have specific teaching requirements described in the Commission on Dental Accreditation requirements for those advanced programs and represent the educational and clinical requirements for teaching deep sedation and/or general anesthesia in dentistry.

The objective of educating dentists to utilize pain control, sedation and general anesthesia is to enhance their ability to provide oral health care. The American Dental Association urges dentists to participate regularly in continuing education update courses in these modalities in order to remain current.

All areas in which local anesthesia and sedation are being used must be properly equipped with suction, physiologic monitoring equipment, a positive pressure oxygen delivery system suitable for the patient being treated and emergency drugs. Protocols for the management of emergencies must be developed and training programs held at frequent intervals.

II. Definitions

Methods of Anxiety and Pain Control

analgesia - the diminution or elimination of pain.

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

Note: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must always be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression especially in combination with sedative agents.

minimal sedation - a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond *normally* to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.[1]

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.

When the intent is minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use.

Nitrous oxide/oxygen may be used in combination with a single enteral drug in minimal sedation.

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

The following definitions apply to administration of minimal sedation:

maximum recommended dose (MRD) - maximum FDA-recommended dose of a drug as printed in FDA-approved labeling for unmonitored home use.

incremental dosing - administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).

supplemental dosing - during minimal sedation, supplemental dosing is a single additional dose of the initial dose of the initial drug that may be necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial total dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD.

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[1] Portions excerpted from *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia,* 2004, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

moderate sedation - a drug-induced depression of consciousness during which patients respond *purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.[2]

Note: 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. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to administration of moderate and deeper levels of sedation:

titration - administration of incremental doses of a drug until a desired effect is reached. Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

deep sedation - a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.[2]

general anesthesia – a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.[2]

[2] Excerpted from *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia,* 2004, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

For all levels of sedation, the practitioner must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.

Routes of Administration

enteral - any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

parenteral - a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].

transdermal - a technique of administration in which the drug is administered by patch or iontophoresis through skin.

transmucosal – a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

inhalation - a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

Terms

qualified dentist – meets the educational requirements for the appropriate level of sedation in accordance with Section III of these *Guidelines,* or a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document.

must/shall - indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

should -indicates the recommended manner to obtain the standard; highly desirable.

may - indicates freedom or liberty to follow a reasonable alternative.

continual - repeated regularly and frequently in a steady succession.

continuous - prolonged without any interruption at any time.

time-oriented anesthesia record - documentation at appropriate time intervals of drugs, doses and physiologic data obtained during patient monitoring.

immediately available – on site in the facility and available for immediate use.

Levels of Knowledge

familiarity - a simplified knowledge for the purpose of orientation and recognition of general principles.

in-depth - a thorough knowledge of concepts and theories for the purpose of critical analysis and the synthesis of more complete understanding (highest level of knowledge).

Levels of Skill

exposed - the level of skill attained by observation of or participation in a particular activity.

competent - displaying special skill or knowledge derived from training and experience.

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

American Society of Anesthesiologists (ASA) Patient Physical Status Classification System[3]

ASA I - A normal healthy patient.

ASA II - A patient with mild systemic disease.

ASA III - A patient with severe systemic disease.

ASA IV - A patient with severe systemic disease that is a constant threat to life.

ASA V - A moribund patient who is not expected to survive without the operation.

ASA VI - A declared brain-dead patient whose organs are being removed for donor purposes.

E - Emergency operation of any variety (used to modify one of the above classifications, i.e., ASA III-E).

Education Courses

Education may be offered at different levels (competency, update, survey and advanced education courses). A description of these different levels follows:

1. **Competency Courses** are designed to meet the needs of dentists who wish to become knowledgeable and proficient in the safe and effective administration of local anesthesia,

[3] ASA Physical Status Classification System is reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

minimal and moderate sedation. They consist of lectures, demonstrations and sufficient clinical participation to assure the faculty that the dentist understands the procedures taught and can safely and effectively apply them so that mastery of the subject is achieved. Faculty must assess and document the dentist's competency upon successful completion of such training. To maintain competency, periodic update courses must be completed.

2. **Update Courses** are designed for persons with previous training. They are intended to provide a review of the subject and an introduction to recent advances in the field. They should be designed didactically and clinically to meet the specific needs of the participants. Participants must have completed previous competency training (equivalent, at a minimum, to the competency course described in this document) and have current experience to be eligible for enrollment in an update course.

3. **Survey Courses** are designed to provide general information about subjects related to pain control and sedation. Such courses should be didactic and not clinical in nature, since they are not intended to develop clinical competency.

4. **Advanced Education Courses** are a component of an advanced dental education program, accredited by the ADA Commission on Dental Accreditation in accord with the *Accreditation Standards* for advanced dental education programs. These courses are designed to prepare the graduate dentist or postdoctoral student in the most comprehensive manner to be knowledgeable and proficient in the safe and effective administration of minimal, moderate and deep sedation and general anesthesia.

III. Teaching Pain Control

These *Guidelines* present a basic overview of the recommendations for teaching pain control.

A. General Objectives: Upon completion of a predoctoral curriculum in pain control the dentist must:

1. have an in-depth knowledge of those aspects of anatomy, physiology, pharmacology and psychology involved in the use of various anxiety and pain control methods;
2. be competent in evaluating the psychological and physical status of the patient, as well as the magnitude of the operative procedure, in order to select the proper regimen;
3. be competent in monitoring vital functions;
4. be competent in prevention, recognition and management of related complications;
5. be familiar with the appropriateness of and the indications for medical consultation or referral;

6. be competent in the maintenance of proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs administered and patient response.

B. Pain Control Curriculum Content:

1. Philosophy of anxiety and pain control and patient management, including the nature and purpose of pain
2. Review of physiologic and psychologic aspects of anxiety and pain
3. Review of airway anatomy and physiology
4. Physiologic monitoring
   - a. Observation
     - (1) Central nervous system
     - (2) Respiratory system
       - a. Oxygenation
       - b. Ventilation
     - (3) Cardiovascular system
   - b. Monitoring equipment
5. Pharmacologic aspects of anxiety and pain control
   - a. Routes of drug administration
   - b. Sedatives and anxiolytics
   - c. Local anesthetics
   - d. Analgesics and antagonists
   - e. Adverse side effects
   - f Drug interactions
   - g. Drug abuse
6. Control of preoperative and operative anxiety and pain
   - a. Patient evaluation
     - (1) Psychological status
     - (2) ASA physical status
     - (3) Type and extent of operative procedure
   - b. Nonpharmacologic methods
     - (1) Psychological and behavioral methods
       - (a) Anxiety management
       - (b) Relaxation techniques
       - (c) Systematic desensitization
     - (2) Interpersonal strategies of patient management
     - (3) Hypnosis
     - (4) Electronic dental anesthesia
     - (5) Acupuncture/Acupressure
     - (6) Other
   - c. Local anesthesia
     - (1) Review of related anatomy, and physiology

(2) Pharmacology
  (i) Dosing
  (ii) Toxicity
  (iii) Selection of agents
(3) Techniques of administration
  (i) Topical
  (ii) Infiltration (supraperiosteal)
  (iii) Nerve block – maxilla-to include:
    (aa) Posterior superior alveolar
    (bb) Infraorbital
    (cc) Nasopalatine
    (dd) Greater palatine
    (ee) Maxillary (2nd division)
    (ff) Other blocks
  (iv) Nerve block – mandible-to include:
    (aa) Inferior alveolar-lingual
    (bb) Mental-incisive
    (cc) Buccal
    (dd) Gow-Gates
    (ee) Closed mouth
  (v) Alternative injections-to include:
    (aa) Periodontal ligament
    (bb) Intraosseous

d. Prevention, recognition and management of complications and emergencies

C. **Sequence of Pain Control Didactic and Clinical Instruction:** Beyond the basic didactic instruction in local anesthesia, additional time should be provided for demonstrations and clinical practice of the injection techniques. The teaching of other methods of anxiety and pain control, such as the use of analgesics and enteral, inhalation and parenteral sedation, should be coordinated with a course in pharmacology. By this time the student also will have developed a better understanding of patient evaluation and the problems related to prior patient care. As part of this instruction, the student should be taught the techniques of venipuncture and physiologic monitoring. Time should be included for demonstration of minimal and moderate sedation techniques.

Following didactic instruction in minimal and moderate sedation, the student must receive sufficient clinical experience to demonstrate competency in those techniques in which the student is to be certified. It is understood that not all institutions may be able to provide instruction to the level of clinical competence in pharmacologic sedation modalities to all students. The amount of clinical experience required to achieve competency will vary according to student ability, teaching methods and the anxiety and pain control modality taught.

Clinical experience in minimal and moderate sedation techniques should be related to various disciplines of dentistry and not solely limited to surgical cases. Typically, such

experience will be provided in managing healthy adult patients. The sedative care of pediatric and special needs patients requires advanced didactic and clinical training.

Throughout both didactic and clinical instruction in anxiety and pain control, psychological management of the patient should also be stressed. Instruction should emphasize that the need for sedative techniques is directly related to the patient's level of anxiety, cooperation, medical condition and the planned procedures.

D. **Faculty:** Instruction must be provided by qualified faculty for whom anxiety and pain control are areas of major proficiency, interest and concern.

E. **Facilities:** Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

IV. Teaching Administration of Minimal Sedation

The faculty responsible for curriculum in minimal sedation techniques must be familiar with the ADA Policy Statement: *Guidelines for the Use of Sedation and General Anesthesia by Dentists*, and the Commission on Dental Accreditation's *Accreditation Standards* for dental education programs.

These *Guidelines* present a basic overview of the recommendations for teaching minimal sedation. These include courses in nitrous oxide/oxygen sedation, enteral sedation, and combined inhalation/enteral techniques.

General Objectives: Upon completion of a competency course in minimal sedation, the dentist must be able to:

1. Describe the adult and pediatric anatomy and physiology of the respiratory, cardiovascular and central nervous systems, as they relate to the above techniques.
2. Describe the pharmacological effects of drugs.
3. Describe the methods of obtaining a medical history and conduct an appropriate physical examination.
4. Apply these methods clinically in order to obtain an accurate evaluation.
5. Use this information clinically for ASA classification and risk assessment.
6. Choose the most appropriate technique for the individual patient.
7. Use appropriate physiologic monitoring equipment.
8. Describe the physiologic responses that are consistent with minimal sedation.
9. Understand the sedation/general anesthesia continuum.

Inhalation Sedation (Nitrous Oxide/Oxygen)

A. Inhalation Sedation Course Objectives: Upon completion of a competency course in inhalation sedation techniques, the dentist must be able to:

1. Describe the basic components of inhalation sedation equipment.
2. Discuss the function of each of these components.
3. List and discuss the advantages and disadvantages of inhalation sedation.
4. List and discuss the indications and contraindications of inhalation sedation.
5. List the complications associated with inhalation sedation.
6. Discuss the prevention, recognition and management of these complications.
7. Administer inhalation sedation to patients in a clinical setting in a safe and effective manner.
8. Discuss the abuse potential, occupational hazards and other untoward effects of inhalation agents.

B. Inhalation Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations.
3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
4. Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and the unconscious state.
5. Review of pediatric and adult respiratory and circulatory physiology and related anatomy.
6. Pharmacology of agents used in inhalation sedation, including drug interactions and incompatibilities.
7. Indications and contraindications for use of inhalation sedation.
8. Review of dental procedures possible under inhalation sedation.
9. Patient monitoring using observation and monitoring equipment, with particular attention to vital signs and reflexes related to pharmacology of nitrous oxide.
10. Importance of maintaining proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs and doses administered and patient response.
11. Prevention, recognition and management of complications and life-threatening situations.
12. Administration of local anesthesia in conjunction with inhalation sedation techniques.
13. Description and use of inhalation sedation equipment.
14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting occupational exposure.
15. Discussion of abuse potential.

C. Inhalation Sedation Course Duration: While length of a course is only one of the many factors to be considered in determining the quality of an educational program, the course should be a minimum of *14 hours*, including a clinical component during which competency in inhalation sedation technique is achieved. The inhalation sedation course most often is completed as a part of the predoctoral dental education program. However, the course may be completed in a postdoctoral continuing education competency course.

D. Participant Evaluation and Documentation of Inhalation Sedation Instruction: Competency courses in inhalation sedation techniques must afford participants with sufficient clinical experience to enable them to achieve competency. This experience must be provided under the supervision of qualified faculty and must be evaluated. The course director must certify the competency of participants upon satisfactory completion of training. Records of the didactic instruction and clinical experience, including the number of patients treated by each participant must be maintained and available.

E. Faculty: The course should be directed by a dentist or physician qualified by experience and training. This individual should have had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain control. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, cardiologists and psychologists, should be encouraged.

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

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

F. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

Enteral and/or Combination Inhalation-Enteral Minimal Sedation

A. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Objectives: Upon completion of a competency course in enteral and/or combination inhalation-enteral minimal sedation techniques, the dentist must be able to:

1. Describe the basic components of inhalation sedation equipment.
2. Discuss the function of each of these components.
3. List and discuss the advantages and disadvantages of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
4. List and discuss the indications and contraindications for the use of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
5. List the complications associated with enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).

6. Discuss the prevention, recognition and management of these complications.
7. Administer enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation) to patients in a clinical setting in a safe and effective manner.
8. Discuss the abuse potential, occupational hazards and other effects of enteral and inhalation agents.
9. Discuss the pharmacology of the enteral and inhalation drugs selected for administration.
10. Discuss the precautions, contraindications and adverse reactions associated with the enteral and inhalation drugs selected.
11. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for management of life-threatening situations.
12. Demonstrate the ability to manage life-threatening emergency situations, including current certification in Basic Life Support for Healthcare Providers.
13. Discuss the pharmacological effects of combined drug therapy, their implications and their management. Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

B. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological profiling.
3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
4. Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and the unconscious state.
5. Review of pediatric and adult respiratory and circulatory physiology and related anatomy.
6. Pharmacology of agents used in enteral and/or combination inhalation-enteral minimal sedation, including drug interactions and incompatibilities.
7. Indications and contraindications for use of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
8. Review of dental procedures possible under enteral and/or combination inhalation-enteral minimal sedation).
9. Patient monitoring using observation, monitoring equipment, with particular attention to vital signs and reflexes related to consciousness.
10. Maintaining proper records with accurate chart entries recording medical history, physical examination, informed consent, time-oriented anesthesia record, including the names of all drugs administered including local anesthetics, doses, and monitored physiological parameters.
11. Prevention, recognition and management of complications and life-threatening situations.

12. Administration of local anesthesia in conjunction with enteral and/or combination inhalation-enteral minimal sedation techniques.
13. Description and use of inhalation sedation equipment.
14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting occupational exposure.
15. Discussion of abuse potential.

C. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course

Duration: Participants must be able to document current certification in Basic Life Support for Healthcare Providers and have completed a nitrous oxide competency course to be eligible for enrollment in this course. While length of a course is only one of the many factors to be considered in determining the quality of an educational program, the course should include a minimum of *16 hours*, plus clinically-oriented experiences during which competency in enteral and/or combined inhalation-enteral minimal sedation techniques is demonstrated. Clinically-oriented experiences may include group observations on patients undergoing enteral and/or combination inhalation-enteral minimal sedation. Clinical experience in managing a compromised airway is critical to the prevention of life-threatening emergencies. The faculty should schedule participants to return for additional clinical experience if competency has not been achieved in the time allotted. The educational course may be completed in a predoctoral dental education curriculum or a postdoctoral continuing education competency course.

These *Guidelines* are not intended for the management of enteral and/or combination inhalation-enteral minimal sedation in children, which requires additional course content and clinical learning experience.

D. Participant Evaluation and Documentation of Instruction: Competency courses in combination inhalation-enteral minimal sedation techniques must afford participants with sufficient clinical understanding to enable them to achieve competency. The course director must certify the competency of participants upon satisfactory completion of the course. Records of the course instruction must be maintained and available.

E. Faculty: The course should be directed by a dentist or physician qualified by experience and training. This individual should have had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain control. Dental faculty with broad clinical experience in the particular aspect of the subject under consideration should participate. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, cardiologists and psychologists, should be encouraged. The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

V. Teaching Administration of Moderate Sedation

These *Guidelines* present a basic overview of the requirements for a competency course in moderate sedation. These include courses in enteral moderate sedation and parenteral moderate sedation. The teaching guidelines contained in this section on moderate sedation differ slightly from documents in medicine to reflect the differences in delivery methodologies and practice environment in dentistry. For this reason, separate teaching guidelines have been developed for moderate enteral and moderate parenteral sedation.

A. Course Objectives: Upon completion of a course in moderate sedation, the dentist must be able to:

1. List and discuss the advantages and disadvantages of moderate sedation.
2. Discuss the prevention, recognition and management of complications associated with moderate sedation.
3. Administer moderate sedation to patients in a clinical setting in a safe and effective manner.
4. Discuss the abuse potential, occupational hazards and other untoward effects of the agents utilized to achieve moderate sedation.
5. Describe and demonstrate the technique of intravenous access, intramuscular injection and other parenteral techniques.
6. Discuss the pharmacology of the drug(s) selected for administration.
7. Discuss the precautions, indications, contraindications and adverse reactions associated with the drug(s) selected.
8. Administer the selected drug(s) to dental patients in a clinical setting in a safe and effective manner.
9. List the complications associated with techniques of moderate sedation.
10. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for the prevention and management of emergency situations.
11. Discuss principles of advanced cardiac life support or an appropriate dental sedation/anesthesia emergency course equivalent.
12. Demonstrate the ability to manage emergency situations.

B. Moderate Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations.
3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
4. Description of the sedation anesthesia continuum, with special emphasis on the distinction between the conscious and the unconscious state.
5. Review of pediatric and adult respiratory and circulatory physiology and related anatomy.

6. Pharmacology of local anesthetics and agents used in moderate sedation, including drug interactions and contraindications.
7. Indications and contraindications for use of moderate sedation.
8. Review of dental procedures possible under moderate sedation.
9. Patient monitoring using observation and monitoring equipment, with particular attention to vital signs and reflexes related to consciousness.
10. Maintaining proper records with accurate chart entries recording medical history, physical examination, informed consent, time-oriented anesthesia record, including the names of all drugs administered including local anesthetics, doses, and monitored physiological parameters.
11. Prevention, recognition and management of complications and emergencies.
12. Description and use of moderate sedation monitors and equipment.
13. Discussion of abuse potential.
14. Intravenous access: anatomy, equipment and technique.
15. Prevention, recognition and management of complications of venipuncture and other parenteral techniques.
16. Description and rationale for the technique to be employed.
17. Prevention, recognition and management of systemic complications of moderate sedation, with particular attention to airway maintenance and support of the respiratory and cardiovascular systems.

C. **Moderate Enteral Sedation Course Duration:** A minimum of *24 hours* of instruction, plus management of *at least 10 adult case experiences* by the enteral and/or enteral-nitrous oxide/oxygen route are required to achieve competency. These ten cases must include at least three live clinical dental experiences managed by participants in groups no larger than five. The remaining cases may include simulations and/or video presentations, but must include one experience in returning (rescuing) a patient from deep to moderate sedation.

Participants should be provided supervised opportunities for clinical experience to demonstrate competence in airway management. Clinical experience will be provided in managing healthy adult patients; **this course in moderate enteral sedation is not designed for the management of children (aged 12 and under)**. Additional supervised clinical experience is necessary to prepare participants to manage medically compromised adults and special needs patients. This course in moderate enteral sedation does not result in competency in moderate parenteral sedation. The faculty should schedule participants to return for additional didactic or clinical exposure if competency has not been achieved in the time allotted.

Moderate Parenteral Sedation Course Duration: A minimum of *60 hours* of instruction, plus management of *at least 20 patients* by the intravenous route per participant, is required to achieve competency in moderate sedation techniques. Clinical experience in managing a compromised airway is critical to the prevention of emergencies. Participants should be provided supervised opportunities for clinical experience to demonstrate competence in management of the airway. Typically, clinical

experience will be provided in managing healthy adult patients. **Additional supervised clinical experience is necessary to prepare participants to manage children (aged 12 and under) and medically compromised adults.** Successful completion of this course does result in clinical competency in moderate parenteral sedation. The faculty should schedule participants to return for additional clinical experience if competency has not been achieved in the time allotted.

D. Participant Evaluation and Documentation of Instruction: Competency courses in moderate sedation techniques must afford participants with sufficient clinical experience to enable them to achieve competency. This experience must be provided under the supervision of qualified faculty and must be evaluated. The course director must certify the competency of participants upon satisfactory completion of training in each moderate sedation technique, including instruction, clinical experience and airway management. Records of the didactic instruction and clinical experience, including the number of patients managed by each participant in each anxiety and pain control modality must be maintained and available for review.

E. Faculty: The course should be directed by a dentist or physician qualified by experience and training. This individual should have had at least three years of experience, including formal postdoctoral training in anxiety and pain control. Dental faculty with broad clinical experience in the particular aspect of the subject under consideration should participate. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, cardiologists and psychologists, should be encouraged.

A participant-faculty ratio of not more than five-to-one when moderate enteral sedation is being taught allows for adequate supervision during the clinical phase of instruction. A participant-faculty ratio of not more than three-to-one when moderate parenteral sedation is being taught allows for adequate supervision during the clinical phase of instruction; a one-to-one ratio is recommended during the early stage of participation.

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

F. Facilities: Competency courses in moderate sedation must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies. These facilities may include dental and medical schools/offices, hospitals and surgical centers.

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Additional Sources of Information

American Academy of Pediatric Dentistry (AAPD). *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update.* Developed through a collaborative effort between the American Academy of Pediatrics and the AAPD. Available at http://www.aapd.org/media/policies.asp.

American Academy of Periodontology (AAP). *Guidelines: In-Office Use of Conscious Sedation in Periodontics.* Available at http://www.perio.org/resources-products/posppr3-1.html.

American Dental Association Council on Scientific Affairs. Acceptance Program Guidelines: *Nitrous Oxide-Oxygen Conscious Sedation Systems, 2000.* Available at http://www.ada.org/prof/resources/positions/standards/denmat.asp#ada.

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Parameters and Pathways: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParPath o1) Anesthesia in Outpatient Facilities.* Contact AAOMS at 1-847-678-6200 or visit http://www.aaoms.org/index.php.

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Office Anesthesia Evaluation Manual 7th Edition.* Contact AAOMS at 1-847-678-6200 or visit http://www.aaoms.org/index.php.

American Society of Anesthesiologists (ASA). *Practice Guidelines for Preoperative Fasting and the Use of Pharmacological Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures.* Available at http://www2.asahq.org/publications/p-178-practice-guidelines-for-preoperative-fasting.aspx.

American Society of Anesthesiologists (ASA). *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists.* Available at http://www.asahq.org/publicationsAndServices/practiceparam.htm#sedation. The ASA has other anesthesia resources that might be of interest to dentists. For more information, go to http://www.asahq.org/publicationsAndServices/sgstoc.htm.

Commission on Dental Accreditation (CODA). *Accreditation Standards* for Predoctoral and Advanced Dental Education Programs. Available at http://www.ada.org/prof/ed/accred/standards/index.asp.

National Institute for Occupational Safety and Health (NIOSH). *Controlling Exposures to Nitrous Oxide During Anesthetic Administration* (NIOSH Alert: 1994 Publication No. 94-100). Available at http://www.cdc.gov/niosh/noxidalr.html.

Dionne, Raymond A.; Yagiela, John A., et al. Balancing efficacy and safety in the use of oral sedation in dental outpatients. JADA 2006;137(4):502-13. ADA members can access this article online at http://jada.ada.org/cgi/content/full/137/4/502.

AMERICAN DENTAL ASSOCIATION POLICY STATEMENT: THE USE OF SEDATION AND GENERAL ANESTHESIA BY DENTISTS

(1985:577; 1994:74; 1996:327; 1998:436; 1999:326, 935; 2005:334)

Introduction

The administration of sedation and general anesthesia has been an integral part of dental practice since the 1840s. Dentists have a legacy and a continuing interest and expertise in providing anesthetic and sedative care to their patients. It was the introduction of nitrous oxide by Horace Wells, a Hartford, Connecticut dentist, and the demonstration of anesthetic properties of ether by William Morton, Wells' student, that gave the gift of anesthesia to medicine and dentistry. Dentistry has continued to build upon this foundation and has been instrumental in developing safe and effective sedative and anesthetic techniques that have enabled millions of people to access dental care. Without these modalities, many patient populations such as young children, physically and mentally challenged individuals and many other dental patients could not access the comprehensive care that relieves pain and restores form and function. The use of sedation and anesthesia by appropriately trained dentists in the dental office continues to have a remarkable record of safety. It is very important to understand that anxiety, cooperation and pain can be addressed by both psychological and pharmacological techniques and local anesthetics, which are the foundation of pain control in dentistry. Sedation may diminish fear and anxiety, but do not obliterate the pain response and therefore, expertise and in-depth knowledge of local anesthetic techniques and pharmacology is necessary. General anesthesia, by definition, produces an unconscious state totally obtunding the pain response.

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 minimal, moderate and deep sedation and general anesthesia, as defined in the American Dental Association (ADA) *Guidelines for the Use of Sedation and General Anesthesia by Dentists.* These terms refer to the effects upon the central nervous system and are not dependent upon the route of administration.

The use of 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 in the treatment of dental patients and is committed to their safe and effective use.

Education

Training to competency in minimal and moderate sedation techniques may be acquired at the predoctoral, postgraduate, graduate, or continuing education level. Dentists who wish to utilize minimal or moderate sedation are expected to successfully complete formal training which is structured in accordance with the ADA's *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students.* 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 accredited by the Commission on Dental Accreditation (CODA) that provides training in deep sedation and general anesthesia are considered educationally qualified to use these modalities in practice.[1] The dental profession's continued ability to control anxiety and pain effectively is dependent on a strong educational foundation in the discipline. The ADA supports efforts to expand the availability of courses and programs at the predoctoral, advanced and continuing educational levels that are structured in accordance with its *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students.* The ADA urges dental practitioners to regularly participate in continuing education in the areas of sedation and anesthesia.

Safe Practice

Dentists administering sedation and anesthesia should be familiar with the ADA *Guidelines for the Use of Sedation and General Anesthesia by Dentists.* Dentists who are qualified to utilize sedation and general anesthesia have a responsibility to minimize risk to patients undergoing dental treatment by:

- Using only those drugs and techniques in which they have been appropriately trained;
- Limiting use of these modalities to patients who require them;
- Conducting a preoperative evaluation of each patient consisting of at least a thorough review of medical and dental history, a focused clinical examination and consultation, when indicated, with appropriate medical and dental personnel;
- Conducting physiologic and visual monitoring of the patient;
- 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;

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[1] Until the CODA accreditation cycles for those advanced education programs in deep sedation and general anesthesia are completed, the 2005 ADA *Guidelines for Teaching* remain in effect.

- Treating high-risk patients in a setting equipped to provide for their care.

The ADA expects that patient safety will be the foremost consideration of dentists who use sedation and general anesthesia.

State Regulation

Appropriate permitting of dentists utilizing moderate sedation, deep sedation and general anesthesia is highly recommended. State dental boards have the responsibility to ensure that only qualified dentists use sedation and general anesthesia. State boards set acceptable standards for safe and appropriate delivery of sedation and anesthesia care, as outlined in this policy and in the ADA *Guidelines for the Use of Sedation and General Anesthesia by Dentists.*

The ADA recognizes that office-based, ambulatory sedation and anesthesia play an integral role in the management of anxiety and pain control for dental patients. It is in the best interest of the public and the profession that access to these cost-effective services be widely available.

Research

The use of minimal, moderate and deep sedation and general anesthesia in dentistry will be significantly affected by research findings and advances in these areas. The ADA 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 that 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.

Council on Dental Practice

Kyger, Billie Sue, Ohio, 2007, chair
Shaw, Robert R., Washington, 2008, vice chair
Ahlstrom, Robert, Nevada, 2010
Carney, Kerry K., California, 2008
DeSnyder, Jerome, New York, 2010
Duncan, David A., Texas, 2009
Dumas, John Dale, Mississippi, *ex officio*[*]
Graham, Frank J., New Jersey, 2009
Howard, H. Fred, Kentucky, 2008
Hunt, Richard F., III, North Carolina, 2007
Kenworthy, Paul, Vermont, 2009
Maletta, John A., Iowa, 2008
Ritz, Mark S., Georgia, 2010
Sameroff, Jeffrey, Pennsylvania, 2009
Steinberg, Teri, Illinois, 2007
Tilton, Jon W., Kansas, 2007
Vandehaar, Kent L., Wisconsin, 2010
Winker, Wade G., Florida, 2008
Willey, James L., director
Porembski, Pamela, senior manager
Dietrich, Joan M., manager
Keating, Linda E., manager

The Strategic Plan of the American Dental Association: The activities of the Council on Dental Practice (CDP) are consistent with and continue to support the *ADA Strategic Plan: 2007-2010*. In keeping with Goal: Achieve Effective Advocacy, Objectives 1 and 5, the Council is involved with the Team Building Conference held during ADA annual session and with the ongoing ADA-OSHA Alliance agreement. For Goal: Build Dynamic Communities, Objective 2, the Council collaborates with the American Dental Hygienists' Association (ADHA), the American Dental Assistants Association (ADAA) and the National Association of Dental Laboratories (NADL) on various projects. Furthermore, the Council develops practice management publications, such as *CEO Crash Course* (published in October 2006), which meets the criteria for Goal: Create and Transfer Knowledge, Objective 3. Additionally, the work of the Council in relation to the ADA *General Guidelines for Referring Patients*, the caries risk assessment form and real time claims adjudication is linked to Goal: Lead in the Advancement of Standards, Objective 3. Finally, the Council supports Goal: Attain Excellence in Operations, Objective 1, by participating in Call Tally Tracking, a divisional tool created to better respond to member requests for information.

Emerging Issues and Trends: Following the dissemination of new referral guidelines by the American Academy of Periodontology (AAP), the Council reviewed those guidelines. Prior to 1991, the Council had developed its own *General Guidelines for Referring Patients*, and the Council has not updated them since then. The ADA Board of Trustees directed the CDP to update its *Guidelines* in collaboration with the Council on Ethics, Bylaws and Judicial Affairs (CEBJA).

Working with CEBJA, CDP completed its update. All specialty groups and the Academy of General Dentistry (AGD) had the opportunity to comment on the revisions. The only comments received were from the AAP and AGD, and both indicated support for the updated ADA's *Guidelines*. Pending Board approval, the revised *Guidelines* will be disseminated to the Association membership via the *ADA News* and ADA.org.

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

Another emerging issue impacting the Council relates to making a dental office more environmentally friendly or "green." Concerns regarding the disposal of amalgam waste and the recent international focus on global warming have led to an increased interest in the environmental impact of products used in dental offices.

A "green" facility assessment includes a close look at four specific areas: water conservation; solid waste reduction and recycling; energy conservation; and pollution prevention. A "green" dental office can also reduce operating costs, by using less water and electrical power, as well as lowering waste disposal costs.

The Council proposed that information on this topic be developed as a Web-based seminar (webinar), through ADA CE Online. This proposed webinar would guide dental practices through a series of practical measures that could be implemented into dental office design, operation and renovations for the dental office. CDP staff is currently working with a consultant and gathering background information. The consultant intends to broadcast the webinar by December 2007.

Impact of Information Technology on Dentistry: The Council and ADA Business Enterprises, Inc. (ADABEI) completed the analysis of their first joint survey project concerning the usage of electronic dental claims. In this survey, when asked about their desire for real time claims, the respondents overwhelmingly indicated their desire for this feature. Electronic funds transfer was only desired by 50% of the respondents. It is unknown whether respondents were dentists or office staff. This factor may have affected the response regarding the value of electronic funds transfer.

The Council's Dental Practice Model 2020 Workgroup (DPM 2020) requested and received a white paper from the Standards Committee on Dental Informatics (SCDI). The white paper identified four future dental practice trends: technology will get better, faster and cheaper; practice models will change; practice management systems, data management and utilization will become more sophisticated; and appropriate standards must evolve to keep up with changes in technology and informatics. DPM 2020 will consider the report in determining further discussions.

Real Time Adjudication: The Council is committed to advancing the use of real time electronic transactions, including remittance advice and funds transfer. Real time transactions could occur during a patient's dental appointment, allowing the dentist and the patient to immediately ascertain the financial obligation of the third-party carrier.

Progress in this area has been slow due to several factors, including the perception of dental software vendors and third-party payers that dentists are not interested in electronic transactions. CDP has requested funding to send members of its Electronic Claims Transactions Workforce to the Real Time Claims Adjudication Conference sponsored by the Accredited Standards Committee X12 (ASC X12) and the Workgroup on Electronic Data Interchange (WEDI) this fall to increase the presence of dental providers at these industry meetings.

The ADA has several existing policies concerning electronic transactions. CDP is reviewing these policies to determine whether they are adequate to support the ADA's strategic goal of leading in the advancement of standards, as well as the Council's work in promoting the use of electronic transactions. If necessary, a separate report will be prepared for the 2007 House of Delegates with a resolution addressing real time claims adjudication.

Emergency Preparedness, Bioterrorism and Disaster Planning and Recovery: Responsibility for emergency preparedness, bioterrorism and disaster planning and recovery were transferred to the Council in May 2007. During the mega-issue discussion held at its May 2007 meeting, the Council was made aware of the steps the ADA has taken to define dentistry's role in declared emergencies. Several guests at the meeting added to the Council's knowledge base by presenting information on the current use of dentists in declared national emergencies, the role of the Medical Reserve Corps (MRC) in disaster planning, and the training that dentists can receive in order to respond to disastrous events.

The ADA has few existing policies that address the dentist's role in declared emergencies and disasters. CDP is reviewing these policies to determine whether they are adequate to support the ADA's strategic goal of creating and transferring knowledge. If necessary, a separate report will be prepared for the 2007 House of Delegates with a resolution concerning the dentist's role in emergency preparedness.

Response to Assignments from the 2006 House of Delegates

Establishment of Formal Liaison Relationships with ADA Agencies: Resolution 27H-2006 (*Trans.*2006:309) recommended that the Councils on Access, Prevention and Interprofessional Relations, Scientific Affairs, Government Affairs and Dental Practice invite, and that the American Dental Political Action Committee (ADPAC) be urged to invite, the Council on Communications (CC) to establish a formal liaison relationship through the 2008 House of Delegates. CDP invited a Council on Communications liaison to its May 3-5, 2007, meeting and will to future meetings. Dr. Dennis Engel, CC liaison, attended the spring CDP meeting.

Rescission of Policy, Prosthetic Cases Sent to Foreign Labs for Custom Manufacture: Resolution 62H-2006 (*Trans*.2006:326) calls for the rescinding of Resolution 83H-2005 (*Trans*.2005:331). The policy has been removed from the current edition of *Current Policies*.

Notification of Prosthetic Cases Sent to Foreign or Ancillary Domestic Labs for Custom Manufacture: Resolution 69H-2006 (*Trans.*2006:326) directed that that the appropriate agencies of the ADA investigate the feasibility of requesting federal or state agencies to require that a subcontracting dental laboratory notify the dentist in advance when prostheses, components or materials indicated in the dentist's prescription are to be manufactured or provided, either partially or entirely, by a foreign dental laboratory or any ancillary domestic dental laboratory, and that the appropriate agencies of the ADA report their findings to the 2007 House of Delegates.

Both the CDP and the Council on Government Affairs (CGA) discussed Resolution 69H-2006 at their respective spring 2007 Council meetings. An understanding of existing regulations is essential in determining the best approach to fulfill the intent of the resolution. The Food and Drug Administration (FDA) has the legislative authority to regulate medical (including dental) devices through the Food, Drug and Cosmetic Act. The FDA does not require the registration of dentists or dental laboratories with respect to a dental prosthesis. Only the materials used are regulated and it is assumed by the FDA that only FDA materials will be used in the manufacture of prostheses. The FDA does regulate dental prostheses, by function:

- *Registration.* If a device is imported from overseas, the FDA requires the foreign exporter to register. The U.S. agent accepting the prosthesis is also required to register.
- *Labeling.* Current FDA regulations require that if a *foreign* dental laboratory fabricates a case, the laboratory must either label the case as "Manufactured for (name of lab contracting with dentist)" or "Distributed by (name of lab contracting with dentist)." This means that dentists do not know prior to delivery where a case will be fabricated or the origin of the materials. Upon delivery of the case, the dentist would need to note the "manufactured by" or "distributed by" label on the case and understand its significance. Some dentists may wish to have this information prior to selecting a dental laboratory.
- *Materials.* As part of importation, the manufacturer must certify that only FDA-approved materials are used. Actual enforcement of this requirement is done by the U.S. Customs and Border Protection in coordination with the FDA.

Both the federal and states approaches were considered as means to address the advanced disclosure of subcontracting of dental prosthesis to a foreign laboratory.

The FDA does not believe it has the authority to regulate dental labs as suggested by Resolution 69H-2006; therefore, pursuing a legislative change to the Food, Drug and Cosmetic Act would be required. The federal approach would require the support of the U.S. Congress to change federal law to give the FDA regulatory authority over dental laboratories that it does not currently have (nor want or support); would be a very long-term process (require years to accomplish both the legislative and then regulatory process); would require a compelling reason to change the law; and ultimately, any subsequent regulation could impact both dentists and dental laboratories in unanticipated ways. Additionally, the federal approach could be considered in conflict with ADA policy that states: "The Association opposes the creation of additional regulatory boards to oversee dental care and therefore, opposes any form of governmental regulation or licensure of dental laboratories not promulgated under the auspices of the state board of dentistry."[1]

[1] Statement on Prosthetic Care and Dental Laboratories (*Trans.*1990:543; 1995:623; 1999:933; 2000:454; 2003:365; 2005:327)

The states approach is consistent with current ADA policy on laboratory regulation and offers many advantages such as, expediency and ability to create state-specific policy based on impact on members, including determining if the regulation should be voluntary or mandatory. One state, Missouri, offers its members a downloadable advance disclosure form on its Web site.

The NADL feels that voluntary regulation will not be effective because there will be no means of enforcement. Rather, the NADL advocates that each state regulate dental labs through registration and/or certification of either laboratories, laboratory technicians or both. Therefore, the Councils recommend adoption of the following resolution.

6. Resolved, that the Statement on Prosthetic Care and Dental Laboratories (*Trans.*1990:543; 1995:623; 1999:933; 2000:454; 2003:365; 2005:327) be amended in the section The Laboratory/Technician by the addition of the following new language before Glossary of Terms Related to Dental Laboratories:

Notification of Prosthetic Cases Sent to Foreign or Ancillary Domestic Labs for Custom Manufacture: Constituent dental societies are urged to pursue legislation or voluntary agreements to require that a subcontracting dental laboratory notify the dentist in advance when prostheses, components or materials indicated in the dentist's prescription are to be manufactured or provided, either partially or entirely, by a foreign dental laboratory or any domestic ancillary dental laboratory.

Council Activities

Dental Schools Program Project/SUCCESS Continuum: The ADA undertook a strategic review of its dental school programs via a Dental School Programs Advisory Group in 2006. This Advisory Group was a cross agency group including representatives of the CDP, the Council on Ethics, Bylaws and Judicial Affairs, the Council on Dental Education and Licensure, the Committee on the New Dentist, the American Student Dental Association (ASDA), and the Practice Administration Section of the American Dental Education Association (ADEA). Using a cross-agency collaborative effort, the ADA has consolidated all programming under the umbrella of an expanded SUCCESS program, starting in the 2007-08 program year. The ADA's goal is to complement and enhance the practice management curriculum at each dental school by offering an interesting, valuable program to every class, every year, at every dental school. All programs will be scheduled and coordinated through the ADA Office of Student Affairs (OSA).

CDP staff continues to be involved in SUCCESS for the 2007-08 school year, assisting the OSA staff in transitioning the program to that department. Additionally, review of the practice management content of the SUCCESS materials will continue to fall under the purview of the CDP. (See the Council on Membership's Annual Report, Dental Student Programming, page 128 for more information.)

Preventive Services for the Very Young: A workgroup consisting of members of the CDP and the Council of Scientific Affairs (CSA) was formed to produce a caries risk assessment form. Proper caries risk assessment allows for interventions that reverse or decrease the incidence of dental caries. The form was viewed as a tool that could be used to help dentists assess caries risk on an individual patient basis.

A caries risk form appropriate for patients under the age of six was developed by the joint workgroup. The CDP has approved the form. The assessment form will be considered by CSA during its July 2007 meeting. CDP also intends to work with the Council on Access, Prevention and Interprofessional Relations (CAPIR) to prepare supplemental educational materials for parents and dentists that will accompany the form. Once approved by CSA, the form could be available by September 2007 and the accompanying materials by November 2007.

Dental Team Advisory Panel: The Council's Dental Team Advisory Panel (DTAP) met on March 16, 2007, at ADA Headquarters in Chicago. The uniquely configured Panel offered suggestions, through the Council, for raising the awareness of the profession of dentistry; generated ideas for promoting ADA CE Online to dental team members; and produced feedback on publications written specifically for dental team members. DTAP also recommended that the Dentist Health and Wellness area develop resources to assist dental team members during a personal crisis, such as a death in the family or a divorce.

Team Building Conference: The Councils on Dental Practice and ADA Sessions cosponsored the eleventh annual Team Building Conference at the 2006 ADA annual session held in Las Vegas on October 16-17. Over 300 dental

team members attended. The 12th annual conference, "Teamwork is Golden – Your Gateway to Success," will take place in San Francisco on September 27-28, 2007.

Liaison with the American Dental Hygienists' Association (ADHA): The ADHA president, director of education and director of government affairs attended the Council meeting held November 9-11, 2006. One of the main topics of the ADHA's presentation was its new strategy to work in partnership with dentists to advance the oral health of patients. Council staff will attend the ADHA's 84th Annual Session in New Orleans on June 22-26, 2007.

Liaison with American Dental Assistants Association (ADAA): The Council continues its collaboration with the ADAA in promoting the recognition of dental assistants by sponsoring Dental Assistants Recognition Week (DARW) each year. The 2007 DARW, March 4-10, was cosponsored by the Canadian Dental Association and the Canadian Dental Assistants Association.

The ADAA president attended the May 2007 Council meeting to discuss current cooperative projects, as well as the potential for joint ADAA/ADA projects. The ADAA will hold its annual meeting in conjunction with the ADA annual session this year and offer a track of courses and a reception for dental assistants. The ADAA supports possible new roles for dental assistants as proposed in the ADA Workforce Task Force report, especially those that provide a career ladder for assistants and expand opportunities for access to care.

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

Liaison with the National Association of Dental Laboratories (NADL): The Council continues to maintain formal liaison activities with the dental laboratory industry. The co-executive director of the NADL remarked to the Council at its May 2007 meeting that NADL supports legislatively mandated certification and registration of both dental laboratories and dental laboratory technicians.

Dr. Robert Talley is serving his third 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. In January 2007, *Transitions: Navigating Sales, Associateships & Partnerships in Your Dental Practice* was published and added to the *ADA Catalog*. *Basic Training for New Dental Staff* has been updated and will be re-titled "Fast Track Training: A Course for New Dental Office Staff."

Dentist Health and Wellness: The Dentist Health and Wellness program area now includes resources concerning crisis and disaster response, ergonomics in dentistry, support for dentists with disabilities, stress management, mental health, infected providers, and substance use disorders. Utilization of health and wellness resources, as demonstrated in phone and e-mail requests for assistance and information, has doubled in the last two years.

The 2006 Golden Apple for Excellence in Well-Being Activities was awarded to the Maryland State Dental Association for its innovation in Web site development and the breadth of support groups it offers to affected dentists.

The Dentist Well-Being Institute has been renamed the Conference on Dentist Health and Wellness. Registration is open for the 2007 program, "Healthy Dentists, Thriving Practices," which will be held August 16-18 at ADA Headquarters in Chicago.

The Council has continued to monitor the Dental Section of the University of Utah School on Alcoholism and Other Drug Dependencies, and recommended continuing ADA support of this program. The Utah School is held each June in Salt Lake City.

Additionally, the Council has two advisory committees that address health and wellness issues. The first is the Dentist Well-Being Advisory Committee (DWAC) and the second is the Ergonomics and Disability Support Advisory Committee (EDSAC). DWAC members generally have expertise in mental health, substance use disorders, healthy workplaces and outreach to specific populations, whereas EDSAC members have expertise in ergonomics and physical rehabilitation.

These committees met concurrently in March 2007 at the ADA Headquarters. Collaborative projects include preparations for the next survey of dentist health and wellness (deferred to 2009), recommendations for expanded collaboration with the CSA and the ADA Foundation utilizing data from the Health Screening Program, and identification of the key characteristics of healthy dental workplaces.

The Council plays a significant role in implementation of the ADA-OSHA Alliance agreement, which was renewed in May 2006. Several conference calls are held each year through which the ADA documents its voluntary efforts with OSHA. The goal is to provide workplace safety information and resources (specifically in the area of ergonomics and infection control) to dental professionals.

Meetings: The Council met in the Association Headquarters Building on November 9-11, 2006, and May 3-5, 2007. Dr. Kathyrn A. Kell, Tenth District trustee, serves as the Board of Trustees' liaison to the Council.

Personnel: At the May 2007 meeting of the Council, Dr. Robert R. Shaw was unanimously nominated as chair for 2007-08 and Dr. Frank Graham was elected vice chair for 2007-08. The 2007 ADA annual session will mark the retirement from the Council of Dr. Billie Sue Kyger, chair, Dr. Richard F. Hunt, III, Dr. Teri Steinberg, and Dr. Jon W. Tilton. The Council wishes to express its appreciation to these individuals for their thoughtful, determined leadership and for the many contributions during their tenure.

Summary of Resolutions

6. Resolved, that the Statement on Prosthetic Care and Dental Laboratories (*Trans.*1990:543; 1995:623; 1999:933; 2000:454; 2003:365; 2005:327) be amended in the section The Laboratory/Technician by the addition of the following new language before Glossary of Terms Related to Dental Laboratories:

> **Notification of Prosthetic Cases Sent to Foreign or Ancillary Domestic Labs for Custom Manufacture:** Constituent dental societies are urged to pursue legislation or voluntary agreements to require that a subcontracting dental laboratory notify the dentist in advance when prostheses, components or materials indicated in the dentist's prescription are to be manufactured or provided, either partially or entirely, by a foreign dental laboratory or any domestic ancillary dental laboratory.

Council on Ethics, Bylaws and Judicial Affairs

Asai, Rickland G., Oregon, 2007, chair
Smith, James F., Nebraska, 2008, vice chair
Black, Richard C., Texas, 2008
Boden, David F., Florida, 2010
Charlton, Dennis J., Pennsylvania, 2007
Cipollina, Joseph F., New York, 2009
Dickey, Keith W., Illinois, 2007
Fisch, Judith M., Vermont, 2010
Fontana, Nicholas A., Michigan, 2008
Largent, Beverly A., Kentucky, 2007
Leffler, William G., Ohio, 2009
Mattson, Rand T., Utah, 2009
Nisselson, Harvey S., New Jersey, 2009
Norbo, Kirk, Virginia, 2010
Stein, Alan R., California, 2010
Waugh, W. Scott, Oklahoma, 2008
Wolff, Carol M., Georgia, 2008
Wils, Wendy J., director

Meetings: The Council on Ethics, Bylaws and Judicial Affairs (CEBJA) met on November 17-18, 2006, and March 15-16, 2007, at the ADA's Headquarters in Chicago. Dr. Raymond F. Gist, trustee of the Ninth District, served as the Board of Trustees' liaison to the Council. Ms. Michelle Mayer, third year dental student at the Nova Southeastern University College of Dental Medicine served as the American Student Dental Association's consultant to the Council.

The Strategic Plan of the American Dental Association: At its November 2006 meeting, the Council established a Visionary and Strategic Planning Subcommittee to ensure that on an ongoing basis the activities of the Council are current and consistent with the *ADA Strategic Plan: 2007-2010*. The subcommittee will be responsible for making recommendations about the Council's regular activities pursuant to the ADA *Bylaws* and the ADA Strategic Plan, input on the development of mega issue discussion items and developing new initiatives to advance the ADA's Strategic Plan.

Emerging Issues and Trends

The Council's mission is to enhance the ethical conscience of dentists by promoting the highest moral, ethical and professional standards in the provision of dental care to the public. Pursuit of this mission includes monitoring trends and emerging issues in professionalism and ethical conduct.

Patient Rights and Responsibilities: During this reporting period, the Council developed a conceptual dental patient rights and responsibilities statement which outlines basic tenets that could serve as a model by the tripartite to promote informed consent principles and awareness of the ADA *Code*. The draft Model Dental Patient Rights and Responsibilities ("Model") was prepared in response to initiatives stemming from a two-day summit held in 2006, which was jointly sponsored by the Council, representing the ADA, and the American College of Dentists (ACD). The Council recognizes the growing challenges which practicing dentists face in managing patient demands and expectations for cosmetic dental services, particularly for what is commonly referred to as "extreme makeovers." Americans are spending billions of dollars for cosmetic dental services and there have been some public press reports alleging that repairing cosmetic dental work is becoming a new business. While the Council acknowledges the importance of patient autonomy and self determination for such services, it is concerned that this trend has a potential to negatively impact the public's trust in dentistry. For the individual dentist, the concern is preserving patient trust. The Council sees patient education as essential in managing patient treatment expectations. To this end, the Council believes a patient rights and responsibility document will be a useful tool. The Council is seeking guidance on its plan for publishing the statement from the Board of Trustees.

Ethics and Integrity In Dental Education: The Council on Dental Education and Licensure and the Council on Ethics, Bylaws and Judicial Affairs, in collaboration with the American Dental Education Association, the American College of Dentists and the American Student Dental Association will conduct a one and one-half day "Symposium on Integrity and Ethics in Dental Education" on June 7-8, 2007, at ADA Headquarters in Chicago. The symposium was developed in response to the ADA's concern over the recent reports of cheating by dental students. A diverse group of stakeholders from among the ADA, other national dental organizations, as well as leaders in other professions such as law and medicine, will convene to build a consensus on collaborative strategies that can be implemented in dental education. The Council chair will address the symposium from the perspective of examining the ADA *Principles of Ethics and Code of Professional Conduct* and whether it should include ethics for dental students. Other Council members, representing CEBJA, will participate as facilitators and note-takers. It is anticipated that proceedings of the symposium will be published.

Use of Patients in Clinical Licensure Examinations: The Council is proceeding in the development of an educational tool for dental students and dental licensure applicants to help promote awareness that the welfare of patients is paramount in the clinical licensure examination process. A draft document, "Ethical Considerations for the Use of Patients in the Clinical Licensure Examination Process," was developed and forwarded as working language to the Council on Dental Education and Licensure for comment. This undertaking grew out of a mega issue discussion. In developing the draft, the Council examined anecdotal information and experiences reported in the literature by licensees and educators, and considered information offered by a panel of experts on licensure examinations and dental education. The Council's draft document addresses potential ethical issues, including patient autonomy, informed consent, patient brokering, order of treatment, follow-up care and adequacy of the patient pool. It reflects ADA policy supporting the elimination of the use of patients in clinical licensure examinations, with the exception of the curriculum integrated format within dental schools (*Trans.*2005:335).

Review of the ADA *Code* Regarding Access to Care: The Council is continuing its examination of the ADA *Principles of Ethics and Code of Professional Conduct* (ADA *Code*) to determine whether individual practitioners' ethical responsibilities regarding access, uncompensated care, charity and *pro bono* care warrant further clarification. The ADA *Code* is regarded as a written expression of the profession's obligations to society and its commitment that members will adhere to the high ethical standards of conduct as described in the ADA *Code*. The Council confirmed that access is addressed in the ADA *Code* within various sections including the Preamble ("…charity complement[s] the ethical practice of dentistry…"), Section 3, Principle: Beneficence, particularly, 3.A. Community Service and Section 4.A. Patient Selection. To remain relevant as both a teaching tool and a professional guidance document, the Council believes the ADA *Code* should clearly enunciate the aspirational responsibilities of the individual dentist in the care and advocacy of the underserved. The Council is circulating working language for possible changes in the ADA *Code* to appropriate ADA agencies, and will review the comments at its next regular meeting in November 2007. If clarification is warranted, the Council anticipates reporting findings to the 2008 House of Delegates.

Dental Tourism: At its March 2007 meeting, the Council explored the potential ethical issues related to dental tourism by way of a mini-strategic discussion. The goal was to understand the potential impact of dental tourism on the ADA and the practice of dentistry and strategize how the ADA could ensure success for itself and its members in this arena. The discussion touched on variances in standards of care and responsibilities when treatments fail. Council members suggested fostering ADA's relationships with international associations to help in handling ethical questions and inquiries that may arise involving mutual members and patients. The Council's discussion also touched on ways to possibly enhance the ADA's dissemination of information to the public regarding the impact of dental tourism. The Council is conveying its observations to appropriate ADA agencies.

Response to Assignments from the 2006 House of Delegates

Annual Revisions of the ADA *Constitution and Bylaws:* The current edition of the ADA *Constitution and Bylaws*, revised to January 1, 2007, reflects amendments that were approved by the 2006 House of Delegates. A current electronic version of this document is available at www.ada.org.

Editorial Review of the ADA *Bylaws* – Resolution 32H-2006—Membership Classifications: By adoption of Resolution 32H-2006 (*Trans.*2006:310), the House of Delegates approved the development of proposed ADA *Bylaws* amendments to implement the approaches presented by the Council on Membership (CM) pursuant to its

comprehensive, multi-year Membership Study Proposal and Report (*Supplement* 2006:3015). In a separate joint CM and CEBJA report, the 2007 House of Delegates will be asked to consider and approve proposed changes to Chapters I, X and XII of ADA *Bylaws*.

Editorial Review of the ADA Bylaws—Request of the Speaker of the House of Delegates on Review of "Two-Thirds Majority Vote" References: In response to a request from Dr. J. Thomas Soliday, ADA Speaker of the House of Delegates, the Council conducted an editorial review of references to the term "two-thirds majority vote" in the ADA *Constitution and Bylaws*. The Council examined all *Bylaws* references to "two-thirds majority" vote. Five different styles were employed to describe eight *Bylaws* references to "two-thirds" or "two-thirds majority" vote.

Two-Thirds Reference	***Bylaws***
1. Two-thirds (2/3) affirmative vote of the members of the House	Amendments to the Constitution
2. Two-thirds (2/3) vote of the House	HOD Introduction of new business
3. Two-thirds (2/3) majority	HOD Power to suspend constituent society
4. Two-thirds (2/3) majority vote of the members (or delegates) present and voting	HOD Approval of dues Special assessments *Bylaws* amendments
5. Affirmative vote of two-thirds of the delegates present and voting	Removal of Board of Trustees and Elective Officers

The Council then carefully reviewed the historical records of the House of the Delegates to ascertain the intent of drafters as to use of the term in question. After further consultation with the Speaker, the Council recommends the following proposals. In brief, the proposals substitute the words "a two-thirds (2/3) affirmative vote of the delegates present and voting" for all other references to "two-thirds majority" or "supermajority" votes to ensure consistency and clarity throughout the ADA *Constitution and Bylaws*. The proposals are presented as two separate resolutions, since one involves a constitutional amendment which would require a lay over to the 2008 House of Delegates.

7. Resolved, that ARTICLE VIII. AMENDMENTS, of the ADA *Constitution* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

ARTICLE VIII • AMENDMENTS

This *Constitution* may be amended by a two-thirds (2/3) affirmative vote of the ~~members of the House of D~~delegates present and voting, provided that the proposed amendments have been presented in writing at any previous session of the House of Delegates.

This *Constitution* may also be amended at any session of the House of Delegates by a unanimous vote, provided the proposed amendments have been presented in writing at a previous meeting of such session.

8. Resolved, that CHAPTER V. HOUSE OF DELEGATES, Section 40. POWERS, Subsection F., of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

F. It shall have the power to grant, amend, suspend or revoke charters of constituent societies. It shall also have the power by a two-thirds (2/3) ~~majority~~ affirmative vote of the delegates present and voting to suspend the representation of a constituent society in the House of Delegates upon a determination by the House that the bylaws of the constituent society violate the *Constitution* or *Bylaws* of this Association providing, however, such suspension shall not be in effect until the House of Delegates has voted that the constituent society is in violation and has one year after notification of the specific violation in which to correct its constitution or bylaws.

and be it further

Resolved, that CHAPTER V. HOUSE OF DELEGATES, Section 130. RULES OF ORDER, Subsection A. STANDING RULES AND REPORTS, subsection d. APPROVAL OF THE DUES OF ACTIVE MEMBERS, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

d. APPROVAL OF THE DUES OF ACTIVE MEMBERS. The dues of active members of this Association shall be established by the House of Delegates as the last item of business at each annual session. The resolution to establish the dues of active members for the following year shall be proposed at each annual session by the Board of Trustees in conformity with Chapter VII, Section 100F of these *Bylaws*, may be amended to any amount and/or reconsidered by the House of Delegates until a resolution establishing the dues of active members is adopted by a two-thirds (2/3) ~~majority~~ affirmative vote of the ~~members~~ delegates present and voting.

and be it further
Resolved, that CHAPTER V. HOUSE OF DELEGATES, Section 130. RULES OF ORDER, Subsection A. STANDING RULES AND REPORTS, subsection e. INTRODUCTION OF NEW BUSINESS, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

e. INTRODUCTION OF NEW BUSINESS. No new business shall be introduced into the House of Delegates less than 15 days prior to the opening of the annual session, unless submitted by a Trustee District. No new business shall be introduced into the House of Delegates at the last meeting of a session except when such new business is submitted by a trustee district and is permitted to be introduced by a two-thirds (2/3) affirmative vote of the ~~House of D~~delegates present and voting. The motion introducing such new business shall not be debatable. Approval of such new business shall require a majority vote except new business introduced at the last meeting of a session that would require a bylaw amendment cannot be adopted at such last meeting. Reference committee recommendations shall not be deemed new business.

and be it further
Resolved, that CHAPTER VII. BOARD OF TRUSEES, Section 70. REMOVAL FOR CAUSE, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

Section 70. REMOVAL FOR CAUSE: The House of Delegates may remove a trustee for cause in accordance with procedures established by the House of Delegates, which procedures shall provide for notice of the charges and an opportunity for the accused to be heard in his or her defense. ~~The~~ A two-thirds (2/3) affirmative vote ~~of two-thirds (2/3)~~ of the delegates present and voting is required to remove a trustee from office. If the House of Delegates elects to remove the trustee, that action shall create a vacancy on the Board of Trustees which shall be filled in accordance with Chapter VII, Section 80.

and be it further
Resolved, that CHAPTER VIII. ELECTIVE OFFICERS, Section 70. REMOVAL FOR CAUSE, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

Section 70. REMOVAL FOR CAUSE: The House of Delegates may remove an elective officer for cause in accordance with procedures established by the House of Delegates, which shall include notice of the charges and an opportunity for the accused to be heard in his or her defense. ~~The~~ A two-thirds (2/3) affirmative vote ~~of two-thirds~~ of the delegates present and voting is required to remove an elective officer from office. If the House of Delegates elects to remove the elective officer, that action shall create a vacancy which shall be filled in accordance with Chapter VIII, Section 80.

and be it further
Resolved, that CHAPTER XVII. FINANCES, Section 40. SPECIAL ASSESSMENTS, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

Section 40. SPECIAL ASSESSMENTS: In addition to the payment of dues required in Chapter I, Section 20 of these *Bylaws*, a special assessment may be levied by the House of Delegates upon active, active life, retired and associate members of this Association as provided in Chapter I, Section 20 of these *Bylaws*, for the purpose of funding a specific project of limited duration. Such an assessment may be levied at any annual or special session of the House of Delegates by a two-thirds (2/3) ~~majority~~ affirmative vote of the delegates present and voting, provided notice of the proposed assessment has been presented in writing at least ninety (90) days prior to the first day of the session of the House of Delegates at which it is to be considered. Notice of such a resolution shall be sent by a certifiable method of delivery to each constituent society not less than

ninety (90) days before such session to permit prompt, adequate notice by each constituent society to its delegates and alternate delegates to the House of Delegates of this Association, and shall be announced to the general membership in an official publication of this Association at least sixty (60) days in advance of the session. The specific project to be funded by the proposed assessment, the time frame of the project, and the amount and duration of the proposed assessment shall be clearly presented in giving notice to the members of this Association. Revenue from a special assessment and any earnings thereon shall be deposited in a separate fund as provided in Chapter XVII, Section 30 of these *Bylaws*. The House of Delegates may amend the main motion to levy a special assessment only if the amendment is germane and adopted by a two-thirds (2/3) ~~majority~~ affirmative vote of the delegates present and voting. The House of Delegates may consider only one (1) specific project to be funded by a proposed assessment at a time. However, if properly adopted by the House of Delegates, two (2) or more special assessments may be in force at the same time. Any resolution to levy a special assessment that does not meet the notice requirements set forth in the previous paragraph also may be adopted by a unanimous vote of the House of Delegates, provided the resolution has been presented in writing at a previous meeting of the same session.

and be it further

Resolved, that CHAPTER XXI. AMENDMENTS, Section 10. PROCEDURE, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

Section 10. PROCEDURE: These *Bylaws* may be amended at any session of the House of Delegates by a two-thirds (2/3) ~~majority~~ affirmative vote of the ~~members~~ delegates present and voting, provided the proposed amendments shall have been presented in writing at a previous session or a previous meeting of the same session.

Judicial Affairs

Appeals from Disciplinary Hearings: One of the Council's *Bylaws* duties is to sit as an appellate body to review decisions of the constituent and component societies in disciplinary matters. The Council is to determine whether the evidence before the society that preferred charges against the accused member supports the decision or warrants the penalty imposed. The Council also reviews the disciplinary procedures used to render the decision to make sure they are fair and in accordance with the *Bylaws*. Since its last report, the Council rendered three decisions that are reported below.

Appeal of Dr. [ ] [*](Appellant) appealed to the Council from a penalty of expulsion imposed against him by his constituent society (Respondent). Respondent's peer review committee considered a complaint about the quality of dental implant services which Appellant provided to a patient. The peer review committee found in favor of the patient and requested Appellant issue a $1,600.00 refund to the patient. Appellant wrote to the patient and Respondent indicating that, due to financial problems, he would pay installments of $50.00 per month to the patient until a full refund was made. When the appeal period closed and the patient objected to installment payments, Respondent requested that Appellant submit a refund check in the full amount within five calendar days of the date of the request. When Appellant did not comply, Respondent informed Appellant that the matter had been referred to the Respondent's Judicial Council for a potential violation of the Respondent's Code of Ethics.

Appellant was notified of the Judicial Council hearing and given the opportunity to appear, either in person and/or through legal counsel to present a defense to the charges brought against him. Appellant failed to appear at the hearing, nor did he explain at that time his absence or ask for a postponement. Based on the record before it, Respondent found Appellant guilty of violating Respondent's Code of Ethics for failure to comply with a decision rendered by the Peer Review Committee, which states in relevant part:

> A dentist has the obligation to comply with the reasonable requests of a duly constituted committee, council or other body of the component society or of this association necessary or convenient to enable such a body to perform its functions and to abide by the decisions of such body.

Respondent concluded that the conduct constituted serious breaches of ethical and professional duties and found Appellant guilty as charged. The penalty of expulsion was imposed. Appellant brought an appeal to the Council

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

pursuant to the ADA *Bylaws*. Both Appellant and Respondent filed written briefs. Both parties appeared at the hearing with 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.

1. *Consideration of Additional Evidence.* Chapter XII, Section 20D(f) of the ADA *Bylaws* provides that the Council is not required to consider additional evidence unless there is a clear showing that either party to the appeal will be unreasonably harmed by the failure to consider the additional evidence. Respondent's written decision provided that the penalty imposed in this case is based on Appellant's failure to meet his obligation to comply with "the reasonable requests of a duly constituted committee," in this case, Appellant's local peer review committee and the fact that Appellant did not appear or offer any mitigation or explanation for Respondent's Council to consider. Appellant did not dispute that Respondent properly served upon him the hearing notice, as required under the ADA *Bylaws* and Respondent's bylaws. Rather, by way of an affidavit, Appellant submitted additional evidence to explain and mitigate his non-appearance at the hearing.

Through their briefs and exhibits, each party provided additional information that was not considered at the hearing by Respondent's Judicial Council. Appellant offered a declaration on his behalf explaining his financial and practice situation, as well as his non-appearance at the hearing. Appellant also offered a declaration from his staff member, explaining that she advised Appellant that he did not need to attend the hearing, based on a conversation she alleged took place with a member of Respondent's staff. Respondent offered declarations from its legal counsel and another legal staff member asserting that neither Appellant nor any member of Appellant's staff contacted Respondent regarding the hearing.

Expulsion, as defined in the ADA *Bylaws*, is an absolute discipline, the most severe penalty that can be imposed against a member. The Council determined that the additional evidence submitted by the parties which pertained to Appellant's nonappearance and his financial circumstances was relevant to the proceeding. For these reasons, the Council accepted the additional evidence.

2. *Relief from Penalty Imposed.* Appellant did not dispute that he failed to respond to the request of the constituent's Peer Review Committee to issue a patient refund. Nor did he dispute that the decision of the Peer Review Committee was reasonable. Appellant admitted that the patient was not paid until the patient prevailed in a lawsuit against him in small claims court and he discovered that his professional liability carrier covered the adverse peer review decision/judgment. By way of declarations, Appellant explained his noncompliance was the product of his own errors, mistakes and financial constraints, not an intentional disregard for the Peer Review Committee's request.

Although satisfied with Respondent's answers from its legal staff not having spoken with Appellant's staff, the Council believed it was an open question as to whether someone outside Respondent's legal department staff may have done so. Appellant was very frank and forthright in describing what the Council deemed were extreme crises involving construction of his office and ongoing litigation, which challenged not only his financial health to the verge of bankruptcy but also burdened Appellant's emotional state.

While Appellant's judgment could be questioned for relying on his staff for such an important professional matter as to his appearance at Respondent's Judicial Council hearing, the Council concluded that an excusable mistake occurred on Appellant's part. Because Appellant failed to appear at the judicial hearing, Respondent's Judicial Council did not have all of the relevant information when deciding on an appropriate penalty.

The Council believes that had Respondent's Judicial Council been privy to the extent of Appellant's financial misfortunes and distraught state of mind, its decision concerning an appropriate penalty might have been different. The Council was persuaded by Appellant's explanation as to trying to meet his peer review obligations in the face of a financial crisis, his sincerity and honesty as to his mistakes, and was satisfied that Appellant had learned valuable professional lessons from this experience. Based on the specific facts in this case, the Council determined that mitigation against the penalty imposed was warranted.

For these reasons, the Council upheld the decision that Appellant violated Section 3 of Respondent's Code of Ethics, but reduced the penalty from expulsion to private censure.

Appeal of Dr. [ ] [†](Appellant) appealed to the Council from a penalty of expulsion imposed by his constituent society (Respondent). Appellant's component society received a complaint about the quality of dental bridge services Appellant provided a patient. The complaint was assigned to Appellant's component Peer Review Committee.

Appellant signed the Agreement to Submit to Peer Review and submitted financial documentation regarding the disputed dental treatment. Appellant's component society then wrote the patient informing her that she must tender for escrow the balance of $167.00 which she owed Appellant. After consultation with the Peer Review Committee, the component society informed Appellant that he was required to place $2,072.29, the total charged for the subject dental treatment less the amount the patient still owed, into escrow pending the outcome of peer review. Appellant was also informed that, alternatively, he could forgo the escrow if his liability carrier would submit a letter representing that it would deposit the amount of the refund within ten days of an adverse peer review decision. Appellant responded by requesting the component society cease the peer review proceedings, stating that if patient wished, she was free to pursue her request for reimbursement in a court of law. Appellant refused to place any amount of money in escrow and also refused to have the other dentists in his dental practice sign the Peer Review Agreement. Appellant and the complainant patient were notified by the component society's Peer Review Committee that because of Appellant's failure to put $2,072.29 in escrow the Peer Review Committee could not hear the case and that Appellant's failure to participate in peer review would result in the case being referred to the component's Ethics Committee. Appellant notified the component's Peer Review Committee that he would let the "issue take its course."

The component's Ethics Committee chair attempted to resolve the matter by telephone conference with Appellant during which he explained that if Appellant would not comply with the peer review requirements, the case would be taken up by the constituent's Ethics Committee. Appellant reiterated his decision not to participate in peer review. Appellant was subsequently notified that his case was being referred to the constituent society's (Respondent) Council on Ethics for appropriate review.

Respondent's Council on Ethics issued charges against Appellant for refusal to comply with the peer review process in violation of Principle-Section 3 of the Respondent's Code of Ethics and Chapter I, Section 30 (D) of the Respondent's Bylaws. Principle-Section 3 states, in pertinent part:

> Professions owe society the responsibility of regulating and disciplining themselves through the influence of professional associations. All dentists, therefore, have the dual obligation of making themselves a part of a professional association and of observing its rules of ethics.
>
> A member's failure to participate in peer review and abide by the decision of peer review constitutes a violation of this Code.

Appellant was notified in writing of the hearing and given the opportunity to appear, be represented by legal counsel, answer the charges against him, cross-examine witnesses and introduce evidence in his defense. Appellant elected to appear at the hearing in person without counsel and chose to plead guilty. The only evidence Appellant submitted on his behalf was his testimony; there were no disputed facts offered concerning the matters surrounding the ethical misconduct charge.

Appellant stated that a main reason for withdrawing from peer review was because he was upset that he was compelled to put money into escrow, despite the fact that the patient "was still enjoying the bridge in her mouth." Had she removed/returned it, he didn't "think (he) would have a problem." Appellant also stated that the escrow requirement made him believe that the Council on Ethics did not trust him. He testified that he had concerns he would not receive a fair hearing. At the end of the hearing, Appellant told the Council on Ethics that he had made a mistake and that if he had it to do over again he would take a different tack.

Appellant was notified in writing of the decision rendered by Respondent's Council on Ethics. The Council on Ethics concluded that the case presented a straightforward issue in which Appellant had refused to participate in the peer review process in violation of the Respondent's Bylaws and Code of Ethics and Chapter I, Section 30 (D) and found no extenuating circumstances to excuse Appellant's misconduct. The Council on Ethics imposed the penalty of membership expulsion against Appellant.

[†] The names of the parties have been purposefully omitted.

Appellant brought this appeal to the ADA Council on Ethics, Bylaws and Judicial Affairs (the Council) pursuant to the ADA *Bylaws*. Both Appellant and Respondent chose to be represented by legal counsel and filed written briefs. Appellant elected not to present oral argument at the appellate hearing and chose instead to rest upon written briefs submitted by his attorney and upon the record of the proceedings below. Respondent, represented by legal counsel, chose to appear at the hearing to present oral argument.

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

1. Is the Decision Supported by the Evidence? On appeal Appellant contended that there was no evidence in the record to suggest that he refused to participate in peer review. He maintained that what he refused to do was to satisfy the two preconditions imposed on him before the peer review process could move ahead, namely: 1) placing in escrow the amount of money he had been paid up to that point for the complainant's dental work and 2) requiring his employees to sign and agree to be bound by the peer review decision. Appellant also claimed that he had no notice of the conditions to which he objected until after he had signed the agreement to submit to peer review.

Council felt that by steadfastly refusing to comply with the peer review requirements, Appellant effectively assured that the peer review process would not go forward. Respondent explained its Peer Review Handbook provides that, for cases involving multiple dentist dental practices such as Appellant's, an escrow may be required as part of the peer review process. The record showed that correspondence and telephone conversations exchanged between Appellant and Respondent reiterated the escrow requirement and that Appellant was offered an alternative through his liability carrier. Regardless of whether Appellant had ever familiarized himself with the various documents relevant to his membership in the Respondent dental society, he clearly had notice that an escrow deposit was needed in order for peer review to proceed, and he simply disagreed with the requirement because the patient was enjoying use of the dental prosthesis in question. Appellant testified that he was unaware that Respondent's Ethics Committee dropped the discretionary requirement for other dentists in his practice regarding peer review. However, he could not claim prejudice as a result of this because his refusal to comply did not form a basis for Respondent Council on Ethics' decision.

2. Was the Component Society's Ethics Committee Biased Against Appellant or Did Appellant at Least Have a Reasonable Good Faith Belief That It Was? Appellant alleged that the component society's peer review requirement regarding an escrow deposit from him indicated that the Committee was biased against him. At Respondent's Council on Ethics Hearing, Appellant failed to offer any evidence to support his allegation. His argument was based solely on his subjective belief that the escrow requirement indicated that the Committee did not trust him. Further, Appellant's own testimony belied his averment that his refusal to proceed with peer review was because he believed, rightly or wrongly, that the Committee was prejudiced against him. Appellant made it abundantly clear at the hearing that his negative attitude toward peer review was attributable to his anger over the fact that he had to deposit money into escrow while the complaining patient was permitted to retain the bridge he made for her.

3. Does Appellant's Belief that the Peer Review Process is "Constitutionally and Legally Infirm" Excuse His Refusal to Participate in Peer Review? Raising the issue for the first time on appeal, Appellant in his supporting brief asserted that Respondent's peer review process is "constitutionally and legally infirm" because it did not permit the parties to be represented by legal counsel, as is provided under applicable state law for arbitration proceedings. Appellant contended that the putative "legal infirmity" of the peer review process meant that it is not "final" and therefore justified his refusal to participate in peer review. Respondent contended that the arguments were untimely, since Appellant failed to make them at the hearing with Respondent's Council of Ethics. Respondent also advised that it had already removed its waiver of counsel rule for peer review. The Council determined that Appellant's arguments were both untimely and not relevant, since the evidentiary record showed that the peer review proceeding never took place.

Given the evidence before it, this Council upheld Respondent's decision in this matter and the penalty of expulsion.

Appeal of Dr. [ ] [‡](Appellant) appealed to the Council from a penalty of a one-year suspension of membership, which the constituent society (Respondent) stayed, conditioned on the successful completion of one-year's probation and the completion of an ethics course and a risk management course.

Respondent's bylaws provide that a member who is found guilty or disciplined for professional misconduct by the state licensing board is automatically referred to Respondent's Council on Ethics. The same provision further states

[‡] The names of the parties have been purposefully omitted.

that once a case has been referred to the full Council, "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 licensing board)."

Appellant's state licensing board disciplined her for professional misconduct, namely, practicing dentistry with negligence on more than one occasion, based on charges that Appellant inappropriately chose to place a molar crown when the bony support was inadequate and fabricated a crown that was ill-fitting. The licensing board imposed a penalty of censure and reprimand.

When Respondent learned of the state's disciplinary action, it notified Appellant of the dental society's ethics hearing and gave Appellant the opportunity to appear, either in person and/or through legal counsel. Appellant attended the hearing but elected to do so without an attorney. Respondent found it significant that even though Appellant had been censured by the state licensing board, Appellant persisted in the refusal to take responsibility for her actions. Under Respondent's questioning concerning her failure to take certain x-rays prior to performing the dental work, Appellant appeared unwilling to concede that she would do anything differently, or that she was in anyway at fault. According to Respondent's decision, Appellant had apparently not learned anything from the finding of professional misconduct other than to "protect [her]self [over] protecting the patient." In addition, Respondent was troubled by the personal attacks that Appellant leveled against dentists who testified against her at the state's disciplinary hearing. Respondent held that ethically disciplining Appellant was warranted and imposed on Appellant the membership penalty of probation and mandatory continuing education.

Appellant brought this appeal to the ADA Council on Ethics, Bylaws and Judicial Affairs (the Council) pursuant to the ADA *Bylaws*. Both Appellant and Respondent filed written briefs. Appellant elected not to present oral argument and chose instead to rest upon written briefs submitted by her attorney and upon record of the proceedings below. Respondent, represented by legal counsel, chose to appear at the hearing to present oral argument.

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

1. Is Respondent's Assessment of the Penalty Based on a Misconception About the State Licensing Board's Ruling? Appellant argued that she was seriously prejudiced because Respondent's imposition of penalty was based at least in part on an allegation against her that had actually been found in her favor and was *res judicata*. According to Appellant, she did not expect the matter to be raised again, and was the victim of unfair surprise when Respondent mentioned it in its written decision. A close review of the record demonstrated that the dismissed allegation was neither raised nor considered by Respondent. The state licensing board agreed with one of the allegations that Appellant was guilty of practicing the profession of dentistry with negligence on more than one occasion. Respondent based its rulings on this finding, as was apparent from its written decision. Respondent properly referenced the allegation of an ill-fitting crown because it was one of the instances of negligence that formed the basis for the state licensing board's decision. It was clear to the Council that Respondent correctly understood the basis for the state board's decision. Appellant does not attempt to argue, nor could she raise a credible argument, that the penalty imposed on her was influenced in any way by the particularities of the negligence charge upon which she had been found guilty by the state board. The salient fact was that Appellant was disciplined by the state board, which constituted a violation of Respondent's bylaws.

In this situation, this Council felt Respondent was fully warranted in exercising its discretion in determining what penalty was appropriate for the violation.

2. Is the Punishment Imposed Against Appellant by Respondent Excessive in Light of the Punishment Imposed by the State Licensing Board? Appellant argued that the penalty of censure and reprimand imposed by the state licensing board should have been "respected" by Respondent and that the membership penalty of probation and mandatory continuing education imposed by Respondent against Appellant was out of proportion to any misconduct that occurred. The Council recognized that the role of Respondent, as a private membership organization, is different and distinct from that of the state board and that Respondent has a right to preserve its long-standing reputation for upholding high ethical standards. Respondent's rulings affect the membership rights rather than the dental license of an individual member. Pursuant to its bylaws, Respondent is vested with the authority to fashion member discipline that will best serve the membership; its discretion in this regard is quite broad and will only be disturbed if such discretion is abused. This Council saw no evidence of such abuse in this case and believed the penalty imposed by Respondent was properly tailored to Appellant's situation.

3. Did Respondent Misunderstand or Misinterpret Certain Comments Appellant Made at the Council on Ethics Hearing? Appellant argued that the Respondent's interpretation of her comments at the Respondent's ethics hearing was patently wrong. Respondent's decision expressed concern over the fact that, in its opinion, Appellant did take

responsibility for her actions despite having been censored by the state. According to Respondent, Appellant was reluctant to concede that she would do anything differently or admit that she bore any degree of fault. Appellant maintained that in response to a question whether she would do the same thing again she emphatically answered, "no," and that she had learned her lesson. However, as Respondent pointed out, she had stated that she would not do the same thing again because the lesson she had learned was to protect herself over protecting the patient.

This Council, based on the record, determined that Appellant's contention in this regard was without merit.

4. Was Respondent Biased Against Appellant? Appellant charged that Respondent's determination was based solely on the negative reaction Respondent's council members had to Appellant personally, based on a statement made in the written decision that Appellant's personal attacks on dentists who testified against her were troubling.

This Council determined that on its face, the identified statement did not indicate bias. Nor would the Council, as an appellate body, second-guess a determination as to a witness's credibility or demeanor made by the body that actually heard the witness's testimony. Based on the adduced evidence, the Council deemed nothing was clearly excessive about the penalty imposed nor was any such penalty required to be "proportionate" to the penalty imposed by another agency that has a different mandate.

For these reasons, this Council upheld Respondent's decision and its imposition against Appellant of the membership penalty of a stayed suspension, one-year's probation and the requirement that Appellant take continuing education courses in ethics and risk management.

Council Activities

Ethics Component of the SUCCESS Program: The year 2007 is the last that the ethics component of the SUCCESS seminar, "An Ethical Perspective to Starting Your Dental Practice," will be offered as a stand-alone ADA program. The original half-day seminar, designed by the Council and cosponsored by the Council on Dental Practice (CDP), officially began in 1995 to acquaint junior and senior dental students with the ethical aspects of starting a dental practice. Students were given the opportunity to apply the ADA *Principles of Ethics and Code of Professional Conduct* to ethical dilemmas faced by new practitioners as presented by Council volunteers. This year, programs were presented at the following dental schools: Meharry Medical College, University of Washington, West Virginia University, Ohio State University, University of Alabama-Birmingham, University of Tennessee-Memphis, University of Mississippi, University of Texas-Houston, University of North Carolina, University of Missouri-Kansas City, Louisiana State University, Baylor College of Dentistry and a combined program with University of Illinois-Chicago and Southern Illinois University. Dental student attendees continued to rate the overall program highly, 4.4 on a one-to-five scale, with five being the highest.

Beginning in the fall of 2007, ethics education will be incorporated into the practice management component of the ADA's newly revised SUCCESS dental educational program for senior dental students. This change comes in response to recommendations made in July 2006 by the ADA's Dental School Programs Advisory Group, which included two Council representatives, to enhance the ADA dental school programming. Ultimately, the ADA will offer a series of programs to all dental schools in the nation every year for each class under the SUCCESS umbrella.

The Council gratefully acknowledges CDP's assistance for its efforts in obtaining corporate sponsorship to fund expenses for half the seminars presented. The Council also extends sincere appreciation to the following dentist-presenters: Dr. Skip Buford, Shreveport, LA; Dr. Terrence A. Clark, Wilsonville, OR; Dr. Kenneth D. Jones, Jr., Mansfield, OH; Dr. Lillian Obucina, Chicago; and Dr. Elizabeth Shapiro, Amboy, IL. These speakers, over the lifetime of the program, spent more than 500 volunteer hours visiting over 145 classes, and interacting with approximately 11,000 dental students to educate them about the ADA *Principles of Ethics and Code of Professional Conduct*. Their contributions to the ethics of the profession are heartily lauded by the Council.

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. The deadline for submissions each year is June 1.

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 monthly feature provides practical answers to everyday dental practice dilemmas based on the ADA *Principles of Ethics and Code of Professional Conduct*. Send your suggestions to ethics@ada.org.

Chair and Vice Chair For 2008-2009: The Council forwarded the name of Dr. James F. Smith to the Board of Trustees for approval as the Council's chair for the upcoming term. Dr. William G. Leffler was elected as vice chair for the upcoming term.

Personnel: The Council welcomed four new members: Dr. David F. Boden, Dr. Judith M. Fisch, Dr. Kirk Norbo and Dr. Alan R. Stein. The 2007 annual session will mark the completion of the terms of service for four Council members: Dr. Rickland G. Asai, chair, Dr. Dennis J. Charlton, Dr. Keith W. Dickey and Dr. Beverly A. Largent. 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

7. Resolved, that ARTICLE VIII. AMENDMENTS, of the ADA *Constitution* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

ARTICLE VIII • AMENDMENTS

This *Constitution* may be amended by a two-thirds (2/3) affirmative vote of the ~~members of the House of D~~delegates present and voting, provided that the proposed amendments have been presented in writing at any previous session of the House of Delegates.

This *Constitution* may also be amended at any session of the House of Delegates by a unanimous vote, provided the proposed amendments have been presented in writing at a previous meeting of such session.

8. Resolved, that CHAPTER V. HOUSE OF DELEGATES, Section 40. POWERS, Subsection F., of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

F. It shall have the power to grant, amend, suspend or revoke charters of constituent societies. It shall also have the power by a two-thirds (2/3) ~~majority~~ affirmative vote of the delegates present and voting to suspend the representation of a constituent society in the House of Delegates upon a determination by the House that the bylaws of the constituent society violate the *Constitution* or *Bylaws* of this Association providing, however, such suspension shall not be in effect until the House of Delegates has voted that the constituent society is in violation and has one year after notification of the specific violation in which to correct its constitution or bylaws.

and be it further
Resolved, that CHAPTER V. HOUSE OF DELEGATES, Section 130. RULES OF ORDER, Subsection A. STANDING RULES AND REPORTS, subsection d. APPROVAL OF THE DUES OF ACTIVE MEMBERS, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

d. APPROVAL OF THE DUES OF ACTIVE MEMBERS. The dues of active members of this Association shall be established by the House of Delegates as the last item of business at each annual session. The resolution to establish the dues of active members for the following year shall be proposed at each annual session by the Board of Trustees in conformity with Chapter VII, Section 100F of these *Bylaws,* may be amended to any amount and/or reconsidered by the House of Delegates until a resolution establishing the dues of active members is adopted by a two-thirds (2/3) ~~majority~~ affirmative vote of the ~~members~~ delegates present and voting.

and be it further
Resolved, that CHAPTER V. HOUSE OF DELEGATES, Section 130. RULES OF ORDER, Subsection A. STANDING RULES AND REPORTS, subsection e. INTRODUCTION OF NEW BUSINESS, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

e. INTRODUCTION OF NEW BUSINESS. No new business shall be introduced into the House of Delegates less than 15 days prior to the opening of the annual session, unless submitted by a Trustee District. No new business shall be introduced into the House of Delegates at the last meeting of a session except when such new business is submitted by a trustee district and is permitted to be introduced by a two-thirds (2/3) affirmative

vote of the ~~House of D~~delegates present and voting. The motion introducing such new business shall not be debatable. Approval of such new business shall require a majority vote except new business introduced at the last meeting of a session that would require a bylaw amendment cannot be adopted at such last meeting. Reference committee recommendations shall not be deemed new business.

and be it further
Resolved, that CHAPTER VII. BOARD OF TRUSEES, Section 70. REMOVAL FOR CAUSE, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

Section 70. REMOVAL FOR CAUSE: The House of Delegates may remove a trustee for cause in accordance with procedures established by the House of Delegates, which procedures shall provide for notice of the charges and an opportunity for the accused to be heard in his or her defense. ~~The~~ A two-thirds (2/3) affirmative vote ~~of two-thirds (2/3)~~ of the delegates present and voting is required to remove a trustee from office. If the House of Delegates elects to remove the trustee, that action shall create a vacancy on the Board of Trustees which shall be filled in accordance with Chapter VII, Section 80.

and be it further
Resolved, that CHAPTER VIII. ELECTIVE OFFICERS, Section 70. REMOVAL FOR CAUSE, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

Section 70. REMOVAL FOR CAUSE: The House of Delegates may remove an elective officer for cause in accordance with procedures established by the House of Delegates, which shall include notice of the charges and an opportunity for the accused to be heard in his or her defense. ~~The~~ A two-thirds (2/3) affirmative vote ~~of two-thirds~~ of the delegates present and voting is required to remove an elective officer from office. If the House of Delegates elects to remove the elective officer, that action shall create a vacancy which shall be filled in accordance with Chapter VIII, Section 80.

and be it further
Resolved, that CHAPTER XVII. FINANCES, Section 40. SPECIAL ASSESSMENTS, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

Section 40. SPECIAL ASSESSMENTS: In addition to the payment of dues required in Chapter I, Section 20 of these *Bylaws*, a special assessment may be levied by the House of Delegates upon active, active life, retired and associate members of this Association as provided in Chapter I, Section 20 of these *Bylaws*, for the purpose of funding a specific project of limited duration. Such an assessment may be levied at any annual or special session of the House of Delegates by a two-thirds (2/3) ~~majority~~ affirmative vote of the delegates present and voting, provided notice of the proposed assessment has been presented in writing at least ninety (90) days prior to the first day of the session of the House of Delegates at which it is to be considered. Notice of such a resolution shall be sent by a certifiable method of delivery to each constituent society not less than ninety (90) days before such session to permit prompt, adequate notice by each constituent society to its delegates and alternate delegates to the House of Delegates of this Association, and shall be announced to the general membership in an official publication of this Association at least sixty (60) days in advance of the session. The specific project to be funded by the proposed assessment, the time frame of the project, and the amount and duration of the proposed assessment shall be clearly presented in giving notice to the members of this Association. Revenue from a special assessment and any earnings thereon shall be deposited in a separate fund as provided in Chapter XVII, Section 30 of these *Bylaws*. The House of Delegates may amend the main motion to levy a special assessment only if the amendment is germane and adopted by a two-thirds (2/3) ~~majority~~ affirmative vote of the delegates present and voting. The House of Delegates may consider only one (1) specific project to be funded by a proposed assessment at a time. However, if properly adopted by the House of Delegates, two (2) or more special assessments may be in force at the same time. Any resolution to levy a special assessment that does not meet the notice requirements set forth in the previous paragraph also may be adopted by a unanimous vote of the House of Delegates, provided the resolution has been presented in writing at a previous meeting of the same session.

and be it further

Resolved, that CHAPTER XXI. AMENDMENTS, Section 10. PROCEDURE, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

> *Section 10.* PROCEDURE: These *Bylaws* may be amended at any session of the House of Delegates by a two-thirds (2/3) ~~majority~~ affirmative vote of the ~~members~~ delegates present and voting, provided the proposed amendments shall have been presented in writing at a previous session or a previous meeting of the same session.

Council on Government Affairs

Long, S. Jerry, Texas, 2007, chair
Raiber, Robert B., New York, 2007, vice chair
Bertoch, Daniel A., Florida, 2008
Butler, Robert E., Missouri, 2010
Conaty, Thomas P., Delaware, 2010
Crowley, Joseph P., Ohio, 2009
Dow, Jeffrey D., Maine, 2008
Gamble, Howard R., Alabama, 2008
Gelfand, Gerald, California, 2007
Gosar, Paul A., Arizona, 2009
Harms, Kimberly, Minnesota, 2009
Kinzel, Timothy R., Wisconsin, 2008
Kwasny, Andrew J., Pennsylvania, 2009
McDonald, Fred T., Arkansas, 2010
Oyster, Gary D., North Carolina, 2007
Parrish, Jeffery L., Washington, 2008, *ex officio*[+]
Shanker, Shiva V., 2007, *ex officio*[*]
Suchy, Keith W., Illinois, 2008
Walker, Mark V., Washington, 2010
Spangler, Thomas J., director

Meetings: The Council met January 25-27 and April 27-29, 2007, in Washington, D.C. The Council's third meeting is scheduled for September 6-8, 2007, in Chicago.

The Strategic Plan of the American Dental Association: Goal: Achieve Effective Advocacy for both oral health and the dental profession, within the health care, public and policy communities. The Council on Government Affairs engaged in a mega issue discussion on federal and state legislation addressing universal medical coverage at its January meeting and followed up with additional deliberations at its April meeting, focusing on the potential impact on dentistry. The Council also supports several new legislative initiatives that should help increase access to oral health care for underserved populations, such as a children's dental health bill and State Children's Health Insurance Plan (SCHIP) reauthorization. The Council sees its role as forwarding the ADA's legislative and regulatory policies and priorities; 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.

Summary of Federal Legislative and Regulatory Activity Addressing the Impact of Information Technology on the Practice of Dentistry: Senator Norm Coleman (R-MN) and Senator Evan Bayh (D-IN) introduced S. 628, the Critical Access to Health Information Technology Act of 2007. While the primary purpose of the bill is to expand rural access to health information technology (HIT), one section of the bill could have the unintended effect of introducing unnecessary complication into the dental claims process. For example, a provision calls for the adoption of new HIPAA electronic healthcare transactions (called version 5010) but the current implementation guide for version 5010 could be interpreted as requiring dentists to report diagnostic codes on dental claim forms. The ADA sent a letter to Senators Coleman and Bayh expressing its concern and again offering assistance to resolve these concerns. In addition, ADA representatives met with Dr. Robert Kolodner, Interim National Coordinator Office of the National Coordinator for Health Information Technology, Department of Health and Human Services, as a follow up to the presentation by Secretary Michael Leavitt to the ADA's House of Delegates last year. The purpose of the meeting was to stress the importance of the need to involve the ADA in the development of the standards and regulations governing HIT. Dr. Kolodner is also scheduled to be one of the featured speakers at this year's Washington Leadership Conference.

Federal Emerging Issues and Trends:

Access. The dental complications that led to the death of a 12-year-old Maryland boy—and the resulting news coverage—have focused state and federal lawmakers on the lack of access afforded by Medicaid and the State Children's Health Insurance Program (SCHIP). ADA president, Dr. Kathy Roth, represented the ADA at a March 27 hearing with the Health Subcommittee of the House Energy and Commerce Committee, which heard from witnesses on ways to improve access to care for underserved children. Dr. Roth told the subcommittee that one of the best ways to avoid tragedies associated with unmet oral health needs is to reform the Medicaid program in a manner that enables more private sector dentists to participate in the program, thereby ensuring that beneficiaries receive timely comprehensive dental care. She offered examples of state-based reform that are working, such as the "Healthy Kids Dental" program in Michigan. She also stressed the need to provide federal grant money to pilot test the ADA-supported Community Dental Health Coordinator (CDHC) model.

The ADA and other dental organizations are also working with the Maryland delegation to draft legislative language for Senators Cardin and Mikulski and Representatives Cummings and Wynn (all from Maryland) that include the following:

- Increase the federal match for Medicaid for states that increase number of dentists participating in Medicaid (so that many more private sector dentists are participating) and increase the number of enrollees actually provided care.
- Authorize pilot funding for the Community Dental Health Coordinator. Provide federal grants to academic institutions to develop a demonstration model for the community dental health coordinator.
- Create a tax credit for dentists who donate dental services to underserved individuals.

Some additional key bills and legislative proposals supported by the ADA are:

- SCHIP Reauthorization and Expansion—H.R. 1535 (Representative Dingell) and S. 895 (Senator Clinton) provide for reauthorization and expansion of SCHIP up to 400% FPL. Includes dental benefit requirement for SCHIP benchmark plans and would allow wrap-around coverage for dental benefits for children with other health insurance.
- SCHIP Reauthorization—Legislation will be introduced by Senators Rockefeller and Snowe and Representative Pallone that focuses on a straight reauthorization of SCHIP that will cost less ($50-60 billion) than the Dingell-Clinton bills referenced above. The ADA is advocating for the dental benefit requirement and dental wrap-around benefit to be included.
- Children's Dental Health Improvement Act—H.R. 1781 (Representatives Dingell and Simpson) and S. 739 (Senator Bingaman) include a state option to provide wrap-around coverage, provide financial incentives to states to increase Medicaid and SCHIP reimbursement rates to market rates, and create a statutory requirement for a chief dental officer in Center for Medicare and Medicaid Services (CMS), Health Resources and Services Administration (HRSA) and Center for Disease Control (CDC). The Dingell-Simpson bill includes a federal guarantee for a dental benefit in SCHIP and requires the Secretary of HHS to encourage private-public partnerships in medically underserved areas, including allowing contractual agreements with private practicing dentists and Federally Qualified Health Centers (FQHCs).

Small Business Loans to Improve Access. Dr. Roth testified before the House Small Business Committee on March 8, offering the ADA's support for loan incentives to encourage dental and medical practices in low-income and rural areas. Her testimony supported a legislative proposal that would decrease the cost of obtaining Small Business Administration loans for physicians, dentists and other health care professionals who open offices in designated health professional shortage areas by reducing origination fees and increasing the guarantees offered to lenders.

Indian Health Care Improvement Act. After discussing all options, the Council developed multiple recommendations regarding possible amendments to the Indian Health Care Improvement Act (IHCIA). Those recommendations were forwarded to Dr. Roth and Dr. Feldman and shared with the Board of Trustees. The House version of the IHCIA, H.R. 1328, which is essentially the same as last year's version, was the subject of three hearings on Capitol Hill in just 30 days at the beginning of the 110th Congress. It looks like the reauthorization bill is finally headed for passage this year, since many hurdles that blocked its path last year have been removed. The dental health aide therapist (DHAT) provision in H.R. 1328 is identical to the DHAT provision in the IHCIA at the end of the last Congress. The Senate

bill, S. 1200, was introduced on April 24 by Senator Dorgan (D-ND), Chair of the Indian Affairs Committee. An earlier hearing on the legislation was held on March 8. The DHAT provision in S. 1200 is identical to the DHAT provision in H.R. 1328. Both bills limit DHATs to Alaska and restrict the scope of DHAT services in the same manner as described in last year's bills.

The dental health aide program was not discussed at the March 8 Indian Affairs Committee hearing. Instead, Chair Dorgan focused on determining whether the Bush Administration (particularly Health and Human Services or the Justice Department) would attempt to hold up passage of the bill with objections to certain provisions. Representatives from both agencies assured the committee that any objections they may have had last year have been addressed. DHATs were brought up at a later hearing, however. The House Natural Resources Committee held a hearing on the IHCIA on March 14. Federal and tribal health officials testified. Valerie Davidson, a spokesperson for the Alaska Native Tribal Health Consortium, was asked to address the DHAT program. She praised the program and expressed satisfaction with a provision in the IHCIA that, among other things, limits the use of DHATs to tribal lands in Alaska only.

Free Standing American Indian/Alaska Native (AI/AN) Access Legislation. The ADA is also developing legislation separate from the IHCIA to improve the delivery of oral health care services to the AI/AN populations across the country. Some of the ideas being discussed by the Council are:

- Create scholarship programs in conjunction with one or more CODA-accredited dental school(s) to sponsor the dental education of all qualified individuals who are willing to make a time-certain commitment to practice dentistry in rural or frontier American Indian/Alaska Native communities. Special consideration for placement in the program will be given to qualified American Indian/Alaska Native students, who will also be offered support programs to help ensure their successful completion of the program.
    - Ensure that scholarships are available to dental students at any point in their dental education.
    - Expansion of student slots in dental schools, under Title VII legislation and through Title VII funding.
- Establish a program to assist non-traditional students to enter dental health professions willing to make a time certain commitment to work in tribal communities.
- Establish a pilot summer program for dental schools to bring AI/AN high school students to their campuses to learn more about dentistry.
- Reach out to persons in the Millennial generation seeking a career change.
- Establish a grant program with the goal of training and funding oral health representatives, who will work to provide dental education and prevention. In instances where due to fiscal constraints it may not be possible to hire enough oral health representatives, a medical provider could be trained to perform these functions.
- Establish projects in schools and other appropriate locations to provide preventive oral health interventions (e.g., fluoride varnish, sealants, and dietary fluoride supplements) as well as nutritional education for American Indian/Alaska Native children.
- Provide for a study to determine the best means of reducing the amount of soft drinks ingested by AI/AN children and substituting more healthful options. Work with health coalitions to establish health education projects in schools and at other locations.
- Expand residency programs with dental schools for tribal and IHS facilities.

Meth Mouth Legislation. ADA lobbyists are lining up supporters in the House and Senate for a bill that addresses the ravages of methamphetamine use, including so-called "meth mouth," and they expect to have the legislation introduced soon. Given the existence of a 134-member House Meth Caucus, this bill should receive a lot of support.

If enacted, the ADA's *Meth Mouth Prevention and Community Recovery Act* would provide the Department of Health and Human Services with funds to:

- Create a media campaign to educate dental patients and the general public about the harmful oral effects of methamphetamine use.
- Implement a grant program to help states get out the message about meth to elementary and secondary school students.

- Help dentists and allied dental personnel to better identify, interact with, and furnish safe and effective oral health care to methamphetamine dependent patients.
- Enhance research examining all aspects of methamphetamine-related tooth decay, including its causes, its public health impact, models for its prevention, and improved methods for its treatment.
- Help states handle the undue burden of inmate meth mouth on correctional health programs.

Emerging Issues and Trends in the States:

Dental Amalgam. Dental societies in several states braced for the introduction of bills to ban placement of amalgams, but bills were introduced only in Maine and Vermont. Amalgam foes waged a tough battle in both states, but the bills were not expected to pass as lobbying efforts by constituent dental societies was supplemented by extensive assistance from the ADA as part of the State Advocacy Initiative program. An anti-amalgam bias was apparent in a number of bills introduced this year. Some would have required patients to sign a written informed consent stating that they had received a notice about the so-called "dangers" of amalgam and still wanted an amalgam filling. Amalgam discharged into wastewater continues to be a problem in some areas. Bills to require amalgam separators in dental offices were introduced in New Mexico, Oregon, and Montana. The Montana bill died for lack of legislative and political support; it was opposed by the Montana Dental Association. Due to the short duration of the legislative session in New Mexico, that bill also failed, although it was supported by the New Mexico Dental Association and will be introduced in the future. The Oregon bill was pending. In New Jersey separators will be required by environmental regulations expected to be issued in the near future, making it the eighth state to require separators, joining all six New England states as well as the state of New York.

Dental Hygiene. As in previous years, state legislatures in 2007 again considered bills that would allow dental hygienists to practice with less supervision, an increased scope of practice, and/or greater self-regulation. Bills introduced in some states would eliminate requirements for a prior dental screening before a dental hygienist can perform services on a patient or allow for collaborative practice arrangements between dentists and hygienists, particularly in institutional settings. The ongoing trend toward loosening or eliminating supervision requirements in institutional settings continues, primarily in schools, clinics, and nursing homes. The impetus for these changes is to provide greater access to health care for the underserved. Although Colorado is the only state that permits unrestricted, unsupervised practice for dental hygienists providing dental prophylaxis, there are 20 states that permit a form of unsupervised practice that is limited in either the type of care rendered or the setting. Another continuing trend is to allow dental auxiliaries and even non-dental personnel, such as nurses, to administer tropical fluoride treatments and apply sealants in institutions. Organized dental hygiene in California and South Carolina continued their previous efforts to establish a separate regulatory board for dental hygienists, with bills introduced this year in both states. To date, no state in the U.S. fully regulates the practice of dental hygiene by an independent dental hygiene board. A number of states proposed changes in the composition of dental boards, primarily to increase slightly the number of allied dental personnel. However, even if all those changes became law, dentists would still constitute the majority of the dental board members in every state.

Licensure. For the last few years, several states have tried to attract dentists from other states to come in to treat the poor by granting them special volunteer licenses and by providing incentives such as immunity from liability if they treat indigent patients or provide services for free in dental clinics. Colorado, Rhode Island and West Virginia had bills of this nature introduced in 2007. Granting state licensure to graduates of foreign (non-accredited) dental schools is an issue that has stirred considerable debate. In the overwhelming number of states, foreign dental school graduates must complete either a two-year or four-year course of study in an accredited dental school before qualifying for a state dental license. California and Minnesota have laws that grant the dental board authority to evaluate foreign dental schools and approve them if they are found to be equivalent to accredited dental schools. If they are, graduates would not have to undertake additional training to qualify for a license. A bill introduced in Maine would grant similar authority to the dental board in that state. But evaluating and approving foreign dental schools is a labor- and resource-intensive process. The California dental board has approved only one or two schools even though it has had authority to do so for several years.

There are currently 186 foreign trained dentists from unaccredited schools that have received a license to practice in Minnesota. Most have settled in metropolitan areas. The bill supported by the Minnesota Dental Association, the University of Minnesota and the Dental Board to require some additional training was not heard by the legislature. A

bill pending in Wisconsin would, if enacted, make Wisconsin the 49th state to require mandatory continuing education (CE) for dentists. Colorado is the only other state that does not require CE for dentists.

Medicaid. Eleven states have filed bills to improve the financing of dental services under Medicaid: Connecticut, Florida, Iowa, Maine, Michigan, Minnesota, Mississippi, Missouri, North Carolina, North Dakota, and Texas. Efforts range from trying to raise dental fees to a certain percentile level (closer to market rates) to providing tax benefits for dentists treating the underserved. Eight states have bills to improve dental services in nursing home care, providing services to pregnant women and coverage of dentures. One state, Connecticut, has even proposed a tax on dentists who do not accept Medicaid patients with the revenue earmarked for improving dental services.

Access to Dental Care. What does access to care mean? It can embrace a number of topics, such as the creation of new categories of dental personnel, financial and other incentives to providers, licensure changes to encourage dentists to serve in underserved areas, increased funding for dental services under Medicaid, etc. Among the innovative state proposals under consideration in 2007 include: a New Mexico bill that would develop, establish and maintain a rural oral health intervention and prevention program for children up to age four who are members of the Navajo Nation, a New Hampshire bill to pay start-up and equipment costs of the Tri-County Community Action Program dental facility, a Montana bill that would cover basic dental care expenses for underinsured children (18 or younger) who are not eligible for health care services under the state's Medicaid program or the children's health insurance program, and a Kentucky bill that would establish a children's dental fund to be financed through a tax on tobacco.

Fluoridation. Fluoride opponents continued to assert their opposition to fluoridating water supplies and 2007 was no exception. Proposals to add fluoride or ban the use of fluoride in water supplies were considered in communities in at least 15 states. A bill in Oregon to require fluoridation state-wide in communities of more than 10,000 people was pending.

Universal Health Care. Considered dead after the fiasco in Congress several years ago over the Clinton Administration proposal, states began to take the initiative, proposing new ideas to cover the uninsured and underinsured. At least a dozen states considered universal health insurance plans. Dental services were part of proposed plans being debated in California, Florida, Indiana, Maryland, Minnesota, Missouri, Montana and Washington. But even though other states did not specify dental coverage in their plans, they may decide to do so later by adopting a broad definition of what services constitute health care coverage.

Ownership of Dental Practices. Twenty states have laws which allow the executor or administrator of a dentist's estate or the legal guardian or authorized representative of a deceased or incapacitated dentist to contract with another dentist or dentists to continue the operations of the deceased or incapacitated dentist's practice for a specific period of time (generally one year) or until the practice is sold, whichever occurs first. Kentucky is the most recent state on this list, having enacted legislation this year. Similar bills were introduced in California, Hawaii, Maine and New Jersey.

Response to Assignments from the 2006 House of Delegates: The following are the 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.

Principles for Pay-for-Performance or Other Third-Party Financial Incentive Programs. Resolution 24H-2006 (*Trans.*2006:326) lists the principles the ADA must use in discussions with organizations designing pay-for-performance (P4P) or other third-party financial incentive programs and requires the ADA to continue to monitor and evaluate P4P programs. On April 3, ADA representatives met with officials at the Center for Medicare and Medicaid Services, Department of Health and Human Services, and provided the CMS delegation with a copy of the ADA's principles. At the present time, there are no pilot P4P programs in Medicaid directed at dentists and the agency has no immediate plans to start such programs. The agency representatives said they wanted to work with the ADA before going forward with any future plans that might affect dentists. The parties agreed to continue to talk.

Establishment of Formal Liaison Relationship with ADA Agencies. Resolution 27H-2006 (*Trans.*2006:309) states that the Council on Government Affairs and other agencies will invite the Council on Communications to establish a formal liaison relationship through the 2008 House of Delegates in order to pilot the enhanced exchange of information on the external image and brand implications of the agencies' decisions. The Council is very pleased to have Dr. Sally

Cram, Chair of the Council on Communications, attend its meetings. Dr. Cram's participation has already offered valuable insights and helped guide the Council in several instances.

Dissemination of Information Contrary to Science. Resolution 54H-2006 (*Trans.*2006:342) states that the ADA urges constituent and component societies to rely on peer-reviewed science as relevant when advocating with state and local government authorities. The Department of State Government Affairs has informed constituent societies of this resolution, and whenever appropriate, the Department provides constituents with scientifically reliable information and advice. It is particularly important this year that sound science be used to counter efforts in some states to ban placement of amalgams and to oppose fluoridation of state and community water supplies.

Insurance Benefits for Necessary Dental Treatment of Certain Medical Conditions. Resolution 58RC-2006 (*Trans.*2006:324) directs the ADA to seek changes in federal statutes dealing with ERISA, and urges constituent dental societies to advocate for state laws requiring that dental treatment, which is integral to the treatment of a diagnosed medical disease, be afforded coverage under the third-party medical payer's contract. Federal legislative activity will be addressed in the Council's supplemental report. The Department of State Government Affairs has informed constituents of this resolution and has offered support for state legislative efforts to require medical insurance plans to cover associated costs of dental treatment. However, the Department has not received any constituent requests for such assistance in response to this resolution.

Mandated Assignment or Authorization of Dental Benefits. Resolution 61H-2006 (*Trans.*2006:315) states that constituent dental societies are urged to seek regulatory or legislative action to mandate that an insurance carrier be required to follow a patient's directive that assigns or authorizes payment directly to the dentist. The Department of State Government Affairs has notified constituents of this resolution and has encouraged constituents for many years to support legislation to require insurance companies to honor a patient's directive to assign payment of benefits directly to the dentist. Several states have this type of legislation.

Notification of Prosthetic Cases Sent to Foreign or Ancillary Domestic Labs for Custom Manufacture. Resolution 69H-2006 (*Trans.*2006:326) states that the ADA investigate the feasibility of having federal or state agencies require dental laboratories to notify dentists when any portion of the dentists' prescription is to be manufactured by a foreign or ancillary domestic lab. The Council supports the Council on Dental Practice's response; see the CDP report for details.

Medicaid and Indigent Care Funding. Resolution 79-2005H (*Trans.*2006:338) states that the ADA should make lobbying for adequate funds to provide oral health care to the Medicaid and other indigent care populations the highest priority and that constituent and component societies be urged to do the same, and that these efforts include an educational program to enlighten the public and government agencies of the value of oral health care. As discussed in detail above, the ADA is developing federal legislation with the Maryland congressional delegation that is intended to provide increased federal matching funds for the dental Medicaid and SCHIP programs. The ADA has also been very active in lobbying for SCHIP reauthorization that includes mandated dental services, a children's dental health bill that provides numerous incentives to the states to improve their Medicaid programs and an ADA initiative to improve access for American Indians.

In addition, the Department of State Government Affairs has notified constituents of this resolution and has assisted many states over the years in their successful lobbying efforts to provide dental care to Medicaid and other indigent populations. This is a top priority of the Department.

Acknowledgments: The Council on Government Affairs announces the addition of four new members: Dr. Robert E. Butler, Missouri; Dr. Thomas P. Conaty, Delaware; Dr. Fred T. McDonald, Arkansas; Dr. Mark V. Walker, Washington. The 2007 annual session will mark the completion of the terms of service of four Council members: Dr. Gerald Gelfand, California; Dr. S. Jerry Long, Texas; Dr. Gary D. Oyster, North Carolina; Dr. Robert B. Raiber, New York. 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.

Council on Members Insurance and Retirement Programs

Bocks, Charles R., California, 2007, chair
Feinberg, Maxine, New Jersey, 2008, vice chair
Axler, Jerrold H., Pennsylvania, 2008
Baker, Gary O., Missouri, 2007
Brewer, Kevin M., Montana, 2008
Browder, Larry F., Alabama, 2010
DerKazarian, Alan K., Massachusetts, 2009
Hoffmann, George P., South Carolina, 2009
Lastra, Idalia, Florida, 2008
Moore, Alan B., Texas, 2009
Morrison, Scott L., Nebraska, 2010
Shall, Stephen M., Ohio, 2010
Simpson, William J., Illinois, 2007
Versman, Kenneth J., Colorado, 2009
Wetzel, Frederick W., New York, 2008
Whitis, Harry W., Arkansas, 2007
Zoutendam, **Gary L.,** Michigan, 2010
Dwyer, David R., director

Mission of the Council: The Council on Members Insurance and Retirement Programs is an agency of the ADA whose purpose is to enhance the value of Association membership by a) overseeing the sponsored and endorsed insurance and retirement programs and b) aiding dentists in the management of their personal and professional risks through educational activities, informational programs and services.

The Strategic Plan of the American Dental Association: The Council supports the Strategic Plan in several ways. Through all of its activities, the Council supports the Strategic Plan's advocacy goal with respect to the small business interests of dental offices. Its professional liability risk management activities further support the Advocacy Goal by providing resources to dentists that will help them maintain their trusted professional image.

The Strategic Plan's goal of building dynamic communities is supported by the Council's activities in several ways. The Association-sponsored insurance and retirement programs provide a significant economic benefit of membership and thus contribute to membership recruitment and retention efforts. In addition, through its efforts to increase lines of communications between organized dentistry and the professional liability insurance industry, the Council is enhancing opportunities for collaborative efforts that could result in improved health care.

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 $500/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 the table below.

Program	2002	2003	2004	2005	2006
Member Term Life	61,179	60,304	59,301	58,545	57,950
Spouse Term Life	21,507	21,184	20,743	20,603	20,252
Child Term Life[1]	9,674	9,309	8,796	8,614	8,381
Student Term Life	5,856	7,983	9,209	10,112	9,860
Term Plus Plan	2,170	2,129	2,079	1,984	1,882
Income Protection	19,280	19,047	18,580	18,249	17,867
Student Disability	465	524	574	552	540
Overhead Expense	8,880	8,871	8,768	8,695	8,600
MedCASH	6,559	6,377	6,190	5,887	5,715

Participation in the insurance plans reflects demographic trends among the membership as well as competitive conditions in the insurance markets. The Council notes that, while membership has been rising, participation in the insurance plans is being impacted by a rising number of terminations due to membership requirements. In 2006, for example, the coverage of 899 participants in the Term Life Plan was discontinued due to non-renewal of their ADA membership, which is 50% more than in 2005.

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.

The table below shows premium credits for each plan during the past year.

Program	Payment Date	Credit
Life Insurance Program	January 1, 2006	38%
	July 1, 2006	38%
Income Protection Plan	May 1, 2006	15%
	November 1, 2006	22%
Office Overhead Expense Plan	February 1, 2006	44%
	August 1, 2006	46%
MedCASH Plan	April 1, 2006	27%
	October 1, 2006	23%

Program Improvements: In 2006, the Council approved a number of enhancements to the insurance programs. For all of the insurance plans, participants are now able to pay premiums by credit card. The Council also approved an increase in the amount of coverage guaranteed to eligible, new members. In addition, improvements were made to several of the plans as follows.

Overhead Expense Plan—Introduction of a 90-day elimination period to allow members who have certain pre-existing conditions to participate. Previously, such members were declined coverage as they could not meet the underwriting requirements for the Plan's standard 30-day elimination period.

Term Life Plan—Introduction of a premium reduction of approximately 30% for the optional Waiver of Premium benefit for participants who meet the Plan's preferred risk underwriting criteria.

MedCASH Plan—Introduction of a benefit, equal to 50% of the payment for daily hospitalization and payable for a maximum of 25 days, for participants who undergo IV chemotherapy or radiation treatment.

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

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 2006, 6,541 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. As of December 31, 2006, the Retirement Program's assets were invested as follows:

Members Retirement Program Assets as of December 31, 2006

Investment Option	Year-end Assets	Percent of Total
Growth Equity Fund	$ 249,228,431	16.70%
Small Cap Growth Fund	149,965,127	10.05%
Equity Index Fund	186,094,987	12.47%
Foreign Fund	144,781,976	9.70%
LifeStrategy Income Fund	24,068,434	1.61%
LifeStrategy Moderate Fund	138,884,045	9.31%
Equity Income Fund	56,440,586	3.78%
Large Cap Growth Fund	49,926,631	3.35%
Small Cap Value Fund	67,497,006	4.52%
U.S. Bond Fund	23,340,830	1.56%
Money Market Guarantee Account	306,812,498	20.56%
5-year Guaranteed Rate Accounts	45,300,724	3.00%
3-year Guaranteed Rate Accounts	50,001,852	3.35%
Total	$1,492,343,127	100.00%

Change in Investment Vehicle for Foreign Fund. The Council approved a change in the investment vehicle for the Foreign Fund. The Templeton Institutional Funds Foreign Equity series will replace the Templeton Foreign Fund Advisor Class. Depending upon administrative and regulatory requirements, the change will likely take place in August 2007.

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, 2006, there were 1,831 participants in the ADA-endorsed IRA. The total value of their investments was $90.7 million, allocated among 15 investment options. The Association assists AXA Equitable in marketing and administering the ADA-endorsed IRA Program. In exchange for this assistance, AXA Equitable pays the Association a fee that is based upon the amount of assets held in the Program. During 2006, the fee paid to the Association totaled $36,541.

Proposal to Endorse AXA Equitable Members Retirement Program and to Terminate ADA Members Retirement Trusts: After a study of the market for administrative and investment services for group retirement plans, the Council has concluded that the participants in the ADA-sponsored Program would benefit significantly if their assets were to be transferred to the AXA Equitable Members Retirement Program. It offers administrative services that are as comprehensive as those of the ADA-sponsored Program and is used by all other association group clients of the Company. The J.P. Morgan Chase Bank serves as Trustees of the AXA Equitable Members Retirement Program and AXA Equitable provides administrative and marketing services.

The Council's study focused on the costs of maintaining a stand-alone program as compared to one in which fixed costs are spread among a greater number of clients. It was concluded that a stand-alone program presented additional costs that were passed to participants in the form of higher expense ratios on their investment accounts as well as higher administrative fees. As part of its study, the Council also evaluated other financial services companies that offered

management services for tax-qualified retirement plans. It concluded that AXA Equitable was best positioned to provide the administrative services required by the ADA Members Program and could do so at reasonable costs.

Following its August 25-26, 2006, meeting, the Council submitted a report to the Board of Trustees calling for the assets of the ADA Members Retirement Program to be transferred to the AXA Equitable Members Retirement Program effective April 30, 2008. Coincident with this change, the Council's duty to serve as Trustees would cease and be assumed by the J.P. Morgan Chase Bank. The Association would then give its exclusive endorsement to the AXA Equitable Members Retirement Program. The assets of each participating dentist or dental office employee would be reinvested, in accordance with their directions, in equity funds offered through two investment trusts managed by AXA Equitable, a money market fund and/or three- or five-year Guaranteed Rate Accounts underwritten by the Company.[2]

The Council's report was considered by the Board at its December 10, 2006, meeting. After considering the Council's recommendations, the Board adopted the following resolution.

> **B-96-2006. Resolved,** that the Board of Trustees supports the recommendation of the Council on Members Insurance and Retirement Programs that the ADA Members Retirement Program in its present form be terminated effective April 30, 2008, and its assets transferred to the AXA Equitable Members Retirement Trust, and be it further
> **Resolved,** that the Association endorse the AXA Equitable Members Retirement Program effective April 30, 2008, and be it further
> **Resolved,** that the Board of Trustees recommends that the House of Delegates amend the *Bylaws* to eliminate the Council on Members Insurance and Retirement Programs duty to serve as Trustees of the ADA Members Retirement Program and to replace it with a duty to advise and recommend courses of action on retirement programs effective April 30, 2008, and be it further
> **Resolved,** that the Board of Trustees authorizes the Council on Members Insurance and Retirement Programs to oversee the ongoing management of Association-endorsed member retirement programs and to recommend changes in those programs when appropriate.

Increased Number of Investment Options. Although final decisions have not as yet been made regarding the specific funds and accounts to be made available to the participants, at present it is envisioned they will have 28 equity options in addition to a money market fund as well as guaranteed rate accounts with three- and five-year maturities. The equity funds will be selected from the AXA Premier VIP Trust, which has 16 funds, and the EQ Advisors Trust, which has 36 funds. AXA Equitable serves as investment manager for the funds in these Trusts but may hire sub-advisors to manage the individual portfolios. Thus, these Trusts have funds that are similar to publicly available mutual funds managed by firms such as Van Kampen, Wells Fargo, Janus, PIMCO, Ariel, Templeton, et. al. A comparison of expense ratios of the funds offered through the AXA investment trusts and the current Program indicates that, for some asset classes, fund expense ratios are higher in one trust than in the other. However, the expectation is that when all assets are viewed in the aggregate, the fund expense ratios will be lower in the AXA investment trusts than in the Members Retirement Program.

Elimination of Separate Account Charge on Equity Investment Options. Most of the assets of the Members Retirement Program are currently subject to a .15% (15 basis point) Separate Account Accounting Charge. When held in the separate account established for the AXA Equitable Members Retirement Program, these ADA Program assets will no longer need their own separate accounts; and the .15% accounting charge will be eliminated. Based upon the amount of money held in the ADA Program separate accounts on January 31, 2006, the elimination of this charge will save participants investing in the equity options approximately $1.5 million in fees annually.

Reduction in Program Expense Charge. The most significant fee paid by each participant in the Members Retirement Program is the expense charge.[3] This charge is the primary source of revenue to AXA Equitable for its administrative services and overall management of the Program. When the Program is merged, it is anticipated that

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[2] Like the ADA Members Retirement Program, all assets invested in the AXA Equitable Members Retirement Program, except those held in the three- or five-year Guaranteed Rate Accounts, would be held in "separate accounts" of the Company. Under New York State law, all assets held in such separate accounts are immune from the claims of the insuring company's other policyholders and credits. Thus, there would be no reduction in the guarantees of the safety of assets that presently exist with the ADA Members Retirement Program.

[3] There are also nominal fixed dollar fees. They include a $12/participant annual record keeping fee plus a one-time $25/participant enrollment fee.

there will be economies of administration. Based upon these expected savings, AXA Equitable will accept a lower expense charge. Assuming January 31, 2006, asset and participation levels, the expense charge would fall from .62% to .5455%. This fee reduction represents annual savings to participants of $1.5 million.

In compensation for the expenses it incurs on behalf of the Council in fulfilling its duties as Trustees of the Members Retirement Program, the Association is currently reimbursed in accordance with the provisions of the Employee Retirement Income Security Act of 1974. For the one-year period beginning May 1, 2006, the participants' are being assessed an annualized charge of .0125% (one and one-quarter basis points.) Under the proposed arrangement, the Association would be paid an annual royalty from the revenues AXA Equitable derives from other Program fees. The royalty will not be directly obtained from participants. The royalty would be determined by a formula that is based upon the amount of assets held in the Program.

Total Participant Savings. Based upon January 31, 2006, asset and participation levels, the expense charges paid by all the participants would decline as shown in the table below.

Program Expense Charge Comparison		
	Current	Proposed
AXA Equitable Component	.6200%	.5455%
ADA Component	.0125%	N/A
Expense Charge	.6325%	.5455%

In addition to the above savings, participants who invest in the equity funds would benefit from the elimination of the .l5% Separate Account Charge. As an example of these savings, if a participant has $500,000 invested, of which $400,000 is held in equity options, his/her annual fees would decline from $3,763 to $2,728, a reduction of nearly 28%.

Council Oversight Duties. Although the Council would not be Trustees of the AXA Equitable Members Retirement Program, the Board has agreed that the Council should oversee the Association's endorsement of the AXA Equitable Members Retirement Program. This oversight authority would be similar to that exercised by the Council with respect to the ADA member insurance programs. The Council would continue to review the reports of the administrator and the Program's investment performance and provide its recommendations to AXA Equitable and/or the Board of Trustees as appropriate. However, the Council would not have the authority to select or remove the Program's investment options. That authority would rest with the new Trustees, the J.P. Morgan Chase Bank.

Conversion Royalty. In addition to the annual royalty, the Association would be paid a conversion royalty. This is in recognition of the substantial contributions the Association has made to the Program's design and growth since 1968. This royalty would be derived from revenues received by AXA Equitable from distributors of some of the mutual funds offered as investment options under the Program. These payments are the result of 12b-1 fees included in some of the investment options' expense ratios as well as sub-transfer agency fees.[4]

At this time, the amount of the conversion royalty has not yet been determined. However, AXA Equitable indicated that it would range between 25% and 50% of the 12b-1 revenues that remain on the date the endorsed arrangement takes effect. AXA Equitable would then use the balance of the 12b-1 account assets solely for advertising and other product promotions in ADA venues (e.g., the annual session, ADA membership card, *Connections* booklet, etc.)

AXA Equitable estimates that by May 1, 2008, there may be approximately $500,000 of revenues from which it could pay the conversion royalty. Therefore, the value of the conversion royalty payment to the Association would be about $125,000 to $250,000.

Endorsement Agreement. The Association's relationship with AXA Equitable will be set forth in an endorsement agreement that is proposed to have an initial term of five years beginning May 1, 2008. The agreement will be developed in the coming months by legal counsel for the Association and AXA Equitable. The Association's legal counsel has reviewed a preliminary draft of the contract and, while the Association will request changes to the legal terms, it is expected that the parties will be able to reach final agreement without delay.

[4] 12b-1 fees are used by distributors of mutual funds to cover the marketing costs, including commissions paid to brokers. Sub-transfer agency fees are paid by distributors to "omnibus" clients, which are groups of clients which, for record keeping purposes act as a single client as is the case with group pension and 401k plans.

House of Delegates Approval. In order to proceed with the implementation of the termination of the ADA Members Retirement Trusts, the transfer of its assets and the endorsement of the AXA Equitable Members Retirement Program, it is necessary that the House of Delegates amend the *Bylaws* to eliminate the Council's duty to serve as Trustees of the ADA Members Retirement Program. To that end, the Council has submitted a resolution calling for the amendment of the *Bylaws* to take effect on April 30, 2008.

9. Resolved, that Chapter X. COUNCILS, Section 120. DUTIES, Subsection I. COUNCIL ON MEMBERS INSURANCE AND RETIREMENT PROGRAMS, of the ADA *Bylaws* be amended by addition of an asterisk and footnote to duty "e" to read as follows (new language underscored):

e. To serve as the Trustees for the American Dental Association Members Retirement Program.*

*This duty shall expire April 30, 2008.

and be it further
Resolved, that Chapter X. COUNCILS, Section 120. DUTIES, Subsection I. COUNCIL ON MEMBERS INSURANCE AND RETIREMENT PROGRAMS, of the ADA *Bylaws* be further amended by adding a new duty "f" and footnote to read as follows:

f. To advise and recommend courses of action on retirement programs.**

** This duty shall commence April 30, 2008.

Risk Management Activities: The Council will be expanding its focus on programs and resources that will assist the membership in managing the financial risks they face in their personal and professional lives. Historically, the Council's activities in this arena have largely addressed the risk of professional liability, but it recognizes that there are many other significant areas of risk, such as long-term disability, property loss, extraordinary medical and/or nursing home care, etc. As a first step in developing a strategy for addressing these issues, the Council adopted the mission statement which begins this report. It further adopted the following goals for the 2007-2010 strategic planning cycle: a) monitor trends in the insurance and financial markets affecting dentistry, such that advice in advance of market conditions can enable proactive decisions; b) create informational programs and resources to assist ADA member dentists in managing their risks and minimizing their exposure to financial liability; and c) educate dentists on proper risk management to enable them to make informed insurance purchasing decisions.

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 2006 scientific program was titled "Everything Dental Staff Need to Know about Risk Management (But Was Afraid To Ask.)" The program was developed and presented by the CNA Insurance Company and The Dentists 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 2006 seminar a success, the Council wishes to acknowledge with appreciation Dr. John Vaselaney, Assistant Vice President, Dental Risk Management, CNA and Ms. Robyn Thomason, Risk Management Coordinator, TDIC.

Acknowledgements

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 AXA Equitable Life Assurance Society.

Support for the SUCCESS Program: The Council also wishes to express its appreciation to The AXA 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 its members who will complete their terms in 2007: Dr. Charles Bocks, Dr. Gary Baker, Dr. William Simpson and Dr. Warren Whitis. The interests of the participants in the Association-sponsored insurance and retirement programs have been wisely represented by these Council members; and the Council is indebted to them for their insights and guidance on matters of strategic planning and risk management.

Summary of Resolutions

9. Resolved, that Chapter X. COUNCILS, Section 120. DUTIES, Subsection I. COUNCIL ON MEMBERS INSURANCE AND RETIREMENT PROGRAMS, of the ADA *Bylaws* be amended by addition of an asterisk and footnote to duty "e" to read as follows (new language underscored):

e. To serve as the Trustees for the American Dental Association Members Retirement Program.*

*This duty shall expire April 30, 2008.

and be it further
Resolved, that Chapter X. COUNCILS, Section 120. DUTIES, Subsection I. COUNCIL ON MEMBERS INSURANCE AND RETIREMENT PROGRAMS, of the ADA *Bylaws* be further amended by adding a new duty "f" and footnote to read as follows:

f. To advise and recommend courses of action on retirement programs.**

** This duty shall commence April 30, 2008.

Council on Membership

Peters, Debra A., Michigan, 2007, chair
Baldassarre, Pamela Z., New Hampshire, 2008, vice chair
Adams, Benjamin S., South Carolina, *ex officio*[*]
Auvenshine, Ronald C., Texas, 2009
Benson, Sean A., Oregon, 2010
Becker Doroshow, Susan, Illinois, 2009
Buckenheimer, Terry L., Florida, 2010
Diaz, Walter D., Mississippi, 2008
Doring, Charles A., Maryland, 2007
Eng, Laura M., Minnesota, 2008
Gehani, Chad P., New York, 2009
Kohler, Joseph J., III, Pennsylvania, 2008
Mollica, Anthony G., Jr., South Carolina, 2007
Morledge, George B., Arkansas, 2010
Nunokawa, Neil, Hawaii, 2009
Weinand, Kenneth J., Missouri, 2008
Williams, John D., California, 2007
Zucker, William J., Ohio, 2010
Toyama, Wendy-Jo Y., director
Yancy, Phyllis A., manager

Membership Update: Since the onset of the Membership Initiative, the ADA has experienced much success, adding 10,742 active licensed members since the launch of the Tripartite Grassroots Membership Initiative (TGMI) in 2001 to end-of-year 2006. The end-of-year 2006 membership market share was 71.8%, the highest level since 1997 (72.6%) with the Association gaining an additional 1,458 active members in 2006. For six consecutive years, the ADA has experienced membership growth, after a decade of membership stagnation or decline. The key to continued growth is the strategy underlying the Tripartite Grassroots Membership Initiative (TGMI)—one-to-one personal outreach.

The ADA continues to strive to reach 75% membership market share. While it has made considerable gains, the high market share that the ADA enjoys also means that it takes a great deal of effort to make even small percentage gains. Those members that are easy to attract are already members. It is the ADA's job to better understand what member value resonates with lagging categories of membership and how to deliver value to these groups of members. Continued emphasis on target markets and innovative strategies to reach them will be important as the ADA strives to reach 75% membership market share.

The ability for the tripartite to make the value of membership transparent at every level will be critical to the incremental membership market share increases that are in the ADA Strategic Plan. Ideally, when it is time for members to renew ADA membership each year, every member should renew with confidence, based on a clear understanding of value received. Consistent messages about whom the ADA is, what it stands for and what value the ADA delivers to members will help the tripartite achieve common membership goals. The brand initiative, currently underway, will support strong, consistent member value messages.

Leadership support, volunteer engagement and recognition will continue to be important elements that enrich tripartite activities. The Council continues to work on identifying new strategies to reach out more effectively to dentists who practice in urban settings, where market share traditionally lags. The Council is also considering developing specific short-term outreach campaigns, revamping its recognition program and encouraging dental societies to reach out to new dental school graduates in new ways.

Momentum for membership recruitment and retention activities was generated at this year's ADA Annual Conference on Membership Recruitment and Retention. The Conference drew a record number crowd with more than 170 attendees, representing 35 states. This year's conference, "Making A Difference," featured a revamped agenda to promote interaction and provide fresh ideas and tangible resources to re-energize recruitment and retention efforts at every level of the tripartite.

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

End-of-Year 2006 Membership Statistics: The aggregate number of active licensed members increased 1,458 to 128,020 at the end of 2006. 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 2006 is 4,628. 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 2000 to 2006, there was an increase of 11,427 active, licensed members and the market increased by 12,639 over the same period.

Table 2 highlights the changes in the market share for key target markets, when comparing year-end 2005 with year-end 2006. The size of the market for all target markets grew except for all faculty and foreign-trained dentists. The ADA experienced membership and market share increases in all target markets except all faculty. The largest gains in market share were with the full-time faculty, which increased by 1.5%, and foreign-trained dentists increased by 1.7%.

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. Once again, as in 2005, only 2.8% of active ADA members failed to renew their membership with the actual number of non-renews decreasing over 2005. There were 2,978 active non-renews in 2006 compared to 2,987 at end of year 2005. As the ADA and state and local dental societies become more successful in convincing nonmember dentists to try membership, a focus on retention will become increasingly important. As in 2005, some of the retention success this year is credited to an outbound calling campaign to nonrenewing members that took place before year-end 2006. In addition, the ADA was successful in promoting a quarter-year dues ($0.00) recruitment offer with 686 dentists taking advantage of the special offer by year end. Follow-up on the part of the local dental societies was encouraged through the TGMI outreach activities. Compared to 2006, in the past there have been about 300 members who paid quarter-year dues when the dues rate was 25% of full dues (315 paid this rate in 2005). This is a 123% increase in this dues category. It is tripartite efforts at all three levels coming together that contribute to this positive retention trend.

Table 3 shows the number and percent of active members who did not renew their membership for the last 12 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 percentage for the ADA.

Table 4 compares the number of affiliate members from end-of-year 2005 to end-of-year 2006 by country. Affiliate members are dentists who are not licensed in the United States who practice outside of the United States. Dues were reduced from 25% of full active dues to a flat dues rate of $75 ($12 in least developed and low income countries as defined by the FDI) in 2006. The new dues structure for this category has had a dramatic impact on the number of affiliate members and has increased by almost 47% in one year.

Table 1

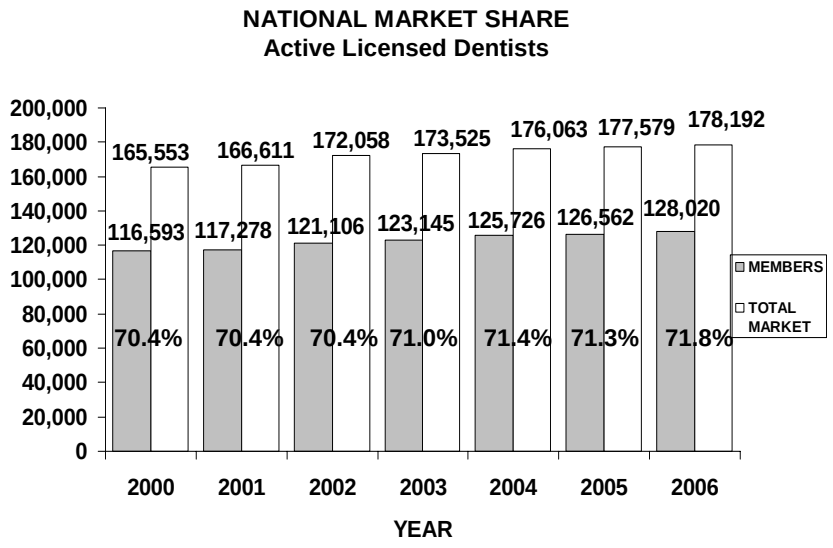


Table 2

Comparison of Members-Active Licensed Dentists
By Target Market
Year-End 2005 with Year-End 2006

Target Group	Increase+/ Decrease- in 2006 Members	2005 Market Share Percentage	2006 Market Share Percentage	Increase+/ Decrease- in Market 2005/2006
Women Dentists	1,063	64.1	65.0	1,146
All Faculty	-562	74.3	74.2	-751
Full-time Faculty	902	68.3	69.8	1,240
General Practitioners	1,236	68.5	69.2	422
Specialists	222	82.3	82.5	191
Federal Dental Service	108	59.6	62.3	115
Foreign Trained Dentists	124	51.7	53.4	-60
Minority Dentists	422	55.2	56.4	128
New Dentists	418	68.7	69.7	20

Note: Target markets overlap and should not be added together.

Table 3

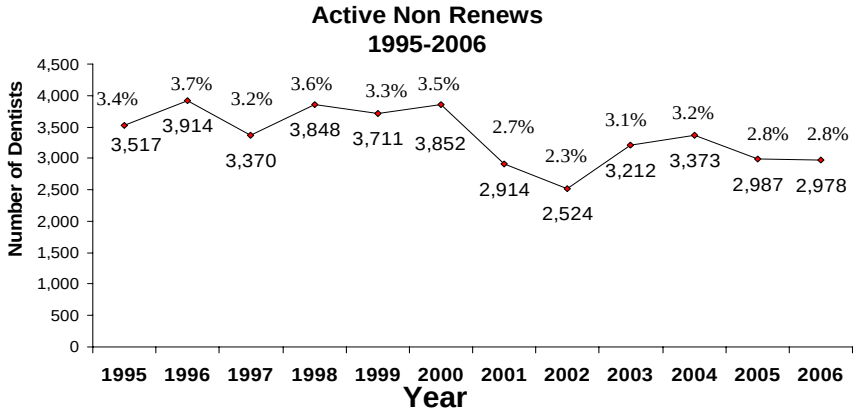


Table 4

Affiliate Members End of Year 2006

Country	2005 Members	2006 Members	Difference
Canada	152	268	116
United States*	76	158	82
Brazil	24	80	56
India	11	70	59
Philippines	8	70	62
Mexico	26	54	28
Japan	49	53	4
United Kingdom	32	49	17
Australia	28	41	13
Germany	30	26	(4)
Saudi Arabia	16	20	4
Peru	8	19	11
Italy	15	18	3
Pakistan	6	15	9
Sweden	12	15	3
Switzerland	11	15	4
United Arab Emirates	7	15	8
Iran	9	14	5
Israel	6	14	8
Jamaica West Indies	6	14	8
Myanmar	0	14	14
Egypt	3	13	10
France	11	13	2
Netherlands	11	13	2
Singapore	9	13	4
Spain	10	12	2
Taiwan	6	12	6
Guatemala	2	11	9
Peoples Rep China	4	11	7
South Korea	6	11	5
Hong Kong	7	10	3
Nigeria, Africa	3	10	7
Total all other countries	121	189	68
Total Affiliate members	**725**	**1,360**	**635**

Note: The chart reflects the countries with ten or more members.
All other countries have fewer than 10 members.
**Indicates affiliate members with U.S. mailing addresses.*

Tripartite Grassroots Membership Initiative: The Council continues to discuss future TGMI activities and specific strategies that could be used to take the TGMI to the next level. At its February meeting, the Council adopted the following purpose statement in an effort to create a rallying call for each level of the tripartite around this important effort.

> The purpose of the Tripartite Grassroots Membership Initiative (TGMI) is to increase membership market share and enhance the ADA brand throughout the tripartite by promoting membership recruitment and retention strategies that encompass a dentist-to dentist or one-on-one personal outreach approach as a means to recruiting and retaining members throughout the tripartite and to assist state and local dental societies in their membership outreach efforts.

As it moves toward the next phase of the Membership Initiative, the Council has been assessing TGMI tools, processes and procedures, utilizing an outside agency to conduct the research. The assessment included perspectives of dentist volunteers involved with the TGMI, ADA staff and state society membership staff. The goal was to benchmark the TGMI against best practices and develop new TGMI opportunities. Assessment outcomes will be shared throughout the tripartite as a resource to enhance TGMI recruitment and retention efforts.

At its February meeting, the Council focused on the future of the TGMI. The Council considered nonmember research that reflects only a small percentage of nonmembers are personally asked to join. However, the experiences of active members support the proposition that recruitment is most successful as a dentist-to-dentist or one-on-one effort. In addition, past experience has shown that "one size fits all" recruitment programs are not as effective as individualized efforts that take place at the local or grassroots level. As ADA membership has seen its biggest increase since the inception of the TGMI, it is crucial that the TGMI continue as a "way of doing business." In order to ensure the continued success of the TGMI, it is imperative to continue the momentum throughout the tripartite. The Council considered ways to move the TGMI forward with renewed energy and increasing urgency around taking the Membership Initiative to the next level. As part of the renewal process, a four-year business plan will be developed that will link to the ADA Strategic Plan, ADA membership marketing plan and include metrics and key performance indicators.

The Council was sensitive to the importance of retention this year in light of the 2007 dues increase. While it is interesting to note that the retention rate has not been demonstrated to be tied to dues increases, nonetheless, the Council felt it was important to place emphasis on retention activities in 2007. Retention efforts were expanded this year and included, among others, a retention issue of the *Initiative Insider*, an e-publication for TGMI teams; a retention session entitled "Converting ADA Accomplishments to R & R Success" at the ADA 2007 Annual Conference on Membership Recruitment and Retention; a series of testimonial member value ads in *ADA News* (Dr. Cissy Furusho on November 6, 2006, Dr. Raoul Santos on March 5, 2007, and Dr. Sharon Harrell on May 16, 2007) and expanded retention resources on the Dental Society Resources (DSR) Web site. All three ads were made available to dental societies via the DSR Web site.

As mentioned earlier, the ADA repeated the successful outbound calling program to members who did not renew. Evaluating the dentists who said they would pay or had paid their 2006 dues, a total of 189 out of the 886 actually did pay their 2006 dues (21%). As of April 30, 2007, 194 dentists who had been contacted by Comnet were paid 2007 members, and 45 were pending members. This strategy also provides rich member data. Based on the experience in 2006, it is planned to include an outbound calling program in the communications plan for lapsed members in 2007 starting in October.

The reduction of dues for nonmember dentists attending annual session continues to be a successful strategy for highlighting ADA membership to dentists who may be reluctant to join the ADA. This strategy demonstrates the value of inter-agency collaboration in developing new and innovative ways to achieve ADA Strategic Plan goals. As of April 21, of the 995 nonmember attendees, 64 dentists who attended the 2006 ADA annual session in Las Vegas have joined the ADA. An additional 20 nonmembers joined in 2006 and have not yet renewed their membership for 2007. Further, the revenue contributions, beyond dues, from these dentists, when considering lecture, workshop fees, registration and salable material purchases for the 2006 nonmember attendees group is more than $184,702, and growing. In 2005, 891 nonmember dentists attended the 2005 ADA annual session and as of March 19, 2007, 158 of them had joined the ADA.

The $0 quarter-year dues recruitment offer, mentioned earlier, resulted in a total of 686 dentists (of the 28,000 dentists who were eligible for this reduced rate) who took advantage of this offer by the end of 2006. The theme of this campaign was "I am an ADA Member," and stressed the importance of all dentists taking an active role in organized dentistry. This represented a 123% increase in this dues category over 2005. As part of this campaign, about 70 business reply cards (BRCs) were returned to ADA Headquarters. The BRCs allowed dentists to tell us "why membership was not right for them at this time." A summary of these comments was shared with constituent societies and TGMI managers worked with the states on appropriate follow-up.

Since the introduction of the TGMI, training requests have diminished. The Council conducted a training survey to better understand how to meet the needs of the Membership Initiative field representatives. The Council will test new

formats for training including use of conference calls and webinars. In 2007, a new resource will be developed to assist dental societies in building inclusion, incorporating the results of the 2005 Survey of Multiculturalism in the Dental Practice. Other TGMI resources will need to be updated as the ADA brand initiative is implemented.

Conversion of dental students to active membership upon graduation is a key tripartite objective. The expansion of the ADA reduced dues program, as of January 1, 2004, has had a positive effect on dental student conversion. The percentage of 2005 dental school graduates converting to membership by end-of-year 2006 was 68.6%, the highest percentage since 1990. For comparison, the class of 2003 at end-of-year 2004 (the year before the expansion of the Reduced Dues Program to include a $0 year) was 59.8%.

By end-of-year 2006, there were 3,403 dentists who took advantage of the $0 first-year out rate; this includes both 2005 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 2007, 2,517 dentists took advantage of the $0 dues rate for 2007 membership (slightly lower in comparison to April 2006).

The expansion of the ADA reduced dues program does have a financial impact on the ADA. The impact for those who "paid" the $0 rate in 2006 can be estimated at $398,151 of foregone revenue, if it is assumed that all such 3,403 dentists would have become members at the previous rate and would have paid $117. In addition, there were 2,983 dentists who paid the second-year-out rate of $117; if the reduced dues program had not been expanded, they would have paid $233. Assuming all would have been members at the higher rate, the foregone dues revenue is estimated at $346,028. In addition, there were 2,652 dentists who paid the third-year-out rate of $233; without the expansion, they would have paid $350. Assuming all would have been members at the higher rate, the foregone dues revenue is estimated at $310,285. Total financial impact is a maximum of $1,054,464.

Conversion for the class of 2006, as compared to the class of 2005 at the same time of the year, is lagging. As of April 30, 2007, there are 2,616 members of the class of 2006 (or 57%) who have been transferred into an appropriate constituent dental society for tripartite or direct membership, compared to 4,032 (88.4%) the previous year. The ADA will undertake additional communications with recent graduates to gather information to share with constituent societies, thereby facilitating recruitment into the appropriate membership category.

Membership Research: The Council continues to review data and utilize knowledge-based decision making to guide its work. The Council and other agencies received the report on the *2005 Member Participation Survey*, which assessed utilization of ADA member products and services and also built a predictive model of member value, providing insight to the factors that build member loyalty. Survey results revealed that while many components of ADA membership are consistent across loyal, neutral, and at-risk members, other factors, such as perceptions of the services the ADA provides, public communications efforts, and advocacy initiatives, vary in correlation with member perceptions of value. In follow-up to this survey, a qualitative research study was undertaken to assess these value drivers, consisting of in-depth interviews of ten loyal, ten neutral and ten vulnerable members. Findings were more indicative of lack of information on the part of less loyal members, rather than dislike of ADA initiatives or positions. An additional follow-up quantitative survey applied the member loyalty model to dentists who joined the ADA in 2006, including both new and reinstated dentists. The results of the study was similar to the findings for members overall, but pointed out the need for more frequent communication.

Data collection for the *2006 Survey of New Dentist Occupations* was completed in 2007 and a report distributed, providing insight into the career choices and related income information, as well as personal information such as marital status, spouse occupation and number of children.

To assess member and nonmember perspectives on the critical professional issues in dentistry, the Council has undertaken the *2007 Survey of Critical Issues*. Distributed to approximately 3,000 members and 1,000 nonmember dentists, the survey addressed dentists' beliefs regarding business, legal, clinical, dental reimbursement, professional and personal issues, and also asked recipients to rate how well the ADA addresses each of these issues. Two additional issues surveys—one addressing scientific issues and the second addressing public communications issues—are in the planning process.

Target Market Trends:

Affiliate Membership (Non-U.S. dentists practicing outside the United States). The 2005 House of Delegates adopted Resolution 31H-2005 (*Trans*.2005:314) that restructured the benefits and dues rates for affiliate members. Affiliate members pay a flat rate of $75 for most non-U.S. dentists, with a $12 rate available to dentists in countries identified by the FDI as least developed and low income. To offset the reduced rate, affiliate members have access to the complete text of *The Journal of the American Dental Association* (*JADA*) on ADA.org, but there is an additional charge to

receive *JADA* by mail. In 2007, affiliate membership continues on an upward trend. As of April 30, 2007, there were 1,330 affiliate members, an increase of 395 (30%) compared to end-of-year 2006 (the second consecutive year with a similar percent increase). Of these 1,330 members, 1,173 paid $75 and 157 paid $12. Countries which posted the largest increases in members to date include Brazil, with 36 additional members as compared to end-of-year 2005, and India, which has 18 more members.

Diverse (Minority) Dentists/56.4%. 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, and the ADA has seen a modest increase in membership participation, both in aggregate numbers and in market share to 56.4% at end-of-year 2006. However, when discussing membership market share for dentists of diverse racial or ethnic background, it should be noted that the ADA database has a large percentage of dentists of unknown race/ethnicity in the new dentist market, so the number of non-white dentists may be undercounted.

Federal Dentists/62.3%. The size of the market for federal service dentists has decreased slightly, with a corresponding decrease in members and a modest increase in market share at 60.7%. ADA *Bylaws* allow federal service dentists one "transition year" as a federal dentist member after leaving the federal services while pursuing a new dental occupation, and at the end of year 2006 there were an additional 191 dentists who took advantage of that opportunity, thus increasing the market share to 62.7%. 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 each of 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. The 2006 ADA annual session in Las Vegas featured an educational track and social activities for federal dentists and an increase in participation over the 2005 level was noted.

Graduate Students/66.8%. The number of ADA members paying the graduate student rate has grown per year, at 2,999 at end-of-year 2005 and 3,204 at end-of-year 2006. As of April 30, 2007, the number of paid 2007 graduate student members is 2,012, slightly higher than the number at the same date in 2006. Since 2003, the ADA has encouraged tripartite membership for graduate students. At end-of-year 2005 and 2006, the number of tripartite graduate student members had grown to 1,191 and 1,222 respectively (about 40%).

Dental Student Outreach: The ADA Office of Student Affairs coordinates outreach to dental students, provides resources to the tripartite, and works closely with the American Student Dental Association to recruit and serve student members. Membership participation among dental students remains high, with a July 2006 market share at the end of the 2005-06 academic year of 84.8%; as of May 2007, the market share is 82.5%. Outreach includes informational mailings including *Financial Planning Issues for Dental Students, Dental Boards and Licensure Information for the New Graduate,* the electronic newsletter *Dental Recap,* and InfoPaks on issues of interest to dental students available on ADA.org and by request. The Office of Student Affairs also manages the Student Block Grant program, which provides reimbursement to constituent dental societies of up to $3,000 per dental school in the state for outreach initiatives upon completion of a descriptive form and submission with receipts. During the 2006 calendar year, the ADA reimbursed $133,856 to 33 constituent societies for activities at 51 dental schools. There were a total of 149 dental school activities which received funding, 118 continuing programs and 31 new programs. Through May 4, 2007, reimbursement funding has totaled $12,929 to four constituent societies for activities at seven dental schools. The deadline for the 2007 Student Block Grant program is December 31, 2007, and most reimbursement requests are received at the end of the calendar year.

Dental Student Programming: Over the years, the ADA has developed a number of programs that are held for dental students on-site at dental schools, including the Smart Start Program (a 90-minute program for freshmen focusing on financial management and student debt), the Transition Program (a 90-minute program for seniors focusing on the transition from student to active membership), the SUCCESS Program (a six-hour program for seniors and juniors focusing on practice management), and the SUCCESS Ethics Program (a half-day program focusing on ethics in dental practice), as well as Pizza and Politics (a lunch-and-learn type of program focusing on advocacy). After conducting appropriate research to determine the interests and needs of dental students, the current dental school curriculum, as well as feedback from practice management faculty, an interagency advisory group recommended that the ADA's dental school programs be consolidated under one umbrella —SUCCESS —and that revisions be made to current

programming and new programs developed in order to provide valuable content to students in every year of dental school, each year and at each school. No changes were recommended for the Pizza and Politics program, which is usually scheduled through the American Student Dental Association chapter at the school. The ADA Board of Trustees reviewed the plan for implementation, and all agencies involved, including the Council on Dental Practice, Council on Ethics, Bylaws and Judicial Affairs, and the Committee on the New Dentist took action to support the plan, and an interagency work group was appointed to review program content.

This process is currently underway and will begin with the 2007-08 academic year. All programs are scheduled through the ADA Office of Student Affairs, which is overseen by the Council on Membership. Affected agencies—the Council on Dental Practice, the Committee on the New Dentist, the Council on Ethics, Bylaws and Judicial Affairs—have worked collaboratively to implement the changes. In the 2007-08 academic year, programs offered to each dental school are the SUCCESS: Smart Start for Freshmen, and the SUCCESS: Practice Management for Seniors programs. The freshman program has been expanded to include an introduction to dental occupations as well as tips for a successful dental education experience (time management and stress management). The senior program has been expanded to include ethical issues commonly faced by new practitioners as well as resources available through organized dentistry. The SUCCESS ethics program and the Transition Program have been discontinued as stand-alone programs, although a resource to assist constituent societies in presenting the Transition Program will be distributed. In the 2008-09 academic year, the ADA will be rolling out two, new two-hour programs: SUCCESS: Professional Preview for Sophomores and SUCCESS: Career Strategies for Juniors.

The Strategic Plan of the American Dental Association: At its February 2007 meeting, the Council discussed the strategic planning process and was introduced to the concept of issues identification and ongoing scanning to build a knowledge base for its work and to contribute to the strategic planning process for the Association. The Council continues to review metrics for key activities and prioritize 2007 projects. In planning for 2007, no new programs were added and no existing programs were dropped. The Tripartite Grassroots Membership Initiative and the Membership Study continue to be two key activities of the Council that support key objectives in the ADA Strategic Plan Goal: Build Dynamic Communities.

Membership Study: The Council on Membership has been conducting a multi-year study that aims to position the ADA as a membership organization that welcomes a broad spectrum from the dental community ensuring that these wider communities lend their perspectives, voices and support to ADA initiatives related to community, advocacy, knowledge and standards. Input from a vibrant, strong membership will build capacity to anticipate future trends in the profession, enabling the organization to stay relevant and proactive, creating ongoing value for its members. This study resulted in an approach to membership that was reported to the 2006 House of Delegates.

In 2006, the House of Delegates adopted Resolution 32H-2006, Further Development of Membership Study Proposal (*Trans.*2006:310).

> **32H-2006. Resolved,** that the Membership Study Proposal containing the following comprehensive approach to ensure that the ADA anticipates current issues facing the dental profession and future trends be approved as a proposal for further development:
>
> - Dentist Member as proposed by the membership study proposal
> - Graduate Student as proposed by the membership study proposal
> - Supporting Professional Member, as proposed by the membership study proposal
> - Pre-doctoral Student, as proposed by the membership study proposal
> - Other Elements, as proposed by the membership study proposal
>
> and be it further
> **Resolved,** that the Council on Ethics, Bylaws and Judicial Affairs, in consultation with the Council on Membership, as needed, develop *Bylaws* changes that will be consistent with the Membership Study Proposal for consideration by the 2007 House of Delegates, and be it further
> **Resolved,** that the constituent and component societies be urged to create parallel membership categories to mirror those available at the ADA level, and be it further
> **Resolved,** that the concept of a Dental Team (non-dentist Member) category of the membership be referred to the appropriate ADA agency for further study and report its recommendations to the 2007 ADA House of Delegates.

The Council on Ethics, Bylaws and Judicial Affairs, in consultation with the Council on Membership, developed ADA *Bylaws* language to be consistent with the membership study proposal, as detailed in the Council's proposal, with the exception of dental team membership. The Council on Ethics, Bylaws and Judicial Affairs and the Council on Membership will send a joint report to the 2007 House of Delegates that includes a resolution for consideration by the House of Delegates with the proposed *Bylaws* changes.

As requested by the House of Delegates, the Council studied dental team membership. The Council is exploring a single category of membership for dental team members with ex officio representation on select councils and earned representation, not to exceed one representative in the House of Delegates. The approach is pending quantitative research and feedback and will be reported in the Council's supplemental report to the House of Delegates.

Response to Assignments from the 2005 House of Delegates:

Continuing Education for Federal Dental Service Members. Resolution 70H-2005 (*Trans.*2005:316) directed the ADA to waive the fees for the mail-in or online versions of *The Journal of the American Dental Association* continuing education services for deployed ADA federal dental service (FDS) members serving in areas where there is limited or no access to continuing education programs. Through April 2007, the Navy and the Army have taken advantage of this opportunity, forwarding the names of interested and approved member dentists who are able to take advantage of the program by mail. The University of Colorado is in the process of updating its Web site for the submission of *JADA* CE online to allow eligible federal dentists to take advantage of the free continuing education program by using a special PIN number. The FDS Membership Office will continue to coordinate communication with the federal service dental corps and assist eligible members to take advantage of the program.

Response to Assignments from the 2006 House of Delegates:

Membership Proposal. Resolution 32H-2006 (*Trans.*2006:310) calls for further development of Membership Study Proposal. A *Bylaws* resolution will be transmitted to the House of Delegates in a joint report of the Council on Membership and the Council on Ethics, Bylaws and Judicial Affairs.

Further, the Council will report on an approach to dental team membership in its supplemental report to the House of Delegates.

Meetings: The Council met at the ADA Headquarters Building on February 23-24, 2007, and again on June 15-16, 2007. Dr. Jeanne Marie Nicolette, trustee, Seventh District, serves as the Board of Trustees' liaison to the Council.

Personnel: At the close of the 2007 annual session, the terms of four highly regarded members of the Council will end: Dr. Debra A. Peters, 2003-2007, who served as chair of the Council for 2006-2007, vice chair of the Council 2005-2006; Dr. Charles A. Doring, 2003-2007, who served as chair of the Subcommittee on Tripartite Issues; Dr. Anthony G. Mollica, Jr., 2003-2007; and Dr. John Williams 2003-2007. 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.

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

Joint Commission on National Dental Examinations

Sand Wall, Darlene, Kentucky, 2008, chair, American Association of Dental Examiners
Shuler, Charles, California, 2007, vice chair, American Dental Education Association
Ackley, Eva, Florida, 2008, American Association of Dental Examiners
Calderbank, Susan, Pennsylvania, 2009, American Association of Dental Examiners
Christensen, Mark, Utah, 2009, American Association of Dental Examiners
Dixon, Barbara Leatherman, Utah, 2010, American Dental Hygienists' Association
Horn, Bruce D., Oklahoma, 2010, American Association of Dental Examiners
Keeter, Donald K., Oklahoma, 2007, American Dental Association
Pappas, William G., Nevada, 2007, American Association of Dental Examiners
Pyle, Marsha A., Ohio, 2009, American Dental Education Association
Reddy, Michael S., Alabama, 2008, American Dental Education Association
Schutze, Jonathan M., New York, 2009, American Dental Association
Seeley, Ron J., North Dakota, 2010, American Dental Association
St. Cyr, Zeno W., II, Maryland, 2010, Public Member
Tessler, Alexis, California, 2007, American Student Dental Association
Kramer, Gene A., secretary
Hinshaw, Kathleen, manager, Test Administration
Tsai, Tsung-Hsun, manager, Research and Development/Psychometrics
Vanek, Carol, manager, Test Development

Meetings: The Joint Commission on National Dental Examinations (JCNDE) met in the ADA Headquarters Building, Chicago, on March 28, 2007. Most of the topics considered by the Joint Commission had been reviewed by one of four standing committees. The Committees on Administration, Dental Hygiene, and Examination Development met on March 27, 2007. The fourth committee of the Joint Commission, the Committee on Research and Development, met on September 15, 2006, and February 9, 2007.

The annual National Dental Examiners' Advisory Forum, sponsored by the Joint Commission, met in Chicago on the morning of March 27, 2007. Approximately 80 dental examiners, dental board administrators, dental educators, and dental hygienists attended the 2007 National Dental Examiners' Advisory Forum. The program included staff updates on examination results and statistics for the National Board Dental Examinations Part I and Part II and the National Board Dental Hygiene Examination. Dr. Darlene Sand Wall, chair of the Joint Commission, Dr. Kenneth Kalkwarf, the invited speaker, and staff provided reports on the following topics.

- Purpose of Meeting
- Brief History and Purpose of the JCNDE
- Trends in Candidate Performance
- Test Development Activities
- Test Administration Issues
- Update on Research and Development
- Report on the ADEA Commission on Change and Innovation in Dental Education (CCI)/Curricular Change in Dental School

Suggestions for next year's Forum included reports relevant to information on test development activities; the future of dental education and an update on CCI, including assessment practices; examining international graduates; and examination results for schools with non-traditional curricula.

Trends in the Number of Test Candidates and Pass Rates:

National Board Dental Examinations (NBDE) Part I. The number of Part I candidates in 2006 was slightly higher than in the previous year. The numbers of candidates in 2005 and 2006 were 7,978 and 8,750, respectively. The number of candidates from accredited (5,925) and nonaccredited (2,825) dental schools increased slightly, compared

with the previous year. Performance of all Part I candidates from accredited schools, which had been fairly stable from 1994-2005 with pass rates of 84-90%, continued to remain stable in 2006 with an overall pass rate of 90%. Performance of all Part I candidates from nonaccredited dental schools has shown slight increases in the past four years with an overall pass rate of 58% in 2006.

National Board Dental Examinations, Part II. The number of 2006 Part II candidates from accredited dental schools (4,192) declined slightly from the previous year. The overall Part II performance of all candidates from accredited dental schools was consistent with the previous year, with a pass rate of 91%. The number of candidates from nonaccredited dental schools (850) declined by 17% from the previous year. Performance of all Part II candidates from nonaccredited dental schools has decreased slightly in 2006, but remains consistent with the pass rates of the past five years, with rates between 47% and 61%.

National Board Dental Hygiene Examination. The numbers of candidates taking the dental hygiene examination in 2006 reached a ten-year high (7,748). Performance on this examination (84% pass rate) remains consistent with pass rates for the past five years (84%-89%).

Pass Rates of Repeating Candidates. Candidates who failed the examinations in the past and chose to repeat the examinations in 2006 had pass rates significantly lower than those of first-time candidates. Part I candidates from accredited dental schools who were taking the examination for the first time had a pass rate of 92%, while repeating candidates had a pass rate of only 78%. Part II candidates from accredited schools who were taking the examination for the first time had a pass rate of 94%, while repeating candidates had a pass rate of only 67%. Repeating dental hygiene candidates from accredited programs had pass rates significantly lower than first-time candidates. In 2006, the repeating dental hygiene candidates had a pass rate of only 45%, while the pass rate for first-time candidates was 94%.

Graduates of nonaccredited dental schools who were taking Part I for the first time in 2006 had a pass rate of 61%, while repeating candidates from nonaccredited schools had a slightly greater pass rate of 62%. Part II candidates from nonaccredited programs who were taking the examination for the first time had a pass rate of 69%, while candidates from nonaccredited schools who were repeating the examination had a pass rate of only 44%.

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 79 dental test constructors and 27 dental hygiene test constructors to another one-year term and selected 11 new dental and two new dental hygiene test constructors.

Research and Development Activities: The Joint Commission's Committee on Research and Development met on September 15, 2006, and February 9, 2007, to review small grant proposals, examination results, statistics and trends, as well as ongoing research and development projects. The Committee's responsibilities relate to both the National Board Dental Examinations and the National Board Dental Hygiene Examination. Topics considered by this committee include any research or development activities related to the examinations.

Innovative Assessment Methods Research Grant Program (Small Grants). The Joint Commission created the small grants program at its meeting in March 2002 to outsource appropriate research projects designed to encourage innovations in the Joint Commission's testing programs. During the second funding cycle, five proposals were submitted and peer reviewed. The five proposals were evaluated for relevance to the goals of the program, for completeness and feasibility, and finally for the potential of the outcomes of the research to contribute substantially to the literature related to educational measurement. The Joint Commission accepted one proposal for funding at the recommendation of the Committee on Research and Development. This research project involves a study of the resistance of testing systems to the conspiracies of agents to obtain secure examination content. The overall quality of the submissions for the first and second cycles was deemed high by the Committee, and the Joint Commission has previously committed itself to continued support of the program for at least three more cycles.

Validity Study Supporting Part II of the Dental Examinations. The overall design of the recently completed validity study underlying Part II involved a two-dimensional model, which was operationalized as a two dimensional matrix. One of the dimensions consisted of 65 competencies, and the second dimension consisted of the existing 2007 Part II content specifications. The competencies included the 63 *Competencies of the New Dentist* promulgated by the

American Dental Education Association, as well as two competencies drawn from the accreditation standards for dental programs published by the Commission on Dental Accreditation. The first phase of the study involved the surveying of 7,000 general dentists to rate the importance of these competencies for patient care. A total of 2,597 dentists responded to the survey. The average importance ratings for each competency were transformed to numbers of Part II examination questions. During 2007, the now completed second phase involved a panel of dentists, working as a committee of the whole, that distributed the number of items devoted to each competency across entries in the examination specifications so that Part II sampled content that supports successful patient care. Minor changes to the Part II examination content will be reflected in the examination content beginning January 2008.

Part I of the National Board examinations is now administered exclusively on computer. Coincident with the transition to computer administrations in January of 2007, the restructured Part I was launched. Part I was restructured as a result of one of the outcomes of the 2000 dental validity study. Based on the findings of the previous validity study, it was determined that the validity of Part I could be enhanced if it was restructured so that it was interdisciplinary in nature and more clinically relevant. Items from the traditional basic and dental science disciplines are intermingled, and Part I includes clinically relevant items in the form of testlets. For the purposes of the Joint Commission, testlets consist of brief clinical scenarios and a series of multiple choice items associated with the testlet. Preliminary research findings on the computer administration of the restructured Part I show that it is performing up to expectations. On a post-examination survey, candidates have indicated that the computer-based format is a largely successful delivery method. Comments provided on the survey suggest that candidates found the testlets to be effective at assessing basic science content in a clinically relevant context. While based on a limited sample, the passing rate on the examination is comparable to that found for the traditional Part I battery.

During the summer of 2007, the Joint Commission will sponsor standard setting activities for both Part I and Part II to confirm the validity of the current standard or minimum passing point along the measurement scale. For each examination, three separate, psychometrically sound, methods will be used.

Examination Administration Issues:

Ethical Conduct and the Licensure Process for Dentists and Dental Hygienists. The Joint Commission incorporated statements of ethical conduct as part of its examination programs. These statements express the importance of ethical behavior in all candidates during the licensure process and the practice of dentistry and dental hygiene. The statements currently appear in the online editions of the candidate guides at www.ada.org/prof/ed/testing/nbde01/nbde01_candidate_guide.pdf, www.ada.org/prof/ed/testing/nbde02/nbde02_candidate_guide.pdf and www.ada.org/prof/ed/testing/nbdhe/nbdhe_candidate_guide.pdf and will also appear in the 2008 print editions of the guides.

Acknowledgements: The Joint Commission acknowledges with appreciation the contributions made by Dr. Donald K. Keeter, Dr. William G. Pappas, Dr. Charles Shuler and Ms. Alexis Tessler who complete their terms on the Joint Commission this year and Dr. Stephen F. Schwartz, first vice president, who served as the Board liaison.

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

Council on Scientific Affairs

Stanford, Clark M., Iowa, 2007, chair
Achterberg, Robert J., Washington, 2008
Carter, Laurie C., Virginia, 2009
Clark, Glenn T., California, 2008
Crews, Karen M., Mississippi, 2010
Golub, Lorne M., New York, 2010
Gotcher, Jack E., Jr., Tennessee, 2007
Gray, Brian J., District of Columbia, 2008
Hargreaves, Kenneth M., Texas, 2009
Hujoel, Philippe P., Washington, 2009
Jacobsen, Peter L., California, 2009
Lingen, Mark W., Illinois, 2010
McGuire, Michael K., Texas, 2007
Mentzelopoulou, Ioanna G., New York, *ex officio*[*]
Murrah, Valerie A., North Carolina, 2007
Rethman, Michael P., Hawaii, 2010
Socher, Jeffrey C., Illinois, 2008
Wong, David T.W., California, 2010
Zentz, Ronald R., senior director

The Strategic Plan of the American Dental Association: The Council on Scientific Affairs (CSA) uses the *ADA Strategic Plan: 2007–2010* to guide its activities. Three interrelated goals of the Strategic Plan are central to the Council's work:

- Build dynamic communities to collaborate through new, cost effective ways on strategic initiatives and policies
- Create and transfer knowledge to improve oral health
- Lead in the advancement of standards that are essential for the safe, appropriate and effective delivery of oral health care

To foster a dynamic and collaborative scientific community, the Council serves as an important forum for the ADA to build alliances, engage internal and external agencies on collaborative projects, and share ideas and dialogue on topics of mutual interest, especially those that bridge the gap between science and dental practice. Liaisons from government agencies and other organizations regularly attend CSA's meetings and provide valuable information and updates.

Most Council programs support the creation and transfer of scientific knowledge to improve oral health, including the Professional Product Review, the Seal of Acceptance Program, "Science in the News" at ADA.org, evidence-based dentistry initiatives and support for clinically relevant research activities. The Council leads in ADA standards development for dental products. These Council programs are discussed in greater detail later in this report.

Response to Assignments from the 2006 House of Delegates: In 2007, the Council addressed the following assignments from the 2006 House of Delegates.

Establishment of Liaison Relationship with the Council on Communications: In accordance with Resolution 27H-2006 (*Trans.*2006:309), the Council on Scientific Affairs initiated a new liaison relationship with the Council on Communications that will support cross-council communications. The liaison arrangement will continue through 2008 as directed by the resolution.

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

Administrative Revision to ADA Policy on Acupuncture. In October 2006, the House of Delegates adopted Resolution 33H-2006, which included a rescission of an ADA policy entitled Guidelines for the Use of Human Subjects in Dental Research (*Trans.*1978:62,536). This action served to rescind by implication the second resolving clause of the following ADA policy on acupuncture (*Trans.*1973:688; 1999:975):

> **Resolved,** that a major and coordinated research effort is needed to provide a valid scientific basis for the use of acupuncture in dentistry, and be it further
> **Resolved,** that the "Guidelines for the Use of Human Subjects in Dental Research" (Trans.1978:62, 536) be observed by dentists who use acupuncture as an adjunct to treatment of patients.

As a result, the second resolving clause will be editorially deleted from future publications of ADA *Current Policies.*

Scientific Information and Research

Evidence-Based Dentistry: The Council has served as the functional lead agency in implementation of the ADA's programs and initiatives in evidence-based dentistry (EBD). Two CSA members serve on the ADA Advisory Committee on Evidence-Based Dentistry, along with one representative each from five other councils. The following subsections address specific EBD-related activities in 2006-2007, led by the Council and Division of Science staff, and initiatives planned for the near future.

EBD Business Plan. In spring 2006, the Advisory Committee established a workgroup to develop a proposal that will allow ADA to enhance the implementation and impact of its EBD activities. Through this proposal, the EBD Advisory Committee recommended establishment of a service center approach to organizing ADA resources devoted to evidence-based dentistry. This Center will be situated in the Division of Science but will also serve other areas of the ADA involved in EBD activities. The proposal will be presented to the Board of Trustees in June 2007.

Council members and consultant experts in EBD will play a key role in the Center's activities, building on the EBD foundation laid to date, although many of the activities will be conducted under the auspices of the ADA Foundation Research Institute through grants from the ADAF and other funding agencies. These activities are described in the annual report of the Research Institute to the 2007 House.

The Center is designed to promote an integrative and collaborative approach to advance the application of scientific evidence in dentistry. The Center will help practicing dentists integrate EBD through several mechanisms such as: expanded development of ADA evidence-based clinical recommendations; launching an EBD Web site that will provide a single location for dentists, patients and other health care professionals to visit for clinically relevant EBD information; developing educational resources and continuing education courses; coordination and support of periodic EBD symposia; and strategic communications to promote the evidence-based approach to clinical practice.

Evidence-Based Clinical Recommendations. In August 2006 *JADA* published the Council on Scientific Affairs' evidence-based clinical recommendations for professionally applied topical fluoride. This report and the executive summary insert provided dentists with a concise, user-friendly reference for use in clinical care. Dissemination of the recommendations has been expanded through the National Guideline Clearinghouse (www.guidelines.gov), the *Journal of Dental Education* (March 2007), the *Evidence-Based Dentistry* journal (fall 2006) and the "Colgate Oral Health Report" (https://secure.colgateprofessional.com/app/cop/repository/article-208/pdf/ocr_v16_n03_print.pdf).

Evidence-based clinical recommendations are currently under development for the placement of pit and fissure sealants. As before, the document will be disseminated through a range of print and online resources sometime in late 2007 or early 2008. Other topics currently in process or planned for clinical recommendations follow, with the year for panel meetings in parentheses: fluoride supplements (2007), oral cancer screening procedures (2007-2008) and fluoride content of reconstituted infant formula (2008).

American Heart Association Guidelines for Preventing Infective Endocarditis: In April 2007, the American Heart Association (AHA) and the American Dental Association announced the release of new Guidelines for the Prevention of Infective Endocarditis (IE). The ADA was involved throughout the guideline-development process through its representative Dr. Peter Lockhart of the Carolinas Medical Center.

Focusing on the dental-related sections of the document, the Council reviewed and approved the updated AHA guidelines before publication in the May 2007 issue of the AHA journal, *Circulation*. Content pertinent to dentistry was posted on ADA.org concurrent with the AHA's release of the guidelines in April 2007. The information will be published in the June 2007 *JADA*, including a legal sidebar for dentists and a "For the Dental Patient" page for patients. These companion pieces were designed to help member dentists implement the new guidelines and discuss them with their patients.

The new guidelines recommend that fewer patients with heart conditions receive antibiotic prophylaxis before dental procedures for the prevention of infective endocarditis. Antibiotic prophylaxis is now recommended only for patients at greatest risk of negative outcomes from infective endocarditis when they undergo dental procedures that involve manipulation of the gingival tissues, periapical region of teeth or perforate the oral mucosa.

Members were notified of the new AHA guidelines through a multifaceted communications strategy, including a press release, a posting for the Executive Director Update, an E-gram, print and online coverage in *ADA News*, a "Science in the News" feature at ADA.org, and a revised patient brochure. A laminated summary page of the new recommendations has been prepared for members and is available upon request. Access the details of the new recommendations via the "Infective Endocarditis" A-Z topic page at ADA.org

Recommendations for Dental Treatment for Patients on Bisphosphonates: The first reports of osteonecrosis of the jaw associated with the use of two intravenous bisphosphonates, zoledronic acid (Zometa®) and pamidronate (Aredia®), began to surface in 2003. These reports of biphosphate-associated osteonecrosis (BON) in cancer patients raised concerns that taking the less potent oral bisphosphonates (Fosamax®, Actonel® and Boniva®) for osteoporosis may increase an individual's risk for developing BON. In light of the large number of patients taking these drugs and the uncertainty surrounding the incidence of BON and concomitant risk factors, dentists questioned how to manage patients receiving oral bisphosphonate therapy.

To address this issue, the Council established an expert panel to develop guidance for dentists in managing patients on oral bisphosphonate therapy. Medical and dental expert panelists examined the sparse available literature and reports, including incidence rates documented by drug manufacturers. In August 2006, the Council's recommendations, entitled Dental Management of Patients on Oral Bisphosphonate Therapy, were published in *JADA*. The report is also available online at the "Osteonecrosis of the Jaw" A-Z topic page at ADA.org. Because of recent reports suggesting a higher incidence of BON than previously thought (e.g., the *Journal of Oral and Maxillofacial Surgery*, March 2007), the Council recommended that the CSA recommendations be continuously updated to include newly published information as appropriate. Revised recommendations will be available later in 2007.

Addressing the Relationship Between Oral and General Health: The Council continues to evaluate the emerging evidence on the relationship between oral health and systemic conditions. At its November 2006 meeting, the Council held a "mega-issue" discussion on the effective use of oral-systemic research and information. The strategic dialogue covered the evolving relationship between dentistry and medicine, the implications of emerging research for dental practice and appropriate use of scientific information.

The Council recommends and will continue to pursue a balanced, science-based approach in this area. Member dentists and the public need rapid, efficient, and appropriate translation of emerging research on oral-systemic relationships, particularly with the growing transition toward Web-based information. The Council will continue to address emerging scientific issues with an increased focus on timely, online information, particularly as new research is published on oral-systemic health relationships, salivary diagnostics, tissue engineering and other issues. Print outlets will continue to be important, and more rapid, as many have or plan to implement their own online journal versions or content.

Because of the increased rate at which information is developed and disseminated, it is increasingly important for dentists and the public to turn to trusted information sources, and to develop the skills to identify questionable sources. The Council assisted in the development of a "For a Dental Patient" page entitled "Surfing for Substance: Evaluating Oral Health Information on the Internet," which was published in the May 2006 JADA. The statement was prepared to help dental patients identify credible online health information supported by sound, peer-reviewed science.

At the 2006 annual session in Las Vegas, the Council sponsored a full-day scientific session entitled "The Dentist's Role in Oral and Systemic Health Care." The session featured presentations and discussions of the latest scientific evidence on the relationship between periodontal disease and major chronic diseases, such as heart disease and stroke, diabetes, low birth weight, and respiratory illness. Expert panelists for the session included Dr. Robert Genco, Dr. Catherine Flaitz, Dr. Michael Glick, Dr. Amid Ismail, Dr. Daniel Meyer, Dr. James Beck, Dr. Timothy DeRouen and Dr. Daniel Malamud. The session was underwritten by a grant from the Colgate-Palmolive Company.

At the 2007 annual session in San Francisco, the Council is sponsoring a related scientific session entitled "Oral-Systemic Health: Exploring the Connection," which will address the dental implications of systemic conditions and chronic diseases seen in today's patients and older adults. The full-day session will also examine the association between infections of the oral cavity, such as those of pulpal and periodontal origin, with systemic diseases such as diabetes mellitus and coronary artery disease. The course will be moderated by Dr. Daniel Meyer, senior vice president, Science.

"**Science in the News**" **at ADA.org:** The Council has teamed with the ADA Division of Science since 2005 to provide an online resource for ADA.org called "Science in the News" (www.ada.org/goto/sciencenews). This online resource is dedicated to dental science news reporting, and presents current information about dental research and related scientific news items receiving coverage in the mainstream media. "Science in the News" examines how the science affects dentistry, and how dentists can integrate the information in everyday practice. "Science in the News" features are accessible worldwide to both ADA members and the general public, and each article offers links to other content on ADA.org and external Web sites

Since its debut, "Science in the News" has gained in popularity, receiving over 34,000 page hits in 2006. Over 45 "Science in the News" features have been developed, averaging three postings per month. An online archive was recently established to provide continued access to content and links after initial posting at ADA.org

ADA Research Agenda: Guided by the *ADA Strategic Plan: 2007-2010* and the ADA *Bylaws*, the Council develops an ADA Research Agenda annually. For the 2006-07 version of the research agenda, the CSA re-focused the development process and altered the timing to better align with ADA advocacy efforts, specifically, to align with the timing for selection of research topics by National Oral Health Advocacy Committee. Before Board approval, various ADA councils, ADEA and AADR have the opportunity to comment on the agenda.

The ADA Research Agenda presents priority research topics that are organized around four broad goals and corresponding specific objectives. The broad goals are consistent for two to three years, but the specific objectives may change annually. The agenda is aligned with key clinical issues identified through a number of vehicles, including member surveys. The 2007/2008 Research Agenda is in development and will be complete in the summer of 2007.

Dental Students' Conference on Research: Forty-three students representing dental schools in the United States and Canada attended the 2007 Dental Students' Conference on Research in Gaithersburg, MD. This annual conference was held on April 15-17, 2007, with sponsorship from ADA Foundation and Johnson & Johnson. Students toured facilities at the Paffenbarger Research Center (PRC) and heard presentations by the Council senior director, PRC senior staff and representatives from Johnson & Johnson, the National Institute of Dental and Craniofacial Research and American Association for Dental Research. Participating students also had the opportunity to present results of their own research in a poster session.

Update on Infection Control in Dentistry: The Council monitors the available literature and surveillance data on HIV and AIDS prevalence among dental health care workers, and provides periodic updates on issues related to infection control. Bloodborne pathogens, such as hepatitis B and C and HIV, present perpetual infectious risks for dentists and their patients. Standard precautions and immunizations continue to keep these potential hazards under control.

Based on data from the National Health and Nutrition Examination Survey (NHANES) 2003-2004, hepatitis B virus (HBV) exposure in the United States is 4.86%, and the incidence of chronic HBV infection is approximately 0.38% (Centers for Disease Control and Prevention, National Center for Health Statistics, April 2007). The NHANES study sampled about 8,000 civilians of the non-institutionalized U.S. population and found that new acute HBV infections declined 75% from 1990 to 2004. Adults accounted for 95% of new HBV infections in 2004. This is consistent with the lower HBV vaccination rate for adults aged 18-49 (34.6%) versus children (92%) and adolescents (86%) (MMWR, May 12, 2006, 55(18); 509-11).

Based on data from the 2006 Health Screening Program, 91% of dentists reported receipt of the hepatitis B vaccine, but the level of dentists showing serological evidence of HBV exposure has remained in the 8-10% range over the past decade. This is likely due to clinical exposures over 20 years ago, before widespread administration of the hepatitis B vaccine.

Similarly, clinical dentist exposures to HCV and HIV remain at very low or undetectable levels. The 2006 ADA Foundation Health Screening Program (HSP) found that 0.53% of dentists were infected with HCV, which is within the range of 0.3 to 0.9% seen since 1999. Recent NHANES data, from April 2007, showed that the U.S. general

population had an HCV seroprevalence of 1.18%, a higher level than found in practicing dentists (based on HSP data). Since 1987, there have been no reported dentist-to-patient transmissions of HBV, none for HIV since 1990, and none for HCV at any time. Therefore, in the absence of an effective vaccine for HCV and HIV, current infection control recommendations remain effective in preventing dentist and patient infections.

While these trends are certainly encouraging, there was also a 2007 report of a patient-to-patient HBV transmission in a single oral surgery clinic, which the Council addressed through "Science in the News" at ADA.org (available at: www.ada.org/prof/resources/topics/science_hbv_dental.asp). No apparent breach in infection control practices was identified in this case, and the exact mode of transmission remains unknown. This single incident should not raise doubts about the efficacy of standard precautions and sterilization or disinfection techniques, but should reinforce the need for consistency in the application of infection control recommendations at all times.

Considerable attention has focused on avian influenza (H5N1), a highly pathogenic influenza virus, commonly referred to as "bird flu." Although it remains very rare in humans, concerns have focused on the mortality rate, which exceeds 50%. Person-to-person transmission is uncommon, with the vast majority of infections occurring from direct contact with infected poultry. As of April 2007, the World Health Organization reported 291 worldwide human cases of H5N1, and 172 deaths since 2003. To date, no H5N1 infections have been reported in the United States. The FDA approved the first U.S. vaccine for adults against the H5N1 influenza virus in April 2007.

Council Reports and Statements: In 2006-2007, the Council developed and/or approved six reports to the profession that were published in *JADA*. Three have been described earlier: Evidence-Based Clinical Recommendations: Professionally Applied Topical Fluoride (August 2006); Dental Management of Patients on Oral Bisphosphonate Therapy (August 2006); and the dental component of the AHA guidelines for the prevention of infective endocarditis (June 2007). The Council also developed:

- *The Use of Dental Radiographs: Update and Recommendations* (September 2006), which provides recommendations for proper radiographic practices, based on updated guidance from the National Council on Radiation Protection and Measurements, the Centers for Disease Control and Prevention, and the U.S. Food and Drug Administration.
- *Mouthguards for the Prevention of Sports-Related Dental Injuries* (December 2006), which was developed in collaboration with the Council on Access, Prevention and Interprofessional Relations. This provides a review of the available literature and describes the role of mouth protectors in reducing the incidence and severity of sports-related oral injuries.
- *Prevention of Premature Discontinuation of Dual Antiplatelet Therapy in Patients with Coronary Artery Stents* (May 2007), a science advisory from the American Heart Association and other health associations that strongly recommends against premature discontinuation of antiplatelet therapy for patients who have implanted drug-eluting stents, particularly within the first 12 months after placement. A "Science in the News" feature coincided with the statement's initial publication in the AHA's journal, *Circulation* (February 13, 2007).

Proposed Development of an ADA Caries Classification System: The G.V. Black caries classification system was first proposed in 1908, nearly a century ago. Black's original concepts focused on treatment and specific cavity preparation designs. The science of cariology has progressed, and new caries classification systems are under development. Carious lesions may be identified before cavitation and in some cases may be remineralized. When restorations are necessary, the original Black designs are rarely used. Cavity designs, instrumentation and restorative materials have all progressed since Black's time.

At its November 2006 meeting, the Council reviewed a draft report on the International Caries Detection and Assessment System (ICDAS), a system primarily designed for caries research, and the proposed FDI World Dental Federation tooth lesion system. After discussion, the Council decided to implement a formal review process, including an international workshop, to further assess the need for, and develop as appropriate, an updated or new international dental classification system. As of spring 2007, the Council is in the process of formulating a draft ADA-sponsored caries classification system in collaboration with other ADA agencies, including the Councils on Dental Practice and Dental Benefit Programs.

A consensus development conference is planned for 2008 involving both internal and external stakeholders. The primary objective of the consensus conference will be to develop an updated caries classification system acceptable to all stakeholders, and one that will be compatible with or adaptable to future electronic health record requirements.

Product Evaluations and Evaluation Criteria

New Professional Product Evaluation Program: The Council launched the ADA Professional Product Review (PPR) in July 2006 as a free member benefit. PPR is distributed quarterly as a supplement to *JADA*. The first issue contained reports on carbide burs, posterior composites and digital radiography systems. Since then, three additional issues have been published:

- October 2006 – LED curing lights, resin-based cements and nickel-titanium rotary endodontic instruments
- January 2007 – Resin bonding agents, electric handpiece systems, local anesthetic delivery systems
- April 2007 – Autoclaves, waterline quality monitoring kits, waterline cleaning products

The Council and staff continue to work closely with PPR's editor, Dr. David S. Sarrett. The Council appointed Dr. Sarrett editor for a period of three years, beginning July 2005. Staff meets with Dr. Sarrett at least bi-weekly to make the myriad editorial decisions needed to meet PPR's demanding publication schedule. Each July, Dr. Sarrett meets with the Council to share information, obtain Council guidance and plan strategically for PPR's future.

Product evaluation categories are selected for the PPR based on reader input. Timing of reports is influenced by editorial considerations and laboratory workflow. Most of the product testing is completed in the Division of Science laboratories at ADA Headquarters, although collaborations have been established with other laboratories to test certain products according to ADA test protocols. Resource-intensive evaluations are coordinated to make effective use of all resources. Work on a particular evaluation often begins 18 months or more before the publication date.

Market Research. Before launching PPR, the Council engaged in substantial qualitative and quantitative market research to determine what information member dentists want from the ADA about professional dental products. The research clearly established that members want information that is scientifically sound, clinically relevant, concise, easy-to-read, and unbiased, and they want information that allows them to compare products within a product category. Member dentists also expressed interest in knowing their colleagues' clinical impressions from using the products in their own offices. Survey respondents strongly supported a print newsletter, supplemented by online, which is precisely what PPR is designed to deliver.

The Council continues to sample reader opinion on a regular basis to ensure that the ADA Professional Product Review meets or exceeds member expectations. Most of the respondents to a December 2006 reader survey rated PPR as "good" or "excellent." Some had specific suggestions to enhance the newsletter's usefulness and readability, which will be reflected in future issues.

ADA Clinical Evaluators (ACE). One of the most notable features of PPR is the clinician's perspective, obtained via the ADA Clinical Evaluators or ACE panel. Currently, over 1,700 member dentists volunteer on the ACE panel, providing real-world clinical input on professional dental products via Web-based questionnaires. ACE members are also instrumental in helping PPR determine which products to include in its evaluations and what dentists want to know about them. Participation with the ACE panel gives members the opportunity to directly contribute to PPR's content and gives readers the input from their colleagues they requested.

2007 Product Forum. PPR also obtains clinical input by convening expert panels to discuss the findings and interpretation of current clinical research, and through dentist participation in the product forum at the ADA annual session. The first product forum, in 2005 in Philadelphia, featured LED curing lights. The 2006 forum in Las Vegas featured high-speed dental handpieces.

For the first time this year, the product forum will be a prominent part of the ADA Pavilion in San Francisco, which should enhance dentist participation and provide additional useful information for PPR. All delegates and other dentist attendees are invited to stop by, try eight different intraoral cameras and record their impressions. The results will be published with the planned evaluation of intraoral cameras in the July 2008 issue of PPR.

Enhancing the Clinical Component. At its November 2006 meeting, the Council began discussion of how to enhance the clinical component of the PPR. The current system provides important and useful clinical perspective but the Council is also interested in continuous improvement, including practical ways to enhance the newsletter's scientific rigor. The Council is investigating a number of options at this time.

Industry Relations. PPR strives to balance the important contributions that dental manufacturers make to understanding their products with the need to be completely unbiased and objective in evaluating products and presenting the results. PPR informs companies when their products are selected for evaluation, gives them the opportunity to review and comment on the test protocol, and shares the test results and the clinical input on their own products prior to publication. Company comments are invited and welcome, through letters to the PPR editor.

Subscriptions. PPR is polybagged with *JADA* and distributed free of charge to most ADA members. Certain ADA membership categories (e.g., those that do not receive print copies of JADA as a privilege of membership) are provided free access only to the online version of PPR on ADA.org. These are primarily the international dentist members of the ADA. PPR is available by subscription to non-ADA members and is available for purchase at bulk rates. Individuals seeking further information are invited to contact pprclinical@ada.org.

ADA Seal of Acceptance Program: In 2007, the Council continued to pursue ideas aimed at strengthening the ADA Seal of Acceptance Program for over-the-counter (OTC) products by making the Seal more meaningful to consumers and stimulating industry participation in the Seal program. A key initiative was development of an enhanced Seal of Acceptance Web area on ADA.org. As of spring 2007, the Council is finalizing several upgrades to the online informational resources available to the public and the profession. The new Web area will:

- Provide consumers and ADA members with more accessible and useful information about ADA-Accepted dental products
- Promote the concept that the ADA Seal on a product means that the product has been reviewed by independent experts according to objective, science-based criteria
- Promote the ADA as a credible source of information on the safety and effectiveness of dental products

In April 2007, the Council considered the available scientific evidence to evaluate support for expanding the ADA's oral hygiene recommendations to include daily use of ADA-Accepted antiplaque or antigingivitis mouthrinses. Based on this review and the benefits of promoting good oral health, the Council recommended the following be added to the ADA's basic oral hygiene messages as appropriate:

- Use of an ADA-Accepted fluoride mouthrinse can help reduce tooth decay.
- Use of an ADA-Accepted antimicrobial mouthrinse or toothpaste can help reduce plaque and gingivitis.

The CSA also recommended that the ADA strengthen and expand its support for tobacco cessation, given the significant negative effects of tobacco on oral and general health. Council staff is pursuing the implementation of these recommendations with other internal agencies.

Standards Activities: In accordance with its *Bylaws* responsibilities, the Council coordinates the development of national and international standards programs for dental products. These standards activities are conducted through the ADA Standards Committee on Dental Products (SCDP) and the International Organization for Standardization/Technical Committee 106, Dentistry (ISO/TC106).

The ADA SCDP has more than 90 projects registered with the American National Standards Institute (ANSI). With the participation of the U.S. Environmental Protection Agency, the ADA SCDP completed the development of a new ANSI/ADA standard for procedures for storing dental amalgam waste and requirements for storage and shipment containers, and submitted revised standards for pit and fissure sealants, root canal barbed broaches and rasps, orthodontic wires, casting and baseplate waxes, and dental units. In cooperation with the ADA SCDP, the Council proposed new standards work items for: dentifrice laboratory abrasion testing methods, high-speed handpieces, and dental implants. Some 28 ANSI/ADA specifications have been recognized by the Food and Drug Administration for use in its premarket product evaluations.

ISO/TC106. The importance of ISO standards development continues to expand internationally and is having an impact in the United States as well. As of December 2006, 27 ISO standards have been adopted as ADA standards, and additional ISO standards are under consideration.

The ADA sponsors U.S. participation in ISO/TC106, Dentistry and is the Secretariat of the U. S. Technical Advisory Groups. Presently, the Association holds the Secretariats for two of the seven ISO/TC106 subcommittees: Subcommittee 2, Prosthodontics, and Subcommittee 8, Implants. Council staff also participates in the ISO working groups as convenors and experts, presenting ADA positions on standardization issues to this international organization.

Based on a recent standards strategy summit, which assessed the current standards development process, the Council has reemphasized the need for clinically relevant standards and test methods and has encouraged that the scope of ISO/TC 106 be modified to reflect this goal. Furthermore, as a result of this summit and other strategic planning sessions, the Council has implemented the use of ADA.org to increase ADA member involvement in standards development.

Outside Standards Committees: Other organizations develop standards that can affect the dental profession, addressing such areas as sterilization procedures, laser safety and indoor air quality. The final voluntary standards adopted by these organizations may be adopted by federal, state or local regulatory agencies.

Council representatives attended meetings of the following outside organizations to present Association positions on their standards: American Society of Heating, Refrigeration and Air Conditioning Engineers (ASHRAE), American Society of Testing and Materials (ASTM), Association for the Advancement of Medical Instrumentation (AAMI), National Fire Protection Association (NFPA), and the Laser Institute of America (LIA). Participation allows the ADA to influence development of clinically relevant standards in these fields.

Guideline Development: In product categories without established ADA standards, the Council develops Acceptance Program guidelines as criteria for evaluating professional and over-the-counter (consumer) dental products. Although the Council is in the process of phasing out the Seal Program for professional products, new and revised guidelines will remain of considerable importance for the Council's evaluation of consumer dental products. Guidelines have also been used to investigate the safety and efficacy of professional products for the new ADA Professional Product Review.

The Council has completed or is developing Acceptance Program guidelines in some 50 product areas. In 2006 and early 2007, the Council revised or completed guidelines for home-use stain removal products and powered and manual toothbrushes. The Council is also developing or revising guidelines for salivary diagnostic products, oral malodor products and fluoride dentifrices.

Information Technology Update: 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 (IT) on the profession or the practice of dentistry.

The Internet continues to develop as one of the most important IT advancements in history with respect to dissemination of and access to accurate and clinically useful research and health care information. The growth of Web-based communications has become increasingly significant to dental practitioners and patients but it also presents an equally impressive advance in the ability for individuals and organizations to distribute inaccurate, scientifically unsupported information. Unfortunately, it is not always easy for the public or dental professionals to distinguish the former from the latter.

The ADA's primary contribution to clarifying reliable oral health information content is ADA.org. The Council and Division of Science provide extensive content to support this important informational tool. It is critical that ADA continue to improve and maintain this tool to allow members and the public to regularly obtain the latest and most accurate information on dental topics. Examples of useful scientific information and CSA-related content may be found at the following ADA.org "goto" addresses:

- the ADA Professional Product Review (www.ada.org/goto/ppr)
- evidence-based dentistry (www.ada.org/goto/ebd)
- the Seal of Acceptance program (www.ada.org/goto/seal)
- Science in the News (www.ada.org/goto/sciencenews)
- oral-systemic health (www.ada.org/goto/oralsystemic)

The coming National Health Information Infrastructure (NHII) is a use of technology that will affect dental practitioners, and will call for dentists to become increasingly competent in integrating clinical care and electronic

records. One important area for Council input will be in the development and refinement of the dental vocabulary that will be necessary for integration with the overall NHII system.

Emerging Issues and Trends: Over the past two years, the Council has implemented a more proactive approach to scanning for emerging issues and trends that may affect dentistry. The approach provides for a more focused effort to identify and discuss emerging issues, including regular opportunities for input from the Council's extensive consultant group.

The Council now regularly considers emerging issues and/or trends through mega-issue discussions. Over the last year, the CSA explored issues related to scientific analysis and decision-making skills in practice and dental education; use and abuse of research reports on oral-systemic connections; and the needs and challenges of risk communication in the dental practice environment. These discussions help Council members better understand the issues to aid with development of more useful and informed member programs and services.

One major challenge that is not new but "re-emerging" is the availability of funding for important basic and applied research. The CSA and its liaisons from the American Association for Dental Research (AADR), the National Institute of Dental and Craniofacial Research (NIDCR) and the American Dental Education Association (ADEA) are working both independently and together to inform the dental profession and the public of the need for and importance of ongoing funding of dental research. The Council maintains close ties with the ADA's advocacy efforts in Washington on this topic and other priority science-related issues through ongoing communications at the staff and volunteer level, and Council meeting reports. Consistent funding of dental research is critical to the continued development, growth and effective application of evidence-based dentistry in clinical practice.

With new techniques for detecting small quantities of salivary components, including proteins and messenger RNA, the field of salivary diagnostics is emerging as one of dentistry's most promising areas of research, and could soon provide dentists and other health care professionals with initial screening tools for patient treatment and care. This development, in tandem with federally funded research that is cataloging the genetic makeup of oral biofilms, could accelerate the development of improved diagnostic tools for periodontal disease and oral cancer.

Meetings: The Council on Scientific Affairs met at ADA Headquarters on November 6-8, 2006, and April 2-4, 2007. Dr. Frank C. Grammer, Fifteenth District trustee, served as the Board of Trustees' liaison. The Council's remaining meeting will be held on July 9-11, 2007.

Personnel: Dr. Clark Stanford served as Council chair for the 2006-2007 term, with Dr. Jack Gotcher serving as vice chair. In fall 2006, the Council welcomed four new members: Dr. Karen Crews, Dr. Lorne Golub, Dr. Mark Lingen, and Dr. David Wong. The Council recognizes the following members whose terms end in fall 2007 for their service to the Council, the Association and the dental profession: Dr. Clark Stanford (chair), Dr. Jack Gotcher Jr., Dr. Michael McGuire, Dr. Valerie Murrah and Dr. Ioanna Mentzelopoulou (*ex officio*).

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

Reports of ADA Foundation

Notes

ADA Foundation

Dugoni, Arthur A., California, 2008, president
Sudzina, Michael R., Ohio, 2007, vice president
Leone, Edward, Jr., Colorado, 2009, treasurer
Bramson, James B., secretary
Cumbus, Benjamin J., Alabama, 2008, director
Ellwein, Orin, South Dakota, 2007, director
Farrell, Lawrence W., Illinois, 2008, director
Feldman, Cecile A., New Jersey, 2008, director
Garcia, Raul I., Massachusetts, 2008, director
Grammer, Frank C., Arkansas, 2007, director
Harrison, Suzan, New York, 2007, director
Henderson, Robert C., Illinois, 2008, director
Kell, Kathryn A., Iowa, 2008, director
Landesman, Howard M., California, 2007, director
Niessen, Linda C., Texas, 2007, director
Perich, Michael L., Texas, 2008, director
Schweinebraten, Marie C., Georgia, 2009, director
Simms, Richard A., California, 2008, director
Sullivan, Timothy J., Wisconsin, 2010, director
Tarrson, Linda C., Illinois, 2008, director
Webb, Russell I., California, 2010, director
Payne, R. Barkley, executive director
Czarnecki, Robert N., director, administration and endowments
Edwards, Dwight S., director, development
Jasek, Jane F., director, programs
Straney, Cecilia, campaign director

The Mission of the ADA Foundation: As dentistry's premier philanthropic and charitable organization, the ADA Foundation is a catalyst for uniting people and organizations to make a difference through better oral health. The Foundation secures contributions and provides grants for sustainable programs in dental research, education, access to care and assistance for dentists and their families in need.

The Foundation's strategic ties with the American Dental Association, coupled with its strong volunteer leadership and generous donors, gives it a powerful yet flexible infrastructure to anticipate and quickly respond to the most pressing needs affecting dentistry and the public's oral health.

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 Strategic Plan: 2007-2010*. However, in fulfilling its charitable purposes, the Foundation materially assists the Association to meet its defined Objective as stated in its *Constitution* "to encourage the improvement of the health of the public and to promote the art and science of dentistry."

Reporting Highlights: 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 for dentists and their families in need. In addition to the many charitable and research programs outlined later in this report, the following are several key accomplishments to highlight during this reporting period.

- Through its Harris Grants program, the ADA Foundation provided more than $321,000 to community-based, not-for-profit oral health promotion programs in the United States. The 72 organization award recipients will improve oral health for hundreds of thousands of children throughout the United States.
- The ADA Foundation raised more than $2 million to support its mission in 2006, while securing nearly 3,696 new, first-time donors.

- Under the leadership of the ADA Foundation, ***Dental Education: Our Legacy – Our Future***, an unprecedented national effort to address the critical challenges facing the very foundation of this profession – was publicly launched in July 2006. The public launch included a Web site, www.ourlegacyourfuture.org, a media launch, and tools for partner organizations such as a four-color brochure, "I am a Dentist. I am a Doctor." *Our Legacy—Our Future* received a Public Relations Society of America Renaissance Award for its compelling communications package detailing the challenges facing dental education.
- As one of the partners of *Our Legacy—Our Future*, the ADA Foundation is launching a campaign to specifically support innovations in dental education. To further demonstrate its commitment to innovation, the ADA Foundation Board of Directors funded a $334,000 grant for the development of a program to train Community Dental Health Coordinators—a new dental team member who will improve access to dental care among the underserved. The ADA House of Delegates subsequently approved the Community Dental Health Coordinator program at the 2006 Annual Session.

Members of the ADA can be proud of the ADA Foundation. The continued support and generosity from the entire dental community is gratefully appreciated. Working together, we are connecting people, changing lives.

Dental Education: Our Legacy—Our Future: This collaborative effort of partner organizations—dental schools, specialty organizations and other dental organizations—is raising awareness of the challenges facing dental education in the United States and is promoting a culture of philanthropy within dentistry that will address these issues. The campaign delivers a strong call to action and encourages every dentist in America to support the partner organizations. As one of the partners, the ADA Foundation is raising $100 million to support innovations in dental education (details follow this section).

Our Legacy—Our Future is not a fundraising entity. It will not solicit or secure contributions. Each of the *Our Legacy—Our Future* partners will raise and utilize its own funds as it decides to address the issues affecting dental education. The increased awareness about the challenges facing dental education, and the tools and resources provided by *Our Legacy—Our Future* will help the partner organizations raise more than $500 million for dental education by December 31, 2014. The ADA Foundation serves as the administrator of *Our Legacy—Our Future* as well as one of its partners.

As planned, *Our Legacy—Our Future* moved forward in 2006, recruiting additional partners, enlisting members of the Steering Committee, and completing its public launch. As of May 15, 2007, 84 partners had joined. This number represents more than 95 percent of American dental schools as well as other dental organizations.

Last year, Dr. Kenneth Kalkwarf joined the *Our Legacy—Our Future* campaign leadership as chair of the Recipient Division, which represents dental school partners, and Dr. Paul Kennedy joined as chair of the Facilitating Division, which represents those organizations that both raise and distribute funds to benefit dental education. Drs. Kalkwarf and Kennedy join Honorary Chair Dr. Art Dugoni, National Co-Chair Dr. Cecile Feldman, National Co-chair Dr. Richard Haught, Vice Chair David Johnsen, and Vice Chair Dr. Leslie Seldin.

As the partners use the campaign tools to increase philanthropy within the dental profession, *Our Legacy—Our Future* will help secure the future of dental education and enhance the oral health of the nation for generations to come.

Update on ADA Foundation $100M Campaign: As one of the partners in *Dental Education: Our Legacy—Our Future*, the ADA Foundation will raise $100 million to support and promote innovations in dental education. The ADA Foundation's campaign will solicit support from current leadership of the ADA and ADA Foundation through the third quarter 2007. It is anticipated that the campaign will be publicly launched soon thereafter.

Dr. D. Gregory Chadwick is campaign chair and Dr. G. Kirk Gleason and Dr. Frank Grammer serve as co-chairs of the Leadership Gifts Committee, which is soliciting the ADA Foundation Board of Directors and ADA Trustees for leadership level, multi-year pledges. Dr. Chadwick has also enlisted Mr. Michael Sudzina as the chair of the Corporate and Foundation Gifts Committee, and Dr. Kathryn Kell as chair of the Stewardship Committee. Dr. Chadwick will continue to enlist chairs for key leadership positions, including the Pacesetter Gifts Committee, which will solicit gifts of $1 million and above.

Through a competitive grant process, the ADA Foundation campaign will support innovations in dental education in four key outcome areas: a) expanding and sustaining high quality dental school faculty; b) developing more financially efficient dental education delivery models; c) creating academic and research-based curricula that will

shape tomorrow's dental leaders; and d) ensuring that the diversity of dental school faculty and students reflect the rich diversity of the United States' general population.

The ADA Foundation's campaign will afford donors an opportunity to influence the future direction of dental education – thus influencing the direction of dentistry in America.

Development Activities: The ADA Foundation conducts an annual giving campaign in support of its core research, education, access to care and charitable assistance programs. During 2006, past donors and the majority of ADA members were solicited through these appeals. The appeals included direct mail and person-to-person solicitations of individuals, companies, dental organizations, foundations and government entities. A total of $2,014,815 was raised during 2006 through these appeals.

ADA Foundation Grant Program: During the reporting period, the Foundation awarded 257 grants totaling $1,479,699. In addition to supporting various ongoing projects, the Foundation provided grants totaling $393,578 for dental research, $135,111 for dental research/education, $209,667 for education programs, $389,526 for access/preventive dentistry programs and $351,817 in charitable assistance for dentists and their families in need.

Research Grants: The ADA Foundation provided financial support in 2006 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. In 2006, the following studies were conducted: "Evaluation of ICTP as a Chairside Diagnostic for Active Periodontitis" and "Chromatin Immunoprecipitation of InsP3 Receptor Gene Promoter Binding Proteins in G-292 Human Osteosarcoma Cells." Funding for these fellowships was made possible by the ADA Foundation through a $6,500 grant contribution from Sunstar Americas Inc.

Young Investigator Award. As a requirement of the Specialized Materials Science Research Grant from the National Institute of Dental and Craniofacial Research, the ADA Foundation Paffenbarger Research Center (PRC) annually appoints two young investigators to the industrial scholars program. The $36,600 award was made possible by a contribution from the Colgate-Palmolive Company.

Research Training Fellowship. The Research Training Fellowship program is conducted at the ADA Foundation 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 2006, the conference was held at 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 Philadelphia meeting, 1,516 dentists took all, or part of, the screenings offered. Additionally, 474 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. Lorne M. Golub the 2006 recipient. Dr. Golub, of the State University of New York, Stony Brook, School of Dental Medicine, received the $25,000 award and will serve on the Association's Council on Scientific Affairs for the next three years. 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. Steven Offenbacher, of the University of North Carolina, Chapel Hill, School of Dentistry, received the $5,000 award in 2006. This program is made possible by Pfizer Consumer Healthcare, Pfizer Inc.

Dental Education Grants:

Scholarships. A total of $155,000 was distributed for 25 dental student scholarships, 25 dental student minority scholarships, 15 dental hygiene scholarships, ten dental assisting scholarships and five dental laboratory scholarships. These annual scholarships are made possible through contributions from the Harry J. Bosworth Company, the Colgate-Palmolive Company, the Procter & Gamble Company, Oral-B Laboratories, Sunstar Americas Inc, Handler Manufacturing Company, and the Foundation's Student Scholarship Fund account.

Robert Wood Johnson Foundation Dental Pipeline Program. As the initial year of a four-year program, $46,667 was directed to support two dental student scholarships at each of five dental schools enrolling underrepresented minority and low-income students. These scholarships are made possible by the generous support of individual donors.

Dr. Edward B. Shils Award & Lecture Series. The Shils award educates individuals through the Shils Fund lectures, enabling entrepreneurs through development grants and annually recognizing excellence through the Shils Awards. In 2006, the $8,000 in awards was made possible through the Foundation's Dr. Edward B. Shils Award & Lecture Series Fund.

Access to Care Grants: Effective in 2005, the Foundation initiated an annual Request for Proposal program focused on dental education, dental research and access to care. In keeping with the cycle established by the Foundation, in the third year of the program, two RFPs, titled "Community Water Fluoridation Infrastructure Grants" and "State Capacity Building and Oral Health Planning Grants" were designed to support state and local efforts to initiate and maintain community water fluoridation and encourage collaborative efforts to address oral health awareness. The RFP was distributed in August 2006 with recipients named in 2007. The Foundation received 24 applications, seven for the fluoridation grant and 17 for the state capacity building. Following review, seven projects/initiatives were awarded support.

Community Water Fluoridation Infrastructure Grants

- Boston Public Health Commission, Boston, MA, $10,000
- Chemung County – Corning Coalition for Water Fluoridation, Corning, NY, $10,000
- City of Palestine, Palestine, TX, $10,000
- City of Sioux City, Sioux City, IA, $5,000

State Capacity Building and Oral Health Planning Grants

- Apple Tree Dental and Minnesota Dental Association, Minneapolis, MN, $25,000
- Arizona School of Dentistry & Oral Health, Mesa, AZ, $20,000
- California Dental Association Foundation, Sacramento, CA, $20,000

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.

Samuel D. Harris Fund for Children's Dental Health Grants Program. In 2006, $321,274 in grants was awarded as part of the Harris Fund grants program to support 72 dental health care and education organizations. The grants were made possible by the Colgate-Palmolive Company and the Foundation's Samuel D. Harris Fund for Children's Dental Health.

- Alaska Health Fair, Inc., Anchorage, AK, $5,000
- Maricopa Integrated Health System, Phoenix, AZ, $5,000
- The Healthy Smile Foundation, Phoenix, AZ, $5,000
- Dental Coalition of Needy Children, Los Angeles, CA, $5,000
- Sacramento City Unified School District, Sacramento, CA, $5,000
- Sycuan Medical Dental Center, El Cajon, CA, $2,550
- UCSD Free Dental Clinic, La Mesa, CA, $5,000
- Venice Family Clinic, Venice, CA, $5,000
- Durango 4-C Council, Inc., Durango, CO, $5,000
- Stratford Health Department, Stratford, CT, $5,000
- D.C. Public Schools Head Start, Washington, DC, $5,000
- Child Care Resource Network, Daytona Beach, FL, $2,536
- Kids Dent of Highlands County, Sebring, FL, $3,000
- Children's Healthcare of Atlanta, Atlanta, GA, $5,000
- Good News Clinics, Gainesville, GA, $5,000
- Hawkeye Area Community Action Program, Hiawatha, IA, $5,000
- Lee County Health Department, Fort Madison, IA, $4,980
- Success by 6, Davenport, IA, $5,000
- Word-of-Mouth, Oral Health Education Connection, Council Bluffs, IA, $5,000
- Eastern Idaho Community Action Partnership, Idaho Falls, ID, $4,644
- Cass County Health Department, Virginia, IL, $4,250
- Central Illinois Dental Education & Services, Urbana, IL, $5,000
- Community Nurse Health Association, La Grange, IL, $1,250
- Provena Health, Danville, IL, $1,236
- Sangamon County Department of Public Health, Springfield, IL, $3,662
- Southern Illinois University, Carbondale, IL, $5,000
- Kansas Children's Service League, Garden City, KS, $4,994
- ERC Resource & Referral Agency, Topeka, KS, $3,575
- Gateway Community Services Organization, West Liberty, KY, $5,000
- Magoffin County Health Department, Salyersville, KY, $1,272
- Lower/Outer Cape Community Coalition, Eastham, MA, $5,000
- The Forsyth Institute, Boston, MA, $5,000
- Allegany County Health Department, Cumberland, MD, $5,000
- Carroll County Health Department, Westminster, MD, $3,700
- Saint Mary's Health Care, Grand Rapids, MI, $4,989
- Washtenaw County Head Start, Ypsilanti, MI, $5,000
- Leech Lake Band of Ojibwe, Case Lake, MN, $4,975
- Dallas County Health Department, Buffalo, MO, $5,000
- Jefferson County Community Partnership, Barnhart, MO, $4,866
- South Side Day Nursery, St. Louis, MO, $4,600
- University of Missouri, School of Dentistry, Kansas City, MO, $3,506
- St. Vincent Healthcare Foundation, Billings, MT, $5,000
- University of Medicine and Dentistry of New Jersey, Newark, NJ, $5,000
- Region IX Education Cooperative, Ruidoso, NM, $5,000
- University of Nevada, Las Vegas, NV, $5,000
- Columbia University College of Dental Medicine, New York, NY, $5,000
- Renaissance Health Care Network, New York, NY, $5,000
- New York University, New York, NY, $5,000
- Alice Aycock Poe Center for Health Education, Raleigh, NC, $5,000
- Community Action Agency for Columbiana County, Lisbon, OH, $5,000
- Coshocton County Head Start, Coshocton, OH, $3,304
- Kent State University, Kent, OH, $4,488
- Multnomah Dental Society, Portland, OR, $1,500

- ACTION Health, Sunbury, PA, $5,000
- Westmoreland Human Opportunities, Inc., Greensburg, PA, $4,968
- North Kingstown Child Opportunity Zone (COZ), North Kingstown, RI, $5,000
- Sunbelt Human Advancement Resources, Inc., Greenville, SC, $5,000
- Youth & Family Services, Rapid City, SD, $5,000
- Coastal Area Health Education Center, La Marque, TX, $5,000
- El Paso City-County Health & Environmental District, El Paso, TX, $5,000
- United Way of Salt Lake, Salt Lake City, UT, $5,000
- Heartland Opportunities & Partnerships, Farmville, VA, $5,000
- People Incorporated of Southwest Virginia, Abingdon, VA, $5,000
- Champlain Valley Head Start, Burlington, VT, $4,795
- Early Education Services, Brattleboro, VT, $3,600
- Klickitat County Health Department, White Salmon, WA, $3,150
- Spokane County Head Start, Spokane, WA, $5,000
- Whatcom County Health Department, Bellingham, WA, $5,000
- Junior League of Eau Claire, Eau Claire, WI, $4,990
- Sheboygan County Human Rights Association, Sheboygan, WI, $4,334
- Kids on the Block, Inc., Clarksburg, WV, $1,620
- West Virginia University Extension Service, Morgantown, WV, $4,940

Give Kids A Smile Awards. The Give Kids A Smile Awards recognizes state and local dental associations that have implemented an exceptional program providing children oral health care. During 2006 the Colorado Dental Association, Denver, CO, and the Multnomah Dental Society, Milwaukie, OR, were identified as Give Kids A Smile Award recipients. The awards are made possible by a contribution from the Procter & Gamble Company.

Community Dentistry Award. The Community Dentistry Award program, known as the Community Preventive Dentistry Award prior to 2006, recognizes individuals and organizations that have created and/or implemented significant community dentistry programs. Judged by the ADA Council on Access, Prevention and Interprofessional Relations, First Place honors in 2006 of $5,000 were given to "The Ben Massell Dental Clinic of Jewish Family & Career Services," Atlanta, GA. Also, three meritorious award winners were acknowledged: "Spanish Catholic Center Dental Clinic," Washington, D.C.; "The Free Clinic's Adult Extraction Clinic," Hendersonville, NC; and "Keystone Dental Care, Inc.," Johnson City, TN. Each meritorious winner receives $2,500. 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 2006, the ADA Council on Access, Prevention and Interprofessional Relations identified "The Ohio State University Oral Health for Seniors in Appalachia" of the Ohio State University College of Dentistry, Columbus, OH, as the $2,500 award recipient. Also presented was a $500 meritorious award to the "Boston Oral Health Equity Project" of the Boston Public Health, Boston, MA. 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 2006, Dr. B. Timothy Dolby of Tumwater, WA, was named the recipient of the E. Bud Tarrson Award. Dr. Dolby donated his $2,500 award to the Olympia Union Gospel Mission Dental Clinic.

In addition to the Foundation's on-going access to care programs, the Foundation awarded two access grants as a result of the generous support of individual donors, including ADA employees.

- Free People's Clinic, Chicago, IL, $15,500
- Salvation Army Harbor Light Dental Clinic, Chicago, IL, $5,000

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 2006.

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 that 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, 28 grants awarded by the Foundation and matched by state relief funds totaled $312,116.

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. The Foundation did not receive any educational retraining loan requests in 2006.

Disaster Response Grants. The ADA Foundation provides grants of up to $2,500 to dentists who are victims of natural or man-made disasters to assist with their immediate needs, e.g., food, clothing and shelter. The Foundation also provides grants for organizations providing oral health care to victims of disasters. During 2006 in response to hurricanes, floods as well as other disasters, the Foundation provided 43 dentists $107,500 in disaster response grants and 3 organizations $88,259 to provide oral health care to disaster victims.

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, 2006. 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 2007 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, 2006, $5,398,682 was expended for sponsored purposes. The major areas of expense were federal government funded research totaling $2,082,343 and corporate and donor sponsored programs amounting to $3,316,339.

Meetings: The ADA Foundation Board of Directors met on March 1, 2006, and August 8, 2006, at the ADA Headquarters in Chicago.

Personnel: The conclusion of the 2007 ADA annual session brings to an end the tenure of Dr. Frank C. Grammer, a valued ADA Trustee and member of the Foundation's Board of Directors. The 2007 ADA annual session will also bring to an end the tenure of Dr. Orin Ellwein a member of the ADA Foundation Charitable Assistance Program Committee and member of the Foundation's Board of Directors. During the reporting period, Mr. Steven W. Kess resigned his position as Vice President of the Foundation to enable him to chair the Give Kids A Smile Advisory Board, under the auspices of the ADA Foundation. The Foundation wishes to express its gratitude and appreciation to Drs. Grammer and Ellwein and Mr. Kess for their continued leadership and contributions to the success of the Foundation. In addition, the following individuals were appointed to the ADA Foundation Board of Directors: Mr. Timothy J. Sullivan of Sullivan-Schein serving as a public member, and Dr. Russell I. Webb, serving as an ADA trustee Representative, both receiving terms of four years. The Member also appointed Mr. Michael R. Sudzina to complete Mr. Kess' term as Foundation Vice President.

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

Schumacher, Gary E., associate director, chief research scientist, clinical research
Carey, Clifton M., director, independent research and grant administration
Bowen, Rafael L., distinguished scientist
Chow, Laurence C., assistant director and chief research scientist, dental chemistry
Dickens, Sabine H., chief research scientist emeritus, polymer chemistry
Vogel, Gerald L., chief research scientist, dental cariology

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 American Dental Association's (ADA) 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. Sixteen active license agreements have resulted from technology transfer efforts that have blossomed into thirty commercially available products.

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 Association Council on Scientific Affairs. PRC scientists published or had accepted 54 peer-reviewed papers, one new United States patent, one foreign patent and presented 14 lectures of dental continuing education and invited talks to universities, academies, study clubs and other organizations. Seventeen PRC researchers presented their data at the International Association for Dental Research meeting. Abstracts of PRC research presentations and publications, as well as reprints of published articles and manuscripts presented at scientific meetings, are available from the PRC by request. Descriptions of the ongoing research projects are available 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 Strategic Plan. However, the Foundation supports the objectives put forth in the Association's *Constitution* and the Future of Dentistry Report by advancing the oral health of the public through basic and applied research and more specifically the development of improved dental materials and treatment technologies. Several examples of how PRC directly addresses objectives within the Strategic Plan are:

- Education by providing quality continuing education programs for constituent organizations. Subjects included dental materials, caries processes and caries management for the at risk dental patient, fluoride therapies and amalgam issues.
- Professionalism by communicating PRC accomplishments directly to the profession through programs, presentations and the public media. Included were press releases on new discoveries (1. resin composites that release calcium and phosphate from nano-sized fillers; 2. biocompatibility of tissue engineered scaffolds), presentations to state dental associations and local societies, and publication of a compact disc highlighting PRC accomplishments. The compact disc is available by contacting Gretchen Duppins (301-975-6806) or by written request at: Paffenbarger Research Center, NIST, 100 Bureau Drive Stop 8546, Gaithersburg, MD 20899-8546. The PRC research highlights are also accessible on-line at the ADA Web site: (www.ada.org/goto/prc), then select Publications.
- 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 media coverage of PRC projects, often supported by the National Institute of Standards and Technology (NIST) public relations office, and hosting the Dental Students' Research Conference, which was sponsored by the ADAF and industry (Johnson & Johnson).

- 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 products for the ADA Professional Product Review quarterly newsletter. PRC serves the practitioner, the patient and manufacturers through involvement in and support of the national and international standards process. PRC researchers serve as an ISO subcommittee secretary, a working group convenor and experts on working groups.

Activities

Clinical Research: Clinical studies involving human subjects are on-going to evaluate sequential calcium and fluoride applications as a means to increase the efficiency of existing fluoride products and to assess the formation of intraoral fluoride reservoirs. A clinical study on a remineralizing chewing gum and a mouth rinse based on a fluoride calcium phosphate complex has been initiated. A new NIDCR grant proposal was submitted and funded to study fracture mechanisms of brittle dental restorative dental materials with results that could lead to a correlation with clinical longevity of restorative materials and an improvement of material durability. The ADAF, NIST, Zeiss and 3M sponsored a successful course, *Dental Fractography*, to a class of international dental researchers. PRC scientist Janet Quinn and guest Dr. Susanne Scherrer, taught the course, and PRC plans to offer fractography continuing education annually because of overwhelming demand and a limited class size.

Dental Chemistry: Progress continues on PRC-developed calcium phosphate bone cements with experiments currently being conducted to address uses, such as bone repair, endodontic procedures and ridge augmentation. An apparatus to synthesize nano-sized calcium phosphate and calcium fluoride particles that was engineered and built by PRC scientists is now operational. The nano calcium phosphate particles will be used in an endodontic sealer and reinforced remineralizing. Experiments to assess the efficacy of nano calcium fluoride particles in an oral rinse have been started. Tissue engineering studies are underway to develop bone repair scaffolds that include novel methodology for cell seeding. In a collaborative study with NIH (NIEHS), calcified specimens from patients suffering from juvenile dermatomyositis will be examined by microscopic Fourier transform infrared spectroscopy to determine the composition.

Polymer Chemistry: Work continues on developing an adhesive remineralizing resin composite for the ART technique. The areas of research for this material include improved strength by reinforcement with ceramic whiskers, evaluation of the calcium phosphate filler, and variations in the resin formulation. A patent application for a remineralizing dental composite material based upon calcium phosphate nano fillers is currently under review. Several acidic monomer resin formulations have been tested for mechanical properties nondestructively using a dynamic mechanical analyzer. Studies involving development of a new adhesive resin formulation based on one of the PRC's synthesized polymerizable cyclodextrin derivatives continue. Initial bond strength tests for bonding a composite material to dentin were encouraging.

Dental Cariology: A clinical study was performed to acquire data that will help develop products that provide enhanced fluoride efficacy. That data was also used as the basis for a grant proposal to NIDCR. PRC laboratory techniques have attracted the interest of commercial manufacturers with resulting collaborative research. A new commercially available anti-caries varnish that contains both fluoride and amorphous calcium phosphate (ACP), which is a PRC licensed remineralizing technology, was launched. The use of ACP as a filler in a resin matrix is part of the on-going "smart composite" research, and the current focus is on the effect of the size of the ACP particles. A study has also begun to determine the effect of raisins on caries causing bacteria, S. mutans, in the new cell culture laboratory. This work is funded through a grant from the California Raisin Marketing Board. Additional goals for the Cariology group include development of international standards for assessing the abrasiveness of dentifrices and for assessing the erosive capacity of oral rinses. Studies to determine the amount of fluoride that is necessary to provide therapeutic efficacy are underway. These studies use a novel model for the mouth, and will begin validating the results in a clinical study.

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

ADA Foundation Research Institute

Frantsve-Hawley, Julie, director, Research Institute
Siew, Chet, senior director, ADA Laboratories

The Research Institute (RI) is a resource center supported by the ADA Foundation (ADAF) and located in the Division of Science laboratories at ADA Headquarters in Chicago. Scientists from the ADAF Research Institute conduct basic and applied research to address emerging and critical professional issues, as identified by the Council on Scientific Affairs and the ADA Research Agenda.

The Research Institute works collaboratively with scientists at the ADAF Paffenbarger Research Center (PRC), hosts research externs recommended by the American Student Dental Association, and pursues collaborative research with extramural research organizations and universities. Research Institute scientists also evaluate research proposals submitted to the ADAF in response to requests for proposals and serve as scientific liaisons to ADAF-funded programs, including the Health Screening Program, which is held each fall in conjunction with the ADA annual session.

The Strategic Plan of the American Dental Association: The ADA Foundation's Research Institute advances the *ADA Strategic Plan: 2007-2010* 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 "Create and Transfer Knowledge" goal 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 surface disinfectants and autoclaves commonly used in dental operatories and developing solutions to reduce biofilm contamination in dental unit waterlines and
- responding to public oral health issues, including research on fluoride levels in infant formulas.

The Research Institute also strives to promote its scientific findings to the research community at large. At the March 2006 International Association for Dental Research/American Association for Dental Research meeting in Orlando, Research Institute staff presented four abstracts of their recent research investigations to meeting attendees. Two oral presentations on EBD initiatives, the topical fluoride clinical recommendations and the sealant clinical recommendations, were given at the 2007 National Oral Health Conference in Denver. Also in 2006, three RI papers were published in peer-reviewed journals, including an evaluation of intensity of light-emitting diode (LED) and tungsten-halogen light sources and depth of cure of a resin composite at different distances (Dent Mater 2006;22(11):988-94). Another RI report, published in the October 2006 *JADA*, evaluated the effect of disinfectants and line cleaners on the release of mercury from amalgam (*JADA* 2006, 137(10):1419-25).

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.

Evidence-Based Dentistry

The Research Institute has successfully pursued several sources of federal grants and corporate funds to support multiple evidence based dentistry (EBD) initiatives. As described in the Council on Scientific Affairs annual report, plans are underway to enhance the ADA's role in EBD as described in the business plan. As this plan is implemented the Research Institute will continue to seek external sources of funding for EBD Projects.

EBD Web Site: In spring 2007, the ADA Division of Science received a grant from the National Library of Medicine (NLM) and the National Institute for Dental and Craniofacial Research (NIDCR) to develop an enhanced evidence-based dentistry Web site. The award was received through the ADA Foundation's Research Institute and will provide $150,000 per year for three years, totaling $450,000. Council members, consultants and staff from several divisions will all contribute to development of the Web site. The intent of this site is to provide user-friendly access to clinically-relevant scientific resources and information, leading to improved implementation of EBD in clinical practice.

Resources on the Web site will initially include a listing of systematic reviews on dental and oral health topics, with critical analyses designed to help clinicians apply the information to real-world situations. The site will also provide access to ADA-developed evidence-based clinical recommendations and links to other EBD resources.

Systematic Review: In 2006, the ADA Foundation funded four systematic reviews targeting high-priority clinical issues identified by ADA members (via survey) and by attendees of the August 2004 ADA Symposium on EBD. The ongoing work funded by these grants covers clinically relevant questions related to: the frequency of dental prophylaxis in the prevention of periodontitis; malocclusion and periodontal disease; outcomes in the treatment of pulpally pathology (including endodontics, extraction and implant or fixed partial denture placement or extraction alone; and identification of the beneficial and harmful effects of endodontic care compared to extraction and implant placement. As of spring 2007, RI staff are following up with the grant recipients to obtain their draft systematic reviews on the above topics. Upon receipt, the systematic reviews will be forwarded to the Council on Scientific Affairs for review later in 2007.

In another planned systematic review, scientific experts and representatives from the Center for Disease Control (CDC), National Institute of Dental and Craniofacial Research (NIDCR), American Academy of Pediatrics (AAP) and American Academy of Pediatric Dentistry (AAPD) met at ADA Headquarters on November 1, 2006, to develop a clinical question for systematic review on the topic of fluoride intake from infant formula. CSA member Dr. Philippe Hujoel will conduct the systematic review on this topic, targeted to be completed by the end of 2007. This systematic review will be considered by a panel of experts and stakeholders in 2008 to develop evidence-based recommendations on reconstituted infant formula.

The Council initiated activities to update the ADA's 1994 fluoride supplement recommendations through the evidence-based clinical recommendation process as noted above. A new systematic review is underway to support development of new recommendations. Questions that serve as the basis for this systematic review are:

- Does the use of fluoride supplements in children (0-16 years old) prevent dental caries?
- Does the use of fluoride supplements in children (0-16 years old) increase the risk of dental fluorosis in the absence of other identifiable causes?
- Does the use of fluoride chewable tablets in individuals older than 16 years of age prevent dental caries?

In addition, a proposal by the ADA and collaborating health care organizations to support a systematic review on the association between periodontal disease and adverse pregnancy outcomes to the Agency for Healthcare Research and Quality (AHRQ) is pending. Originally submitted in 2005, a decision on the proposal expected in fall 2007.

EBD Conferences: Plans are underway to convene an Evidence-Based Dentistry Champion Conference in 2008, 2009 and 2010 at ADA Headquarters, in collaboration with the *Journal of Evidence-Based Dental Practice* (JEBDP). Approximately 150 dentists per year will be recruited through an application process. Participants will become "EBD Champions" and will agree to share the knowledge and skills acquired with their local colleagues through at least one dissemination mechanism. A large conference grant (R13 funding mechanism) that would provide $100,000 for each year has been submitted to the AHRQ. However, corporate funding for the conference of $100,000 for each year has been secured, allowing the organizing committee to move forward with definitive plans for first conference in May 2008.

The ADA is also collaborating with *JEBDP* to convene the third International Evidence-Based Dentistry Conference in May 2008, which will explore clinical decision support evidence-based practice. Participants will include dental practitioners, educators, professional society leaders, industry and others. Corporate funding of $100,000 has been secured for the conference.

R21 Grant Application: In June 2006, the ADA Foundation submitted an exploratory grant proposal to NIDCR (R21 grant) entitled "An Interactive Online Program for the Implementation of Evidence-Based Dentistry." The goal of this proposal is to identify strategies for translating evidence-based clinical recommendations into dental practice. Dr. Amid Ismail, immediate past Council chair, is the principal investigator on the grant application. NIDCR recommended revisions to the grant proposal in November 2006. The grant was resubmitted in March 2007 under Dr. Ismail's institution, the University of Michigan and a decision is expected later this year.

Research Activities

Fluoride Content of Infant Formula: Staff scientists are investigating the fluoride content of several brands of ready-to-feed, powder, liquid concentrate infant formulas (both milk and soy based). When completed, the results of this investigation will be submitted for publication in a peer-reviewed journal. The results of this investigation will be considered by a panel of experts and stakeholders in 2008 to develop evidence-based recommendations on reconstituted infant formula.

ADAF Health Screening Program: The ADA Foundation's Health Screening Program (HSP) has significantly influenced the quality of dental care, and the manner in which it is safely and effectively provided today in the United States. Data collected at the HSP has grown to become the largest resource on the health of dental professionals of its kind in the world, and has been used by the ADA and stakeholders to identify and manage occupational risks.

The mission of the Health Screening Program (HSP) is to make the dental office safer for dental professionals and the patients they serve and to expand the scientific knowledge in areas of importance to dentists and their patients. The HSP also promotes scientific research by making the nation's largest database of aggregated information about the health of dental professionals available to scientific investigators. The overall goals of the HSP are to:

- collect, analyze and disseminate information on the health of dental professionals and the occupational health risks to dental professionals
- collaborate in basic, applied and clinical research on topics important to the dental profession
- provide a forum for assessing new technology and educating the profession about its use and
- provide a valuable health service to participants.

HSP data has been used to monitor occupational risks and has been used by both the CDC and ADA to develop numerous guidelines and policies for the profession. Key examples include:

- evaluating occupational exposure to HIV and HBV upon which HBV immunization and bloodborne pathogens recommendations were made
- determining occupational exposure to mercury upon which mercury hygiene practices and BMPs were developed and
- evaluating the incidence of latex hypersensitivity upon concern that this may be prevalent among the dental profession and concluding that the incidence of this hypersensitivity is actually low.

Revisioning the Health Screening Program. Over the years, the HSP has evolved into an increasingly complex research program with a growing number of screening stations. An example is screening for saliva biomarkers of oral cancer in collaboration with Dr. David Wong of UCLA, which was added in 2006. A more sophisticated approach to management of the HSP is needed to ensure that it continues to achieve its scientific goals and affords participants a rewarding experience.

The success of the HSP has stretched its available resources to the breaking point. In 2006, insufficient numbers of volunteers, inexperienced temporary staff and problems with contracted phlebotomy services led to breakdowns in crowd control and long lines of participants waiting to enter the HSP, especially in the mornings. Staff is currently working on a business plan that reexamines the Health Screening Program from the bottom up to create a sound research and financial foundation for the years 2008 and beyond.

Although planning for the 2007 HSP must proceed before the business plan is completed, the 2007 HSP will be used to set the stage. The plans for 2007 call for:

- *Limiting attendance to 1,500 participants, providing pre-registration for specific appointment times and opening a half hour earlier in the morning*. In order to better anticipate and manage crowds, using no more than the existing number of ADA staff, participation will be limited to 1,500 dentists and auxiliary staff. Since attendance is typically highest in the mornings, the HSP will open a half hour earlier at 7:30 each morning. Dentists will have the opportunity to pre-register for a specific date/time. Appointments will be available for the mornings, and walk-in participants, including dentists without appointments and all auxiliary staff, will be eligible to participate during the afternoons or any morning appointment time that is not filled with pre-registrants.

- *Improving phlebotomy services.* The ADAF will retain a high-quality vendor with an exceptional reputation of phlebotomy services.
- *Improving online questionnaire utilization.* All participants of the HSP must fill out a questionnaire about their general health and dental practice. In 2007, greater efforts will be made to encourage online completion of the questionnaire. This will enhance the collection and dissemination of HSP data for research purposes.
- *Continuing in 2007 the same screenings that were offered in 2006.* The 2007 HSP will focus on enhancing the experience of HSP participants and doing a bottom-up review and revisioning of the HSP for 2008 and beyond. The actual screenings will remain unchanged from 2006 to 2007 to enable staff to focus on these priorities.

Participation in the 2006 Health Screening Program. Of the 12,380 dentists registered for the 2006 ADA annual session, 12.25% (1,516 dentists) participated in the HSP. Additionally, 474 hygienists and assistants received health screenings, boosting total participation to 1,990. The average age of dentists was 52.5 years of age for males and 45.9 years of age for hygienists and chairside assistants. The HSP continues to see a greater number of women dentists, including 27.8% of all dentists in 2006.

The following basic screenings were offered to dentists and dental auxiliaries at the 2006 HSP and will be offered in 2007: blood pressure and weight; carpal tunnel syndrome screening (CTS); head and neck screening, including oral cancer screening with Oral CDx (when necessary); latex hypersensitivity; periodontal screening recording (PSR); resting electrocardiogram; C-reactive protein; comprehensive metabolic panel with differential cholesterol; hemoglobin A1c; Hepatitis B virus (HBV) serum markers; Hepatitis C virus (HCV) antibodies; *Legionella pneumophila* antibodies and urinary mercury levels. In addition, the 2006 Health Screening Program offered the following elective evaluations to dentists and dental auxiliaries at a nominal charge: C-telopeptide (osteoporosis); prostate specific antigen (PSA); thyroid stimulating hormone (TSH); and the Vertical Auto Profile (VAP) cholesterol test. Influenza vaccine was provided to the first 1,500 participants in the Health Screening Program. Due to budget restraints, this vaccine will not be offered in 2007.

ADA Foundation Sponsors Student Awards at Intel Science Fair: To stimulate interest in oral health research and recognize the work of young scientists, the ADA Foundation sponsored awards at the 2006 and 2007 Intel International Science and Engineering Fairs (ISEF) held in Indianapolis and Albuquerque, New Mexico (respectively).

In 2006, the $1,000 award, for best project with relevance to dental research, was presented to Justin (a senior) and Christine Johns (a junior) for their project entitled, "Xylitol Xtreme Two: A Time Sequencing Study Assessing the Inhibitory Effect of Pentahydroxypentane (Xylitol) on the Bacterial Growth Curve of *Strep. mutans*." Their study examined the time frame at which xylitol can maximally inhibit *S. mutans.*

In 2007, ADAF increased sponsorship to three awards ($2,000 for 1st place, $1,000 for second place and $500 for third place). First prize went to sophomore Yale Stern Michaels for his project entitled, "Probing for Cancer with Smart shRNA." Michaels developed a novel RNA probe designed to detect expression of the SV40 large tumor antigen, a viral oncogene. Second prize went to the team of Fei Chen (a senior) and William Decker Neiswanger (a junior) for their project entitled, "Increased Precision, Versatility and Control in Laser-based Surgeries through the Intersection of Superimposed Varied Frequency Lasers." They created a novel laser beam with controllable periods of constructive and destructive interference. Third prize went to junior Heng Jiao for his project entitled, "A Novel Cyclodipeptide with a Significant Anti-tumor Activity from a Marine *Bacillus*." Jiao isolated a cyclodipeptide from marine *bacillus* that proved to induce apoptosis in tumor cells *in vitro* and *in vivo*.

Held each May, the Intel ISEF is the world's largest pre-college celebration of science, bringing together more than 1,200 high school students from 40 countries. Organizations representing a wide variety of scientific disciplines affiliate with the Intel ISEF as Special Awards Organizations. Special Awards sponsorship is open to: corporations; scientific, mathematical, and engineering societies; agencies of the Federal government; and colleges and universities. Visit http://www.sciserv.org./isef/about/ for more information on Intel ISEF.

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

Notes

ADA Business Enterprises, Inc.

Notes

ADA Business Enterprises, Inc.

Wholly-Owned Subsidiary Annual Report and Financial Affairs

Webb, James, chair (outside director)
Kalebjian, Dennis, vice chair (at large member dentist)
Bramson, James B., secretary (ADA executive director)
Zimmermann, William T., chief executive officer
McInerney, Erin, treasurer (outside director)
Bruce, Steven M. (at large member dentist)
Cadle, Jr., Donald I. (ADA trustee)
Calnon, William R. (ADA trustee)
Feldman, Mark J. (ADA president-elect)
Hanks, Thomas (outside director)
Roth, Kathleen (ADA president)
Williams, Edward J. (outside director)

Introduction: The American Dental Association is the sole shareholder of the Association's wholly owned subsidiary, ADA Business Enterprises, Inc. (ADABEI). This annual report outlines the business and financial affairs of ADABEI and *ADA Member Advantage* program for 2006 and early 2007.

ADA Member Advantage Program: ADABEI's endorsed products and services are branded under the program "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 royalty revenue to support the ADA's non-dues revenue stream.

Focus: The Company's focus for 2006 was as follows:

1. Complete a new product development initiative to support future growth of the company.
2. Add new customers and retain existing customers.
3. Manage the existing product lines to maximize member benefits and revenues.
4. Grow brand awareness of *ADA Member Advantage* through marketing efforts.

Products: The current *ADA Member Advantage* program includes 20 products/services, including services for the members' practice as well as for use outside their practice. The program includes products such as several financing options including a credit card with Citibank, patient financing with CareCredit, practice financing with Matsco, and credit card processing with Chase-Paymentech, as well as hotel discounts with Starwood, apparel with Lands'End, and health savings accounts with First Horizon. The fee recovery/collection program was eliminated due to lack of member interest. A shipping program with DHL was added to the program in early 2007.

Marketing: Members are able to find out about the *ADA Member Advantage* program through integrated marketing and communication including 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
- Logging on to www.adamemberadvantage.com.

State Endorsements: Currently 49 state dental societies endorse one or more products in the *ADA Member Advantage* program and the majority average ten endorsements each. Over $750,000 in royalties is shared annually with state dental societies, the majority of which is contributed by the Credit Card and Electronic Claims Transactions.

ADA Member Advantage Financials: Both ADA and ADABEI receive income from the *ADA Member Advantage* program. ADA licenses its name and member list to endorsed providers in exchange for a royalty fee, and ADABEI receives a service fee for providing marketing services to the endorsed providers.

The total program generated $6,556,000 of revenue in 2006, representing growth of 2.1% over the 2005 level of $6,418,000. The increase in revenue was due to increased utilization of products, particularly patient financing and practice financing, as well as interest on investments. The ADA received approximately 60% of this revenue stream, with the remainder directed to ADABEI. The first quarter of 2007 shows total program revenue of $1,982,000, approximately 0.3% ahead of planned revenue for the period. Early indicators are that full-year program revenue will meet or slightly exceed the 2007 revenue budget of $7,264,000.

For 2006, ADABEI reported net income of $5,000 compared to $369,000 in 2005. The decrease between years is mainly due to the unbudgeted expenses associated with the New Products Growth Initiative outlined below. This unbudgeted funding was approved by the ADABEI Board of Directors.

As in prior years, a $60,000 contribution was made to the ADA Foundation.

The Endorsement Model: For a number of reasons, including the global consolidation of various businesses and the emergence of the Internet, affinity endorsement relationships have become less valuable. In ADABEI's case, overall revenue growth has become much harder to achieve, due mainly to the plateauing of the Citibank Credit Card program. For this reason ADABEI invested in a disciplined new product development initiative in early 2006. There were two primary goals of this initiative: 1) Identify new products and services with significant growth potential, and 2) Seek opportunities to diversify from the endorsement model by obtaining equity ownership.

New Products Growth Initiative: In 2006, ADABEI undertook a major new products growth initiative to determine potential areas of growth for the company. Members' needs were assessed via market research and internal and external interviews; new product concepts were then developed based upon such research and tested with dentists through electronic surveys. Members expressed interest in the ADA providing resources for a variety of services including help with insurance claims, marketing services, practice management consulting and telecommunications. Business cases were then developed for those concepts in which members indicated strong interest, and they were presented to the ADABEI Board of Directors. Three scenarios were evaluated in the business case: buy a company, build the capability internally, or endorse a company. The ADABEI Board of Directors gave top priority to the marketing services growth opportunity, and subsequently approved pursuing a joint-venture or buy scenario. A request for proposal was developed and sent to numerous marketing service companies. The key criteria for selecting a company included: 1) the company needed to be focused in the dental marketplace, 2) have a full suite of marketing services, and 3) be interested in a joint-venture with the ADA. After thorough due diligence and successful negotiations, a joint venture was established in February 2007 with Intelligent Dental Marketing. In exchange for a $600,000 capital contribution, ADABEI obtained a 50% ownership in the new company called ADA Intelligent Dental Marketing L.L.C.

ADA Intelligent Dental Marketing: ADA Intelligent Dental Marketing, an Illinois limited liability company with its main office located in Salt Lake City, Utah, provides a comprehensive offering of effective and affordable marketing products and services to help dentists attract and retain patients. The product categories offered include:

- *Branding/Identity* – Including the dental practice name, logo and identity material such as a Web site, letterhead, business cards, etc.
- *External Marketing* – Including advertising to create awareness of the dental practice and direct mail, flyers and print advertising to increase patient flow.
- *Internal Marketing* – Reinforcing the dental practice brand to existing patients is critical. Items such as message on-hold, e-mail marketing, a referral brochure, patient rewards, and personalized wall art all support and promote the dental practice brand.
- *Case Presentation* – This four-step patient education system helps the dentist and his staff standardize their communication, improve case acceptance, and increase practice profitability. Treatment Pro offers a reception area DVD, Operatory DVD, a comprehensive laminated-paged treatment plan binder, and Internet-based treatment proposals customized for each patient.

Over the next year, ADABEI staff will be focused on assimilating the two companies, enhancing products and services, developing and implementing an integrated communications plan to create marketplace awareness, and growing the new company's business.

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

ADA Audit

Notes

Association Finances: A Joint Letter from the Treasurer and the Executive Director

Introduction

We are pleased to present this report to the membership summarizing the Association's financial position as of December 31, 2006. This report highlights the significant financial events that occurred during the year, provides an overview of the consolidated audit, analyzes the Association'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 2006 budget approved by the House of Delegates.

The Association again produced very strong financial performance in 2006. Consolidated total assets increased $14.7 million to $187.2 million. Consolidated revenues increased $7.7 million or 6.7% to $121.6 million in 2006. The 2006 operating deficit of the ADA itself was ($664,902), approximately $1.2 million less than the budgeted deficit of nearly ($1.9 million). The transfer of this deficit from reserves was far exceeded by robust investment returns which brought year-end 2006 reserves to 47.9% of budgeted 2007 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 2006 financial statements. Those audit reports follow this introductory letter.

ADA and Subsidiary Operations

The comments that follow relate to the audit reports of the Association and its subsidiaries.

General Overview of Financial Statements: The financial statements reflect revenues and expenses separated into natural account categories. Certain reports also include disclosure of expenses in functional classifications.

In addition to the basic consolidated statements of financial position, activities, and cash flows, the 2006 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
- ADA Business Enterprises, Inc.
- American Dental Real Estate Corporation (merged into ADA January 1, 2006)
- ADA Foundation
- American Dental Political Action Committee

Consolidated Association Statement of Financial Position: The Association's equity position on a consolidated basis increased $10.8 million in 2006.

Consolidated, December 31:	2006	2005
Total Assets	$187,219,704	172,514,264
Total Liabilities	(36,744,389)	(32,852,592)
Total Net Assets	$150,475,315	139,661,672

The net increase of $14.7 million in total assets is primarily attributable to a $12.7 million increase in marketable securities. The increase in marketable securities is attributable to strong investment performance and the transfer of the ADA's 2005 operating surplus of $1.3 million to reserves, partially offset by headquarters building renovation spending and other capital expenditures.

Liabilities increased because of higher accounts payable and accrued liabilities, which is primarily due to differences in the timing of payments between years.

Consolidated Association Revenues and Expenses:

Consolidated:	2006	2005
Total Revenues	$121,598,604	113,932,174
Total Expenses	(109,803,632)	(104,819,674)
Income Taxes	(981,329)	(1,480,658)
Net Income	10,813,643	7,631,842
Decrease in Minimum Pension Liability	—	3,476,568
Increase in Net Assets	$ 10,813,643	11,108,410

Total revenues increased approximately $7.7 million in 2006. Investment income rose almost $5 million due to stronger returns coupled with higher asset levels. Meeting and seminar income increased by $1.2 million due primarily to the 2006 annual session venue of Las Vegas compared to the 2005 Philadelphia location, which impacted exhibit sales, registration fees and ticket sales.

New additions of both Current Dental Terminology Manual and *ADA Guide to Dental Therapeutics* in late 2006 and more *JADA* supplements resulted in a $1.5 million increase in publication and product sales. Higher revenues were also generated in testing fees, royalties and rental income.

On the other hand, advertising revenue declined approximately $910,000 due to a lower advertising page count in *ADA News* and *JADA*.

Expenses rose almost $5 million with several categories exhibiting increases. Professional services increased $2 million; meeting expenses, and printing, publication, marketing costs both increased approximately $600,000. Salaries expense rose $2 million due to merit increases and new staff in the ADA Foundation.

Income taxes decreased $500,000 mainly as a result of the decline in advertising revenues in the ADA's publications.

A decrease in the minimum pension liability impacted net assets in 2005. The ADA recorded this liability at the end of 2002, initially valued at $7.3 million. 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 was strictly an accounting calculation which has no funding requirement, and thus no effect upon the Association's cash and reserve assets. The Minimum Pension Liability was reduced $3.1 million in 2003, approximately $700,000 in 2004 and finally $3.5 million in 2005, to a current value of zero, as a direct result of the investment returns achieved by the pension plan during those years.

Reserve Investments: The reserve division of the Association is segregated into two categories: Capital Formation, which holds long-term investments that are not easily liquidated, such as ADABEI; and the Reserve Investment

Account, which is primarily comprised of investments in mutual funds. During 2006, the American Dental Real Estate Corporation (ADREC) that housed the Washington D.C. office building was merged into the ADA and is no longer reflected in the Capital Formation account.

Following is a recap of year-end balances for the five-year period ended December 31, 2006. 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	Reserve Investment Account	Capital Formation		Total Reserve Accounts
2002	$16,042,160	17,146,755		33,188,915
2003	34,931,542	13,299,532		48,231,074
2004	43,994,473	13,280,807		57,275,280
2005	51,077,406	13,557,175		64,634,581
2006	58,382,631	4,448,648	*	62,831,279

*ADREC, formerly included as an investment here, was merged into the ADA in 2006. The net book value of the ADA Washington D.C. building continues to be reflected on the balance sheet in Property and Equipment.

Capital Improvement Account: During 2006 $854,706 was expended on the tenant floors of the Headquarters Building through the Capital Improvement Program. This activity is supported by a previously collected membership dues increase of $55 effective from 1993 to 1996.

Through December 31, 2006, improvements with the following costs, net of depreciation, have been completed:

Asbestos Abatement	$ 6,179,519
Remodeling	16,440,848
Total Capital Expenditures	22,620,367
Less Accumulated Depreciation	12,850,322
Net Expenditures	$ 9,770,045

Unspent monies collected for this activity are maintained in a separate short-term investment account to generate interest earnings. At December 31, 2006, the Capital Improvement investment account had a balance of $2,163,580. These monies are being utilized to convert certain space currently used by the ADA into tenant space and to support the renovation of the building lobby.

ADA Renovation Program: The 2000 House of Delegates approved a plan for renovation and asbestos abatement of Association occupied space in the Headquarters Building. To help fund this initiative, a six-year $30 dues assessment for Association members was enacted, effective from 2001 to 2006. Additionally, $2.5 million and $1.5 million were transferred from the Capital Improvement Account and the Building Fund, respectively.

Also $1 million of budgeted funds were transferred annually to the Renovation Program from the Operating Account beginning in 2004, when the Building Fund was eliminated. 2006 was the last year of such funding.

Through December 31, 2006, improvements with the following costs, net of depreciation, have been completed:

Asbestos Abatement	$ 3,213,756
Remodeling	24,687,358
Total Capital Expenditures	27,901,114
Less Accumulated Depreciation	5,897,273
Net Expenditures	$22,003,841

Unspent monies collected for this activity are maintained in a separate short-term investment account to generate interest earnings. At December 31, 2006, the Renovation Program Account held $1,518,312 in short-term investment funds. This project is now in the final stages of completion. In addition to finishing the remodeling of ADA floors, remaining monies are supporting the renovation of the building lobby.

Subsidiary Operations: In 2006 ADABEI realized net income of $4,867 compared to $369,044 in 2005. The decrease between years is primarily due to expenses incurred in researching and developing new product growth initiatives.

American Dental Real Estate Corporation (ADREC) was merged into the ADA effective January 1, 2006.

In 2006, the American Dental Association Foundation (ADAF) generated net income of $2,598,812 compared to $827,658 in 2005. The primary change between years is higher investment returns in 2006. In addition, grant expenses were higher in 2005 due to the hurricane and tsunami disasters.

The American Dental Political Action Committee (ADPAC) realized net income of $70,234 in 2006 versus $161,183 in 2005, primarily due to a higher level of spending on candidate support leading up to the fall 2006 elections.

ADA General Fund Operating Account

The 2006 budget projected a net deficit of ($1,867,018) while actual results yielded a net deficit of ($664,902). This represents a favorable variance of approximately $1.2 million to budget.

The deficit amount 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 2006 financial statements	$ 560,931	
Additions to net income:		
Net capital expenditures	700,621	(1)
Reserve funding	942,165	(2)
Deductions from net income:		
Renovation Program funding	(1,000,000)	(3)
Pension adjustment to restate expense per accounting rules to contribution amount	(1,868,619)	(4)
Net Deficit	$ (664,902)	

Notes:

(1) 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.

(2) The Board approved reserve funding for certain activities that were initially spent from the operating account. Such reserve funding does not reduce expenses in the audited financial statements.

(3) The transfers 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 Vs. Budget: The 2006 operating deficit of ($664,902) was $1,202,116 better than the budgeted deficit.

Revenue	2006 Actual	2006 Budget	Variance Favorable/ (Unfavorable)
Membership Dues Revenue	$47,387,798	48,294,250	(906,452)
All Other Revenue	53,303,436	53,805,500	(502,064)
Total Revenue	100,691,234	102,099,750	(1,408,516)
Operating Expenses	100,085,702	102,683,368	2,597,666
Net Operating Results Before Taxes	605,532	(583,618)	1,189,150
Income Tax Expense	(971,055)	(1,540,000)	568,945
Net Operating Results After Taxes	(365,523)	(2,123,618)	1,758,095
Cash Items			
Capital Expenditures	(3,364,970)	(2,967,600)	(397,370)
Depreciation (add back)	4,065,591	4,224,200	(158,609)
Net Capital Expenditures	700,621	1,256,600	(555,979)
Renovation Program Funding	(1,000,000)	(1,000,000)	—
Net ADA Operations	$(664,902)	(1,867,018)	1,202,116

The following key items contributed to the higher than budgeted net operating results:

	Variance Favorable/ (Unfavorable)	
Membership Dues Revenue	$ (906,452)	
Testing Fees and Accreditation Revenue	779,817	
Investment Earnings	641,184	
Salaries and Temporary Help	497,762	(1)
Income Taxes	568,945	
Direct Reimbursement Program Expenses	423,688	
Science Division, net margin	361,409	
Travel	341,077	(1)
Indirect Cost Recovery on Government Grants	283,156	
Info Technology and Standards Division consulting fees	256,270	
Information Technology Telephone Usage and Watts Line	218,214	
Publishing Division net margin	(999,405)	(2)
Salable Materials Division, net margin, including royalties	(1,057,424)	
All other variances, net	(206,125)	
Total Improvements in net operating results	$ 1,202,116	

(1) Net of budgeted savings.

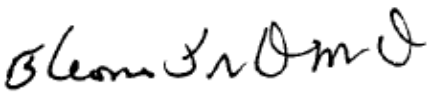
(2) These amounts are net of compensation and travel variances.

Conclusion

The ADA had another very successful year in 2006. Although operations generated a net deficit, results were significantly favorable to the budgeted deficit. Additionally, the Association 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 the public. And all of this was achieved without a dues increase.

Strong reserves are one aspect of the Association's financial strategy. Additionally, the Association strives to achieve real growth in non-dues revenue. With a firm foundation of reserves and non-dues revenue, the long-term goal is to maintain annual dues increases within inflationary levels.

The Association's finances will be discussed at the Reference Committee on the Budget, Business and Administrative Matters scheduled for the annual meeting in San Francisco. Any questions can be addressed at that meeting, or we can be contacted directly and would be happy to respond to any concerns.



Edward Leone, Jr., D.M.D.
Treasurer

James B. Bramson, D.D.S.
Executive Director

American Dental Association
Supplemental Financial Information

Year Ended December 31, 2006 (Unaudited)

	2006 ACTUAL	2006 BUDGET
NATURAL ACCOUNTS		
REVENUES		
Membership Dues	$ 47,387,798	48,294,250
Advertising	6,741,551	8,263,350
Rental Income	4,642,697	4,690,890
Publication and Product Sales	8,190,546	9,410,800
Testing and Accreditation Fees	10,012,917	9,233,100
Meeting and Seminar Income	9,359,735	9,791,650
Grants, Contributions and Sponsorships	2,151,143	1,907,500
Royalties	5,913,842	5,419,900
Investment Income	1,761,183	1,120,000
Other Income	4,529,822	3,968,310
TOTAL REVENUES	100,691,234	102,099,750
EXPENSES (Note A, B)		
Staff Compensation	47,195,075	47,236,600
Printing, Publication and Marketing	13,129,194	13,831,350
Meeting Expenses	3,092,967	3,020,050
Travel Expenses	5,693,124	6,034,200
Professional Services	11,320,957	11,751,330
Office Expenses	4,749,908	5,418,468
Facility and Utility Expenses	4,377,216	4,262,170
Grants and Awards	341,304	398,800
Grant to ADA Foundation	3,202,523	3,334,050
Royalty Expenses	763,479	790,800
Depreciation and Amortization	4,065,591	4,224,200
Bank & Credit Card Fees	718,711	847,600
Other Expenses	1,435,653	1,533,750
TOTAL EXPENSES	100,085,702	102,683,368
NET REVENUE/(EXPENSE) BEFORE INCOME TAXES	605,532	(583,618)
Income Tax Expense	(971,055)	(1,540,000)
NET REVENUE/(EXPENSE) AFTER INCOME TAXES	(365,523)	(2,123,618)
CASH FLOW ITEMS		
Capital Expenditures	(3,364,970)	(2,967,600)
Depreciation	4,065,591	4,224,200
Net capital expenditures	700,621	1,256,600
Renovation Program Funding	(1,000,000)	(1,000,000)
NET SURPLUS (DEFICIT)	$ (664,902)	(1,867,018)

Notes:

(A) The contingency fund is included by natural accounts based on the activities approved by the Board.

(B) Expenses do not include activities funded by reserves approved by the Board.

Divisional Summary Worksheets

Division of Administrative Services

NATURAL ACCOUNTS	2006 ACTUAL	2006 BUDGET
REVENUES		
Meeting and Seminar Income	$ 21,000	25,400
Grants, Contributions and Sponsorships	30,000	30,000
TOTAL REVENUES	51,000	55,400
EXPENSES		
Staff Compensation	3,321,041	3,368,550
Printing, Publication and Marketing	206,977	221,600
Meeting Expenses	118,718	126,650
Travel Expenses	1,311,806	1,300,500
Professional Services	1,384,013	1,342,600
Office Expenses	623,125	645,300
Facility and Utility Expenses	576	-
Grants and Awards	7,050	9,200
Bank & Credit Card Fees	249	200
Other Expenses	354,799	513,100
TOTAL EXPENSES	7,328,354	7,527,700
NET REVENUE/(EXPENSE)	$ (7,277,354)	(7,472,300)

Division of Legal Affairs

NATURAL ACCOUNTS	2006 ACTUAL	2006 BUDGET
REVENUES		
Publication and Product Sales	$ 720	1,300
Other Income	65,403	35,700
TOTAL REVENUES	66,123	37,000
EXPENSES		
Staff Compensation	1,509,818	1,601,000
Printing, Publication and Marketing	3,431	7,500
Meeting Expenses	448	2,400
Travel Expenses	60,557	80,700
Professional Services	661,202	628,900
Office Expenses	40,816	46,800
Facility and Utility Expenses	168	-
TOTAL EXPENSES	2,276,440	2,367,300
NET REVENUE/(EXPENSE)	$ (2,210,317)	(2,330,300)

Division of Government Affairs

NATURAL ACCOUNTS	2006 ACTUAL	2006 BUDGET
REVENUES		
Meeting and Seminar Income	$ 24,650	17,200
TOTAL REVENUES	24,650	17,200
EXPENSES		
Staff Compensation	1,881,191	2,258,750
Printing, Publication and Marketing	24,738	34,550
Meeting Expenses	125,004	146,000
Travel Expenses	688,965	766,200
Professional Services	253,597	242,380
Office Expenses	217,998	268,450
Facility and Utility Expenses	4,688	7,920
Grants and Awards	28,326	78,600
Bank & Credit Card Fees	466	500
TOTAL EXPENSES	3,224,973	3,803,350
NET REVENUE/(EXPENSE)	$ (3,200,323)	(3,786,150)

Division of Communications and Corporate Relations

NATURAL ACCOUNTS	2006 ACTUAL	2006 BUDGET
REVENUES		
Meeting and Seminar Income	$ 1,730	7,200
Grants, Contributions and Sponsorships	212,696	75,000
Royalties	16	-
TOTAL REVENUES	214,442	82,200
EXPENSES		
Staff Compensation	1,973,015	2,036,300
Printing, Publication and Marketing	1,054,745	1,100,500
Meeting Expenses	163,963	213,200
Travel Expenses	154,092	166,650
Professional Services	332,178	214,700
Office Expenses	97,347	136,800
Facility and Utility Expenses	78	-
TOTAL EXPENSES	3,775,418	3,868,150
NET REVENUE/(EXPENSE)	$ (3,560,976)	(3,785,950)

Division of Membership and Dental Society Services

NATURAL ACCOUNTS	2006 ACTUAL	2006 BUDGET
REVENUES		
Advertising	$ 72,000	65,000
Meeting and Seminar Income	101,015	172,900
Grants, Contributions and Sponsorships	319,007	373,700
Royalties	-	250
TOTAL REVENUES	492,022	611,850
EXPENSES		
Staff Compensation	3,179,936	3,326,600
Printing, Publication and Marketing	606,063	681,600
Meeting Expenses	127,134	146,600
Travel Expenses	406,962	531,550
Professional Services	399,046	487,650
Office Expenses	239,322	245,750
Facility and Utility Expenses	1,151	-
Bank & Credit Card Fees	1,956	1,000
Other Expenses	2,394	-
TOTAL EXPENSES	4,963,964	5,420,750
NET REVENUE/(EXPENSE)	$ (4,471,942)	(4,808,900)

Division of Conference and Meeting Services

NATURAL ACCOUNTS	2006 ACTUAL	2006 BUDGET
REVENUES		
Advertising	$ 232,475	409,250
Rental Income	153,178	62,500
Publication and Product Sales	-	34,000
Meeting and Seminar Income	8,562,404	8,630,250
Grants, Contributions and Sponsorships	980,000	895,000
Royalties	174,652	110,000
Other Income	147,842	152,950
TOTAL REVENUES	10,250,551	10,293,950
EXPENSES		
Staff Compensation	1,690,496	1,673,400
Printing, Publication and Marketing	916,311	885,450
Meeting Expenses	2,421,962	2,242,850
Travel Expenses	544,858	565,050
Professional Services	1,716,032	1,598,900
Office Expenses	602,242	703,100
Facility and Utility Expenses	96,185	52,800
Royalty Expenses	5,000	5,000
Bank & Credit Card Fees	133,662	129,400
Other Expenses	15,693	2,000
TOTAL EXPENSES	8,142,441	7,857,950
NET REVENUE/(EXPENSE)	$ 2,108,110	2,436,000

Headquarters Building

NATURAL ACCOUNTS	2006 ACTUAL	2006 BUDGET
REVENUES		
Rental Income	$ 3,061,760	3,210,600
Other Income	7,737	14,700
TOTAL REVENUES	3,069,497	3,225,300
EXPENSES		
Staff Compensation	267,524	263,950
Printing, Publication and Marketing	44,783	27,600
Professional Services	140,369	133,600
Office Expenses	62,726	62,650
Facility and Utility Expenses	3,567,858	3,496,500
Bank & Credit Card Fees	3,038	-
Other Expenses	75,693	72,000
TOTAL EXPENSES	4,161,991	4,056,300
NET REVENUE/(EXPENSE)	$ (1,092,494)	(831,000)

Washington DC Building

NATURAL ACCOUNTS	2006 ACTUAL	2006 BUDGET
REVENUES		
Rental Income	$ 1,427,759	1,417,790
Other Income	2,189	2,160
TOTAL REVENUES	1,429,948	1,419,950
EXPENSES		
Travel Expenses	-	2,500
Professional Services	36,830	38,900
Office Expenses	5,712	6,000
Facility and Utility Expenses	677,688	675,950
Bank & Credit Card Fees	644	1,100
Other Expenses	12,210	16,500
TOTAL EXPENSES	733,084	740,950
NET REVENUE/(EXPENSE)	$ 696,864	679,000

Division of Finance and Operations

NATURAL ACCOUNTS	2006 ACTUAL	2006 BUDGET
REVENUES		
Publication and Product Sales	$ 64,656	54,100
Royalties	510,874	520,900
Investment Income	1,761,183	1,120,000
Other Income	846,828	887,500
TOTAL REVENUES	3,183,541	2,582,500
EXPENSES		
Staff Compensation	2,767,956	2,911,800
Printing, Publication and Marketing	39,859	27,700
Meeting Expenses	20	-
Travel Expenses	54,400	69,150
Professional Services	365,486	451,500
Office Expenses	83,756	83,650
Facility and Utility Expenses	171	-
Bank and Credit Card Fees	1,246	700
Other Expenses	228,914	231,300
TOTAL EXPENSES	3,541,808	3,775,800
NET REVENUE/(EXPENSE)	$ (358,267)	(1,193,300)

Salable Materials

NATURAL ACCOUNTS	2006 ACTUAL	2006 BUDGET
REVENUES		
Publication and Product Sales	$ 6,854,183	8,134,000
Grants, Contributions, Sponsorship	70,560	-
Royalties	1,129,794	800,000
TOTAL REVENUES	8,054,537	8,934,000
EXPENSES		
Staff Compensation	548,292	558,900
Printing, Publication and Marketing	3,283,547	2,895,450
Meeting Expenses	30,821	35,900
Travel Expenses	29,684	21,050
Professional Services	408,732	545,000
Office Expenses	61,853	45,100
Facility and Utility Expenses	497	-
Bank & Credit Card Fees	118,484	179,000
Other Expenses	24,478	50,000
TOTAL EXPENSES	4,506,388	4,330,400
NET REVENUE/(EXPENSE)	$ 3,548,149	4,603,600

Central Administration (Without Contingency Fund)

NATURAL ACCOUNTS	2006 ACTUAL	2006 BUDGET
REVENUES		
Membership Dues	$47,387,798	48,294,250
Royalties	3,971,566	3,881,150
Other Income	2,767,590	2,278,600
TOTAL REVENUES	54,126,954	54,454,000
EXPENSES		
Staff Compensation	14,187,478	12,170,950
Printing, Publication and Marketing	241	-
Travel Expenses	-	(250,000)
Professional Services	46,547	38,250
Office Expenses	81,268	46,400
Facility and Utility Expenses	14,106	10,000
Grants and Awards	205,000	205,000
Grant to the ADA Foundation	3,202,523	3,334,050
Royalty Expenses	758,479	785,800
Depreciation and Amortization	4,065,591	4,224,200
Bank & Credit Card Fees	296,940	438,100
Other Expenses	445,885	416,950
TOTAL EXPENSES	23,304,058	21,419,700
Income Taxes Expenses	971,055	1,540,000
NET REVENUE/(EXPENSE)	$29,851,841	31,494,300

Contingency Fund

NATURAL ACCOUNTS	2006 ACTUAL	2006 BUDGET
EXPENSES		
Printing, Publication and Marketing	$ 61,965	135,100
Meeting Expenses	7,674	2,900
Travel Expenses	135,568	307,350
Professional Services	402,042	405,500
Office Expenses	10,050	16,500
Grants and Awards	25,000	25,000
Other Expenses	123,408	155,700
TOTAL EXPENSES	765,707	1,048,050
NET REVENUE/(EXPENSE)	$ (765,707)	(1,048,050)

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	2006 ACTUAL	2006 BUDGET
REVENUES		
Publications and Product Sales	$ 11,736	11,200
Royalties	3,514	600
Other Income	23,403	43,700
TOTAL REVENUES	38,653	55,500
EXPENSES		
Staff Compensation	3,345,831	3,643,100
Printing, Publication and Marketing	2,144	5,700
Meeting Expenses	8,037	13,100
Travel Expenses	164,478	151,700
Professional Expenses	803,023	1,069,200
Office Expenses	1,408,820	1,720,700
Bank & Credit Card Fees	9	400
TOTAL EXPENSES	5,732,342	6,603,900
NET REVENUE/(EXPENSE)	$ (5,693,689)	(6,548,400)

Division of Dental Practice

NATURAL ACCOUNTS	2006 ACTUAL	2006 BUDGET
REVENUES		
Publication and Product Sales	$ 2,161	5,500
Meeting and Seminar Income	471,846	791,700
Grants, Contributions and Sponsorships	488,480	497,800
Other Income	9,143	8,000
TOTAL REVENUES	971,630	1,303,000
EXPENSES		
Staff Compensation	2,632,097	2,816,000
Printing, Publication and Marketing	1,520,144	2,069,050
Meeting Expenses	32,724	42,150
Travel Expenses	497,129	659,000
Professional Services	478,788	678,000
Office Expenses	178,283	139,300
Facility and Utility Expenses	1,520	1,300
Bank & Credit Card Fees	434	1,500
Other Expenses	24,040	20,200
TOTAL EXPENSES	5,365,159	6,426,500
NET REVENUE/(EXPENSE)	$ (4,393,529)	(5,123,500)

Health Policy Resources Center

NATURAL ACCOUNTS	2006 ACTUAL	2006 BUDGET
REVENUES		
Publication and Product Sales	$ 270,879	307,000
TOTAL REVENUES	270,879	307,000
EXPENSES		
Staff Compensation	1,217,214	1,280,200
Printing, Publication and Marketing	28,901	28,700
Meeting Expenses	1,280	6,500
Travel Expenses	77,323	140,300
Professional Services	527,744	635,850
Office Expenses	154,409	133,550
Facility and Utility Expenses	536	-
Bank & Credit Card Fees	2,210	4,900
Other Expenses	147	-
TOTAL EXPENSES	2,009,764	2,230,000
NET REVENUE/(EXPENSE)	$(1,738,885)	(1,923,000)

Division of Education

NATURAL ACCOUNTS	2006 ACTUAL	2006 BUDGET
REVENUES		
Publication and Product Sales	$ 542	-
Testing and Accreditation Fees	10,012,917	9,233,100
Meeting and Seminar Income	177,090	147,000
Other Income	96,267	102,500
TOTAL REVENUES	10,286,816	9,482,600
EXPENSES		
Staff Compensation	3,993,582	4,264,700
Printing, Publication and Marketing	284,151	338,100
Meeting Expenses	21,212	14,850
Travel Expenses	1,386,766	1,244,300
Professional Services	2,931,705	2,863,350
Office Expenses	387,069	381,418
Facility and Utility Expenses	3,632	2,600
Grants and Awards	75,928	81,000
Bank & Credit Card Fees	139,354	78,200
Other Expenses	13,134	-
TOTAL EXPENSES	9,236,533	9,268,518
NET REVENUE/(EXPENSE)	$ 1,050,283	214,082

Division of Science

NATURAL ACCOUNTS	2006 ACTUAL	2006 BUDGET
REVENUES		
Publication and Product Sales	$ 22,589	-
Grants, Contributions and Sponsorships	50,400	36,000
Other Income	554,052	434,000
TOTAL REVENUES	627,041	470,000
EXPENSES		
Staff Compensation	2,758,361	3,132,900
Printing, Publication and Marketing	206,343	206,100
Meeting Expenses	20,836	15,100
Travel Expenses	148,125	213,550
Professional Services	228,881	182,800
Office Expenses	305,592	565,100
Facility and Utility Expenses	1,526	
Bank & Credit Card Fees	196	-
Other Expenses	1,359	-
TOTAL EXPENSES	3,671,219	4,315,550
NET REVENUE/(EXPENSE)	$ (3,044,178)	(3,845,550)

Division of ADA Publishing

NATURAL ACCOUNTS	2006 ACTUAL	2006 BUDGET
REVENUES		
Advertising	$ 6,437,076	7,789,100
Publication and Product Sales	963,080	863,700
Royalties	123,426	107,000
Other Income	9,368	8,500
TOTAL REVENUES	7,532,950	8,768,300
EXPENSES		
Staff Compensation	1,921,243	1,929,500
Printing, Publication and Marketing	4,844,851	5,166,650
Meeting Expenses	13,134	11,850
Travel Expenses	32,411	64,650
Professional Services	204,742	194,250
Office Expenses	189,520	171,900
Facility and Utility Expenses	6,836	15,100
Bank & Credit Card Fees	19,823	12,600
Other Expenses	113,499	56,000
TOTAL EXPENSES	7,346,059	7,622,500
NET REVENUE/(EXPENSE)	$ 186,891	1,145,800

2006 Contingency Fund

Board-Approved Allocations Compared with Actual

	Actual Expenses Net	Board Approved Allocations
Administrative Services		
Enhanced February and April 2006 Board Meetings	$ 13,596	20,200
National Healthcare Information Infrastructure	7,830	15,100
Tecker Implementation Planning	178,324	160,300
Search for AED Government Affairs	45,290	78,250
Summer Medical and Dental Education Program	25,000	25,000
Refining and Testing Clinical Vocabulary	30,079	30,000
On-going Environmental Scanning	25,000	28,400
ADA Council Member Lapel Pins	2,957	2,850
Celebrate 150 Task Force Meeting	1,314	4,500
Legal Affairs		
Collaborative ACD-ADA Ethics Summit on Commercialism	6,031	6,800
Annual Session Event Cancellation Insurance	79,971	79,700
Government Affairs		
Enhancing ADA's Advocacy Efforts through Effective Communications	39,845	64,500
Communications and Corporate Relations		
Advocacy Public Relations	133,683	127,000
Dental Practice		
Combined Meetings of EDSAC and DWAC	5,695	11,200
American Indian/Alaska Native Oral Health Access Summit	17,766	70,350
Market Research of On-Line Continuing Education	15,000	15,000
American/Indian Alaska Native Clinic Volunteer Support	21,362	104,500
Fluoride Commemorative Request for Support	25,000	25,000
Health Policy Resources Center		
Access to Care Issues & Economically Depressed Area Practices	34,846	33,200
The Economic Impact of Dental Therapists	4,010	32,850
2006 Technology Survey	32,878	45,850
Publishing		
ADA News Increase in Pages	20,230	67,500
Total Expense Allocation for 2006 Contingency Fund	$ 765,707	1,048,050

Appendix

Notes

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Res. 1	*Reports:* 41	**Council on Dental Education and Licensure** Definition of Curriculum Integrated Format
Res. 2	*Reports:* 42	**Council on Dental Education and Licensure** Approval of the Guidelines for the Use of Sedation and General Anesthesia by Dentists and the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students
Res. 3	*Reports:* 42	**Council on Dental Education and Licensure** Approval of the Policy Statement: The Use of Sedation and General Anesthesia by Dentists
Res. 4	*Reports:* 44	**Council on Dental Education and Licensure** Rescission of Policy "Dentists Right to Administer Conscious Sedation, Deep Sedation and General Anesthesia"
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Res. 8	*Reports:* 98	**Council on Ethics, Bylaws and Judicial Affairs** Amendment of the ADA Bylaws—Editorial Language Regarding References to "Two-thirds Vote"
Res. 9	*Reports:* 120	**Council on Members Insurance and Retirement Programs** Amendment of the ADA *Bylaws* Regarding the Duties of the Council on Members Insurance and Retirement Programs

Notes